SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	17 January 2020
Overview of key issues/areas covered at the meeting:	The committee was attended by both the Chair and the Chief Executive. This meeting first considered several ***Management Responses*** (*responses to previous items scrutinised by the committee)*, including: **Safeguarding Training Assured** In November 2019, the Trust Board asked the committee to consider its concern from the IPR about the relatively low completion of safeguarding training. A good paper was received which assured the committee that the 85% training target would be met by March 2020 (progress had been made since the November Board meeting). The committee was equally assured by the awareness of staff demonstrated by the positive level of safeguarding referrals. **Communication with CFRs Partially Assured** This related specifically to how urgent messages are communicated to CFRs. The committee was told that while management can be clear about messages being sent, there is currently no mechanism to ensure these are received, read, and understood. Two solutions are being explored to address this, informed by meeting held recently with South Central Ambulance Service, about how they support CFRs. **SI Actions Not Assured** As confirmed in November, the committee was concerned by the timeliness with which SI actions are closed, and so asked for a further management response to confirm progress. While it acknowledged the focus this is being given, it remains not assured. The committee therefore will continue to monitor this at each meeting until sustained improvement is made. **EPCR Assured** The committee received a good quality paper, which helped to demonstrate not just that this project has been a success, but why it has succeeded. This includes the way in which management ensured good staff engagement from the very outset and throughout. The project is in the continuous improvement stage; tweaking the system to help ensure it works more intuitively. The committee suggested there be a 'Board story' on the impact of EPCR and will receive an update at its meeting in May, about the percentage of staff using it. **Quality Impact Assessments (QIA) Assured** The committee is now assured about the QIA process having received evidence about the good awareness among staff regarding the need for a QIA, and about changes that were not approved due to the assessed adverse impact. The committee asked the executive to review how decisions are communicated and

	noted the approach to ensuring consistency with QIAs, with the Trust's supply chain partners. **EOC Audit Partially Assured** There is some increased capacity with non-clinical audit, and the Trust is now very close to compliance with NHS Pathways. However, audit of clinicians continues to be an issue due to clinical auditors being more difficult to recruit. There is much focus in this area to ensure a consistent approach to the audits and how these are fed-back to staff. The business case approved by the Board last year has still to be fully delivered, due to some HR-related issues scheduled to be resolved by March. Overall the committee felt assured by the approach to ensuring audit compliance, but remains concerned by the current gaps. It has asked for a further update in March. The meeting also considered several ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **Key Skills Partially Assured** In November the committee received a paper quantifying the risk by OU, of delivering all Key Skills. This meeting focussed on the approach for 2020/21, and the need to 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. The committee welcomed the different approach for next year, whereby abstraction will be spread over 38 weeks. It also felt that the process is robust for agreeing what is included and acknowledged that there is positive feedback regarding the quality of training. In terms of this year, it is likely that some Key Skills will falls in to Q1 of 2020/21; up to 15%. However, the committee agreed with management that the probability is high that a DCA would have at least one member who has completed Key Skills. The committee will confirm in March the latest completion numbers. **Clinical Supervision Not Assured** A paper was received that set out an approach to clinical supervision, but it did not really provide assurance about the extent to which it is being carried out. The committee also felt that there needs further thought about what is needed, acknowledging that clinical supervision is not a well-established within ambulance services. This is an area that will likely be a focus within the Trust's Quality Account for next year, and the committee reinforced the need to explore the different models and guard against confusing clinical supervision with appraisal/1:1s. Although the committee is not yet assured, this is in the context of clinical supervision

	being new to ambulance services and is relatively low risk. A further paper will be considered later in the year. **EOC Clinical Safety Partial Assurance** The focus this meeting was on the impact of clinicians within the EOC. The committee noted that while the Trust is getting closer to its target establishment of 43 clinical supervisors (current at 34), this is not translating into the hours being provided; quite often the EOC is running with less than 50%. The committee will seek to get a deeper level of assurance in March, when it will review more specifically the role of clinicians and how they manage patients waiting for a response. **Clinical Outcomes – Cardiac Arrest Assured** The committee has a focus at each meeting on clinical outcomes and at this meeting the focus was cardiac arrest. The committee noted that the Trust benchmarks positively against the national average and received information about the steps being taken to further improve the management of patients in cardiac arrest. The committee is assured by the comprehensive approach being taken, supported by this being a quality priority for the past two years. The committee also received reports under its section on *Monitoring Performance*, including: **Vehicle Cleanliness – follow up** While the committee noted that the deep cleans are not being undertaken in line with the agreed schedule, the evidence (random swab testing) is demonstrating that the vehicles are clean in the context of infection prevention and control. The committee therefore wondered whether the cleaning schedule is too onerous, which management is exploring. **Safeguarding - Mid-Year Review** Safeguarding referrals continue to increase (by 18%), which helps to demonstrate good awareness and effectiveness of training. There is a 77% increase in referrals relating to domestic abuse, which is consistent in other parts of healthcare.
Any other matters the Committee wishes to escalate to the Board	**Serious Incident Thematic Review** Following a report earlier in the year, the committee explored the link between spikes in activity and SIs. It was surprised from the evidence provided that there is in fact no correlation identified between periods of surge / activity / handover delays. **Volunteer Strategy** There was a good discussion about the draft community resilience (volunteer) strategy. The committee provide feedback on different aspects of the strategy, including the need to guard against considering community resilience about just CFRs, but instead to demonstrate how the Trust is the architect of urgent and emergency care, engaging in placed based care / population health. This needs to link to the new Trust strategy and so will be reviewed in the light of this and come to the Board via

	the committee in March. Finally, overall the meeting was very constructive, supported by good quality papers.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	23rd January 2020
Overview of issues/areas covered at the meeting:	Attendance by staff was good and papers of a good standard. The meeting was quorate with AR on the phone. The meeting opened with two presentations from managers leading their area's response to the staff survey. WWC is assured that the systems in place for responding to the staff survey are effective and are embedding change. The work of the Gatwick OU was particularly impressive in how all staff are being engaged in improvement. The meeting considered several ***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** We continued the scrutiny of the HR transformation programme and a useful summary of progress was provided. This programme covers a number of areas of activity and the view of WWC for each is as below: <u>HR Staffing – senior appointments</u> **Assured** Although HR still requires a small number of senior posts to be held by staff on fixed term contracts, WWC was assured that it now has the senior capacity necessary to continue to drive the essential change in the organisation and to provide high quality support to divisional teams. <u>Electronic Staff Records</u> **Assured** Progress towards a successful implementation is on target for completion as per project plan. <u>Personnel Files</u> **Partially Assured** Progress has not met the highly aspirational targets set for it by senior staff, but WWC had earlier identified that it thought these were not achievable and reported the same to the Main Board. Senior staff are confident that this programme will become business as usual for the next financial year and this was considered satisfactory by WWC. However, it was assured that where there was significant risk, these aspects would be prioritised. <u>E-Expenses</u> **Partially Assured** On track for successful implementation. However, driving license compliance was not satisfactory and is a key component of this system working satisfactorily for all staff. WWC was clear that failure of staff to produce either valid insurance documents or driving license was considered very serious, the latter being a contractual obligation. Again, there

	was confidence from managers that these issues would be resolved by the end of the financial year. Nonetheless, **WWC felt that this pace was not satisfactory** and would be expecting both insurance and license issues to resolved as soon as possible. AuC has this as an action but WWC would be keen to see it resolved early, and not to an end of financial year deadline. Culture Mandate **Partially Assured** Progress in this area has not been as rapid as we would have wished. However, progress on many of the systems that have been seen to be part of this mandate including appraisal development, management fundamentals, (the new training programme for managers) and a new mediation scheme have been developed to plan and would be expected to have a very positive impact. It may be that the Board would wish WWC to take a greater role in governance and oversight of this work so that developments in terms of how the organisation behaves is captured as well as the quantitative indicators linked to the mandate. **Friend and Family Test Plan Assured** WWC heard of the plans to develop the friends and family test and supported the direction of travel. **Staff Survey Assured** Linked with the programme of presentations, WWC was assured that a sound process was in place to analyse and disseminate the findings of the staff survey and was confident that actions planned would support managers and their staff in addressing areas seen as weaknesses in the Trust. **Clinical Education Partially Assured** WWC continues to get good information from managers about the necessary transformation in Clinical Education. We had received confidential overview of the findings of the Future Quals report which is yet to be released into the public domain. WWC was keen to be assured that those involved in teaching and related activities moving forward would hold, or be expected to gain, appropriate qualifications. We remained disappointed at the quantity of marking outstanding but could see progress. Strong links with external providers are being developed and we can only benefit from the increasing professionalisation of clinical education. However, there is clearly much left to do and strong executive leadership remains necessary. **Safe Staffing Dashboard Not Assured** WWC continues to expect a safe staffing dashboard but is also conscious that the workforce plan must be updated reflecting two years of data from the implementation of the Ambulance Response programme. Should the workforce profile change, it would seem pointless developing a dashboard based on a defunct operating model. WWC expects that sufficient flexibility is built into projections to allow abstraction of staff for essential programmes of professional development including appraisals and mandatory training. However, WWC was clear that a great deal of good work was underway and that the

	organisation probably had the best grip on data for this area that it has ever had. It was felt that there was still a great deal of work to be done internally to agree a revised operating model compliant with both our contractual obligations and the realities presenting themselves now we are working to the ARP. WWC would hope to see a new workforce plan with associated dashboards at its March meeting. **Support to Staff Assured** Unusually, WWC took a late paper under AOB to provide a degree of assurance to how we support staff who might experience issues of mental health. The paper detailed the support available and addressed issues of broader media interest in the particular challenges to ambulance staff. Whilst accepting the Trust could never fully address all needs there is a very significant range of support available that are well advertised to staff.
Reports *not* received as per the annual work plan and action required	None. The pre-agenda meeting continues to work effectively to ensure required Reports are developed in a timely manner, and that those do not meet the expectations of WWC are redrafted 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.
Any other matters the Committee wishes to escalate to the Board	Board will want to note that WWC passed a formal vote of thanks for the work of Paul Renshaw, the outgoing Interim Director of HR, and noted the good progress made not just in operational HR matters since his joining us but also in the reputational improvement of HR.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	16 January 2020
Overview of key issues/areas covered at the meeting:	This meeting focussed on the following areas: **Operational Performance Partially Assured** Overall, given the review including the Christmas and New Year period, performance was relatively stable. The committee explored in some detail the strong link between resource and performance and noted how the Trust compares nationally, which helps to set into context the pressures across the system. Call answer performance has been exceptional and in the reporting period, SECamb's performance is the best across all ambulance services in England. The committee recognises the efforts of all the staff involved in achieving this. It also asked for a paper next time to set out how we have made such significant improvement. The issue of resilience was discussed, and the committee acknowledged the fragility, in particular with regards abstraction. The deputy director of operations attended the meeting and, on this point, outlined the approach to 2020/21, whereby Key Skills (key aspect of abstraction) will be delivered over 38 weeks. A paper on this was due to be considered by QPS committee – see separate escalation report. The committee also explored the variance across the region and was assured by the focus and planning in place to ensure this is managed and there is efficient use of available resources. Sickness levels continues to be a concern and the committee has asked this to be specifically considered by the Workforce and Wellbeing Committee, especially the trend over the last six months in front-line operations. Finally, the committee reinforced that while its level of assurance needs to be informed by past performance, going forward greater focus will be placed on the expected resilience over the next 3 months. Overall, while the committee acknowledges that there is good management focus and grip, it can only be partially assured given the current position and levels of resilience expected over the next few months. **111/CAS Mobilisation Partially Assured** The committee considered where the Trust was against the mobilisation plan and the summary is that there are currently two main risks. Firstly, there is a delay with the telephony supplier; an interim solution has been agreed internally and the Trust is working with the relevant stakeholders to out this plan in place. Secondly, as the Board has been made aware previously, there is a continues risk relating to e-prescribing. There is increasing hope that the supplier can obtain accreditation sooner than initially expected, but in the meantime an interim solution is being worked through with IC24.

	At its meeting in March, the QPS Committee will be reviewing the quality and safety aspects of the mobilisation and, specifically, these two interim solutions. **Financial Performance 2019/20 Assured** The Trust is on track at month 8 to deliver against plan. The underlying position is broadly the same as last month and the income risk remains, subject to the conclusion of the discussions with commissioners; the income risk is circa £2m. The priority for the committee will be to test the extent to which the operating model delivers efficiency and is sustainable. It will explore this is greater detail at the next meeting. Subject to the outcome of the discussions with commissioners, the committee is assured that the Trust will deliver the year end forecast. There was also a review of the initial planning assumptions for 2020/21. The committee will consider next time in the context of the budget, how best to allocate resources to deliver operational (ARP) performance. **Outline Business Cases** The committee was really pleased to consider two outline business cases for the Medway and Banstead MRCs. Both are recommended to the Board for approval. Aligned to our estate strategy, this is a really positive step forward and helps to demonstrate the Board's commitment to meeting the needs of staff in delivering the best possible care to patients.
Any other matters the Committee wishes to escalate to the Board	The committee supported the plan to refresh the assumptions in the **demand and capacity review**, which will inform the plan and expected performance trajectory for next year. The committee was expecting to receive the **fleet strategy implementation plan** but instead received a position statement. There was a wide-ranging discussion about this, which resulted in an action to set up a workshop, to include NEDs. This will aim to clearly define a plan that sets out how we achieve the fleet profile needed for the future. Finally, in reflection of the meeting itself, the committee will work to ensure the papers received strike the right balance between detail and strategic overview.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	94-19

Name of meeting	Trust Board
Date	30 January 2020
Name of paper	Hospital Handover Programme
Responsible Executive	Joe Garcia, Executive Director of Operations
Author	Gillian Wieck, Programme Director, Handovers
Synopsis	This update was requested by the Board, to set out the hospital handover system wide learning programme, which is led by SECamb.
Recommendations, decisions or actions sought	For information.

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/**~~**No**

Ambulance Handover Delay Programme Update – December 2019

Background

1.1 Ambulance handovers are a patient safety issue. Many delays are a symptom of system wide pressures. Delays are often indicative of a mismatch between demand and capacity, and poor patient flow across the system. They increase during winter when there is an increased demand for urgent and emergency care.

1.2 Whilst it is acknowledged that delays are often a system wide issue, Implementing and embedding good practice, and streamlining processes at individual hospital sites contributes significantly towards reducing handover delays.

1.3 In line with national policy, on arrival at hospital, the target turnaround time for a crew to handover a patient and to be available to respond to the next incident is 30 minutes. This is broken up into two sections;

- 15 minutes for the hospital to book in their patient, receive the patient handover and transfer the patient onto hospital furniture

- 15 Minutes for the ambulance crew to complete any outstanding documentation, re-commission their vehicle and press clear on their Mobile Data Terminal

1.4 There are often hospital handover delays across the sites where SECAmb transport patients to, and significant delays at specific hospital sites. Some patients are experiencing delays of up to and over 60 minutes. This has a direct impact on both patient safety and experience, and adversely affects SECAmb's ability to respond appropriately to 999 calls in the community.

Hospital Handover Programme

2.1 A programme of work began in December 2017 with an overall aim of reducing hours lost due to handover delays at all 18 sites (12 acute hospital trusts) across Kent, Surrey and Sussex.

2.2 For the year 2019/20 all hospitals were required (as part of their operating plan) to submit trajectories to eliminate all hospital handover delays >30 minutes.

2.3 It should be noted that 6 acute trusts within SECAmb's region, are included in the national hospital handover programme where progress is reported monthly. The hospitals are Brighton and Sussex University Hospitals NHS Trust, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust,

Dartford and Gravesham NHS trust, East Kent University Hospitals NHS Foundation Trust and Surrey and Sussex Healthcare NHS Trust.

Ambulance Handover Programme - Governance Structure

3.1 The programme was originally set up to run for 6 months - from December 2017 to May 2018 but has since been extended.

3.2 The programme is led by a dedicated Programme Director for Ambulance Handover Delays: Gillian Wieck (seconded in from Sussex Community NHS Foundation Trust).

3.3 An Ambulance Handover Task and Finish Steering Group is in place and is Chaired by an Acute Trust CEO - Suzanne Rankin (Ashford and St Peters NHS Foundation Trust), representatives from NHSI and NHSE, SECAmb, CCG's and an ambulance lead from ECIST Jerry Penn Ashman are members. Its purpose is to drive the improvement work required to reduce hours lost as a result of handover delays. It reports into the SECAmb System Assurance Meeting as well as SECAmb's Quality and Patient Safety Group.

3.4 East and West Operational Groups were in place from January 2018 – June 2018. Both were chaired by an Acute Trust Chief Operating Officer - Angela Stevenson from Surrey and Sussex Healthcare NHS Trust and Joe Chadwick-Bell from East Sussex Healthcare NHS Trust. Members included senior leaders from Acute Trusts, SECAmb and CCGs. The groups were established to deliver the improvement work required to reduce hours lost as a result of handover delays across the East and West areas of SECAmb's region and they reported into the steering group

What has happened so far?

4.1 Work has been undertaken at nearly all individual hospital sites and most hospitals have been supported by Jerry Penn-Ashman who is the Steering Group ECIST Ambulance Advisor. Jerry has undertaken diagnostic visits and also provided site- based advice. A number of hospitals have established joint operational working groups with SECAmb, focused on reducing delays. Some of the groups are supported by the local CCG leads and some groups are directly facilitated by them. The operational meetings have been key to building relationships and establishing local ownership.

4.2 NHSI / Emergency Care Intensive Support Team (ECIST) have been working with several sites to improve overall ED flow and wider hospital flow. Liaison with ECIST local teams has been helpful in supporting the work on ambulance handover delays, ensuring the approach is consistent and is seen as part of the wider hospital / whole system flow.

4.3 The handover programme has concentrated on streamlining processes and embedding best practice to improve handover times, and also to improve general flow within EDs.

4.4 Peer reviews were undertaken at some of the most challenged sites in 2018; Darent Valley, Medway, Royal Sussex County Hospital and St Peters. The chairs of the East and West operational groups led a small group that reviewed action plans and did a walk-through of the EDs. This promoted open conversation and feedback where Trusts could share their learning, offers support and the opportunity to understand more about each other's EDs and challenges. The Trusts that received peer reviews found them helpful.

What evidence-based practice and processes have helped in reducing handover delays?

Dedicated handover nurse:

Dedicated administrative support

Front door streaming

Direct access to non-ED areas including ambulatory care/MAU and SAU etc

The use of early warning triggers and associated actions to avoid queues forming and dealing with surges in demand.

Fit2Sit

5.1 The use of Fit2Sit, at many of the sites, is either in place or implementation is planned. Most sites are streaming patients out of the ED into the waiting room if they are Fit2Sit and do not require majors care. Some sites are operating Fit2Sit within majors directly (Also known as Sub-wait/enhanced Fit2Sit/seated majors). The benefit to having this in place is that capacity within ED can be increased as one trolley can be replaced with 4+ chairs.

5.2 The Fit2sit areas in majors are for patients where it is expected treatment can start <1 hour and the patient discharged within 4 hours. By treating patients who are deemed Fit2Sit in these areas, the ED's are improving patient flow through the department and can reduce handover delays by creating more capacity within the ED.

5.3 Direct access for Crews to Same Day Emergency and Ambulatory Care units, Medical and Surgical Assessment Units and other non-ED destinations has been valuable to EDs as it helps stream patients away reducing congestion. Not all EDs are supportive of this approach however, and some EDs want every patient to be handed over in ED and not taken directly to non-ED destinations. This often leads to congestion and consequently handover delays frequently occur.

5.4 Where direct access is in place, it is generally GP/Medically expected patients, who are taken direct to non -ED areas. There are sometimes challenges relating to where these departments are located in the hospital, if they are not near ED, and there can be issues when these departments are full, and crews are redirected to ED.

5.5 Direct access to UTCs and direct access to minors also has a positive impact on handover delays. Crews are confident to take patients to the UTC based on accepted criteria, again meaning that streaming away from ED can occur and reduce congestion.

5.6 A dedicated handover Nurse with dedicated administrative support, and a Rapid Assessment and Triage (RAT) area, has been shown to support reduction in handover delays. By having staff dedicated to receiving the ambulance handovers, crews can identify quickly who they need to hand over to and dedicated bays mean staff know where the handover will be taking place.

5.7 Early warning triggers with associated actions are important at times of surge, when queues start to form and when Exit Block in ED occurs This can involve senior clinicians reviewing queues (deploying a mobile RAT) using a cohort nurse or implementation of a full hospital protocol.

What has made the difference in being able to make and sustain improvements

6.1 Senior Leadership Oversight and Support has been key. Executive Boards (at individual organisations) and also A&E Delivery Boards' understanding of the importance of addressing ambulance handover delays has been vital. It has facilitated traction within individual EDs, hospitals and the wider health and social care systems. It has enabled and empowered staff individually and collectively to place focus on handover delays and work on improvements. It has been extremely supportive when Boards have included handover delays within their overall performance framework.

6.2 Close operational working between SECAmb and hospital staff has been another key enabler Front line SECAmb, ED staff and system partners building relationships and creating/embedding improvements together, has also been a key to driving improvement. Having the right people round the table in the operational group has led to a shared understanding of the problem and appreciation of the challenges different system partners have

6.3 Having front line operational teams working together has meant that they are able to make process changes and be on hand to embed them and challenge if they are not being consistently followed. Hospital sites where improvements have been made are usually ones with good operational relationships

6.4 Focusing on handover delays as a patient safety issue is essential. Highlighting the reason why it is important to reduce delays needs to be emphasised. Sharing individual patient stories of the impact delays have had on them personally has been really powerful. Sharing also the impact delays have on ambulance crews and staff within the Emergency Operation Centres (EOCs) has also been important. Recognising the need to address the risk for patients waiting in the community has been key in facilitating improvements.

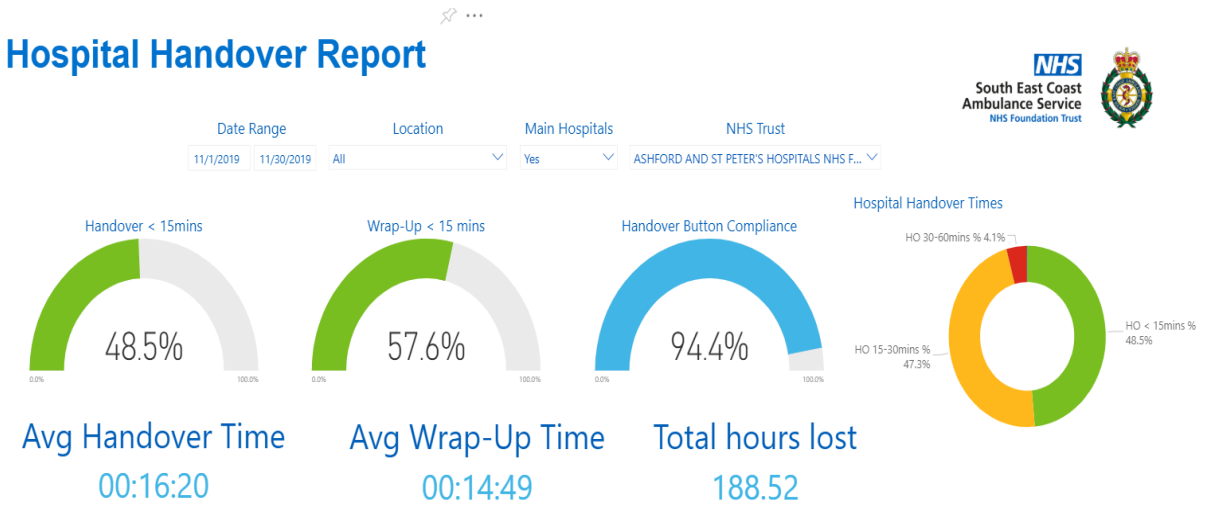
Improved Performance Reporting

7.1 An automated report is sent out daily which reports on the previous days' handover delays performance across Kent Surrey and Sussex

7.2 Monthly detailed reports are provided to all the individual hospitals and OUs, with granular detail on handover and crew to clear performance at individual sites

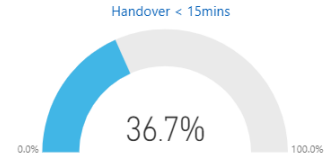
7.3 An overall monthly performance report covering all 18 sites within Kent Surrey and Sussex is also produced and circulated to hospitals, CCGS and NHSE/I.

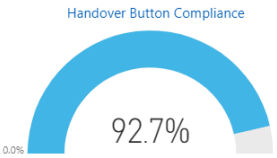
7.4 To improve further access to performance data, SECAmb have produced a suite of reports/dashboards via a dedicated hospitals power bi app that provides both retrospective and live data. Hospitals, SECAmb and CCGs can all access the app.

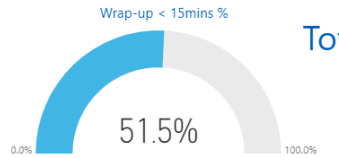


Hospital Handover Report

NHS South East Coast Ambulance Service NHS Foundation Trust

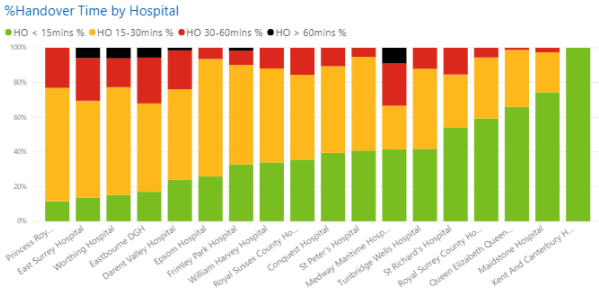


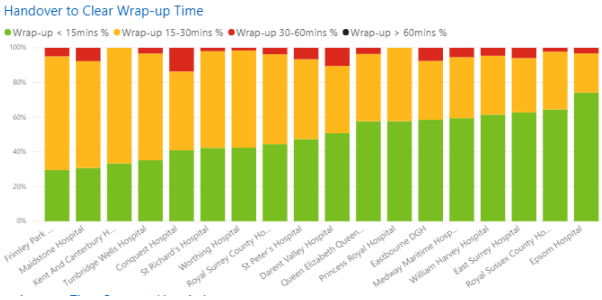


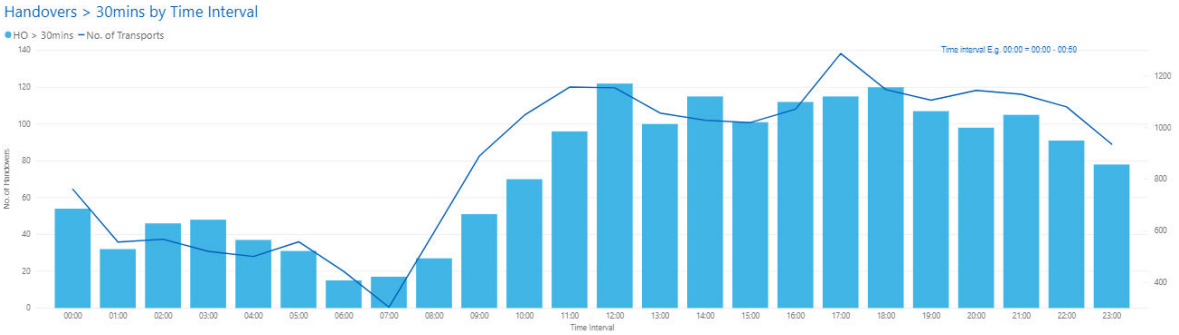


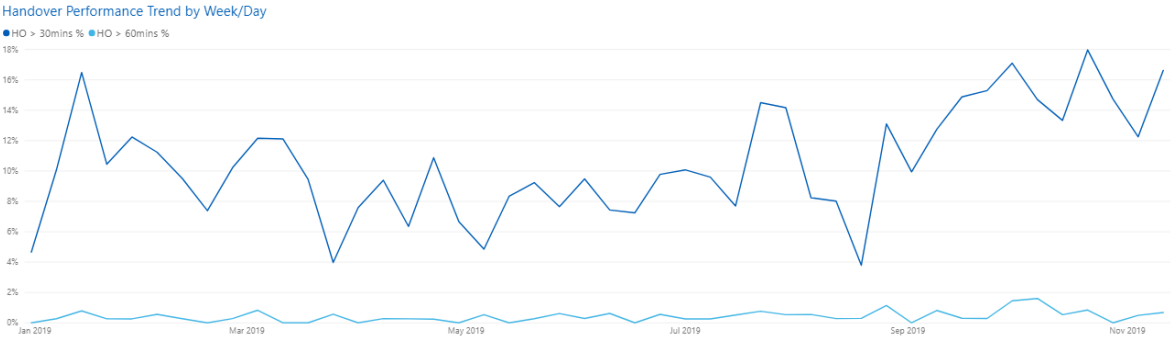
Total hours lost

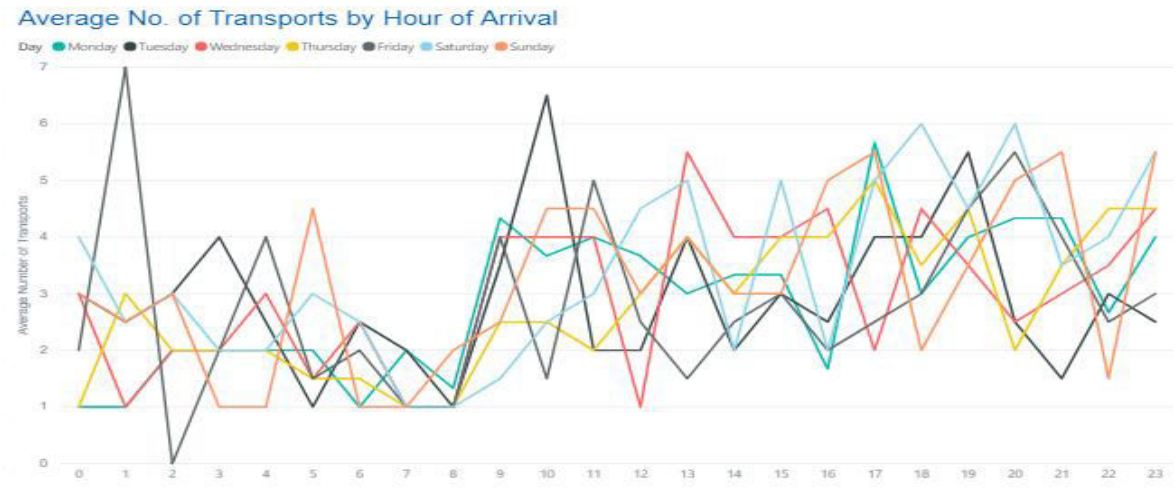
186.50











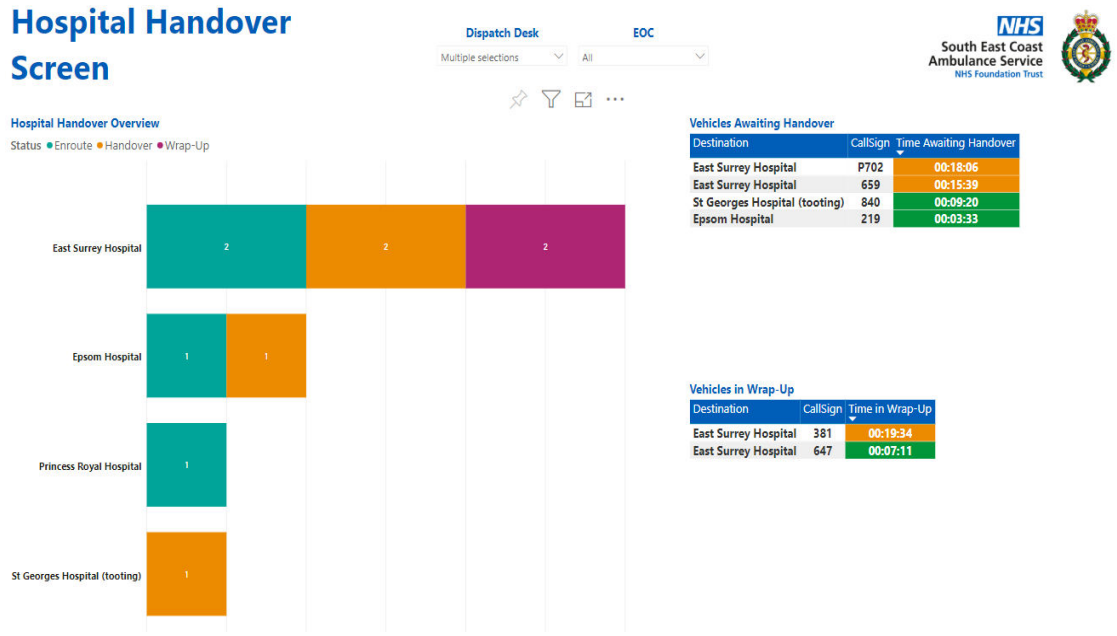
7.5 The retrospective data allows hospitals to see patterns and trends of delays as well as patterns and trends in timings of ambulance arrivals.

7.6 The app also provides access to data about crew to clear times and supports SECAmb team leaders in identifying any barriers to crews clearing within 15 minutes.

7.7 The live hospital handover dashboard supports Hospitals, EOC and operational team leaders, in managing handover and crew to clear times at individual hospital sites. It shows ambulances on their way in, ambulances at hospitals currently waiting to handover, and crews at hospital post-handover, in the "wrap up" stage.

7.8 Some hospitals have chosen to have the live handover dashboard permanently displayed in their Operational control rooms as part of their overall monitoring of ED performance

7.9 The SMP live dashboard enables hospitals to see the unmet need in the community and be aware of when SECAmb is under pressure.



Joint Live Conveyance Reviews

8.1 To ensure crews are optimising all community pathways available before conveyance is considered, live joint reviews of conveyances have been undertaken at several sites. They include St Peters, East Surrey, Queen Elizabeth Queen Mother Hospital, Eastbourne Hospital, Darent Valley, Tunbridge Wells and St Richards. Further reviews will be undertaken in January 2020 at Medway and Conquest Hospital.

8.2 The reviews have provided a live, real time insight into the reasons that crews convey. The review teams are usually made up of SECAmb clinicians and clinicians from local community services, primary care, and also clinicians from ED. The reviews have highlighted any barriers that crews have experienced in accessing community pathways that have meant a patient had to be conveyed to hospital unnecessarily.

8.3 Of the reviews undertaken, the results show that crews are attempting to access available pathways where appropriate, with strong evidence of crews often liaising with other services /clinicians and making collaborative decisions before conveying.

8.4 Lessons learnt and any recommendations that are made following the live conveyance reviews are presented at local A&E delivery boards to progress.

8.5 The reviews have developed over time and are now undertaken over 4 days within 1 week covering 4 slots of 4 hours. This ensures that the reviews cover peak times, as well as, in hours and out of hours.

8.6 The reviews also look at opportunities for front door streaming rather than all ambulance arrivals being managed through EDs. The aim is to identify opportunities to establish /increase direct access to non-ED destinations e.g. same day ambulatory care, MAU, SAU, UTC etc.

8.7 The review includes where the initial call originated i.e. 999, 111 or HCP and includes numbers of patients that are Fit2Sit. Information relating to patient outcomes e.g. admission, referral from ED to onsite non-ED services e.g. ambulatory care, frailty units is also collected. If the patient was discharged information is also collected about any follow ups e.g. with community services or primary care etc

ePCR and Service Finder roll out

9.1 The introduction and roll out within SECAmb of ePCR, NHS number matching, and the introduction of a Clinical Frailty Score will support future ongoing work to reduce handover delays by further enabling streamlining of processes and improving access to the right care pathways.

9.2 The introduction and roll out of Service Finder from the 25th November gives crews easy access to the Directory of Services from their iPad so that they can view in one place all local available community pathways.

9.3 Community pathways include for example UTCs, community fast response services and community nursing services. This facility supports crews in their ability to access available l community pathways however it is reliant on providers and CCGs ensuring that the DOS is profiled accurately.

What are the challenges?

10.1 Operational pressures, especially leading into the winter period mean it can be difficult to stick to process and maintain focus on handover delays. It can also lead to difficulty continuing local operational meetings which support relationship building and act as a forum for resolving any issues and to avoid potential conflict.

10.2 Logistics within some Trusts are a high impact issue. Many sites have limited space for Fit2Sit. ED layouts may not support the best physical flow of handovers and patients through the department. Ambulatory or Assessment units may not be co-located, which leads to delays in transporting patients to these areas, particularly if the patient needs to come back to ED due to lack of capacity at non-ED destinations.

10.3 Hospitals struggle to manage peaks in demand when there is a “surge “of ambulance arrivals. Exit block from ED is often a problem and some hospitals do not have the full support of the wider hospital when ED is at capacity despite the use of a Full Hospital Protocol.

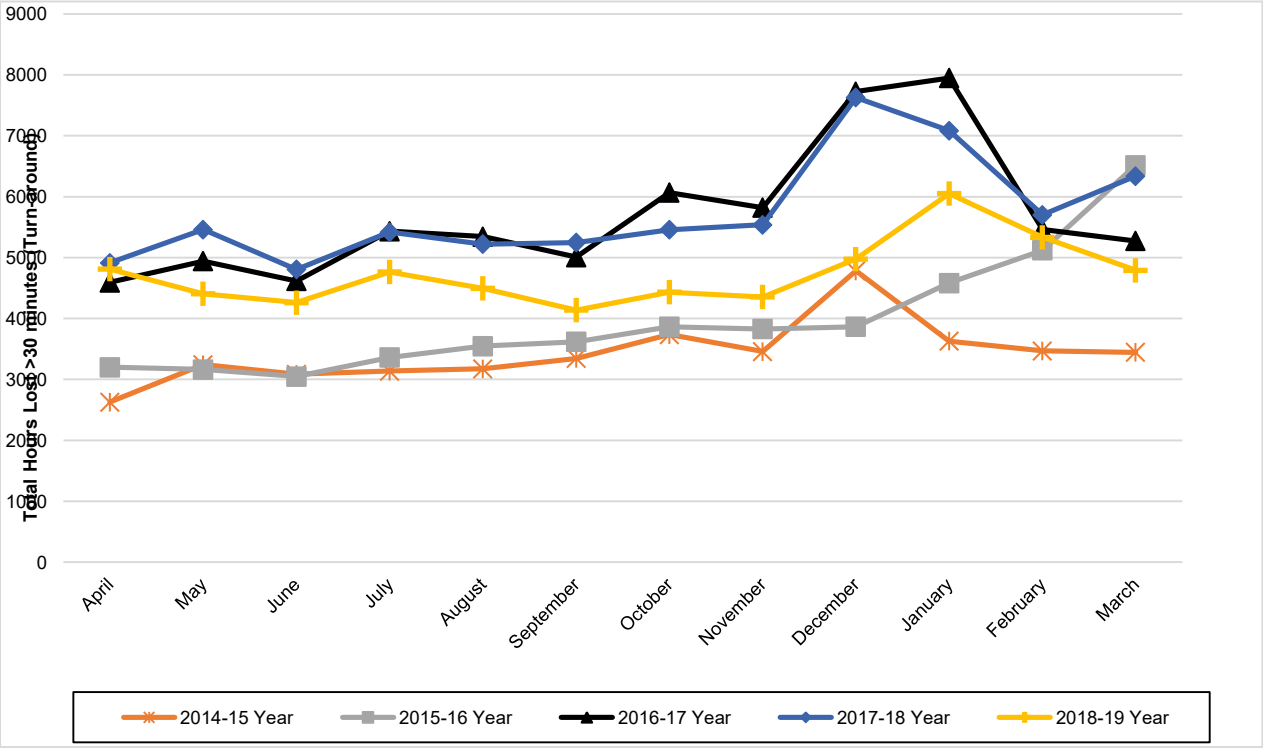
10.4 Staffing often poses a significant risk to the system when working to reduce handover delays. Within ED’s, for example there is not always the ability to consistently staff handover roles or the Fit2Sit area.

10.5 System working and ensuring all system partners are sighted and involved in improvement work is not consistent. In addition, not all Acute Trusts have been fully engaged in the handover delay work, particularly when staff turnover (including senior leadership) is high. This can mean that operationally on a day to day basis relationships at some sites are strained. This can be exacerbated at times of high pressure.

What progress has been made?

11.1 A well-attended regional system wide “stock take event “was held in Crawley in May. The event celebrated success and also shared examples of how handover delays had been reduced at specific sites.

11.2 Sum of hours lost >30-minute turnaround



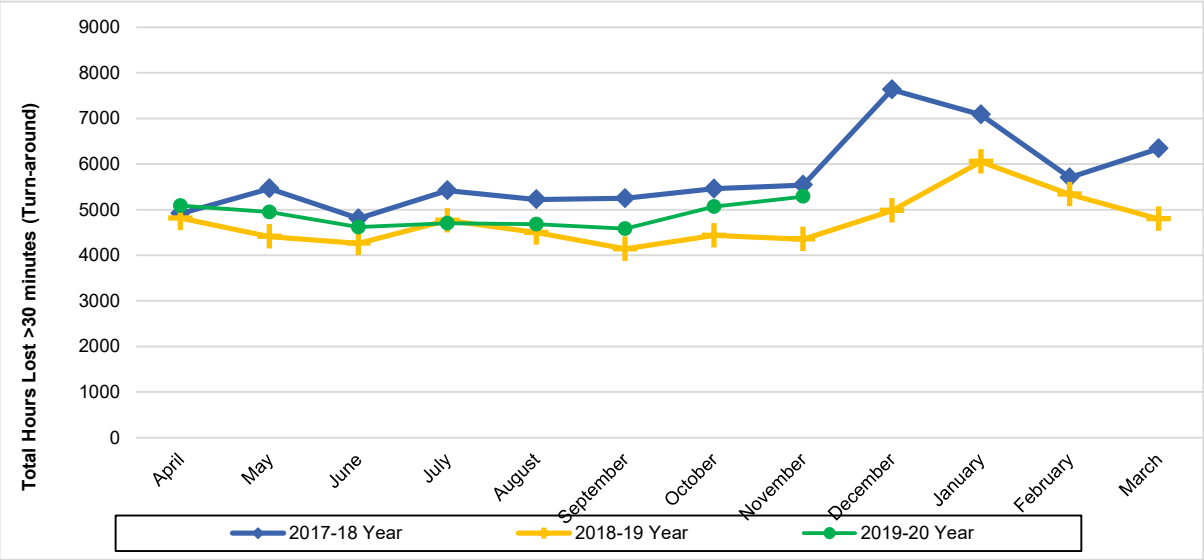
11.3 During the year April 2018 to March 2019 overall hours lost were lower than the previous 2 years, and the specific improvements below were made:

- 12,000 (17%) reduction in hours lost compared to the previous year.
- 34% reduction in the numbers of patients who waited over 60 minutes for a handover.
- 17% reduction in the numbers of patients who waited between 30 and 60 minutes for a handover.

11.4 Within the overall improvement however, it should be noted that there were marked variances. Some hospitals made significant improvement, and some ended the year being in a worse position than the previous year.

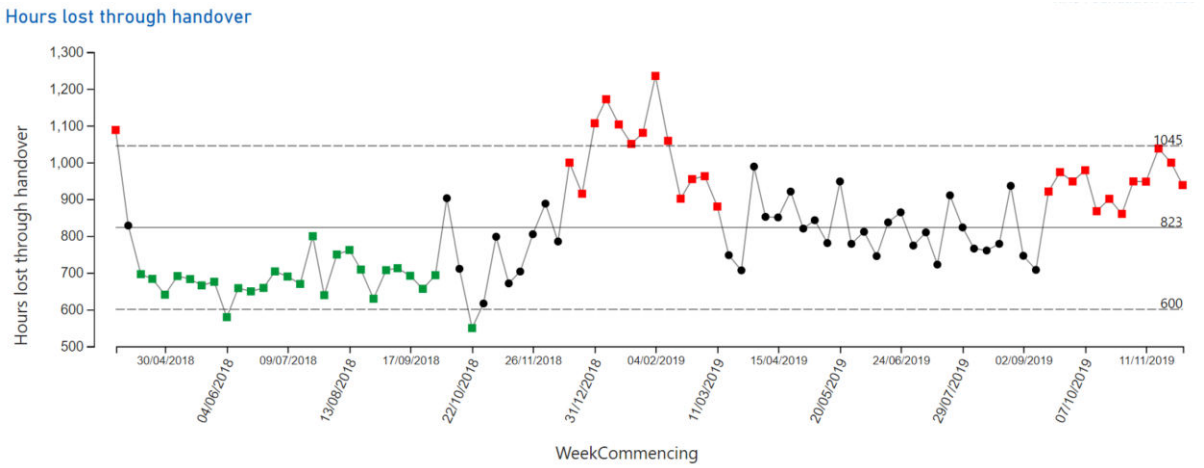
Current Situation - November 2019

12.1 Sum of hours lost >30-minute turnaround –November 2019 position

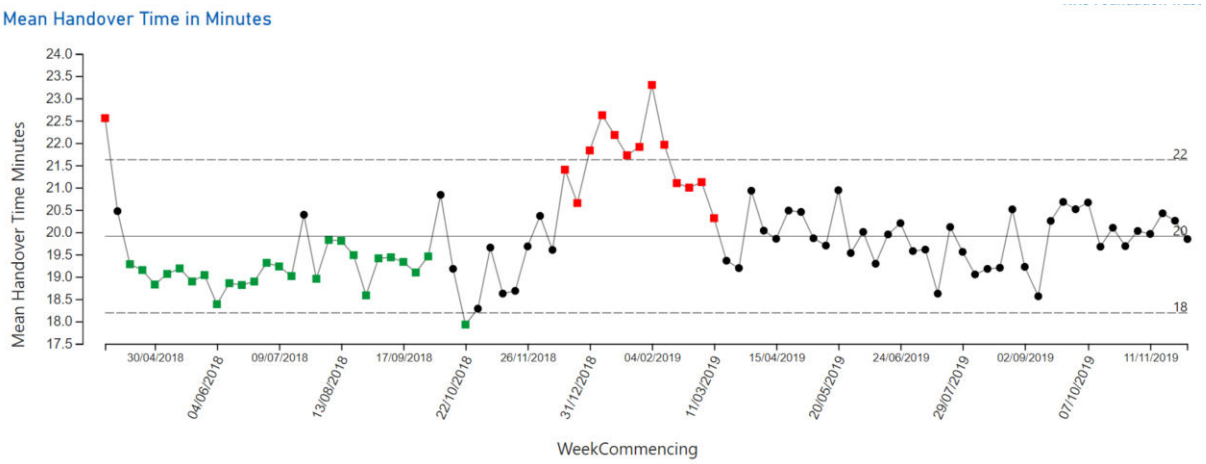


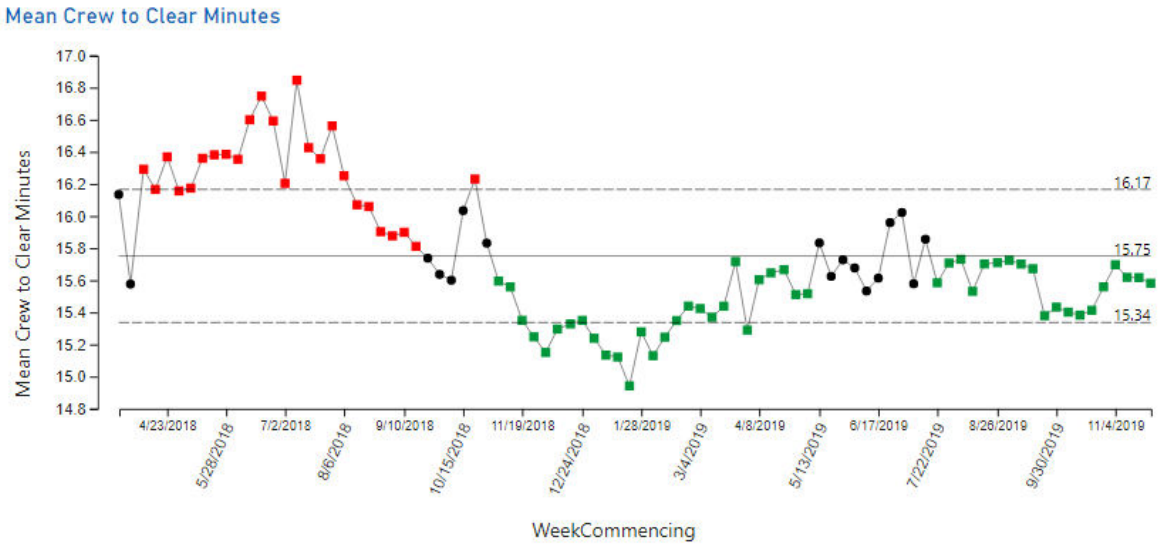
12.2 This financial year some hospitals have managed to maintain improvements that had been made in the previous year. Some hospitals did not make improvements in the previous year but have now begun to show signs of performance improving. Delays at some hospitals however continue to deteriorate even further. The impact of this has had an overall negative effect on the total number of hours lost compared to last year

12.3 In addition, it should be noted that there has been an increase in demand across all urgent and emergency care systems. This is recognised nationally, as well as across SECAmb's own regional footprint. As we move into winter, demand is increasing, and this has translated into an increase in the number of conveyances into hospitals across Kent Surrey and Sussex compared with last year. This has inevitably affected handover performance in terms of total hours lost.



However, despite the increase in the number of conveyances, the mean handover time together with mean crew to clear time has remained stable





12.4 There are some individual sites, where significant improvements have been made this year and are continuing to be made despite increased pressures. These sites include St Peters hospital, Queen Elizabeth the Queen Mother Hospital and Royal Surrey County hospital where handover performance is continuing to improve, despite an increase in the number of conveyances.

12.5 There are small signs of improvement noted at Royal Sussex County, Epsom, and William Harvey Hospital. These are sites where improvements have not been seen previously and where consistent engagement has not always been possible

12.6 More focused work is currently being undertaken at hospital sites where handover times have been a significant challenge throughout the programme. These sites include Medway , Maidstone and Tunbridge Wells Hospital and Darent Valley With a more focused approach and consistent engagement, improved performance is expected at these sites.

Next Steps

13.1 There are still further opportunities for improvements to be made at key sites. Those sites are where not all elements of good practice have been introduced (or are not yet fully embedded).

13.2 More focus at all sites will be placed on improving direct access to non-ED destinations including ambulatory care and frailty units to reduce congestion in ED

13.3 There are some sites however where good improvements have already been demonstrated, and it will be difficult to further improve handover performance without changes that involve improving whole system flow. Any further improvement in handover delays will be reliant on this system wide approach. This will need to be tackled through local A&E delivery boards.

13.4 The steering group is currently working on a proposal which will outline the suggested future direction of the handover programme. As the steering group has now been in existence for two years it is timely that a review takes place. The steering group would like to present the proposal to the February meeting of the System Assurance Meeting.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	95-19

Name of meeting	Trust Board
Date	30/01/2020
Name of paper	Violence and Aggression towards Staff
Responsible Executive	Bethan Eaton-Haskins
Author	Adam Graham, Giles Adams
Synopsis	This paper provides a summary of the current position in relation to Violence and Aggression, the work that has taken place already to address this going problem and the actions being considered for future support.
Recommendations, decisions or actions sought	For Information

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~~/No**

Violence and Aggression

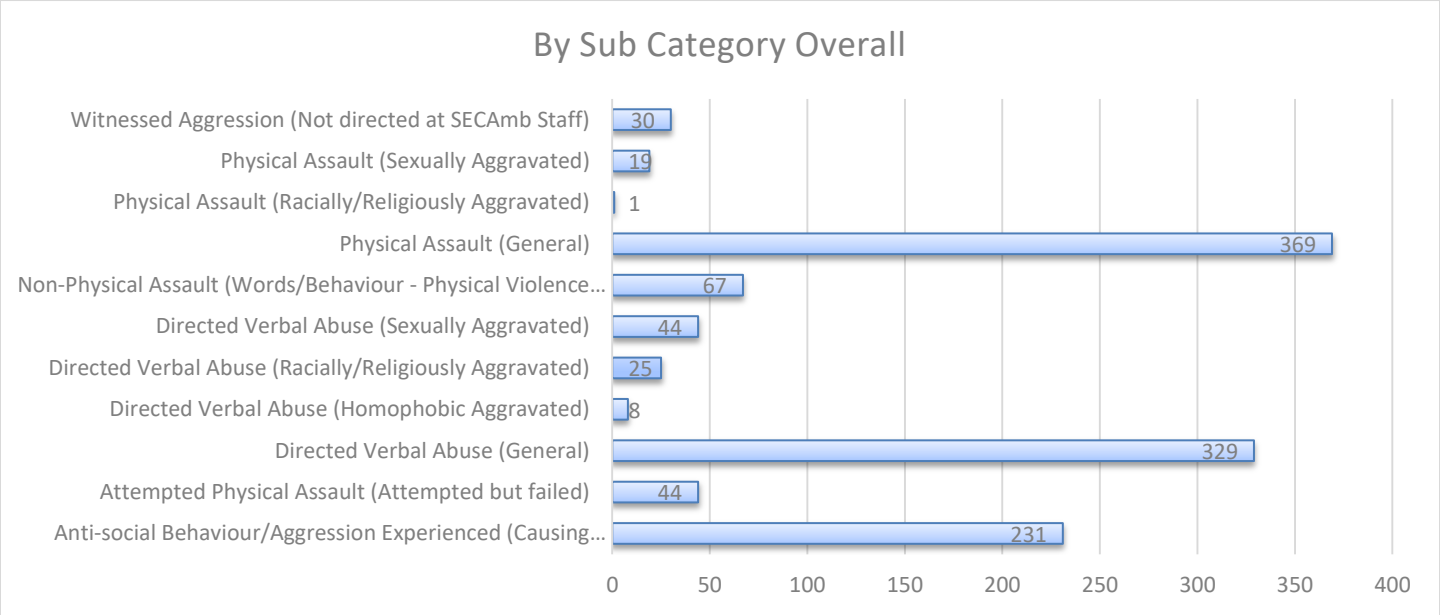
Background

Violence and aggression continues to be a high profile matter internally and externally with increases seen year on year across the NHS as a whole.

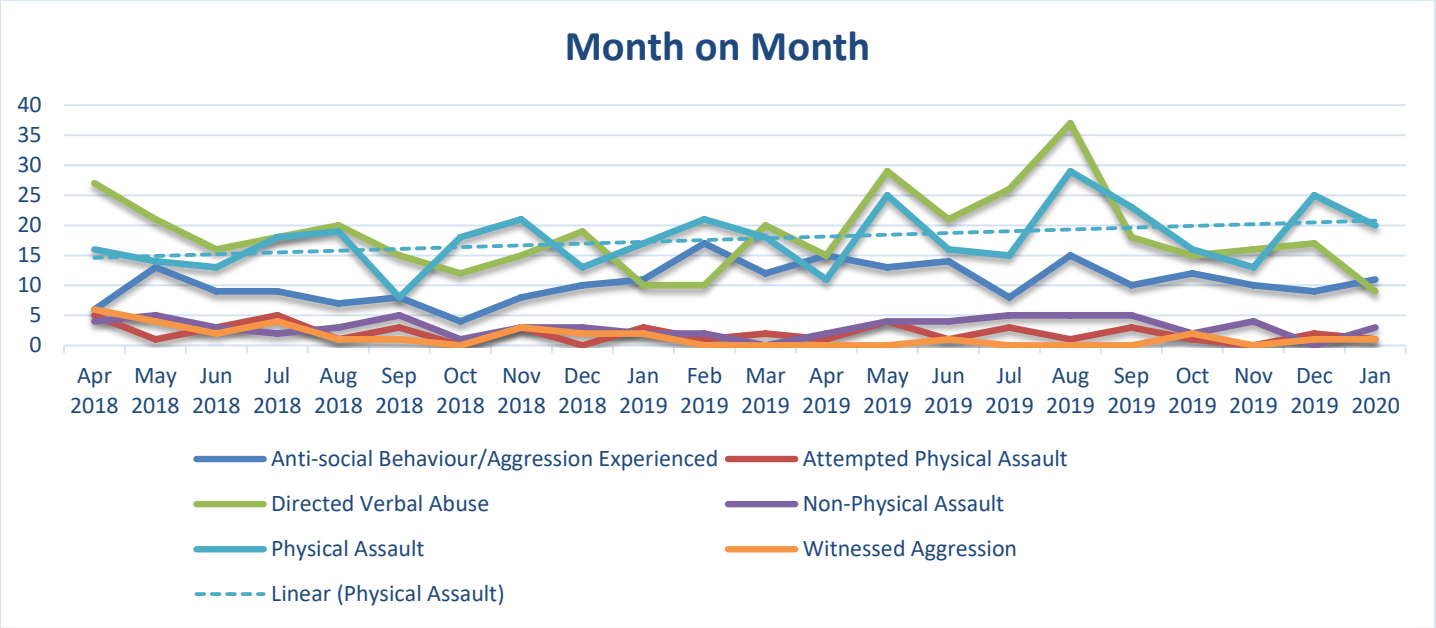
NHS England now holds responsibility for security following the dissolution of NHS Protect and are actively reviewing the risks around violence and aggression, updating the National Security Standards and are engaging with the Ambulance Sector National Security Group. As part of the new direction, there is more focus on all categories of incidents such as aggression and verbal abuse in addition to physical assaults. Additionally, NHS England have now published a new agreement between NHS England, Security Specialists and the Police amongst other services.

Trend Analysis

Considering the last 20 months (01/04/2018-YTD) within the Trust, the data highlights trends around the highest areas of reporting, risks and gaps. Overall during this period by the nature of the incident which occurred the highest reported category is physical assault (general), followed by verbal abuse (general) and then anti-social behaviour. The term 'general' indicates the incident was not aggravated by a protected characteristic;



The following chart breaks down the data in relation to overall physical/verbal incidents;



This demonstrates the month on month trend including a spike in verbal abuse across Q1-Q2 of this financial year to the summer which coincided with two of the three physical assault spikes, the third of which occurring during the winter period. A deep dive was undertaken into the physical assaults during the Christmas period and identified a significant number within this spike were medically related incidents, which whilst are recorded, would not require a security response due to the mitigating circumstances. Generally underlying the spikes and dips, physical assaults and anti-social behaviour have seen a rise overall during this time.

Please note all data provided above is by the number of incident reports, rather than the exact number of victims which will moderately increase these numbers. A further audit, mirroring physical assaults will soon begin to determine the exact number of victims for all sub-categories for the previous financial year.

There continues to be a specific focus around the impact of physical assaults and this forms part of the Annual Security Report and national Reported Physical Assaults (RPA) submissions. This data has previously been validated to the number of victims and the sanction/redress obtained against the offender through Security Management and Police routes;

FY	Physical Assaults*	Year on Year Increase	Sanctions	Sanction Rate
2011-12	98	N/A	22	22.40%
2012-13	111	13.30%	16	14.40%
2013-14	113	1.80%	9	8.00%
2014-15	126	11.50%	0	0%
2015-16	207	64.30%	49	23.70%
2016-17	234	13.00%	104	44.40%
2017-18	220	-5.90%	123	55.90%
2018-19	224	1.80%	104	46.40%
2019-20 *FYTD*	239	TBC	38	TBC

A significant programme of work was introduced during FY2016-17 which had and still has a positive impact to the number of successful sanctions. Maintaining the impetus however has been challenging due to increased activity to support the improvements in station, medicine and vehicle security required to safeguard patients and staff. It should be noted some sanctions may be delayed in confirmation and final numbers for this financial year will not be available until Q1 2020-21.

Additionally, when comparing the associated aggravating factors across 2017-18 and 2018-19 for physical assault it has been a common trend (also historically) that alcohol has been the predominant factor. However last FY saw for the first time in the 8 years of recorded data, none i.e. no aggravating factor, simply general aggression, associated with the highest cause,

2017-18

Alcohol	Drugs	Drug Seeking Behaviour	Mental Health	Medical	None	Other	Racial	Religious	Sexual	Weapons
64	16	Category did not exist	55	18	37	0	0	0	11	0

2018-19

Alcohol	Drugs	Drug Seeking Behaviour	Mental Health	Medical	None	Other	Racial	Religious	Sexual	Weapons
49	4	6	40	25	50	0	0	0	11	0

Risks and challenges

Training

There is a legal requirement for the Trust to provide an appropriate level of training to cover conflict resolution for all frontline staff. Training has been provided historically during annual statutory and mandatory training, but this has become outdated and withdrawn as it focused predominantly on breakaway techniques which was the national approach. Following national thematic discussions and reviews of the incident reports and associated factors above, it is widely identified and recommended that a focus on verbal interaction and de-escalation for both Field Ops and EOCs is the way forward. There are off the shelf solutions available such as the “management of actual or potential aggression foundation programme” provided by the Crisis Prevention Institute (CPI) however there are elements of such courses that are not appropriate in our setting so other Trusts have adapted these to produce an ambulance specific one day session with accompanying on line elements. It is recognised there will be a financial cost to the organisation with any programme of training, predominantly due to abstraction, however this would need to be offset against the potential to reduce staff sickness and improve individual resilience and morale by providing the appropriate self-awareness and de-escalation skills to handle difficult situations. These potential options are currently being explored.

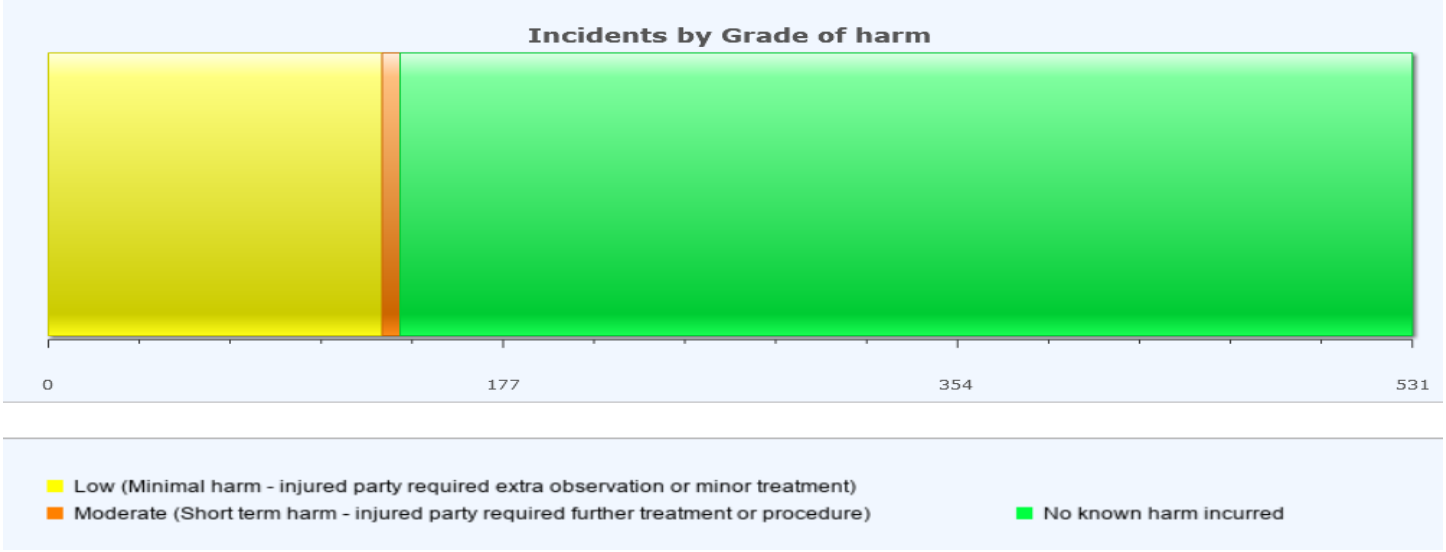
Capacity

There have been historical structural challenges within security and the evolution of the services and workstreams. Options around how the Trust further supports this function are being considered with one being to affiliate Security with Health and Safety as several other ambulance trusts have done, which would improve resilience and resource capacity. Historically Security Management provided induction talks, local management meetings, development of guidance and support with training needs, which allowed for short, medium and long term benefits and triangulation of data to complete

learning outcomes and drive strategic developments. Previous work which yielded positive results can be revisited when the current discussions and reviews are concluded.

Psychological harm

A factor which, from incident analysis and staff engagement, has highlighted increasing numbers of incidents is where the responder/call taker etc. has experienced notable psychological harm as a result of the incident and/or post incident activity. A review of the recorded harm on Datix cites (for the FYTD) predominantly no harm, which appears inaccurate and is potentially a current gap in our data. The grading may be thought of it terms of physical harm and therefore results in a hesitancy on quantifying psychological harm however may corollate to the increase in absence due to stress from cumulative incidents.



<u>Positive work and successes</u>

Whilst this year has been more challenging the previously developed programme in place through Security Management for specialist support following incidents and pursuing sanctions and redress is in place. Since inception within FY 2016-17 the sanction rate has increased from 0% in the previous year to 44.4% (104 sanctions) 2016-17 55.9% (123 sanctions) 2017-18 and 46.4% (104 sanctions) 2018-19.

More recently initiatives to revitalise engagement with Police Forces within our region have progressed positively. The Trust Lead for Security and Deputy Director of Operations are liaising with the Police, Fire and other NHS Services under what Sussex Police have termed Operation Cavell, which is designed to improve the culture and support regarding assaults on emergency workers and taking a tougher line on these incidents. Initial meetings have been extremely positive and open to explore the issues and implement an improved cultural approach.

A significant internal step has also been the establishment of the Reduction of Violence and Aggression Group, a sub group of the Health and Safety Committee. This is currently in the scoping stages to complete data and gap analysis, trends and confirm the main objectives however the initial

meeting was extremely positive, open and engaging with Operations represented at all levels including staff side.

A recent communication was released in response to a number of incidents in one area and we intend to continue to be proactive in this way to continually remind people that we will take action and seek criminal prosecutions;

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Media Release ***16 January 2020***

Trust to take action against those who assault and abuse staff

South East Coast Ambulance Service (SECAmb) staff serving the Worthing and Tangmere area reported being physically or verbally abused by patients the equivalent of close to once a week in the last four months of 2019.
Between 28 December 2019 and 5 January 2020 alone, four incidents of physical abuse were reported by local ambulance crews. In total from September 2019, 14 incidents of some kind of physical or verbal abuse were recorded.
SECAmb is reminding the small minority of people that commit these offences that this kind of behavior is completely unacceptable and will not be tolerated. Ambulance crews are encouraged to report all incidents and those responsible will be held accountable for their actions.
The Assaults on Emergency Workers (Offences) Act 2018 increased the sentencing powers of courts for such offences and the Crown Prosecution Service recently announced 50 people are being prosecuted each day under the Act. The Association of Ambulance Chief Executives welcomed the increase in prosecutions and called for the judiciary to routinely hand out tougher sentences to those who physically or verbally abuse ambulance staff.
SECAmb paramedic and Operating Unit Manager for Tangmere and Worthing, Paul Fisher said: "We will look to take action against anyone who assaults, threatens or abuses our staff. Our ambulance crews deserve to be able serve their community without the fearing they may be subjected to this kind of behaviour.
"We know that the people who seem to think this kind of behaviour is acceptable are a tiny minority of the total patients we treat and that the huge majority would never consider attacking or abusing someone who is trying to help them.
"We will continue to encourage our staff to report all incidents and will work with partners to ensure any individual is held responsible for such despicable actions."

With a wellbeing dynamic also associated with the aftermath of violence and aggression it has been positive that initial discussions have led to a level of data beginning to be captured the number of wellbeing assessments. Between the 30th September 2019 – 31st December 2019, 9 wellbeing assessments which related to an assault at work/ violence at work have been conducted. Some of these have led to onward specialist referral for paid treatment A wellbeing assessment is undertaken by a Wellbeing Practitioner, following a referral made by the individual or manager with their consent. In January the Wellbeing team also began collating information on physiotherapy sessions associated with the treatment of injuries caused by acts of violence and aggression

Finally the Trust will in FY2020-21 start the journey towards the provision of body worn cameras. This will provide vital evidence to support the prosecution of the minority of the public who look to verbally or physically abuse our staff. More importantly, as has been found in police studies, it is likely to modify behavior and therefore reduce the number of incidents occurring.

Conclusion

Unfortunately we are seeing an annual increase in violence and aggression incidents. We are working hard to improve this by seeking appropriate sanctions, providing wellbeing support, exploring training options and supporting local leadership teams to take a proactive and consistent approach. However, having identified some of the significant risks and challenges, work to address these along with further continued positive action building on our current successes, can have a significant positive impact to the direct and in-direct aspects of the work stream.

SECAMB Board

Summary Report on the Audit & Risk Committee (AUC) Meeting of 12th December 2019

Date of meeting	**12th December 2019**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting were • Internal Audit Progress Report • Counter Fraud Report on Annualised Hours Contracts • External Audit plan for the year end 31 March 2020 • Plan for production of the Annual Report • Management Update on Driving License checks • Data Quality • Whistleblowing • Risk Management Review and Board Assurance framework Risk Report
Internal Audit Progress Report	AUC was pleased to note the Reasonable Assurance outcomes from the audits of • Properties – Capital & Maintenance • Staff Wellbeing, Culture and Freedom to Speak Up AUC was disappointed with the outcome of the Targeted Follow Up review (for example 7 out of 11 high priority actions remain outstanding) but pleased to see evident focus from the new Chief Executive to ensure more consistent and more timely execution of agreed audit actions in the future.
Counter Fraud **External Audit Plan** **Plan for production of the Annual Report** **Driving License Checks**	The Committee received a Counter Fraud Report on Annualised Hours Contracts which had been commissioned by the Executive. The committee was assured that the executive is aware of, and had made a comprehensive response to, the issues raised. WWC will oversee issues resolution in due course. The Committee received a proposed audit plan from KPMG in respect of the year to 31 March 2020. Following discussion, the Committee approved the plan The committee asked to see a draft of relevant parts of the annual report at its meeting in March 2020 to ensure that overall message(s) are appropriate and consistent The Committee noted early progress (around 15% of licenses checked in the first two weeks) and requested a further update in March 2020
Date Quality	The committee received a paper on the processes deployed to assure Data capture/quality. Following discussion, the committee was assured by evident management focus on data

	quality and robustness.
Whistleblowing	AUC received a paper setting out the routes available for internal whistleblowing. To date use of those routes has been limited. Following discussion, the Committee was assured by the range of routes available to raise issues.
Risk Management Review	The Committee received and, overall, was assured by the Risk Management Report; better calibration of scoring is being addressed through training. EU Exit risk management was discussed at some length. A proposal as to a broad/high level Risk Appetite will be brought to the Committee in March 2020
Board Assurance Risk Report	Whilst some concerns were raised concerning the low score for culture related risks, overall the Committee was assured by the report and happy to recommend it to the Board

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	97-19

Name of meeting	Trust Board
Date	22.01.2020
Name of paper	Board Assurance Framework Risk Report
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic goals and sets out the controls, assurances, and actions. This version includes some changes to the risks included in the BAF risks report, demonstrating the dynamic nature of the risk.
Recommendations, decisions or actions sought	The Board is asked to review the BAF risks, and confirm its level of assurance that it is sufficiently focussed on the most relevant risk areas. It is also asked to agree the changes recommended in section 4.

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

Board Assurance Framework (BAF) Risk Report

1. Introduction

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

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

2. Structure of the BAF Risk Report

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

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

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

Each BAF Risk is aligned to a committee of the Board, with the relevant risks being considered at each meeting. In addition, the Audit & Risk Committee takes an overview of all BAF risks. Based on its most recent meeting(s), the table below illustrates how the focus of each Board committee reflects the BAF risks.

Committee	Agenda Item	BAF Risk
Finance and Investment	Financial Performance	178
	Operational Performance Demand and Capacity Review Fleet Plan	123 269
Quality and Patient Safety	EOC clinical safety EOC Audit	269 & 579
Workforce and Wellbeing	Personnel Files	362
	Workforce Planning Culture	111 334

Management Review & Recommendation

As set out in Appendix A, each risk has a nominated scrutinising forum, where the subject matter experts consider the risk, and update accordingly. Where the forum is not EMB, it will make recommendations to EMB about any changes to the risk. When applicable, EMB will recommend removal and / or an addition of a BAF risk(s). EMB agreed the following which was considered by the Audit & Risk Committee on 12 December 2019.

i. Risk 269 – Call answer performance.
Despite noting the need to monitor the extent to which the improvement is embedded, this risk score should be reduced from 20 to 15, on the basis that the mitigation is positively impacting performance, whereby the Trust is consistently within the APR targets for call answering.

ii. Risk 123 – ARP standards
On review of the impact EMB felt that this should be 4 (major) rather than 5 (catastrophic), on the basis that this risk is mostly specific to Cat 3. Therefore, reducing the score from 25 to 20, and the target score to 8.

iii. To include within the BAF risk report a new risk relating to clinical education. This will be included in the version that come to the Trust Board in March 2020.

iv. Remove the EU Exit Risk from the BAF risk report.

4. Conclusion

The Executive believes that the BAF risk report is sufficiently focussed on the right high-risk areas that affect the Trust's ability to meet its strategic goals. The Executive Management Board will continue to refine the report, so that is clearly sets out the controls, actions and sources of assurance it relies on. The BAF risk report will continue to be used by the Board and its committees, to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

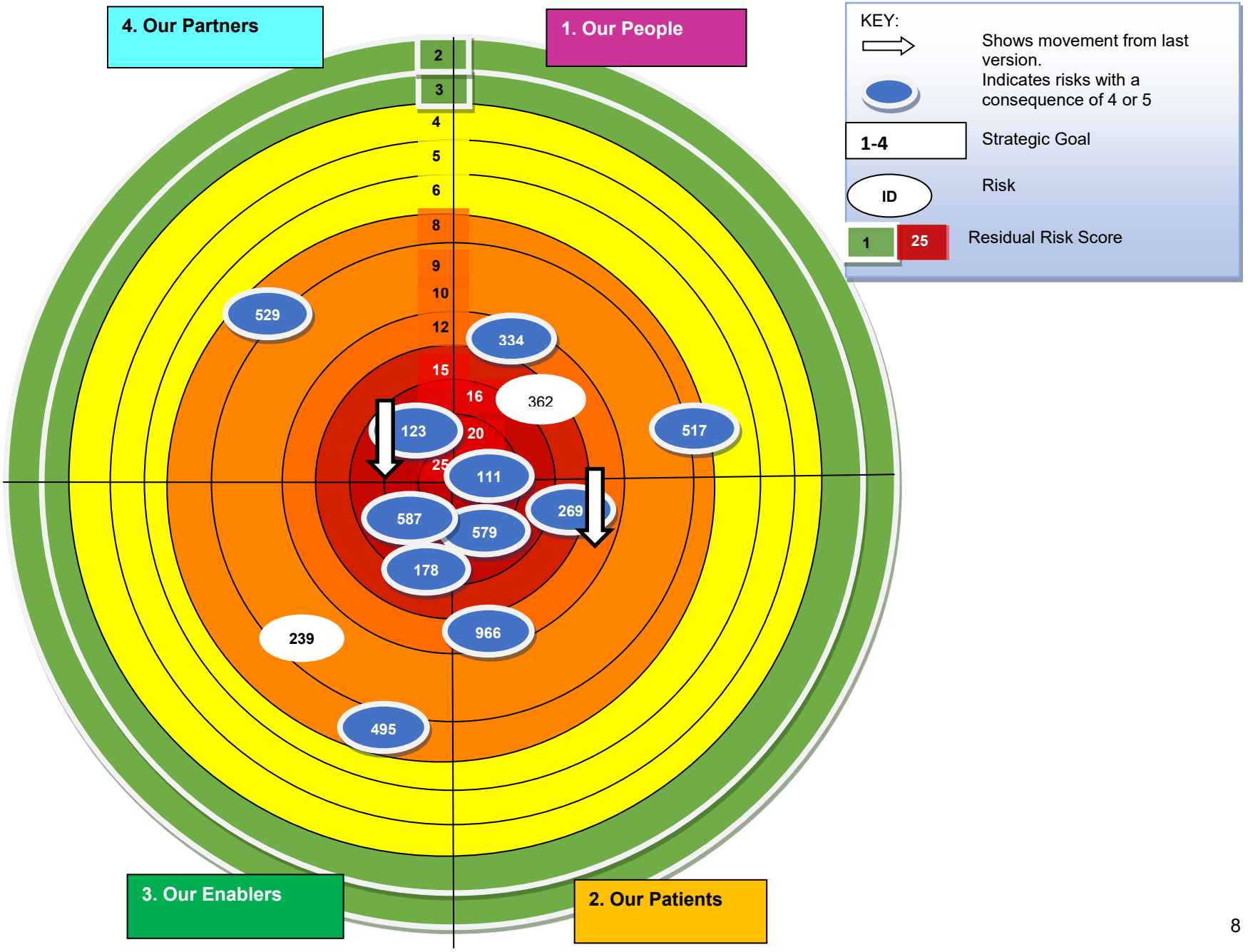
Dashboard

Links to objectives	Link to Delivery Plan (current RAG)	Risk ID / Theme	BAF Dashboard	Initial Score	Current Score	Target Score	Target Date	Board Oversight
2, 3, 4	Service Transformation Delivery Resourcing Plan	Risk ID 111 Workforce	Risk that we will not deliver the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	25	25	10	01.04.2020	WWC
8, 9,		*New* Risk ID 587 EU Exit	There is a risk that the Trust's ability to provide effective services is significantly affected by the UK's exit from the European Union, especially in the event of a 'no deal'.	20	20	10	31.03.2020	AUC
5,6, 7, 8, 9, 11	Service Transformation Delivery	Risk ID 123 ARP	Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm. Currently, the principal risk relates to Cat 3 patients.	20 ⇩	20 ⇩	08 ⇩	01.04.2020	FIC

5, 6, 7, 8, 9, 10	EOC	Risk ID 579 Care & Treatment	Risk that patients waiting for a response are not appropriately prioritised, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.		20	20	4	To be revised	QPS
8, 9, 12, 13		*New* Risk ID 178 Control Total	Risk that the Trust fails to achieve its planned income and expenditure targets (control total), as a result of loss of financial control. This may lead to limiting or delaying key investments and the Trust being place in 'Financial Special Measures'.		16	16	4	31.03.2020	FIC
5, 6, 7, 8	EOC	Risk ID 269 EOC	Risk that the Trust does not consistently answer calls within the national standards (Mean 5 seconds & 90th Centile 10 seconds) as a result of; •non-delivery of the planned workforce (see separate workforce risk) •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment		25	15	5	To be revised	QPS
2, 7	**Personnel Files**	Risk ID 362 Safer Recruitment	Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.		15	15	6	To be revised	WWC
5, 6, 7, 8	CQC tracker	Risk ID 966 111 Service	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which may lead to patient		16	12	4	To be revised	FIC

			harm.						
1, 2, 3, 4, 7	Culture Change	Risk ID 334 Culture	Risk of not improving the culture and behaviours within the Trust, as a result of; •not embedding the Trust's values and behaviours •poorly developed leadership and management styles This may lead to low staff morale, issues with retention, adverse impact on patient care and reputational damage.		12	12	4	To be revised	WWC
7	H&S	Risk ID 517 H&S	Risk that we do not comply with H&S legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.		16	08	4	To be revised	WWC
10	EPCR Cyber Security	Risk ID 495 IT	Risk that IT does not enable delivery of services as a result of; •system development maturity and integration not achieved at right pace •inability to respond to a major cyber crime This may lead to inability or delay to provision of care		16	08	4	To be revised	FIC
7	N/A	Risk ID 239 IG	Risk that the Trust does not adhere to Information Governance requirements and standards as a result of inadequate systems, resourcing and controls, which may lead to sanctions from the ICO and reputational damage.		9	9	3	To be revised	AuC
13, 14, 15	N/A	Risk ID 529 Change	Risk that the Trust is unable to substantively engage with Integrated		12	8	4	To be revised	FIC

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


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
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239
495
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
ID
Risk
1
25
Residual Risk Score

Appendix A

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

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

Controls in place (what are we doing currently to manage the risk)	
Resourcing improvement plan (IP) delivered 227 new ECSWs and 44 new AAPs. Improved EMA recruitment in to the EOC Manchester Triage (enabler to increase clinical capacity within EOC) HR transformation programme	Improving working conditions, e.g. meal breaks / shift overruns Rotational paramedic roles aimed and better attraction and retention Different approach to student paramedics ensuring higher number of job offers

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

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. 10-year front line workforce plan 2. Clinicians to be appointed from overseas 3. HR transformation programme developed 4. Development of a retention strategy	1. Workforce model provides a detailed, evidence-based and robust approach to strategic workforce modelling. Workshop is being held 04.12.2019 to revise the model. 2. Contracts in place for 8 new staff from overseas 3. HRT business case approved in June 2019 – see delivery plan. 4. Scheduled to come to Trust Board in March 2020

Last management review	Executive Management Board	**Last committee review**	16.01.2020 Workforce & Wellbeing Committee

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

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

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

Project established to review the various issues relating to personnel files; this sits under the HR Transformation programme, and includes the management actions from the Internal Audit report.
DBS checks (renewals/no initial) are being regularly monitored.

Gaps in Control

Policy to be approved relating to renewal of DBS checks
HRT Plan (Phase 2) – aimed at improving basic controls
Plan to ensure all personnel files are complete with key documents

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Decision taken to write to all staff asking them to provide key ID documents so that every file is up to date 2. DBS policy has been reviewed. 3. Deliver Phase two of the HRT Plan	1. Letter to all staff being sent w/c 18.11.2019. Aim to conclude this work by 31.12.2019 – see separate Board update (28.11.2019) 2. Policy going through the approval route. 3. HRT Business Case approved by the Trust Board in June 2019 (see delivery plan for progress update).

Last management review	Executive Management Board	**Last committee review**	16.01.2020 Workforce & Wellbeing Committee

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

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

Controls in place (what are we doing currently to manage the risk)
Established a values and behaviours framework Staff recognition programme / staff awards Leadership development programme Modules completed for senior managers (>Band 8B) Exec and Senior Managers individual and team coaching Wellbeing Hub Honest Mistakes Policy implemented Staff engagement champions in place Staff Appraisals New vision established to have an organisational culture where **'Our people are listened to, respected and well supported'**
Gaps in Control
Delivery of the plan to ensure the vision for the new culture

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Culture Plan agreed with the aim of developing an organisational culture where our people are listened to, respected & well supported.	See Delivery Plan for progress update

Last management review	Executive Management Board	**Last committee review**	16.01.2020 Workforce & Wellbeing Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Nursing & Quality
Risk that we do not comply with Health & Safety legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.	**Scrutinising Forum**	Central H&S Working Group
	Inherent Risk Score	**16** (Consequence 4 x Likelihood 4)
	Residual Risk Score	**08** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
A number of specific H&S risks have been identified (on the risk register) with related mitigating actions. A H&S dashboard for the H&S working group has been developed to ensure focus in the right areas, and metrics included in the Integrated Performance Report >90% of Board members have completed IOSH training 12 month Improvement Plan (in response to the independent H&S review) – delivered and all objectives have been met as reported to WWC. A gap analysis has been undertaken of the Trusts' Health & Safety policies - 10 new Health & Safety related policies have been implemented. The annual Health & Safety audit plan has been implemented and 40 audits have been completed
Gaps in Control

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Independent Review May 2018 (-) manual handling incidents high (-) RIDDOR reporting (+) HSE inspection visit in February 2018 focussing on Muscular Skeletal Disorders (+) violence and aggression to staff showing a slow downward trend. (+) increase in H&S reporting – showing greater awareness (+) Delivery Plan showing H&S as Green (+) WWC Sept 19 – assured with delivery of the improvement plan	
Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. MDT training	1. Over 200 operational managers have received classroom based H&S training

Last management review	Executive Management Board	**Last committee review**	16.01.2020 Workforce & Wellbeing Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently answer calls within the national standards (Mean 5 seconds & 90th Centile 10 seconds) as a result of; •non-delivery of the planned workforce (see separate workforce risk) •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment	**Scrutinising Forum**	Teams A/B (EOC)
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current Risk Score	**15** (Consequence 5 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**05** (Consequence 5 x Likelihood 1)

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

Gaps in Control
Improvement in the effectiveness of in line support adversely impacted by supplier delays (see delivery plan)

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) NHS Pathways / MT audit compliance (-) November EOC call answer performance action plan RAG-rated Amber from Green (+) Call Answer performance – consistently within ARP. (+) EMA capacity (+) reduction on EMA turnover against trajectory	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. EOC Action Plan	1. All actions on track – see Delivery Plan

Last management review	Executive Management Board	**Last committee review**	17.01.2020 Quality & Patient Safety Committee

Goal 2 Our Patients	**BAF Risk ID 579** [link to BAF Risks 123, 111, 269] Care & Treatment – clinical management of calls waiting.	**Date risk opened: 13.09.2018**

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

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

CAD upgrade provides better visibility of the types of calls requiring triage.
Specific EOC improvement plan has been developed and is in place (see delivery plan)
Overseas recruitment - 8 with contracts (3 started 5 due to start by the end of the year)
Implementation of Clinical Support Worker to support patient welfare calling
Clinical recruitment – target is 76 which is expected to be exceeded by Jan 2020.
Agency pathways clinicians introduced.
Revised EOC governance group.

Gaps in Control	
Welfare call compliance Clinical capacity	Pathways & Clinician Audits / Live feedback Improvement Plan implementation

Assurance: Positive (+) or Negative (-)		**Gaps in assurance**
(+) CQC – assured re improvements (+) clinical support compared to 2018 (-) ARP performance, esp. Cat 3-4 (-) clinical recruitment IAP Amber	(-) compliance with welfare calls (-) Instances of surge (-) staff retention (-) QPS Jan 2020 – clinical hours	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Clinical Recruitment Action Plan 2. See also linked mitigation within BAF risks 111, 123 & 269	1. See Delivery Plan for progress – November RAG-rating is Amber.

Last management review	Executive Management Board	**Last committee review**	17.01.2020 Quality and Patient Safety Committee

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

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

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

Gaps in Control

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) (+) clinical performance not meeting national standards but compares well to national average (-) High number of referrals to 999 (-) Improvement Plan RAG rated in November Amber from Green (+) Impact of the additional Service Advisors and the use of Patient Safety callers (+) Maintenance of full NHS Pathways compliance with regards to audit (+) W/C 18 Nov call answer improved from 72 seconds to 40 seconds (+) abandonment rate reduced	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
Service Development Improvement Plan includes aim to ensure national average for 999 referrals by January 2020.	See Delivery Plan for update on progress.

Last management review	Executive Management Board	Last committee review	16.01.2020 Finance and Investment Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm. The principal risk relates to Cat 3 patients.	**Scrutinising Forum**	Executive Management Board
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**20** (Consequence 4 x Likelihood 5)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

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

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

Gaps in Control

Skill Mix / utilisation of NET/ECSW crews (see BAF risk 111)
Clinical Support in the EOC (see BAF risk 111 & 269)
Hospital Handover delays – lost hours

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Performance under trajectory (-) Lost hours from handover delays (-) recovery actions, save for RPI which is on target. (+) Call answer performance (+) Booked on hours increasing (-) FIC not assured with sustainable long term plan to meet ARP	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Handover Programme 2. Demand and Capacity Review 3. 999 operational recovery actions	1. On-going 2. Re-running demand and capacity model with current data to confirm a reasonably achievable improvement trajectory – workshop on 4 December 2019. 3. Monitored weekly.

Last management review	Executive Management Board	**Last committee review**	16.01.2020 Finance and Investment Committee

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

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

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

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

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

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Improving performance to ensure generation of planned income	1. Getting to more patients
2. Discussions with commissioners about meeting income plan for the year	2. Ongoing
3. Focus on budgetary control, specifically around Fleet, Procurement and Estates	3. Ongoing
4. A rigorous process to consider the merit of identified cost pressures and to approve additional budget funding through critical scrutiny of business cases	4. EMB has approved the cost pressures and keeps them under close review.

Last management review	Executive Management Board	Last committee review	16.01.2020 Finance and Investment Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
There is a risk that the Trust's ability to provide effective services is significantly affected by the UK's exit from the European Union, especially in the event of a 'no deal'.	**Scrutinising Forum**	Resilience Forum
	Initial Risk Score	**20** (Consequence 5 x Likelihood 4)
	Current Risk Score	**20** (Consequence 5 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**10** (Consequence 5 x Likelihood 2)

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

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

Gaps in Control

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

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

Last management review	Executive Management Board	**Last committee review**	12.12.2019 Audit & Risk Committee

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

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

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

Gaps in Control

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

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

Last management review	Executive Management Board	**Last committee review**	16.01.2020 Finance and Investment Committee

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

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

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

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

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

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Undertake an organisation wide records review. Create a centralised repository for records management. 2. Create a new GDPR compliant Information Asset Register this will link into the organisational wide records review and records management repository 3. GDPR Action Plan Delivery	1. Information obtained from the review will be used to create a robust centralised records repository. This will ensure that the Trust is compliant with Article 30 of the GDPR 'Records of Processing Activities'. This action forms part of the standing agenda items for the IG Working Group, which now meets on a monthly basis. 2. There are Information Asset Owners in place and this will remain a standard agenda item for the monthly IGWG meetings. Work is to commence on implementing the new IAR during

4. IG Manager Recruitment has been completed. Individual to commence in post 2 January 2019 5. FOI process mapping underway 6. Baseline submission of Data Protection & Security Toolkit due 31 October 2019 and completion of DSPT Action Plan 7. RA local model – initial scoping has taken place in conjunction with NHS Digital 8. Localised training for HR Portfolio in relation to SAR Process – September 2019 9. ICO Action Plan completion – target date November 2019			Quarter 3 2019, meetings have now been scheduled for late November / December 2019 3. PMO engaged. The 'Peer to Peer' review of the revised GDPR Action plan took place with London Ambulance Service on 20 August 2018. A summary report and updated GDPR action plan was presented to the Audit Committee and IGWG in September 2018. 4. Interviews for the IG Manager role have taken place – at this time an unconditional offer has been made subject to suitable references. IG Manager insitu from 2 January 2019 5. Due to report to senior leadership committee in November 2019 6. Baseline submission completed. This is currently at an unsatisfactory level as we would expect at this time and further work must commence during the coming months in order to remain compliant. 7. Meetings have taken place with NHS Digital RA Lead to review gaps in assurance around Registration Authority (smartcards). Printers have been potentially sourced at no cost to the organisation – this is to be confirmed. New roles / sponsors allocated and confirmed within Trust to locally manage process and roll out within EOC
Last management review	Executive Management Board	**Last committee review**	Audit and Risk Committee 12.12.2019

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

Underlying Cause / Source of Risk:		
Risk that the Trust is unable to substantively engage with Integrated Care Services and the service delivery architecture in place across region, as a result of capacity. This may lead to the inability to pursue the Trust's overall strategy and supporting objectives.	**Accountable Director**	Director of Strategy
	Scrutinising Forum	Executive Management Board
	Initial Risk Score	**12** (Consequence 4 x Likelihood 3)
	Current Risk Score	**08** (Consequence 4 x Likelihood 2)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Members of the relevant Boards Identified Trust personnel attend core work-stream and pathway development meetings within local systems. Reciprocate sharing and agreement of overall strategic planning with ICSs in terms of clinical case for change and to support work of Trust services. Re-focussed System Assurance Meeting where the Trust and its partners consider development risks and issues in the context of urgent and emergency care.

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

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

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

Last management review	Executive Management Board	Last committee review	16.01.2020 Finance and Investment Committee

Appendix B

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

Appendix C

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

		report	Challenging report	Critical report	Severely critical report

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

SECAMB Board

Summary Report on the Charitable Funds Committee (CFC) Meeting of 9th July 2019

Date of meeting	**12 December 2019**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting related to Accounts and Governance
Governance	A Full/Comprehensive Review of the Trust's Charitable funds and the role of the Charitable Funds Committee remains outstanding due to prioritisation of other activity. After 18 months this is now a matter of significant concern. It was agreed that the Executive would prepare a paper for the private session of the January Board meeting setting out a clear roadmap for resolution of governance matters.
Charitable Fund Accounts	The Committee determined to recommend the formal Financial Accounts of the Charity (year end March 2019) to the Corporate Trustee, subject to an amendment stating that a full governance review to be completed early 2020/21 which would be reported in the next set of accounts.