South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

25 March 2021
10.00-13.00

Via Video Conference

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
73/20	10.00	Welcome and Apologies for absence	-	-	Chair
74/20	10.02	Declarations of interest	-	-	Chair
75/20	10.02	Minutes of the previous meeting: 28 January 2021	**Y**	Decision	Chair
76/20	10.03	Matters arising (Action log)	**Y**	Decision	PL
77/20	10.05	Board Story	-		
78/20	10.15	Chairs Report	**Y**	Information	Chair
79/20	10.25	BAF Risk Report	**Y**	Decision	PL
80/20	10.40	Chief Executive's report	**Y**	Information	PA
81/20	11.00	Integrated Performance Report Incl. Committee Reports	**Y**	Information	PA
82/20	12.25	Freedom to Speak Up Gurdian Report	**Y**	Information	BH
83/20	12.40	Gender Pay Gap	**Y**	Information	AM
84/20	12.50	Disciplinary Review Process - Amin Abdullah	**Y**	Assurance	AM
Closing					
85/20	13.00	Any other business	-	Discussion	Chair
86/20	-	Review of meeting effectiveness	-	Discussion	ALL

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

Date of next Board meeting: 27 May 2021

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 28 January 2021

Via Video Conference
Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Philip Astle	(PA)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Ali Mohammed	(AM)	Executive Director of HR & OD
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Fionna Moore	(FM)	Executive Medical Director
Howard Goodbourn	(HG)	Independent Non-Executive Director
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Senior Independent Director / Deputy Chair
Michael Whitehouse	(MW)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Company Secretary

Chairman's introductions

DA welcomed members, those in attendance and those observing.

DA acknowledged the 100,000 lives lost to COVID, offering condolences to their families and friends. We have recently lost four colleagues, three related to COVID, which PA will reference in his report.

60/20 Apologies for absence

Janine Compton	(JC)	Head of Communications

61/20 Declarations of conflicts of interest

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

62/20 Minutes of the meeting held in public 26.11.2020

The minutes were approved as a true and accurate record.

63/20 Action Log

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

64/20 **Board Story** [10.04 -10.08]
The story today relates to vaccinations, which BH introduced. It is a video made on day we went live with the vaccination centre in Crawley. We were the first ambulance trust to use the Oxford Astra-Zeneca vaccine and his has truly been a team effort to get this up and running.

After watching the video DA thanked the team on behalf of Board for setting this up. PA added that it is important to also recognise the contributions of our partners, who have been supporting the vaccinations of our staff, in particular Maidstone and Brighton hospitals.

65/20 **Chair's Report** [10.08 – 10.16]
DA outlined the focus of today's meeting. COVID has dominated the focus in recent weeks, and special reference to colleagues who spent much time planning to minimise the risks to delivery our services from the EU Transition. This has been two years of planning for all eventualities.

DA then updated on board succession planning, including support to the NExT Director Scheme, which helps to demonstrate the commitment of the Board to ensuring diversity around the Board table.

DA acknowledged colleagues who were identified in the New Year's honours list, in particular JG and BH who received MBEs for their contributions to the NHS, in particular during the current pandemic.

Finally, DA confirmed that this is AR's final Board meeting and recognised his significant contribution to the Board. In particular, AR has been a champion of staff welfare and provided expertise in fleet management. We wish him well for the future. On behalf of the executive team, PA also thanked AR for his serve to lead leadership qualities. AR thanked colleagues for the crest and flowers and reflected on the enormous privilege is has been to serve the SECAmb family. He noted the commitment of font line staff and all those that support them.

66/20 **BAF Risk Report** [10.16 – 10.21]
PL outlined the structure of the report which the Board is now familiar with, including the cross reference to the Board Committees as illustrated in section 3. The focus since November has been on risks to operational performance / clinical safety, in the context of COVID and the impacts of the EU Transition, to which many of the risks did not materialise. Some changes to the report are set out in section 4, which includes the removal of the EU Transition risk. The COVID and ARP risks have increased given the issues over the past two months.

Looking forward, during February EMB will be taking time to assess the risks for the coming 12/18 months to agree what these are and the controls that will need to be put in place.

The Board felt that the forward look by the executive is very important as currently the BAF risks are more related to the here and now. The workforce is tired and so we need to anticipate the impact if this, especially the psychological impacts of COVID. Staff will need support over the next few years given the mental health impacts and the Workforce and Wellbeing Committee will need to seek assurance on the plan to support and sustain our people.

67/20 **Chief Executive Report** [10.21 – 10.58]
PA highlighted aspects of this report beginning with the very sad news about four members of staff who have died since Christmas. Three were from one station (not connected) and a fourth from the clinical education team. We remember them and their contribution over many years of service. PA confirmed we are doing what we can to support their families.

PA then turned to what has happened since the Board last met, regarding COVID. A new variant has emerged which almost certainly originated in Kent and has now spread across our region and into other parts of the country. 80% of COVID caseload is this new variant. Sadly, we expect the death rate to continue and while the peak of the disease has passed, the peak of deaths has not. Looking forward, the numbers of infections is expected to continue to decrease.

There continues to be a significant impact at hospitals. In our region, the Kent system in particular has really struggled over the past weeks leading to very long ambulance handover delays; some patients have been waiting 9-10 hours in the back of ambulances. These challenges have led to vast efforts and innovation to create solutions. We were moving patients as far away as Devon and Manchester and are using Sussex and Surrey for Kent patients, although more recently this is abating. Dynamic conveyance was introduced where we choose where patients go rather than the nearest hospital. This is incredibly inefficient and not good for patient experience, but it has helped to maintain safety.

PA reinforced that the other effect of course has been on our staff. The prevalence of disease has impacted staff sickness much more than during the first wave; we peaked at circa 550 staff off with covid related issues. In the past two weeks this number has reduced and is now closer to 200. This has affected the hours we have been able to put out and so during these extraordinary times we have taken extraordinary measures, including asking for support from the army.

The answer to the pandemic lies in vaccination and we have pushed this really hard. It has been very well organised and we have managed to provide the first dose of the vaccination to over 60% of staff, with a much higher percentage when counting just front line staff.

PA moved on to other areas reflecting that it hasn't all been COVID-related since November. We have also:

- Continued the planning for the impacts of the EU Transition, focussing on the worst case scenarios. Thankfully these did not materialise and so the projects have now been closed.
- Deployed 111 Frist across Sussex Kent and Medway. This was a huge effort right in middle of the pandemic and pre-Christmas / New Year preparations.
- Opened Falmer Brighton MRC; agreed the land and building for Medway; and finished preparation work for Banstead.

DA thanked PA for this important update and he welcomed military colleagues thanking them for their support. He then opened up for questions.

TP asked about cooperation across the region, at is seems never to have been better, and about whether the spread of vaccinations is consistent across Kent Surrey and Sussex. With regards cooperation, PA confirmed that we have worked very closely with the ICSs in our region and relations have changed in the past few months especially in Kent where we had been less engaged previously. There was some fractious moments at times of extreme crisis, but despite the long hospital delays the forbearance of our managers and staff and care they gave to patients at the back of ambulances was exceptional. There was also forbearance with hospitals with a lack of a blame culture. Relationships have improved and the system better understands what we can do. In terms of vaccinations, there has been more availability in Sussex and Kent but spread is split across the three counties.

AR asked about 111 First and how we measure how effective it is for both patients and emergency departments. PA explained that this is a difficult one to answer as it is not a zero sum game, but the strategic intent is to take 20% of unheralded arrivals at emergency departments. DH added that this was deployed from 1 December when the national campaign went live. At the same time COVID started to peak. So, it has definitely helped, but the absolute effectiveness will only become clearer in more normal

circumstances. It has been deployed well and commissioners are happy with what we have done. While 111 First originated from the impacts of COVID, it is definitely here to stay.

The Board reflected that 111 First is an embryonic channel shift to integrated care and we can and should provide the system leadership.

Action
111 First is an embryonic channel shift to integrated care and SECAmb should provide the system leadership. Using a Board development session, the Board should think about this and how we establish a robust evaluative framework to ensure we realise the benefits.

There was then a discussion about how we relate with system, between ICSs and acute systems / hospitals across the region and how we ensure most influence. The Board noted that OUMs are connected through ICPs and directors to ICSs, and that this matrix relationship need to be well coordinated to ensure consistency in relationships.

There were also some questions about our capital programme, specifically related to our estate , and how much more work is needed until we have a fully modernises estate portfolio. Much of the focus has been on MRC development (80% complete) and the Board noted that the next focus will be review of ARCPs to ensure they are in the right place and fit for purpose. The refreshed estates strategy will pick this up.

68/20 IPR /Committee Reports (10.58 – 12.40)
PA introduced the report, reminding the Board on how it is structured and the specific areas of escalation that the relevant directors will pick up. It is still a developing report but PA is really pleased with it as it provides an increasingly useful set of data to guide our efforts and check the impacts of what we are doing. One area of escalation is 999 operational performance and the areas of focus in the past two months has been more on maintaining safety than meeting APR, given the exceptional circumstances.

DA then asked that executive directors to start by highlighting any specific areas. There will then be questions before asking the committee chairs to introduce their escalation reports.

<u>Performance & Finance / Finance and Investment Committee</u>
JG complimented PA's update to give a feel for the pressure over the past couple of months, by showing some data that reflects difference between the COVID incidents when compared with wave 1. The percentage is much higher as is sickness and other COVID related abstraction. Page 9 of the IPR gives the surge levels. Pressures are generated not by high demand but how resources have been consumed by factors such abstraction and handover delays.

Page 18 shows front line hours provided. In December, despite all the pressures, we were still able to mobilise additional resource and achieved over 95% of hours. However, this was met mostly through overtime and using response capable managers. Despite these efforts, APR has been performance poor, but as PA mentioned this is in the context of the unique challenges and our focus on keeping patients safe.

Questions:
MW explored our resilience going forward, specifically our training to ensure an adequate pipeline. JG responded that we have been conscious not to derail anything that will impact our future workforce. For example, we have continued driver training and allowing AAPs to go to College. TQ added that we need to mitigate any risk to those at University that have placements, noting the assurance from JG that we have done much to facilitate University placements; for example, we have factored in students for PPE / powered hoods and are also offering contracts much earlier. DA confirmed that this is within the remit of the

workforce and wellbeing committee to ensure we further relations with education partners and get upstream of the talent pipeline.

TP asked about how we are providing respite for staff as pressures continue, such as ensuring leave is taken. JG assured the Board that we will continue to support staff to take annual leave.

LB noted the see and hear and see and treat is improving and asked how we maintain this. JG felt that firstly the one change driving this is the type of activity we are now getting. He then outlined some of the steps to ensure better validation of C3 and C4, where we are joining a national pilot that allows us to validate these calls prior to dispatch to see if they are more appropriate for hear and treat.

More broadly, the Board reflected the benchmarking data in the IPR where many trusts do much better than us, reaffirming the 'case for change' work that will look at what we need to do differently; this will be the focus of the Board development session in February.

DH then updated on financial performance, which continues to run as plan and we expect this to run through to the end of year. There are currently no specific concerns. The system conversations relating to the level of deficit against the system control total are continuing. The current contracting (block) will roll over into Q1 of next year across the NHS and the planning guidance is expected by the end of March. The expectation is that from Q2 we will then go back to more familiar arrangements, but the detail of this is to be confirmed. In terms of COVID costs, we acknowledge the internal business cases for some of these costs need to be updated, to take account of the pandemic running longer than initially expected. In terms of capital expenditure, estates works continue and the orders for fleet are going through as per the business case approved by the Board.

Before questions, HG introduced his report from the last meeting of the finance and investment committee, highlighting the importance of resolving discussions with commissioners on the deficit.

DA then opened up to questions on this aspect of the IPR / FIC report.

MW asked about the financial performance of 111 CAS, as the business case was predicated on breaking even and while we are in exceptional circumstances we need to know where we are for the coming year. He added that when we come to the financial statements, we need to clarify our changing costing model, in some respects positive but in others any detriment needs to be confirmed for transparency with commentary on how we have used resources, e.g., support staff to the front line.

DH explained that 111 CAS is currently covering its costs and overheads. We went back to commissioners due to the higher activity levels arising from Think 111 First, and baseline costings being agreed on different activity levels. Extra funding has been granted and we are in discussion with commissioners to re-baseline the contract. To-date there is good support from them on this. In response to financial statements, DH confirmed we are in discussions with KPMG, and we can also use the wider annual report and AGS given the limitations on the statements themselves.

[comfort break 11.45 – 11.55]

<u>Quality and Patient Safety / QPS Committee</u>
FM highlighted two exceptions (slide 14 and 15). Firstly, clinical education is a new section in the IPR, and under the standards 'course capacity utilisation', transition to practice shows the percentage of learners at risk. Secondly, the decrease in performance against Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle. This relates to the recording of two pain scores and provision of pain relief, and the sub optimal

performance is partly due to non-registered staff being unable to give medication; the other is recording of the pain score, which is an area we are working on.

BH drew the Board's attention to RIDDOR delays, explaining this is in part due to time pressures given the pandemic. There does however remains focus on this and each one is reported, albeit outside of timeframe. HG asked about the numbers and whether we have a plan to reduce the incidents. BH confirmed that we have fewer reported incidents compared with our peers, but we are working through the H&S Group to check for themes and trends.

BH also highlighted to the Board the indicator related to section 136 9of the Mental Health Act), where performance is not as good as we would want, due to current pressures. We have struggled with all Cat 2 responses. DA asked if we can be assured this is given appropriate attention. BH confirmed that it is, led by consultant mental health nurse. TP asked if there is any evidence of harm and BH explained we look at harm for all cases and there are no identified trends specifically for those section 136 calls.

LB added that there is an increase in incidents reported and a significant increase since October, which at the quality and patient safety committee we anticipated mainly due to CAS go live, in addition to handover delays and COVID issues. The committee is assured we are sighted and it is something we review regularly, including a harm review.

LB then updated the Board on the issues covered by the quality and patient safety committee in December and January, as set out in her report.

DA thanked Lucy for a very detailed update and supported the addition of extraordinary meetings, noting that the one in a few days will consider a review of oxygen supplies, PPE stock levels and powered hoods roll out.

Workforce and Wellbeing / WWC Committee

AM highlighted the continuing issue relating to staff being out of the workplace due to COVID, and the impact of this, which links to the people recovery issue post COVID. Page 26 includes sickness rates due to mental health. And page 44 confirms the continuing reduction in turnover. The workforce and wellbeing committee will review shortly the retention strategy agreed last March. Finally, AM confirmed the plan to include in the IPR a time to recruit metric as this is important.

The Board welcomed the introduction of e-timesheets, despite the pandemic, and this is an important step forward.

LB asked about the total number of grievances and how these sit against the timelines we set for resolution. AM explained that firstly, in the IPR we need to report on individual grievances, as over the past couple of years we are seeing the numbers slightly reduce. Despite recent pressures the average time to resolution has almost halved to 40 days, compared to last year. We have a 3-point strategy - timeliness; management and development, to equip staff with skills to deal with issues well; and also professional development within the HR team. AM confirmed we have approximately 30 live cases. A number below 20 is more the norm when you benchmark, but historically it's been upwards of 80-100.

TQ noted the chart shows a flat line against whistleblowing and asked what this actually means. AM explained that we know our FTSU Guardian is receiving a high level of enquiries. BH added that the cases tend to go through FTSU. PA agreed, and so we can look at how this is reflected in the IPR. The Board then explored the link between management development and staff feeling more confident in the line management process for raising issues.

LM then highlighted the key issues from the recent meetings of the workforce and wellbeing committee as set out in the report. On education training and development, he confirmed we have time at the February Board session to discuss in greater detail including the tension between operational pressures and giving the time needed. In March, a focus of the committee will be on staff engagement and inclusion and how we use the different channels, in addition to our approach to corporate affairs.

DA thanked LM for this helpful summary reflecting that there is lots here to pick up over the next year.

69/20 Learning from Deaths Report Q1 [12.40 – 12.47]
This is the report from Q1 and FM confirmed that this corresponds with wave 1 of the pandemic. Deaths were mostly in 70+ age group and an increased number of dead on arrival, as seen in other trusts. There was also an increase in advanced care plans /DNRs. 98% of the structured reviews demonstrated good or excellent case. One case identified poor care related to the delay. An issue was also identified about the risk of non-conveyance, reinforcing the importance of record keeping. Good practice included the compassionate care and use of specialist paramedics.

TQ felt this is a really helpful report and new to ambulance trusts. On process, he noted there are three doctors involved in the reviews, and no paramedics. He asked how we get messages / learning out to staff. FM responded that there are four doctors who do a small number each month and we are planning to extend this to the Consultant Paramedics. Regarding learning, FM confident that the messages are being reinforced.

70/20 Ockendon Report [12.47 – 12.51]
FM explained that this is the report into the maternity deaths at an NHS Trust, and all trusts were asked to review the seven immediate actions and confirm the same to their Boards. This paper therefore sets out our response. We are one of three ambulance trusts who employ midwives and host midwives in the control room. Some actions don't apply to ambulance trusts but where they do, we have outlined what we have in place and/or plan.

FM also confirmed that there is also a recommendation to appoint a NED to lead maternity and we will talk to TQ as our clinical NED in due course about how best to implement this.

71/20 AOB
There was no AOB, but before closing the meeting DA thanked all our workforce including those working from home in not ideal situations. He reflected that as a Board it is important we recognise their role and the role of volunteers and those manning the welfare vehicles.

TQ also felt it was important to acknowledge the work of executive colleagues. Being new it has been impressive how they have responded to the challenges and very senior leaders often don't get the recognition they deserve.

59/20 Review of meeting effectiveness
The Board was content they had the opportunity to have their say and a shared view that there was good discussion moving between appropriate detail and strategic objectives.

There being no further business, the Chair closed the meeting at 12.54

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
24.09.2020	44 20	DA asked that the Board schedules some time to discuss the tangible progress being made against our WRES plan.	PL	Q4	Board	C	This was reviewed by WWC as per the escalation report on the agenda
26.11.2020	56 20	Due to their role in quality and safety, QPS committee to seek assurance on the pipeline for specialist paramedics (PPs and CCPs).	FM	2021/22	QPS	C	Added to the committee COB
28.01.2021	67 20	111 First is an embryonic channel shift to integrated care and SECAmb should provide the system leadership. Using a Board development session, the Board should think about this and how we establish a robust evaluative framework to ensure we realise the benefits.	PL	29.04.2021	Board	IP	

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	78-20

Name of meeting	Trust Board
Date	25.03.2021
Name of paper	Chair's Report
Report Author	David Astley, Chairman

The enduring purpose of SECAmb is to *respond to the immediate needs of our patients and to improve the health of the communities we serve*. Our strategy and everything we do is aimed at helping to achieve this purpose.

I deliberately open with this statement as a reminder of why we are here.

My report this month outlines the main focus of the meeting and of the work of the Board and its committees since January's meeting.

Each of the main Board committees have met during February and March and the outputs of these meetings are helpfully summarised in the escalation reports, which we take as a Board as part of the integrated performance report (IPR).

While it is true that much of focus over the past couple of few weeks has of course been on our response to the challenges caused by the COVID pandemic, our attention is now starting to turn to some of the underlying issues, some of which are highlighted in the IPR. At this meeting, we will use the IPR to assess the areas requiring improvement and the corrective actions being taken, and triangulate this with the work of the committees.

I mentioned last time that the Council of Governors were in the final stages of appointing a new Independent Non-Executive Director. I am really pleased that Subo Shanmuganathan has now joined us and this will be her first Board meeting. In addition, we have now agreed placements for two individuals as part of the NExT Director scheme. This is a scheme led by NHSE/I to support senior people from groups who are currently under-represented on Trust Boards with the skills and expertise necessary to take that final step into the NHS Board room. Both Christopher Gonde and Mamta Gupta will officially start from 1 April and I really look forward to working with them over the next 12 months.

As we welcome Subo, Christopher and Mamta, we say goodbye to Joe Garcia, who has been our Executive Director of Operations since 2017. This will be Joe's last Board meeting and on behalf of the Board I would like to thank him for everything he has done and wish him the very best for the future. Joe will be greatly missed. We are in the process of recruiting Joe's replacement and, in the meantime, Emma Williams has been appointed as interim Executive Director of Operations.

As Chair, much of my time since January has been spent in routine duties of Board governance. In particular, I have attended meetings with the Chairs of our three main Integrated Care Systems. The publication of the NHS White Paper has led to conversations with them all about the new working arrangements.

I was particularly pleased to be able to spend time with the Welfare Vans funded by NHS Charities Together at three Accident and Emergency Departments in Kent. This enabled socially distanced conversations with Ambulance crews to thank them for their excellent work.

Finally, as we start to see a glimmer of light, I will be working with Philip over the coming weeks to ensure we have a clear plan for the "new normal" once the COVID emergency has abated. I am aware senior colleagues are working through this at the moment and I am really keen that we balance the advantages of remote working with meeting in person. I will confirm the plan for the Board and its committees at the Board meeting in May.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	79/20

Name of meeting	Trust Board
Date	25 March 2021
Name of paper	BAF Risks Review
Author name and role	Peter Lee, Company Secretary

At its meeting in January, the Board reflected that the current BAF risks were now too operational and challenged the executive to revise them such that they were longer term/strategic in nature.

A review has been undertaken, and the Executive Management Board agrees that overall, these capture the principal risks to achieving the Trust's strategic objectives. The Audit & Risk Committee also considered this at its most recent meeting and was supportive. Therefore, subject to agreement of the Board, the detail of each risk will now be developed in line with the usual BAF risk report structure. This will include analysis of the resources being allocated to mitigate the risks, to ensure this is consistent with their potential impacts.

In the meantime, the table below outlines the proposed risks and shows which one(s) they will replace from the current version. The intention is that the current risks will be closed in the risk register save for the last two (safer recruitment and COVID 19), which will be managed in the usual way via the register.

The Board used some of its development session in February to review elements of the operating model risk, and regular updates will come to the Board from April.

At this meeting (in part 2 due to timing and commercial sensitivities) an update will be received on the 'workforce' risk, before coming to the next Board meeting held in public.

The other risks are reflected in the Board committee escalation reports:

Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development	Workforce & Wellbeing
Risk that we do not substantively engage with Integrated Care Systems and the service delivery architecture in place across the region, impacting the ability to pursue the Trust's overall strategy and supporting objectives.	Workforce & Wellbeing
Risk that we are unable to develop a robust long term financial plan to deliver safe and effective services, due to uncertainty over the future with national/regional plans.	Finance & Investment

Proposed		Current	
Workforce	Risk that we will lose a significant number of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce.	**Workforce**	Risk that the Trust will not deliver the planned operational workforce as a result of inability to recruit and retain sufficient staff
Operating Model	Risk that our operating model is not suitably designed to ensure efficient and effective management of demand and patient need.	**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
		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.
		111	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which may lead to patient harm
Education Training & Development	Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development.	**Clinical Ed**	Risk that we will not train and develop sufficient staff to meet the needs of our patients as a result of a historically poorly functioning Clinical Education service
System Leadership	Risk that we do not substantively engage with Integrated Care Systems and the service delivery architecture in place across the region, impacting the ability to pursue the Trust's overall strategy and supporting objectives.	**System Leadership**	Risk that the Trust is unable to substantively engage with Integrated Care Systems 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.
Financial	Risk that we are unable to develop a robust long term financial plan to deliver safe and effective services, due to uncertainty over the future with		

	national/regional plans.		
		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
		COVID 19	There is a risk that in the event of an outbreak of COVID-19 in the United Kingdom, the Trust will experience severe disruption to key elements of its service

Strategic Priorities:

1	2	3	4
Delivering Modern Healthcare for our patients	**A Focus on People**	**Delivering Quality**	**System Partnership**
A continued focus on our core services of 999 & 111 Clinical Assessment Service	Everyone is listened to, respected and well supported	We Listen, Learn and improve	We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	80-20

Name of meeting	Trust Board
Date	25.03.2021
Name of paper	Chief Executive's Report

1 This report provides a summary of the Trust's key activities and the local, regional and national issues of note in relation to the Trust during February and March 2021 to date. Section 4 identifies management issues I would like to specifically highlight to the Board.

A. Local Issues

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

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

4 As the pandemic continues, EMB is continuing to focus and monitor the impact of COVID-19 on the Trust, as well as looking ahead to the post-pandemic period. In addition to the main weekly meeting, we hold short daily Executive 'huddles' to ensure that there is a frequent opportunity for issues to be raised and discussed and action taken. Specific COVID-related issues discussed recently have included the on-going delivery of the vaccine programme to staff and any actions required in response to the publication of the Government's 'road map' for the coming months.

5 Other issues overseen by EMB during this period include:

- Operational activity in terms of both performance and quality/patient safety, including the significant pressures experienced during December and January
- Financial performance and planning
- Workforce planning for 2021/22
- Initial Staff Survey results reviewed
- Restoration of 'business as usual' following winter pandemic response

6 EMB have also taken decisions specifically on a number of issues including:

- The go live of e-timesheets
- Establishing an internal Partnership Board to oversee our system partnerships

	• A pilot to evaluate the use of video consultation in our PP Hubs
7	**Engagement with stakeholders and staff** During recent weeks, I have continued my on-going programme of spending time at our Trust locations, taking all appropriate precautions.
8	I have spent time engaging with staff recently at Dartford, Chertsey, Medway and Polegate Operational Units. It has been great to see the positivity shown by colleagues who, despite the challenges faced, have remained upbeat and in good humour.
9	**Progression of key estates projects** During recent weeks, we have continued to see good progress being made on our key estate developments.
10	Medway: Following completion of the land purchase of Bredgar Road on 29 January 2021, the contractor, Westridge Construction Ltd, has attended site to undertake asbestos surveys and soil sampling ahead of taking formal possession of the site in April. Following advance notice to staff, For Sale boards have gone up outside Medway, Sittingbourne and Coxheath and agents are arranging block booked site visits to strict Covid guidelines.
11	Staff communications and engagement is well established for both the 999 & 111 teams with the communications group meeting monthly, temperature check surveys completed and a second project webinar scheduled to take place in April.
12	Banstead: Demolition work and clearance of the site is almost complete. It is still anticipated that the building will be completed in Quarter 1 2022/23. Following advance notice to staff, For Sale boards have gone up outside Dorking, Godstone, Leatherhead and Redhill stations with agents reporting a healthy amount of interest in all sites.
13	Staff communications and engagement is well established with the communications group meeting fortnightly, temperature check surveys completed and two project webinars held. A separate sub-group has been established to review the re-provisions of ACRPs and reporting bases to cover the Redhill Dispatch Desk, and to keep staff engaged in this process.
14	**Staff Awards Ceremony** Due to the pandemic, two of the three Staff Awards events scheduled to take place in the Spring of 2020 sadly had to be postponed.
15	Staff due to receive their awards at the two postponed events were given the option to attend an event in October 2021 (if restrictions allowed) or to participate in a virtual event in April 2021. Approximately 50 members of staff have chosen the option to attend the virtual event, taking place on 20th April.
16	Our Communications Team have been working hard to make the virtual event as special as possible, which will include award winners receiving an afternoon tea hamper to enjoy during the event. We will also be joined virtually by the Lord Lieutenants or their representatives.

17	Awards, medals and certificates will be presented, in person, by the local management teams.
	B. Regional Issues
18	**Electronic Prescribing Service (EPS) goes live** Following 18 months of collaboration with NHS England, NHS Digital and other stakeholders including Cleric, the Computer Aided Dispatch (CAD) provider for SECAmb, we commenced testing of our Electronic Prescribing Service (EPS) in mid-March.
19	SECAmb has been providing EPS as part of the new KMS 111 IUC Clinical Assessment Service (CAS) which commenced on 1 October 2020, although all prescribing to date has been undertaken through SECAmb's 111 subcontract via IC24. The planned operating model for the KMS 111 CAS is for all functions to be undertaken on one CAD, and the ability to use EPS from Cleric will facilitate the transition to all colleagues using Cleric going forward. This will realise a better, more efficient and effective operating model whilst also being easier to have full clinical governance oversight.
20	EPS is an integral part of having a fully functioning CAS, as per the NHS England Integrated Urgent Care (IUC) specification. Currently the Trust only allows General Practitioners to generate prescriptions from the CAS however, once the appropriate governance is in place, the intention remains for SECAmb to utilise Non-Medical Prescribers (NMPs) like Advanced Nurse Practitioners and other appropriately skilled independent prescribers including Pharmacists and Urgent Care Practitioners to prescribe.
21	Once the testing is complete and Cleric has full EPS functionality, for which the goal remains early April 2021, this will allow us to electronically generate prescriptions for patients via our 111 Clinical Assessment Service (CAS).
	C. National Issues
22	**COVID-19 outbreak** As the pandemic continues to develop, I remain extremely proud of the way that our staff, regardless of role, have remained completely focussed on delivering the best service possible, despite the challenging regional and national environment.
23	Governance**:** The Operational Response Management Group (ORMG), chaired by Bethan Eaton-Haskins, our Lead Director for COVID-19 continues to meet regularly during the week and at weekends, ensuring that all decisions and actions related to COVID are considered appropriately.
24	'Roadmap' through the pandemic: Following the publication on 22nd February 2021 of the Government's 'road-map' for lifting the restrictions currently in place, we are continuing to monitor these closely. The key focus to date has been on understanding the position for those staff who have been shielding, as well as looking ahead to key dates when we may see

	a particular operational impact.
25	Crew Welfare Vehicles: December saw the return of the Crew Welfare Vehicles at hospitals across our region, crewed by our CFRs and providing hot drinks and snacks for staff. As with earlier in the pandemic, they have been very much appreciated by staff and I would like to thank our volunteers for the fantastic support they have provided.
26	As the operational pressures begin to ease, we have decided to end the provision of the Welfare Vehicles on 31st March 2021, as we also see increasing numbers of our CFRs return to their front-line operational role. Following evaluation, we will ensure that we take forward any positives into our planning for future prolonged incidents.
27	Roll-out of Powered Hoods Following a great deal of cross-department work, we are nearing completion of the roll-out of 'powered hoods' to frontline staff, with more than 97% of staff having now been issued with a hood.
28	The hoods are utilised in conjunction with Level 3 PPE to provide additional protection when aerosol generating procedures are undertaken on patients. The onset of the COVID pandemic and risks around national shortages in FFP3 masks (the Level 3 alternative to powered hoods) accelerated the delivery of this programme, although it was in the planning stage previously.
29	The Working Group overseeing the roll-out have been able to make changes throughout based on feedback from frontline colleagues. I am pleased to report that the hoods have been well received by staff so far and, following the issues that led to a review of their procurement (as outlined in the Audit & Risk Committee escalation report), we have worked with the supplier to ensure that the product will be fully supported in the future.
30	COVID Vaccination programme: On 21st December 2020 we began our staff vaccination programme, when we were able to allocate vaccine slots provided by one of our system partners at Caterham to our most vulnerable staff. Since then, thanks to the support of some of our system partners, our staff have been able to access vaccine slots at a number of hospital sites, in line with the national prioritisation.
31	On 10th January 2021, following a great deal of preparatory work, we began to vaccinate our own staff directly with the AstraZeneca Oxford vaccine from a vaccination centre established at our Headquarters. Patient-facing and EOC/111 staff were prioritised initially, followed subsequently by all staff and volunteers, and then eligible staff household members in line with the national criteria.
32	As of 18th March, 82% of our staff have received their first vaccine, including at least 77% of patient-facing staff in every Operational Unit. This is a fantastic achievement and I would like to thank everyone who has been involved in delivering our vaccination programme.
	We have now begun to deliver the second vaccines to our staff via the vaccination centre at Crawley HQ; those colleagues who received their first vaccine dose through one of our

33	system partners will return to those sites for their second dose. Given the numbers of staff now vaccinated, we will cease providing first vaccines directly to staff as of 31st March 2021.
34	National Day of Reflection: On 23rd March, we will participate in the National Day of Reflection. This will be the anniversary of the UK entering the first period of lockdown and is an opportunity to remember those colleagues we have lost during the past year, as well as showing support for all those who have been bereaved during this time.
35	**NHS Staff Survey** On 11th March the results of the 2020 NHS Staff Survey results were published, following our highest ever response rate to the survey of 63%.
36	Analysis of the results shows that the majority of our results haven't changed significantly when compared to last year, although we did see improvement in about 12% of questions. Whilst this isn't as high as we would have liked, the primary focus over the past year has been the COVID pandemic and I am glad we have still seen some improvements despite this.
37	We know, however, that there is a lot more that needs to be done, as illustrated by those questions that have less positive responses. The Executive and Senior Leadership Teams are already looking at where we have seen declines in our results along with where we have seen improvements and how we can share best practice.
38	Rather than starting new initiatives, we need to ensure that we re-focus and re-energise the on-going work that is already underway to tackle the underlying issues that we know influence the results.
39	**Launch of Gender Equality Network** On 8th March, coinciding with this year's International Women's Day, we launched our new Gender Equality Network (GEN). Once established and as it builds its membership, GEN will work to raise awareness of gender issues within the Trust and help to promote a more inclusive workplace. We know that, within the Trust, we have lower representation of women in leadership roles and I hope that the new network will help us to address this moving forwards.
40	The energy and enthusiasm were fantastic to see during the launch and it was great to hear from many colleagues about their often very personal reasons for getting involved. I look forward to seeing the network grow and progress.
	D. Escalation to the Board
41	**999 Operational Performance** We saw some improvement in our response time performance during February, although we did not consistently meet all of the national response time standards. During March, we have seen a more challenging picture, including sizeable fluctuations in demand day to day, which has resulted in variable performance.

42	Our Category 1 performance in particular has been challenged, particularly when compared to other ambulance Trusts. We have also seen instability in our Category 3 and 4 performance, as well as more challenged 999 call answer performance.
43	One of the factors impacting on our response time performance has been significant variation in our provision of workforce hours. Despite recent improvements in abstraction, we still have 120 front-line colleagues abstracted for COVID-related reasons – this in on top of usual sickness levels. We are also concerned that our provision of hours is more reliant than we would like to see on overtime hours.
44	We are continuing to focus closely on maximising the resources available on the road and in our EOCs to respond to patients, including planning ahead as far as possible and practicable. We are particularly mindful of the potential impact of forthcoming issues including second vaccines for staff, the partial easing of national restrictions on 12th April and the Easter period/bank holidays. Through our quality and safety governance framework, we also continue to closely monitor the impact of any delays on our patients.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
March 2021

Data up to and including February 2021

Best placed to *care*, the *best* place to *work*

Contents

CQC Rating and Oversight Framework

NHSI Oversight Framework*	2	●
CQC Rating **	**GOOD**	●
Information Governance Toolkit Assessment ***	Level 2 Satisfactory	●
REAP Level ****	3	▲

*	NHSI segments Trusts (1-4) according to the level of support each Trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability, with level 4 requiring the most support (Trusts in special measures).
**	Our rating following the most recent CQC inspection. These can help patients to compare services and make choices about care. There are four ratings that are given to health and social care services: outstanding, good, requires improvement and inadequate. **GOOD:** We are performing well and meeting CQC expectations.
***	The Information Governance Toolkit is a system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit Assessments. Levels range from 0 to 3; 3 being the highest.
****	Resourcing Escalatory Action Plan (REAP) is a framework designed to maintain an effective and safe operational and clinical response for patients and is the highest escalation alert level for ambulance trusts. Level 3: Major pressure (September 2020)

Symbol Key

▲ Improving performance	▼ Deteriorating performance	-	Data not provided
● No change	■ Aspirational metric	PD	Performance direction

How to use this report

Format & Reporting Aspirations

- The aim is to present a holistic overview of Trust performance, under CQC domains, which brings together the most helpful indicators to allow the Board to better understand performance across the totality of the Trust.
- There is more to do, but in building this new IPR within the Trust's Business Intelligence Power BI Platform, we have put in place the foundations for much-improved performance management across the Trust using accessible data that can be drilled down into as required, and datasets selected and exported according to the user's needs.
- We are now reporting a month in arrears, where this is possible.

Performance Dashboards

- The Board is presented with one new data set this month: complaints relating to privacy and respect. Targets have been added in a few places.
- The Board will note that some newer data sets do not have historic data provided, however the data sets will grow in coming months to give a better sense of trends etc.
- As an indication of the types of metrics we will seek to report on in the coming months, 'aspirational' metrics are included (with no data attached). Where there is no data this does not mean the Trust does not monitor these areas of performance, merely that those metrics are not routinely presented to the Board and work is still to be done to provide them in this format.
- The vision for the IPR is that it is dynamically generated, with RAG ratings and performance direction automatically populated, giving us the ability to maintain a core set of metrics but also to select those most relevant for the Board in order to tell our story more fully.
- More work is to be done to include all targets and to distinguish internal targets from national ones.

Performance Charts

- In the future, we intend to include trend lines on charts, where it will help the viewer understand the data better, and where possible targets too. We also aspire to include forecasting and performance versus forecast wherever possible.
- **Please note** that the SPC charts are no longer functioning as a licence has lapsed, according to the BI Team. The Team are working on replacing this functionality.

A Focus on CQC Domains

- Our suite of 'aspirational' metrics includes numerous across all domains, and when populated will provide a far more rounded snapshot of performance to the Board.
- Work is ongoing in the Quality and Nursing Directorate to develop indicators which will enable us to flesh out the Caring domain – an exception report is provided as this is taking longer than anticipated for good reason.

Reporting Performance Highlights & Exceptions

- Rather than provide commentary against all metrics, which was often repetitive or uninformative, we are keen to focus the Board's attention on what is going well, and what requires improvement.
- In order to sharpen this focus, exception reporting has not been provided for every instance of performance deterioration – rather only where the deterioration is sustained or outside acceptable tolerances.

Chief Executive Overview

The IPR continues to develop and each month we are improving and adding to the metrics. Its aim is to show the key performance indicators and highlight to the Board through the exception reports the areas where the executive is most concerned. Directors will talk to these areas at the meeting, and this month I will specifically draw the Boards attention to; **Operational performance improvements; the 'Caring data sets'; and the additional information about complaints and patient experience.**

When I last wrote my overview of the IPR in early January, I reported that we were in REAP 4 and had requested support from military aid to deal with the unprecedented pressures being faced within the South East region.

This IPR shows a significantly better position and a region and an organisation, coming out of the 'winter' pandemic. In February, we have seen improvement in our response times, and although we did not consistently meet the national response time standards we have downgraded our escalation level to REAP 3.

During March we have seen a more challenging picture than February, including sizeable fluctuations in demand day to day. This has resulted in variable performance. In addition to increased and inconsistent demand, we have also experienced an increase in short term sickness meaning we are still heavily reliant on overtime.

The focus over the next few months is to complete the second vaccinations for our staff and to ensure that we are planning for end of lockdown.

In the next few weeks, we will ensure that response capable staff who normally work outside of front-line and who have contributed to the delivery of patient care during wave 2 of the pandemic response, are able to return to their normal roles. I would then expect to see improved performance in areas such as audit, training, appraisals and HR compliance. We will also be looking at the results of our latest staff survey and ensuring that the IPR highlights the areas requiring further improvement.

Philip Astle
Chief Executive

Trust Overview:
Strategy, Values & Ambition

Our Purpose

As a regional provider of urgent and emergency care, our prime purpose is to respond to the immediate needs of our patients and to improve the health of the communities we serve – using all the intellectual and physical resources at our disposal.

Our Strategy

SECAmb will provide high quality, safe services that are right for patients, improve population health and provide excellent long-term value for money by working with Integrated Care Systems and Partnerships and Primary Care Networks to deliver extended urgent and emergency care pathways.

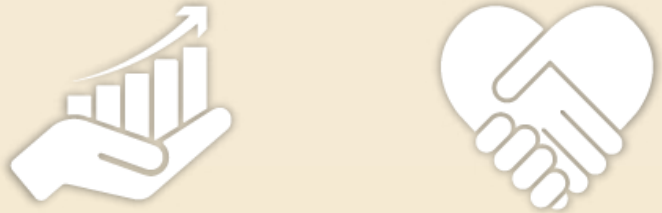
Our Priorities

- *Delivering modern healthcare for our patients* – a continued focus on our core services of 999 and 111 CAS;
- *A focus on people* – they are listened to, respected and well supported;
- *Delivering quality* – we listen, learn and improve;
- *System partnership* – we contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent & Emergency Care

Our Values

Our values of *Demonstrating Compassion and Respect*, *Acting with Integrity*, *Assuming Responsibility*, *Striving for Continuous Improvement* and *Taking Pride* will underpin what we do today and in the future.

***Best** placed to **care**,*
*the **best** place to **work***



Trust Overview:
Domain Overview Dashboard (March 2021)

Key indicators at a glance for February 2021 (unless otherwise indicated)

Safe

Metric	Feb-21	PD
999 Frontline Hours Provided %	103.20%	▲
Number of Incidents Reported as SIs	7	▼
Hand Hygiene Compliance %	93.00%	▼
Violence and Aggression Incidents (Number of Victims - Staff)	60	▼
Medicines Management % of Audits Completed	88.00%	▼
DBS Compliance %	100.00%	●
Number of RIDDOR Reports	12	▼

Effective

Metric	Feb-21	PD
**Cardiac ROSC Utstein %	40.90%	▼
**Stroke - Assessed F2F Diagnostic Bundle %	96.60%	▼
**Sepsis Care Bundle %	87.00%	▲
**Acute STEMI Care Bundle Outcome %	65.60%	▲
ECAL Mean Response Time	00:23:36	▲
999 Operational Abstraction Rate %	32.50%	▲
Statutory & Mandatory Training Rolling 3 Years %	76.20%	▲

**Latest data is December 2020

Caring

Metric	Feb-21	PD
Proportion of Complaints Relating to Crew Attitude %	50.00%	▼
End of Life Care Performance		■
Falls Performance		■
Complaints relating to privacy and respect %		■
Dementia Performance		■

Responsive

Metric	Feb-21	PD
Cat 1 Mean	00:07:33	▲
Cat 1 90th Centile	00:13:53	▲
Cat 2 Mean	00:16:48	▲
Cat 2 90th Centile	00:31:09	▲
Cat 3 90th Centile	02:01:52	▲
Cat 4 90th Centile	02:44:51	▲
999 Call Answer Mean	00:00:02	▲
111 Calls Answered in 60 Seconds %	74.00%	▲
111 Calls Abandoned - (Offered) %	3.00%	▲
111 to 999 Referrals (Answered Calls) %	15.00%	▼
Complaints Reporting Timeliness %	64.50%	▼

Well-Led

Metric	Feb-21	PD
Disciplinary Cases	1	●
Collective Grievances	1	▼
Bullying & Harrassment Internal	1	●
Annual Rolling Turnover Rate	10.50%	▲
Annual Rolling Sickness Absence	7.30%	▼
Absence Relating to Mental Health %	8.10%	▼
Absence Relating to MSK %	8.10%	▼
999 Frontline Late Finishes/Over-Runs %	51.00%	▲
Staff Successfully FIT-Tested %	91.30%	-

Symbol Key

▲	Improving performance	-	Data not provided
●	No change	PD	Performance direction
▼	Deteriorating performance		
■	Aspirational metric		

Current Operational Performance
999 Emergency Ambulance Service (as of 15/03/2021)

	Target		Month to Date			Quarter to Date		
Category	Mean	90th Centile	Incidents	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	1699	00:07:37	00:14:05	9268	00:07:60	00:14:35
C1T	00:19:00	00:30:00	1041	00:08:50	00:16:25	5404	00:09:34	00:17:41
C2	00:18:00	00:40:00	13301	00:16:59	00:31:22	78483	00:21:14	00:41:02
C3		02:00:00	9499	00:59:46	02:17:20	44999	01:28:09	03:28:18
C4		03:00:00	156	01:10:43	02:47:14	792	01:38:16	03:43:26
HCP 3			546	01:19:47	02:48:15	2495	01:56:24	04:06:58
HCP 4			427	01:33:31	03:36:20	1859	02:26:48	05:17:39
IFT 3			274	01:15:41	02:56:31	1073	01:44:02	03:35:39
IFT 4			48	02:18:41	05:18:52	277	02:14:18	05:05:13
ST			9168	33.09%		53295	35.61%	
SC			16766	60.51%		85661	57.24%	
HT			1773	6.40%		10703	7.15%	
Count of Incidents			27707			149659		
Count of Incidents with a Response			25934			138956		
999 Mean	Call Answer Target 00:05		25200	00:04		146080	00:09	
999 90th	Call Answer Target 00:10			00:02			00:14	
Trust EOC 999 Abandoned Calls			18	0.1%		382	0.3%	
A0	EOC All Calls		30187			168380		

Current Operational Performance
999 Emergency Ambulance Service (22/02/2021 – 14/03/2021)

CAT 1

	22/02	01/03	08/03	Last 13 Weeks
Mean	00:07:28	00:07:27	00:07:31	
90th Centile	00:13:51	00:13:12	00:14:37	
RPI	1.61	1.53	1.57	
Count of Incidents	912	819	869	

CAT 1T

	22/02	01/03	08/03	Last 13 Weeks
Mean	00:08:44	00:08:49	00:08:44	
90th Centile	00:16:07	00:16:15	00:16:27	
RPI	1.58	1.52	1.55	
Count of Incidents	567	512	518	

CAT 2

	22/02	01/03	08/03	Last 13 Weeks
Mean	00:16:47	00:16:06	00:17:36	
90th Centile	00:30:35	00:29:41	00:32:37	
RPI	1.06	1.07	1.06	
Count of Incidents	6664	6401	6779	

CAT 3

	22/02	01/03	08/03	Last 13 Weeks
Mean	00:54:55	00:54:49	01:03:48	
90th Centile	02:02:23	02:06:35	02:28:27	
RPI	1.06	1.06	1.06	
Count of Incidents	4735	4755	4698	

CAT 4

	22/02	01/03	08/03	Last 13 Weeks
Mean	01:06:58	01:06:34	01:16:56	
90th Centile	02:21:00	02:39:54	02:50:40	
RPI	1.03	1.07	1.04	
Count of Incidents	91	75	72	

Demand/Supply

	22/02	01/03	08/03	Last 13 Weeks
999 Call Volume	12525	12048	12858	
Incidents	13887	13490	13977	
Transports	8299	8226	8422	
Staff Hours Provided Vs 67635 target	100.3%	97.7%	97.1%	

999 Call Handling

	22/02	01/03	08/03	Last 13 Weeks
Mean Call Pickup Time (Seconds)	2	3	5	
Call Pickup Time 90th Percentile (Seconds)	1	1	2	
Call Pickup Time 95th Percentile (Seconds)	2	2	32	
Call Pickup Time 99th Percentile (Seconds)	26	63	95	
Average Call Length (seconds)	393	386	372	
Abandon Rate	0.07%	0.06%	0.09%	
Staff Hours Provided Vs 3941 target	127.0%	120.5%	110.2%	

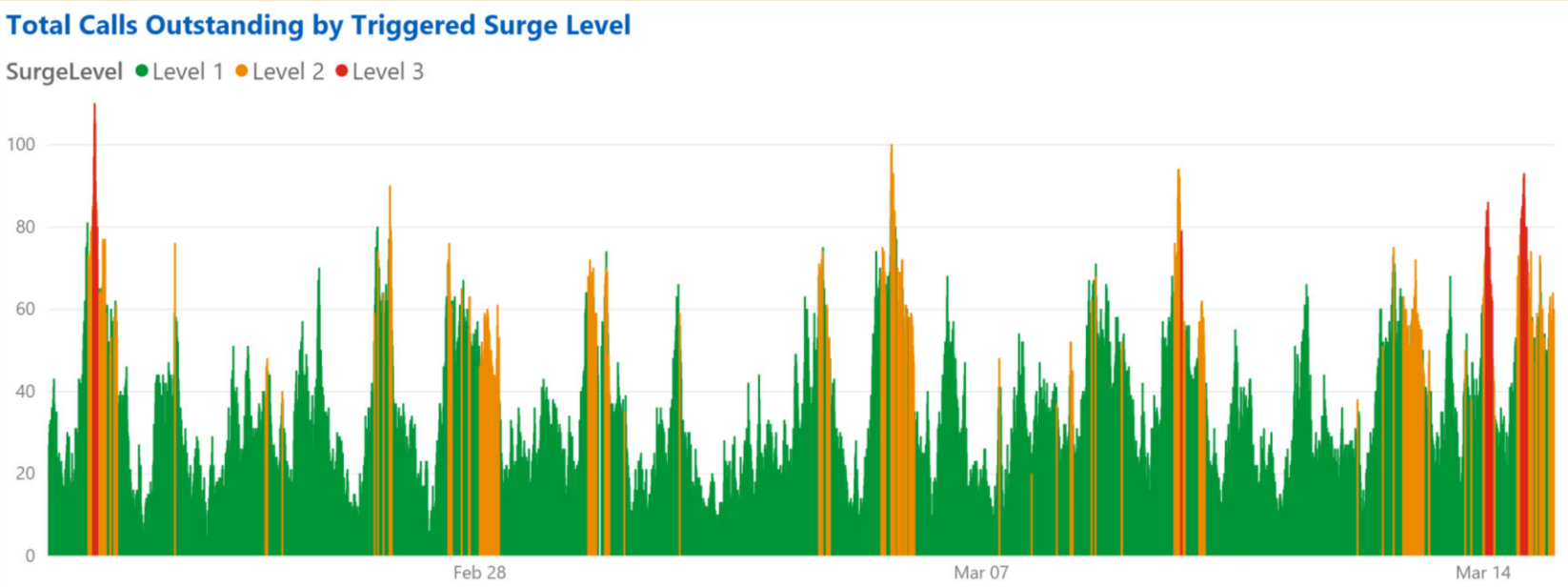
Incident Outcome

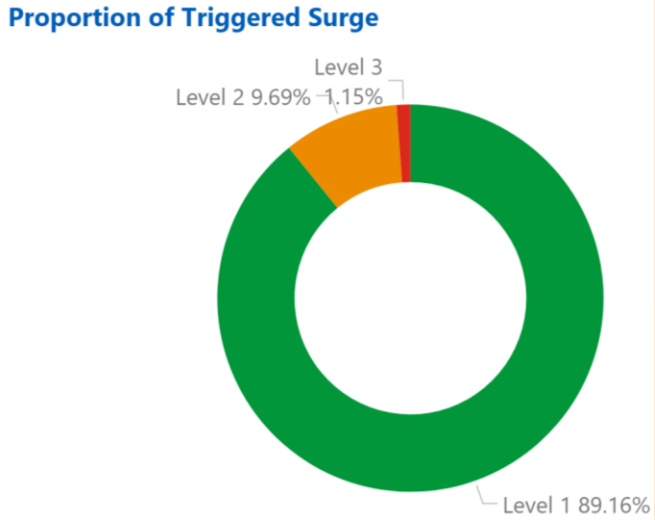
	22/02	01/03	08/03	Last 13 Weeks
See and Convey	59.8%	61.0%	60.3%	
See and Treat	34.0%	33.1%	33.3%	
Hear and Treat	6.3%	5.9%	6.4%	

Call Cycle Time

	22/02	01/03	08/03	Last 13 Weeks
Clear at Scene	01:21:57	01:21:51	01:20:50	
Clear at Hospital	01:50:37	01:49:40	01:49:27	
Hours Lost at Hospital	1055	924	931	

Current Operational Performance
999 Emergency Ambulance Service (22/02/2021 – 14/03/2021)





Surge Management Plan Triggers	
Level 1	Business as Usual (BAU) Ability to dispatch and respond to meet patient needs as identified within Ambulance Response Programme (ARP) metrics
Level 2	**Any of the triggers below:** • 2x Category 1 unassigned for >7 Minutes **or** • 8x Category 2 unassigned for >9 Minutes **or** • 20x Category 3 unassigned for >60 Minutes **or** • 20x Category 4 unassigned for >120 Minutes **or** • 20x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or** • **A combined total of 30 from any of the above triggers**
Level 3	**Any of the triggers below:** • 5x Category 1 unassigned for >7 Minutes **or** • 15x Category 2 unassigned for >9 Minutes **or** • 35 x Category 3 unassigned for >60 Minutes **or** • 35 x Category 4 unassigned for >120 Minutes **or** • 35x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or** • **A combined total of 45 from any of the above triggers**
Level 4	**Any of the triggers below:** • 10x Category 1 unassigned for >7 Minutes **or** • 30x Category 2 unassigned for >9 Minutes **or** • 60 x Category 3 unassigned for >60 Minutes **or** • 60 x Category 4 unassigned for >120 Minutes **or** • 60x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or** • **A combined total of 80 from any of the above triggers**

Trust Overview:
Summary of Performance Highlights

Domain	ID	Performance Highlight
Safe	Frontline hours provided (%)	A strong month of front-line hours produced. This was due to an improving position regarding COVID-related abstractions and high levels of overtime.
Effective		Nothing new to report.
Caring		Nothing new to report.
Responsive	111 Calls abandoned (%)	An improvement over previous months, now achieving a performance under the 5% national target as a result of improved Health Advisor hours and reduced abstractions.
Responsive	999 Call answer mean and 90th Centile	Consistent call answering performance well within national call handling target, linked to delivery of strong Emergency Medical Adviser hours.
Responsive	Cat 1 mean, Cat 2 mean and 90th Centile, Cat 4 90th Centile	Performance across the majority of the 999 ARP performance metrics have met or exceeded the national performance targets. This is primarily due to strong delivery of front-line resource hours with a decrease in COVID-related abstractions.
Responsive	Time spent in SMP 3 or higher (%)	1.31% is significantly lower than the preceding months. This was as a result of a more balanced position between the incoming demand and the resource hours produced.
Well-led		Nothing new to report.

Trust Overview:
Summary of Exceptions

Domain	ID	Exception
Safe	Duty of candour (DoC)	Missed DoC contacts as recorded for Serious Incidents in January, but 2 of 3 due to recording error. All contacts now made and 100% achieved in February.
Safe	Medicines management % of audits completed	Reduction in percentage of required audits completed, partially due to building familiarity with a new reporting system and also some gaps in reporting to be followed up by OUMs.
Caring	Complaints	Reporting on the proportion related to dignity and respect delayed.
Caring	Dementia care	Development of metrics delayed.
Caring	Patient experience	Development of metrics delayed.
Well-led	Organisational risks	The proportion of organisational risks outstanding review is increasing due to management focus elsewhere. As the focus on COVID response diminishes, managers will be reminded of their responsibilities.
Well-led	Objectives and appraisals	Management focus on completing appraisals has slipped and a renewed focus will be requested of managers in March.
Well-led	First line manager training	Training has yet to commence due to management capacity (REAP) and will re-commence end Q2 / start Q3 2021.
Well-led	Late finishes / over runs	High level of late finishes / overruns and length of average overrun exceeds 40-minutes.
Well-led	Provided overtime hours	Level is running high at present and is being monitored.
Well-led	999 remaining annual leave	Reduction in leave taken this year due to COVID.

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-3	Standards: Duty of candour (DoC) contact within 10 days Definition: Percentage of required contacts recorded as made within the specified timeframe	As part of our commitment to being open and transparent, we seek to contact relevant persons in relation to Serious Incidents (SIs) within 10 days of registering the SI. Although 100% of contacts were achieved in a timely way in February, we missed contact on 3 SIs in January and reported 67% compliance for that month. In 2 cases this was recorded incorrectly as the day DoC contact was achieved, not when we started attempts and received no answers to calls made. 2 were caused by delays in allocating Investigating Managers. DoC was completed for all SIs.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The SI Team manage the DoC process and have been reminded to complete contact where no Investigating Manager has been allocated and to record the date of attempted contacts when there is no response to attempts.	Named person: Bethan Eaton-Haskins Executive Director of Nursing and Quality Complete by date: 10 March 2021 (complete)

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
MM-7	Standards: Medicines Management % of audits completed Definition: Percentage of required audits on effective meds management completed at OUs	In the latter part of last year (2020) the process was changed for medicines reporting and placed onto the Power BI system. This made it quicker and easier for all those that required access to have up to date information in a timely manner. The OTLs are responsible for completing a weekly report for which the OUMs have oversight and accountability. The QI hub send out an exception report once a month to each OUM for the them to review and confirm that any actions from the previous month reported by the OTLs have been completed. During February the % dropped to around 80% for the weekly reports. The reasons are known and set out below.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The change of process has led to some initial gaps in reporting that will be followed up by OUMs. Some sites were not up and running on the system during the recent reporting period and others closed down during the period but the system was not updated to reflect this as information flows were not effective. However, not all of the decrease is down to the new system teething problems as there are some areas that are persistently under-reporting (such as HART West, Sittingbourne and Sheppey, and Paddock Wood medicines stores) and OUMs have been advised.	Named person: Joe Garcia Executive Director of Operations Complete by date: Ongoing

Performance by Domain
Caring: Exception Report

Our staff involve and treat our patients with compassion, kindness, dignity and respect

ID	Standard	Background
QS-12	Standards: Proportion of complaints relating to dignity and respect Definition: TBC	A number of developmental metrics were included within the IPR as suggestions. However considerable work is required to start to measure many of the metrics relating to patient experience. This is directly related to changes required to the Datix system to capture such data when the Trust migrates across to Datix Cloud.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The Trust continues to seek to recruit a Datix lead to commence work on Datix Cloud - due to start in post 15 March. The postholder will require training from Datix to start development on data capture. Metrics relating to dignity and respect will be developed by the Patient Experience Group, which is on hold until May due to transitioned exit from REAP 4.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: End of December 2021

Performance by Domain
Caring: Exception Report

Our staff involve and treat our patients with compassion, kindness, dignity and respect

ID	Standard	Background
M-17	Standards: Dementia care Definition: TBC	A number of developmental metrics were included in the IPR as suggestions. Work is ongoing in order to monitor, analyse and report on metrics.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: A dementia strategy has been developed over the past few months in collaboration with internal and external stakeholders and the Trust's friends and family test (FFT) project. The draft is ready for consultation - both internally and externally. This has been delayed due to gentle transition back to BAU from REAP 4. Following consultation a final version will be provided to the Board for approval. In the interim work has begun on a dementia dashboard, which will support monitoring of the Trust's strategy.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: July 2021

Performance by Domain
Caring: Exception Report

Our staff involve and treat our patients with compassion, kindness, dignity and respect

ID	Standard	Background
QS-11	Standards: Patient Experience Definition: TBC	A number of developmental metrics were included in the IPR as suggestions. However, considerable work is required to start to measure many of the metrics relating to patient experience. This is directly related to changes required to the Datix system to capture such data when the Trust migrates across to Datix Cloud.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The Trust continues to seek to recruit a Datix lead to commence work on Datix Cloud - due to start in post 15 March. The postholder will require training from Datix to start development of data capture. Metrics relating dignity and respect will be developed by the Patient Experience Group, which is on hold until May due to transitioned exit from REAP 4. In addition, work has been undertaken over the past few months to explore and put in place a system to collate data on the protected characteristics of patients / families who contact the Trust relating to complaints and compliments. From 1 April, the Trust will start to collect this data and reports will be provided following three months' data collection which will allow initial trend analysis.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: August 2021

Performance by Domain
Well-led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
QS-24	Standards: Organisational risks outstanding a review %	The timely review of risks has reduced during recent months; whilst this is reflective of risk owners prioritising other work it is now a concern due to many significant risks not having been reviewed for some time.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Risks are routinely reported to the Board sub-committee they are aligned to for oversight, scrutiny and assurance. However, as of this month, the risk papers are highlighting significant risks that are considerably out of date to assist the groups with challenging risk owners. This additional step should increase the number of risks reviewed. Pending future changes to the risk management process, and the build and rollout of the new Datix Cloud risk module, we will also train / re-train risk owners and remind them of their responsibilities. This coupled with the introduction of risk training as part of the new Fundamentals Leadership Course (due to commence Summer 2021) will also teach new managers their responsibilities from the outset.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: Ongoing

Performance by Domain
Well-led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
WF-5	Standards: Objectives and career conversations held (%) Definition: The proportion of staff with objectives and career conversations recorded	In February 2020, we achieved a completion rate of 61.26%. This year however, due to the combination of COVID, winter pressures and subsequent lack of abstraction, we are currently running at 46% year to date; with a rolling figure of just over 50%.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: As demand on operations begins to ease, line managers will be encouraged to resume staff appraisals.	Named person: Ali Mohammed Executive Director of HR and OD Complete by date: 31 March 2021

Performance by Domain
Well-led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
WF-27	Standards: First Line Managers who have had leadership training (Fundamentals) % Definition: Proportion of staff who have completed training	During Feb/Mar 2020, we launched a new first line manager training programme. Due to COVID the initial cohorts were forced to pause and training has yet to be reinstated due to operational pressures / demand. As a result, this programme was left incomplete and no delegates saw this course through to completion.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Over recent months the L&OD Team have worked to refresh the Management Development Programme and ensure materials are appropriate for virtual delivery. We plan to recommence delivery during end Q2 /start Q3 2021.	Named person: Ali Mohammed Executive Director of HR and OD Complete by date: Ongoing

Performance by Domain
Well-led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
999-15	Standards: 999 frontline late finishes / overruns (%) Average late finish / overrun time Definition: The proportion of shifts on which staff finish after their planned shift end, and average length of time over shift end of these overruns	51% of shifts resulted in late finishes in February, while an improvement on the preceding two months, this adverse position is a direct result of the balance between demand and resources available. Average overrun time was just over 40-minutes in February and again while the lowest in 8 months, again reflects this imbalance.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Actions include ensuring meal breaks are managed well, improvements (i.e. decrease) in cross-border working, and overall dispatch functions.	Named person: Joe Garcia Executive Director of Operations Complete by date: Ongoing focus in Q1 2021-22

Performance by Domain
Well-led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
999-21	Standards: Provided overtime hours (%) Definition: The proportion of frontline hours provided by staff working overtime	February's performance is 15.37%. This level is a further increase from an 8 month high in January.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Monitoring the position in light of total hours produced. Greater understanding of where all hours are allocated on a daily b asis is required - this is underdevelopment with the BI Team.	Named person: Joe Garcia Executive Director of Operations Complete by date: Ongoing

Performance by Domain
Well-led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
999-22	Standards: 999 remaining annual leave Definition: Proportion of annual leave yet to be taken relative to the month of the financial year	February's performance had 27.00% of annual leave remaining to be taken with one month of the year remaining. There has been an overall reduction in annual leave that has been taken this year as compared to previous years, due to COVID. End of year position for 2019-20 was 15% outstanding.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The Trust has agreed staff who have been unable to take leave can carry over additional annual leave to be used in the next 12-24 months.	Named person: Joe Garcia Executive Director of Operations Complete by date: N/A

Performance by Domain
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-1	Number of Datix Incidents	1043	1028	834	973	905	940	861	952	1342	1470	1751	1595	1070					▲
QS-2	Number of Incidents Reported as SIs	9	2	5	7	9	10	5	2	4	9	8	6	7					▼
999-12	999 Frontline Hours Provided %	90.70%	87.50%	97.30%	99.10%	93.80%	89.30%	92.50%	91.20%	94.60%	99.40%	95.10%	96.10%	103.20%	100.00%		+		▲
QS-3	Duty of Candour Compliance %	90.00%	100.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	84.00%	80.00%	67.00%	100.00%	100.00%		=		▲
QS-7	Hand Hygiene Compliance %	93.00%	92.00%	95.00%	95.00%	92.00%	82.00%	97.00%	93.00%	99.00%	95.00%	96.00%	94.00%	93.00%	95.00%		-		▼
QS-8	Safeguarding Training Completed (Children) Level 2 %	72.30%	86.90%	12.30%	35.60%	60.20%	67.10%	69.90%	72.70%	74.90%	74.90%	78.20%	79.40%	82.00%	95.00%		-		▲
QS-13	Violence and Aggression Incidents (Number of Victims - Staff)	3	5	60	67	68	69	75	66	124	74	70	53	60					▼
MM-1	Number of Medicines Incidents	165	135	112	168	111	146	103	89	162	141	125	125	142					▼
MM-3	Single Witness Signature Use CDs Omnicell	4	5	4	2	0	0	14	0	3	0	6	5	9	0		-		▼
MM-4	Single Witness Signature Use CDs Non-Omnicell	3	4	0	1	0	0	0	0	0	0	3	1	1	0		-		●
MM-5	Number of CD Breakages	21	11	20	17	17	16	14	14	17	9	25	21	10					▲
MM-7	Medicines Management % of Audits Completed	99.00%	99.00%	99.00%	100.00%	99.00%	99.00%	99.00%	98.00%	98.00%	94.00%	94.00%	93.00%	88.00%	100.00%		-		▼
WF-1	Number of Staff WTE (Excl bank and agency)	3667	3667	3734	3768	3784	3793	3806	3859	3888	3967	3956	3959	3968					▲
WF-2	Number of Staff Headcount (Exc bank and agency)	4001	4005	4075	4120	4141	4154	4173	4231	4271	4354	4345	4353	4358					▲
WF-3	Finance Establishment (WTE)	3924	3905	3905	3905	3905	3800	3816	3818	3880	3925	3950	3951	3956					▲
WF-4	Vacancy Rate %	6.50%	6.10%	4.40%	3.50%	3.10%	0.20%	2.60%	-1.10%	-0.20%	-1.10%	-0.20%	-0.20%	-0.30%					▲
QS-9	Number of RIDDOR Reports	6	12	2	8	6	11	8	7	16	5	9	9	12					▼
WF-16	DBS Compliance %					100.00%	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		=		●
M-20	Compliant NHS Pathways Audits (Clinical) %	80.00%	74.00%	77.00%	80.00%	84.00%	95.00%	95.00%	83.00%	96.00%	94.00%	92.00%	93.00%	90.00%					▼
M-21	Required NHS Pathways Audits Completed (EMA) %					82.00%	102.00%	102.00%	100.00%	100.00%	100.00%	100.00%	98.00%	49.00%					▼

▲ Improving performance
▼ Deteriorating performance
● No change
■ Aspirational metric

\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
M-22	Compliant NHS Pathways Audits (EMA) %					84.00%	84.00%	84.00%	90.00%	100.00%	94.00%	92.00%	82.00%	83.00%	100.00%		-		▲
M-23	Required NHS Pathways Audits Completed (Clinical) %								85.00%	85.00%	94.00%	100.00%	100.00%	97.00%					▼
QS-17	Outstanding Actions Relating to SIs, Outside of Timescales	507	538	500	448	320	288	248	172	158	127	111	126	112					▲
QS-19	Deep Clean Compliance %			77.00%	107.00%	105.00%	103.00%		92.00%	95.00%	86.50%	82.50%	72.80%						-
QS-20	Health & Safety Incidents					43	42	35	42	37	35	22	35	33					▲
WF-24	Current licence details held for Operational Staff %							79.30%	88.80%	88.50%	88.10%	86.40%	89.50%	90.40%	100.00%		-		▲
QS-22	Manual Handling Incidents					22	46	30	26	29	26	24	29	32					▼
QS-25	Flu Vaccine Compliance (Winter 2020-21)									58.00%		78.80%		79.80%	90.00%		-		-

▲ Improving performance
▼ Deteriorating performance
● No change
■ Aspirational metric

\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Effective: Performance Dashboard

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

** Latest data: **December 2020**

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-11	JCT Allocation to Clear at Scene Mean	01:15:55	01:19:00	01:22:33	01:19:55	01:19:20	01:16:03	01:14:37	01:15:23	01:16:39	01:18:48	01:20:16	01:22:00	01:19:51					▲
999-11	JCT Allocation to Clear at Hospital Mean	01:50:08	01:51:21	01:50:08	01:47:51	01:46:43	01:46:34	01:47:37	01:47:30	01:49:01	01:51:39	01:57:53	01:57:24	01:51:48					▲
M-1	**Cardiac ROSC Utstein %	22.00%	42.00%	33.00%	43.00%	45.00%	32.00%	46.00%	45.00%	44.00%	47.70%	40.90%							▼
M-2	Cardiac ROSC ALL %	25.00%	18.00%	24.00%	22.00%	24.00%	15.00%	24.00%	29.00%	27.00%	21.50%	15.70%							▼
M-12	**Sepsis Care Bundle %	87.00%	87.00%	88.00%	84.00%	81.00%	87.00%	88.00%	87.00%	85.00%	85.40%	87.00%							▲
M-3	Cardiac Survival Utstein %	9.00%	31.00%	14.00%	24.00%	31.00%	8.00%	19.00%	23.00%	20.00%	23.80%	15.90%							▼
M-4	Cardiac Survival ALL %	7.00%	7.00%	9.00%	11.00%	9.00%	4.00%	7.00%	10.00%	12.00%	7.60%	4.20%							▼
M-11	Cardiac Arrest - Post ROSC %	77.00%	78.00%	81.00%	62.00%	74.00%	80.00%	79.00%	78.00%	72.00%	79.70%	85.50%							▲
M-5	**Acute STEMI Care Bundle Outcome %	69.00%	73.00%	71.00%	73.00%	64.00%	64.00%	68.00%	67.00%	64.00%	62.20%	65.60%							▲
M-6	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean																		-
M-7	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile																		-
M-8	Stroke - Call to Hospital Arrival Mean																		-
M-9	Stroke - Call to Hospital Arrival 90th Centile																		-
M-10	**Stroke - Assessed F2F Diagnostic Bundle %	99.00%	97.00%	98.00%	98.00%	97.00%	98.00%	98.00%	97.00%	98.00%	97.00%	96.60%							▼
M-13	Sensitivity of Cardiac Arrest Detection During Telephone Triage %								96.00%	91.00%	94.30%	93.30%							▼
M-14	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %								79.00%	81.00%	75.10%	73.80%							▼
M-15	Time to Commence Telephone-Guided CPR Mean																■	■	■
M-16	Proportion of Non-EMS Witnessed Cardiac Arrests with PAD Applied to Patient %								6.00%	8.00%	7.50%	6.30%							▼

▲ Improving performance
▼ Deteriorating performance
● No change
■ Aspirational metric

\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Effective: Performance Dashboard

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

** Latest data: **December 2020**

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-13	ECAL Mean Response Time	00:27:49	00:26:21	00:23:15	00:23:51	00:24:00	00:25:49	00:23:34	00:24:10	00:23:41	00:24:03	00:24:23	00:23:54	00:23:36					▲
999-12	999 Operational Abstraction Rate %					32.50%	32.50%	32.60%	38.40%	38.30%	32.70%	35.30%	36.00%	32.50%	28.00%		-		▲
WF-6	Statutory & Mandatory Training Rolling 3 Years %	76.60%	83.70%	68.60%	70.80%	75.10%	76.10%	75.90%	75.40%	75.00%	74.30%	76.10%	75.60%	76.20%	100.00%		-		▲
999-17	Responses Per Incident	1.10	1.08	1.08	1.09	1.10	1.12	1.12	1.08	1.08	1.08	1.08	1.08	1.09	1.09		=		▼
999-18	Section 136 Mean Response Time					00:19:17	00:17:16	00:16:57	00:18:30	00:16:38	00:20:49	00:25:04	00:24:02	00:16:07					▲
999-19	Section 135 Mean Response Time					00:22:07	04:44:00	00:54:56	00:05:19	00:03:44	00:14:55	N/A	N/A	00:06:04					-
999-20	ePCR Usage					94.70%	93.80%	95.30%	93.70%	94.80%	96.10%	96.40%	96.20%	96.10%	95.00%		+		▼
999-24	Number of Hours Lost at Hospital Handover	3753	3192	2289	2046	1916	3610	4202	3958	4435	3358	5426	4583	2296					▲
999-25	Hours Lost at Handover as a Proportion of Provided Hours %	1.40%	1.10%	0.80%	0.70%	0.70%	0.20%	1.50%	1.40%	1.60%	1.20%	1.90%	1.60%	0.80%					▲
WF-23	Recruitment: Advert to Start Date														100.00%		■	■	■
M-24	ClinEd: Course Capacity Utilisation Associate Ambulance Practitioner %											96.00%	93.00%	93.00%					-
M-24	ClinEd: Course Capacity Utilisation Transition to Practice %											65.00%	65.00%	65.00%					●
M-25	ClinEd: Students at Risk of Not Obtaining Qualification %											40.00%		39.00%					-
M-26	ClinEd: Course satisfaction score																■	■	■
WF-34	Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	31.00%	31.10%	31.10%	31.30%	31.50%	31.90%	31.40%	30.80%	30.80%	31.30%	31.40%	31.20%	31.60%	29.10%		-		▼
WF-35	Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	22.10%	22.00%	22.30%	22.10%	22.70%	22.80%	20.50%	20.20%	19.10%	18.60%	18.60%	18.90%	18.80%	23.00%		-		▼
WF-36	Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	46.80%	46.90%	46.60%	46.60%	45.80%	45.30%	48.10%	49.00%	50.10%	50.10%	50.00%	49.90%	49.60%	47.90%		-		▼

▲ Improving performance
▼ Deteriorating performance
● No change
■ Aspirational metric

\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Caring: Performance Dashboard

Our staff involve and treat our patients with compassion, kindness, dignity and respect

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-12	Complaints relating to privacy and respect %																■	■	■
QS-10	Proportion of Complaints Relating to Crew Attitude %					48.00%	42.00%	40.00%	37.00%	23.00%	59.00%	37.00%	38.00%	50.00%					▼
M-17	Dementia Performance																■	■	■
M-18	End of Life Care Performance																■	■	■
M-19	Falls Performance																■	■	■
111-6	111 SMS Feedback																■	■	■
QS-11	Patient Experience																■	■	■

▲ Improving performance
▼ Deteriorating performance
● No change
■ Aspirational metric

\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Responsive: Performance Dashboard

Our services are organised so that they meet our patient's needs

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
111-1	111 Calls Offered	85080	162194	89757	81333	70230	71925	85338	90438	104059	111727	115809	93018	87249					-
111-2	111 Calls Answered in 60 Seconds %	61.50%	16.50%	48.70%	87.90%	93.50%	91.20%	84.00%	60.10%	66.60%	59.60%	55.40%	62.90%	74.00%	95.00%		-		▲
111-3	111 Calls Abandoned - (Offered) %	8.00%	50.20%	18.60%	1.40%	0.60%	1.00%	2.00%	9.70%	5.40%	6.30%	8.20%	6.10%	3.00%	6.00%		+		▲
111-4	111 to 999 Referrals (Answered Calls) %	12.70%	9.80%	11.90%	13.00%	13.80%	13.60%	12.40%	11.60%	11.80%	14.10%	13.90%	14.90%	15.00%	13.00%		-		▼
111-4	999 Referrals	7960	5443	6734	8768	8443	8407	8864	7943	11110	12276	12384	11903	11064					▲
111-5	A&E Dispositions %	9.70%	6.00%	9.20%	11.60%	13.40%	13.80%	12.70%	12.10%	12.00%	13.40%	14.60%	14.70%	15.40%	9.00%		-		▼
111-5	A&E Dispositions	6047	3316	5235	7795	8161	8544	9102	8320	11350	11718	12925	11683	11349					▲
999-10	999 Calls Answered	63620	77690	56319	54224	55915	62772	69541	64025	67031	62456	76806	70262	50316					-
999-10	Incidents	61110	64209	58064	60484	58653	61196	64489	61313	63644	62332	66615	65239	56470					-
999-1	999 Call Answer Mean	00:00:02	00:00:07	00:00:01	00:00:01	00:00:02	00:00:02	00:00:03	00:00:03	00:00:02	00:00:04	00:00:07	00:00:15	00:00:02	00:00:05		+		▲
999-1	999 Call Answer 90th Centile	00:00:01	00:00:12	00:00:01	00:00:01	00:00:01	00:00:01	00:00:02	00:00:01	00:00:01	00:00:01	00:00:01	00:00:54	00:00:01	00:00:10		+		▲
999-2	Cat 1 Mean	00:07:43	00:07:52	00:07:05	00:07:00	00:07:31	00:07:38	00:07:53	00:07:42	00:07:33	00:07:35	00:08:23	00:08:25	00:07:33	00:07:00		-		▲
999-2	Cat 1 90th Centile	00:14:30	00:14:55	00:13:32	00:12:10	00:14:01	00:14:34	00:14:50	00:14:22	00:13:59	00:13:49	00:15:07	00:15:16	00:13:53	00:15:00		+		▲
999-3	Cat 1T Mean	00:09:26	00:09:25	00:08:28	00:07:59	00:08:59	00:09:18	00:09:43	00:09:20	00:09:20	00:09:06	00:10:16	00:10:17	00:09:01	00:19:00		+		▲
999-3	Cat 1T 90th Centile	00:17:44	00:17:32	00:15:38	00:14:31	00:16:40	00:17:51	00:17:38	00:17:40	00:17:41	00:16:48	00:18:48	00:18:43	00:16:36	00:30:00		+		▲
999-4	Cat 2 Mean	00:19:15	00:21:26	00:14:50	00:14:28	00:16:43	00:18:31	00:18:57	00:18:55	00:18:20	00:17:34	00:26:49	00:25:52	00:16:48	00:18:00		+		▲
999-4	Cat 2 90th Centile	00:36:29	00:41:02	00:27:32	00:26:58	00:31:02	00:34:56	00:34:57	00:35:28	00:33:41	00:32:19	00:51:55	00:51:18	00:31:09	00:40:00		+		▲
999-5	Cat 3 90th Centile	03:25:09	04:00:52	01:54:57	01:40:20	02:38:05	03:19:04	03:31:37	03:15:36	03:06:47	02:52:45	05:51:35	05:38:23	02:01:52	02:00:00		-		▲
999-6	Cat 4 90th Centile	04:46:32	04:56:30	02:42:46	02:14:44	03:30:44	04:40:05	05:01:24	04:50:26	04:28:26	03:56:04	07:42:55	08:27:07	02:44:51	03:00:00		+		▲
999-7	HCP 3 Mean	02:00:42	02:18:26	01:11:25	01:11:14	01:41:16	02:06:57	02:20:06	01:51:46	01:56:51	01:57:59	03:16:55	03:01:30	01:25:11					▲
999-7	HCP 3 90th Centile	04:09:57	04:59:29	02:43:28	02:40:50	03:39:26	04:20:06	05:01:43	04:10:32	03:52:35	03:52:54	06:45:20	06:30:54	02:55:47					▲
999-7	HCP 4 Mean	02:49:16	03:08:44	01:32:09	01:34:23	02:28:17	02:53:34	03:09:26	02:21:41	02:52:18	02:50:22	04:18:54	03:45:45	01:49:46					▲
999-7	HCP 4 90th Centile	05:44:04	07:17:56	03:50:42	04:00:58	05:23:41	06:15:50	06:29:29	05:33:15	05:23:36	05:19:06	07:46:24	07:26:58	04:10:26					▲
999-9	Hear & Treat %	6.50%	8.40%	6.70%	5.90%	6.30%	6.60%	7.20%	6.40%	6.20%	6.60%	8.60%	8.00%	6.00%	7.80%		-		▼
999-9	See & Treat %	31.80%	37.10%	42.40%	37.10%	34.60%	33.60%	33.80%	33.30%	33.40%	33.70%	36.30%	37.40%	35.20%	35.00%		+		▼
999-9	See & Convey %	61.70%	54.40%	50.90%	57.00%	59.10%	59.80%	59.00%	60.40%	60.40%	59.70%	55.10%	54.60%	58.80%	57.20%		-		▼

▲ Improving performance
▼ Deteriorating performance
● No change
■ Aspirational metric

\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Responsive: Performance Dashboard

Our services are organised so that they meet our patient's needs

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-10	CFR Attendances	1051	785	0	0	75	152	520	614	673	800	648	749	580					▼
999-10	FFR Attendances	261	243	144	180	192	171	201	171	190	224	175	205	142					▼
QS-4	Complaints Reporting Timeliness %	78.00%	90.00%	92.00%	86.00%	95.00%	95.00%	96.00%	83.00%	88.00%	95.00%	69.00%	95.00%	64.50%	95.00%		-		▼
QS-5	Number of Complaints	66	56	43	48	56	73	55	82	65	69	61	69	48					-
QS-6	Number of Compliments	187	197	169	168	191	224	177	208	167	182	140	173	191					-
QS-15	Complaints per 1000 999 Calls Answered					1.00	1.16	0.79	1.28	0.97	1.11	0.79	0.98	0.95					▲
QS-16	Compliments per 1000 999 Calls Answered					3.26	3.66	2.75	3.25	2.49	2.91	1.82	2.46	3.80					▲
QS-14	Learning from deaths: Number of Structured Judgment Reviews	20	20	20	20	20	20	20	20	20					20				-
QS-26	Learning from deaths: Number of SJRs showing harm																■	■	■
999-14	Time Spent in SMP 3 or Higher %	31.70%	43.90%	3.90%	0.60%	13.70%	29.10%	38.10%	27.90%	25.90%	20.50%	75.00%	60.70%	1.30%					▲
C-2	Number of BCIs					2	2	3	1	2	1	7	3	2	0		-		▲

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Performance by Domain
Well-Led: Performance Dashboard

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
WF-5	Objectives & Career Conversation	61.30%	71.70%	5.40%	16.50%	22.90%	28.20%	31.70%	34.10%	36.70%	39.70%	41.60%	43.20%	45.70%	80.00%		-		▲
WF-7	Annual Rolling Turnover Rate	15.90%	15.80%	15.60%	14.80%	13.90%	13.40%	12.60%	11.90%	11.70%	11.10%	11.20%	10.90%	10.50%					▲
WF-8	Annual Rolling Sickness Absence	5.70%	5.80%	6.10%	6.00%	6.00%	5.90%	6.00%	6.10%	6.20%	6.30%	7.40%	7.10%	7.30%	5.00%		-		▼
WF-9	Disciplinary Cases	5	2	6	4	9	6	4	4	3	3	2	1	1					●
WF-10	Individual Grievances	8	6	4	4	8	7	5	10	11	8	9	8	5					▲
WF-11	Collective Grievances	2	1	1	0	1	0	0	2	0	0	0	0	1					▼
WF-12	Bullying & Harrassment Internal	1	2	2	1	2	2	5	3	3	5	1	1	1	0		-		●
WF-13	Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0	0					●
WF-26	Vacancy Rate for Leadership Roles %																■	■	■
WF-28	Staff Affected by Restructures %																■	■	■
WF-29	Staff Acting Up/Secondments %								3.30%	2.50%			2.70%	2.60%					▼
WF-37	Diversity: Disability - declared %								3.40%	3.40%	3.40%	4.00%	4.00%	4.00%					●
WF-38	Diversity: Disability - declined to declare %								46.30%	46.30%	47.90%	10.00%	10.00%	10.00%	0.00%		-		●
WF-39	Diversity: Ethnicity - BAME %								5.30%	5.30%	5.30%	5.50%	5.50%	5.50%					●
WF-27	First Line Managers who have had Leadership Training (Fundamentals) %					0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%		-		●
WF-18	Absence Relating to Mental Health %					12.10%	12.00%	12.10%	9.90%	10.80%	7.60%	5.30%	4.70%	8.10%					▼
WF-19	Absence Relating to MSK %					4.60%	2.80%	3.60%	3.60%	4.20%	3.60%	3.10%	2.80%	8.10%					▼
WF-25	Number of Wellbeing Hub Referrals						112	104	112	124	98	112	95	96					▼
WF-30	Time from referral to offered wellbeing appointment (days)									14	14	14	14	14	14		=		●
999-15	999 Frontline Late Finishes/Over-Runs %					47.60%	51.10%	52.20%	50.60%	50.60%	50.10%	61.10%	59.50%	51.00%					▲
999-15	Average Late Finish/Over-Run Time					00:45:44	00:45:44	00:43:40	00:47:24	00:40:46	00:44:20	00:54:50	00:53:25	00:40:19					▲
999-16	Staff Successfully FIT-Tested %						93.90%	88.30%		90.50%		91.30%		91.30%	100.00%		-		-
999-21	Provided Bank Hours %					2.90%	2.80%	2.80%	3.00%	2.80%	2.30%	5.60%	2.30%	0.30%					-

▲ Improving performance
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Performance by Domain
Well-Led: Performance Dashboard

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ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-21	Provided Overtime Hours %					7.40%	7.90%	8.10%	9.30%	9.10%	10.40%	9.10%	11.50%	15.40%					-
999-21	Provided PAP Hours %					9.10%	6.80%	7.20%	6.50%	6.40%	6.40%	5.80%	5.90%	6.10%					-
999-22	999 Remaining Annual Leave FY							42.50%	44.90%	50.70%	48.00%	45.00%	33.00%	27.00%	16.70%		-		▲
FL-1	Vehicles Older Than Target Age %					55.00%	55.00%	55.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	0.00%		-		●
C-1	Policies & Procedures Outstanding Review %						11.90%	12.60%	11.90%	13.20%	10.60%	11.80%	11.80%	11.00%	0.00%		-		▲
QS-24	Organisational Risks Outstanding Review %							14.00%	10.00%	18.00%	21.00%	14.00%	59.00%	57.00%	0.00%		-		▲

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Performance by Domain
Well-Led: Performance Dashboard

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ID	Metric	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£19410.00	£23188.60	£21877.40	£22787.20	£22393.60	£22042.20	£22557.10	£22396.50	£22430.00	£22133.40	£23376.60	£23858.00	£26134.50	£21725.70	£4408.80		
F-9	Income (£000s) YTD			£21877.40	£44664.60	£67058.20	£89100.40	£111657.50	£134054.00	£156484.00	£178617.40	£201994.00	£225852.00	£251986.50	£239837.40	£12149.10	£272965.80	£735.00
F-2	Operating Expenditure (£000s) Month	£19428.00	£22280.80	£21877.40	£22787.10	£22393.70	£22052.20	£22558.80	£22399.30	£23020.10	£23093.50	£24451.80	£25312.10	£24952.70	£21725.60	£3227.10		
F-10	Operating Expenditure (£000s) YTD			£21877.40	£44664.50	£67058.20	£89110.40	£111669.20	£134068.50	£157088.60	£180182.10	£204633.90	£230346.00	£255298.70	£239837.20	£15461.50	£284773.40	£-6082.00
F-3	Capital Expenditure (£000s) Month	£1012.00	£1859.99	£1262.00	£254.00	£861.53	£686.74	£1195.86	£1237.16	£834.38	£2343.59	£1080.59	£4378.10	£1223.15	£2621.41	£-1398.26		
F-14	Capital Expenditure (£000s) YTD			£1262.00	£1516.00	£2377.53	£3064.27	£4260.13	£5497.30	£6331.68	£8675.27	£9755.85	£14138.03	£15361.18	£15611.86	£-250.68	£19547.53	£1038.00
F-4	Cost Improvement Plan (CIP) (£000s) Month	£700.00	£776.00	£0.00	£0.00	£1022.00	£252.48	£147.52	£681.00	£71.00	£673.00	£8.00	£522.00	£478.00	£508.00	£-30.00		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD			£0.00	£0.00	£1022.00	£1274.48	£1422.00	£2103.00	£2174.00	£2847.00	£2855.00	£3790.00	£4268.00	£5007.00	£-739.00	£5515.00	£0
F-6	Surplus/Deficit (£000s) Month	£-18.00	£907.80	£0.00	£0.10	£-0.10	£-10.00	£-1.70	£-2.80	£-590.10	£-960.10	£-1075.20	£-1454.10	£1181.80	£0.10	£1181.70		£-5349.00
F-7	Cash Position (£000s) Month	£26577.00	£28326.00	£48150.00	£44676.00	£43742.00	£46283.00	£46647.00	£46862.00	£48231.00	£46275.00	£46819.00	£41747.00	£51441.00	£43848.00	£7593.00	£43848.00	£2176.00
F-8	Agency Spend (£000s) Month	£-145.00	£145.97	£231.94	£69.41	£284.92	£210.65	£174.87	£259.01	£84.98	£81.95	£205.95	£106.34	£-80.27	£210.00	£-290.27		
F-16	Agency Spend (£000s) YTD			£231.94	£301.36	£586.27	£796.92	£971.79	£1230.81	£1315.79	£1398.74	£1603.68	£1710.00	£1630.00	£2280.00	£-650.00	£2280.00	£-650.00

▲ Improving performance
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■ Aspirational metric

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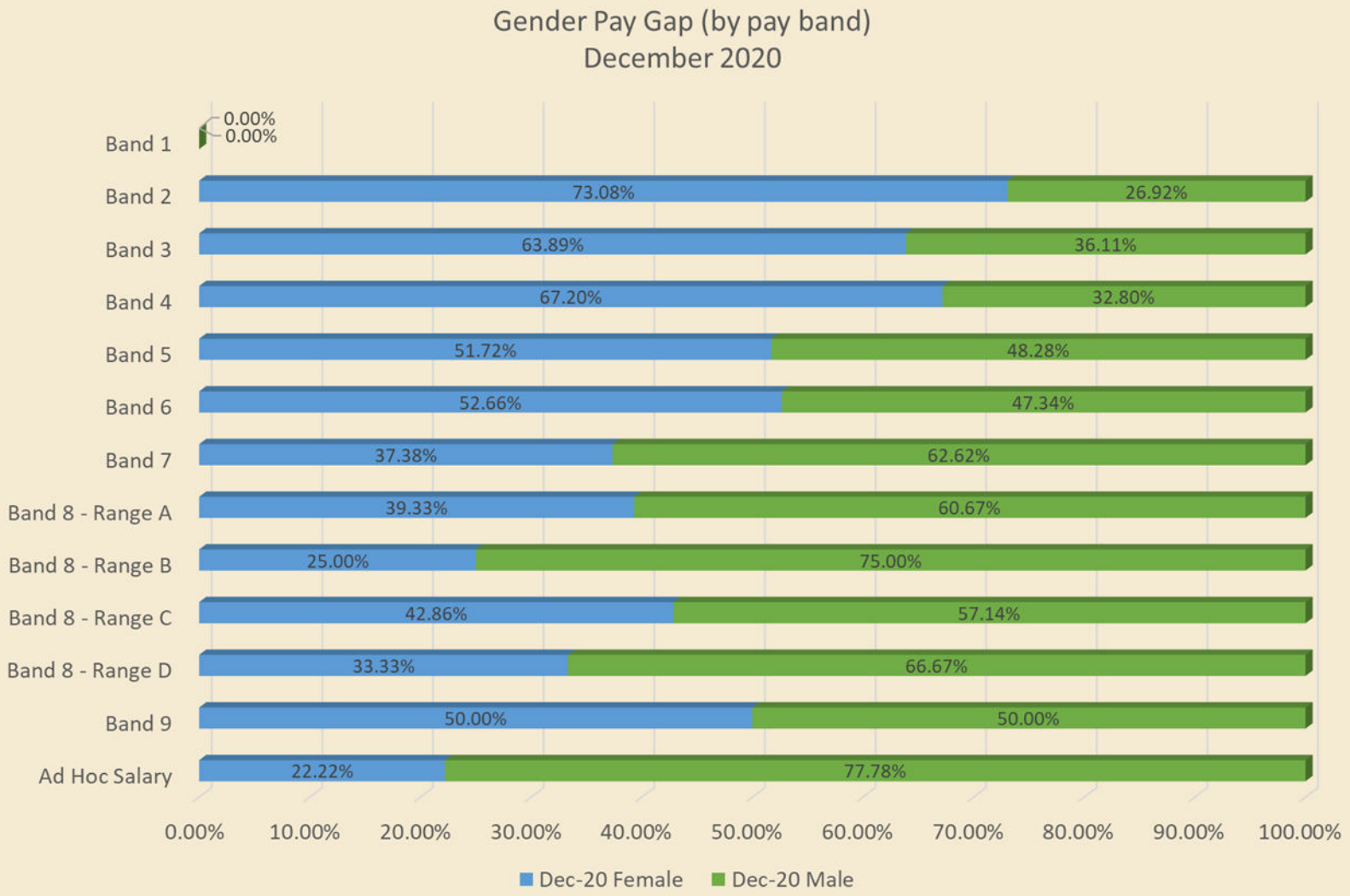
Performance by Domain
Well-Led: Gender Pay Gap by Pay Band – December 2020 (Q3)

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture



National Benchmarking
999 Emergency Ambulance Service (February 2021)

Key indicators at a glance for February 2021

Primary Triage Software	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
	NHS Pathways	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS

999 Call Answer	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Call Answer Time	00:00:03	00:00:01	00:00:05	00:00:04	00:00:23	00:00:01	00:00:20	00:00:01	00:00:04	00:00:03	00:00:00	00:00:01
Calls Answered	579464	50316	56573	59718	1234	91747	28898	81512	33181	63783	68233	44269
Mean Call Answer Time	00:00:03	00:00:02	00:00:03	00:00:06	00:00:08	00:00:00	00:00:09	00:00:01	00:00:05	00:00:03	00:00:00	00:00:04

Incident Proportions (Over All Incidents)	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	668443	56505	70565	61814	1973	93295	33096	88996	45741	66974	86960	62524
C1 Incidents %	7.37%	6.05%	7.41%	8.17%	5.12%	6.25%	6.54%	8.36%	7.98%	9.35%	6.68%	6.85%
C2 Incidents %	51.29%	48.32%	54.48%	56.93%	42.88%	54.87%	53.62%	50.06%	44.00%	51.18%	45.04%	54.35%
C3 Incidents %	24.34%	34.70%	18.29%	20.08%	34.16%	22.52%	20.78%	19.23%	30.50%	24.32%	34.43%	19.08%
C4 Incidents %	1.19%	0.65%	0.54%	0.21%	2.43%	1.06%	1.34%	2.33%	2.35%	0.52%	2.20%	0.35%

Incident Outcomes	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	8.32%	6.13%	9.78%	8.88%	7.75%	10.61%	8.90%	9.73%	9.87%	5.38%	4.75%	9.38%
See & Convey %	52.62%	57.01%	54.42%	51.63%	58.13%	52.96%	54.39%	53.48%	50.24%	50.60%	49.21%	53.42%
See & Treat %	33.71%	35.11%	33.47%	33.33%	33.30%	32.46%	27.49%	29.39%	35.10%	39.99%	39.35%	28.84%

Response Performance	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:12:06	00:13:55	00:12:25	00:12:35	00:13:37	00:10:01	00:11:28	00:12:10	00:10:38	00:13:45	00:11:35	00:12:10
90th Centile Response Time: C2	00:36:04	00:31:09	00:36:47	00:47:09	00:36:43	00:20:53	00:52:27	00:42:39	00:23:30	00:48:29	00:21:51	00:44:40
90th Centile Response Time: C3	01:43:22	02:01:53	01:43:15	02:42:54	02:08:55	01:01:59	02:51:24	01:50:45	01:18:50	02:20:28	00:52:12	02:19:17
90th Centile Response Time: C4	02:28:21	02:44:51	02:30:47	03:03:18	01:43:15	02:19:19	02:52:04	03:30:10	01:45:24	03:29:02	01:17:55	04:02:22
Mean Response Time: C1	00:06:51	00:07:33	00:06:44	00:07:08	00:07:36	00:05:57	00:06:40	00:07:12	00:05:48	00:07:28	00:06:35	00:07:07
Mean Response Time: C2	00:18:19	00:16:49	00:18:19	00:23:26	00:18:36	00:11:41	00:26:03	00:21:04	00:12:29	00:24:14	00:12:01	00:21:20

National Benchmarking
999 Emergency Ambulance Service Clinical Outcomes (February 2021)

Key indicators at a glance for February 2021

Cardiac Arrest	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Proportion of cardiac arrests discharged alive %	7.94%	12.06%	10.10%	5.43%	16.67%	5.57%	3.95%	5.43%	5.13%	14.50%	7.42%	8.42%
Proportion of cardiac arrests discharged alive utstein %	20.53%	20.00%	31.71%	18.42%	100.00%	26.19%	26.67%	16.67%	3.57%	25.00%	16.36%	17.14%
Proportion who had ROSC on arrival at hospital %	25.54%	26.92%	27.33%	14.62%	25.00%	28.24%	25.70%	23.05%	18.97%	33.70%	28.43%	25.08%
Proportion who had ROSC on arrival at hospital utstein %	42.82%	44.44%	43.90%	32.50%	100.00%	54.90%	58.82%	40.00%	14.29%	48.94%	48.21%	34.21%

National Benchmarking
NHS 111 Service (February 2021)

Key indicators at a glance for February 2021

Metric	SECAmb	Care UK	Devon Doctors	DHC	DHU	HUC	IC24	IOW	Kernow Health	LAS	LCW	Medvivo	NEAS	NWAS	SCAS	Vocare	WMAS	YAS
Calls Answered in 60 secs %	67.44%	92.08%	77.12%	82.02%	91.14%	83.92%	88.84%	84.39%	80.55%	88.66%	90.06%	79.80%	45.95%	67.31%	72.04%	79.65%	81.49%	80.23%
Abandoned Calls %	2.97%	0.91%	3.77%	2.00%	0.20%	0.84%	0.57%	3.92%	0.98%	0.57%	0.54%	1.41%	11.79%	4.13%	4.46%	1.37%	1.36%	1.25%
111 to A&E Transfer %	15.44%	11.78%	6.75%	10.15%	4.86%	4.78%	9.49%	15.00%	14.92%	13.24%	16.36%	10.51%	11.41%	11.06%	6.10%	10.77%	9.86%	13.98%
111 to 999 Transfer %	13.92%	15.08%	12.11%	14.28%	13.57%	8.56%	13.58%	13.62%	8.96%	7.79%	11.53%	12.03%	15.22%	12.47%	10.63%	11.75%	12.95%	11.94%

Appendix 1

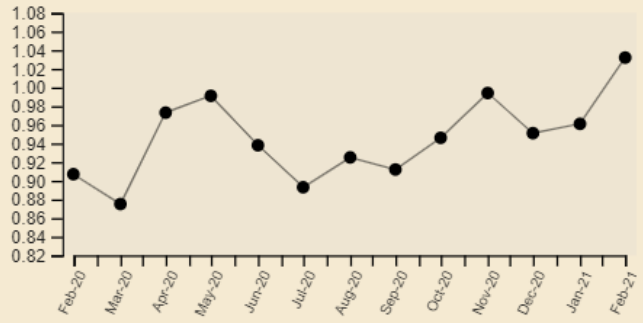
Performance Charts

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

999-12

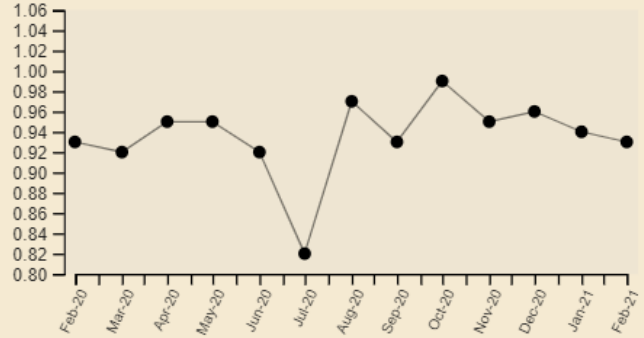
999 Frontline Hours Provided %



February 2021	Target
103.20%	100.00%

QS-7

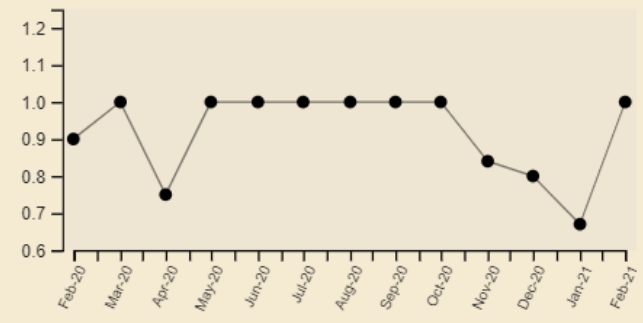
Hand Hygiene Compliance %



February 2021	Target
93.00%	95.00%

QS-3

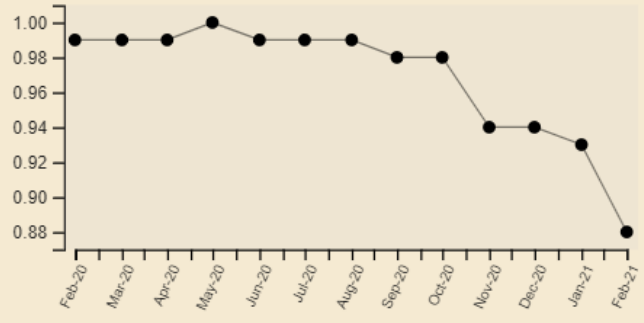
Duty of Candour Compliance %



February 2021	Target
100.00%	100.00%

MM-7

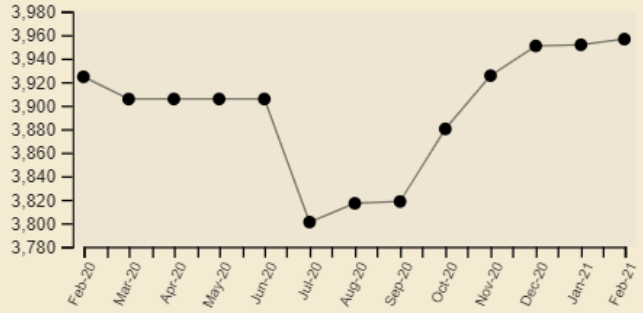
Medicines Management % of Audits Completed



February 2021	Target
88.00%	100.00%

WF-3

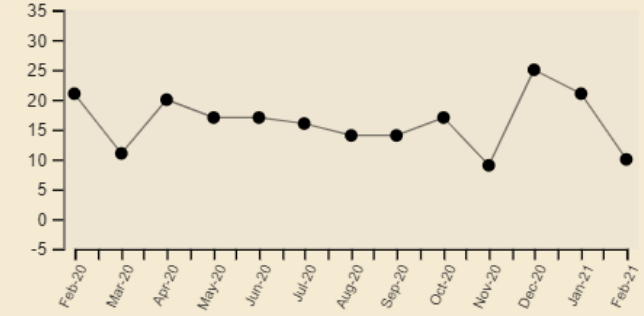
Finance Establishment (WTE)



February 2021	Target
3956	N/A

MM-5

Number of CD Breakages



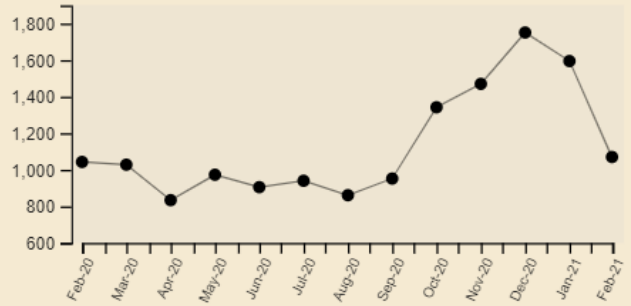
February 2021	Target
10	N/A

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

QS-1

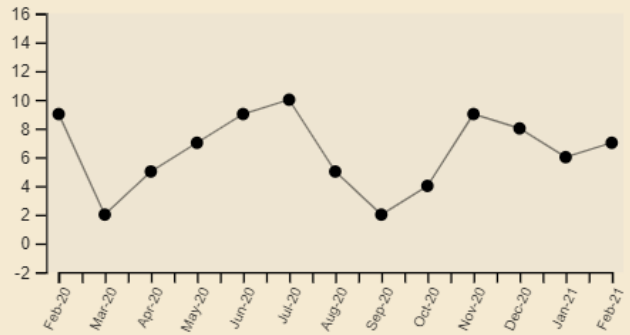
Number of Datix Incidents



February 2021	Target
1070	N/A

QS-2

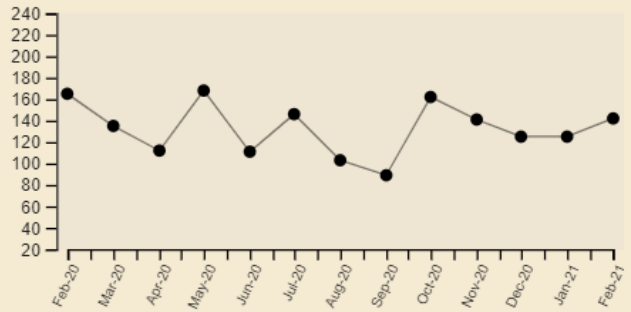
Number of Incidents Reported as SIs



February 2021	Target
7	N/A

MM-1

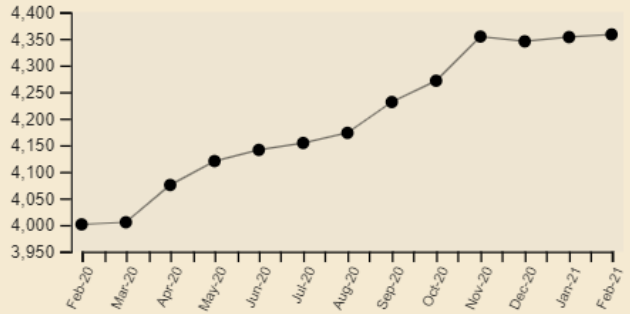
Number of Medicines Incidents



February 2021	Target
142	N/A

WF-2

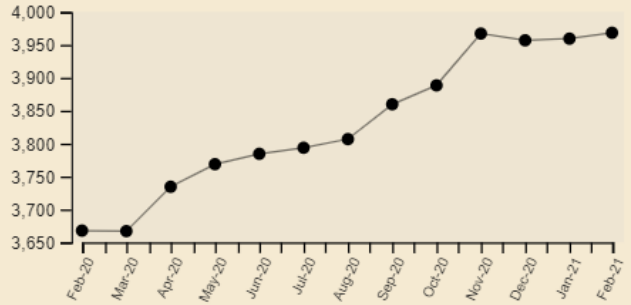
Number of Staff Headcount (Excl bank and agency)



February 2021	Target
4358	N/A

WF-1

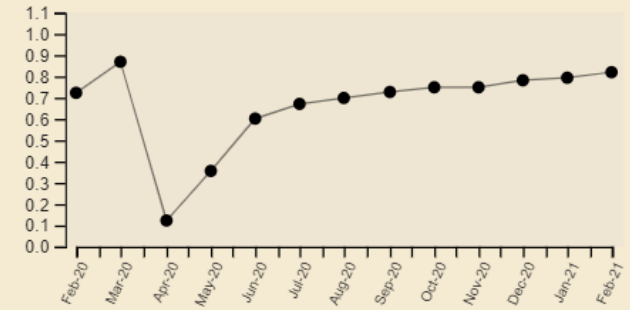
Number of Staff WTE (Excl bank and agency)



February 2021	Target
3968	N/A

QS-8

Safeguarding Training Completed (Children) Level 2 %



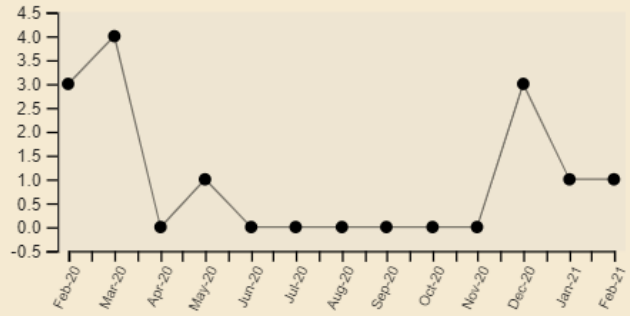
February 2021	Target
82.00%	95.00%

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

MM-4

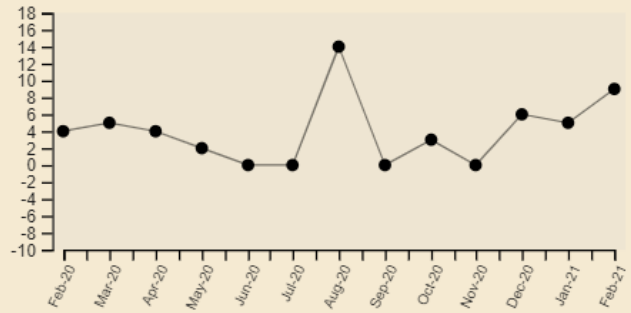
Single Witness Signature Use CDs Non-Omnicell



February 2021
1
Target
N/A

MM-3

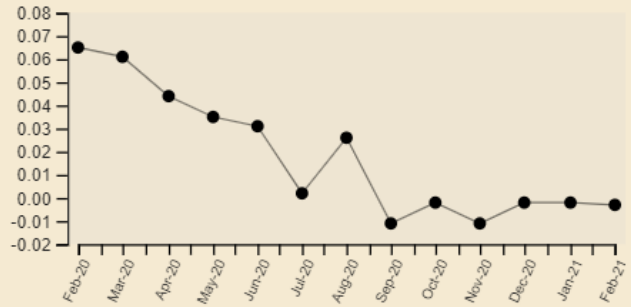
Single Witness Signature Use CDs Omnicell



February 2021
9
Target
N/A

WF-4

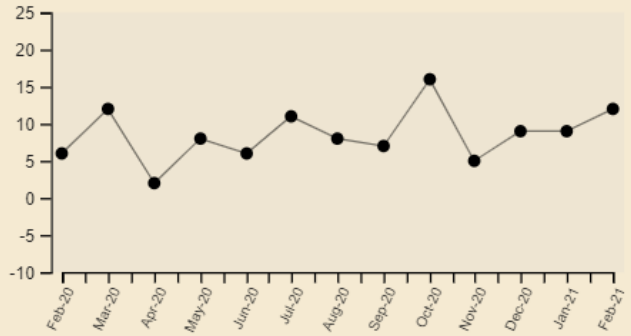
Vacancy Rate %



February 2021
-0.30%
Target
N/A

QS-9

Number of RIDDOR Reports



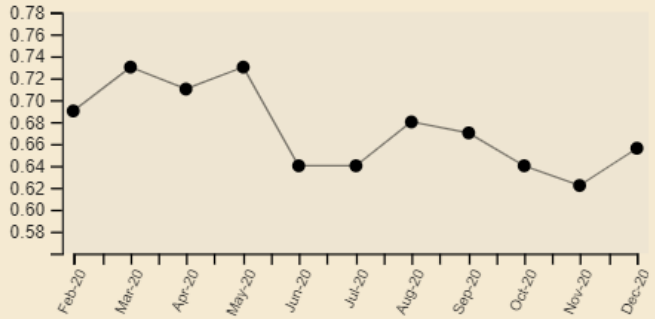
February 2021
12
Target
N/A

Performance by Domain
Effective: Performance Charts

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

M-5

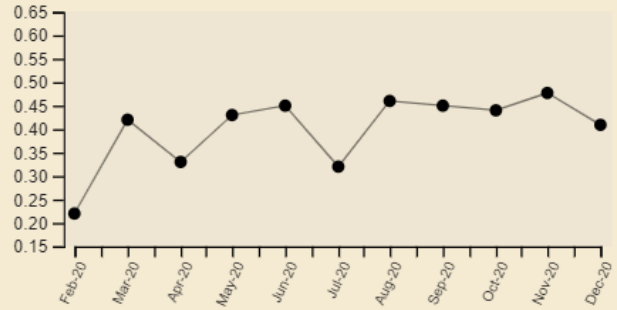
**Acute STEMI Care Bundle Outcome %



December 2020: 65.60%
Target: N/A

M-1

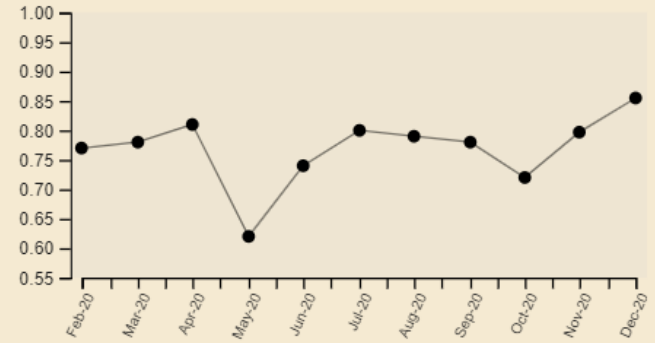
**Cardiac ROSC Utstein %



December 2020: 40.90%
Target: N/A

M-11

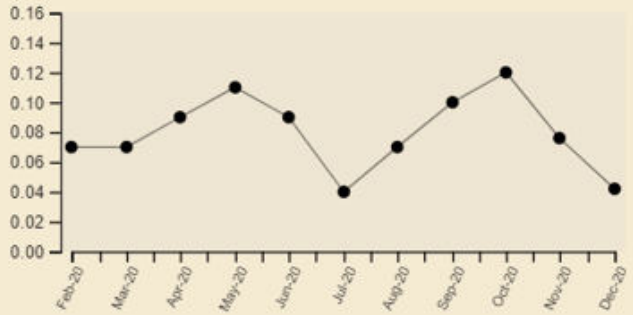
Cardiac Arrest - Post ROSC %



December 2020: 85.50%
Target: N/A

M-4

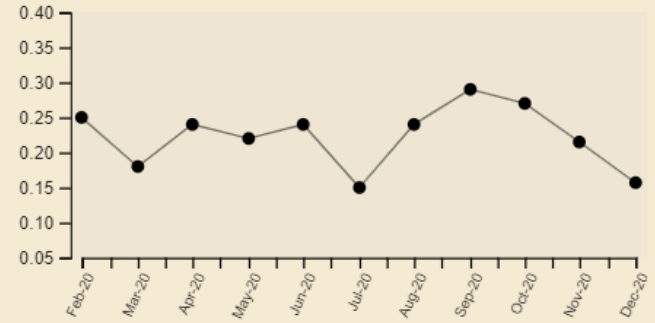
Cardiac Survival ALL %



December 2020: 4.20%
Target: N/A

M-2

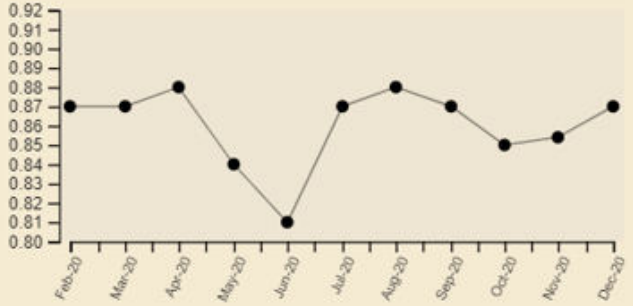
Cardiac ROSC ALL %



December 2020: 15.70%
Target: N/A

M-12

**Sepsis Care Bundle %



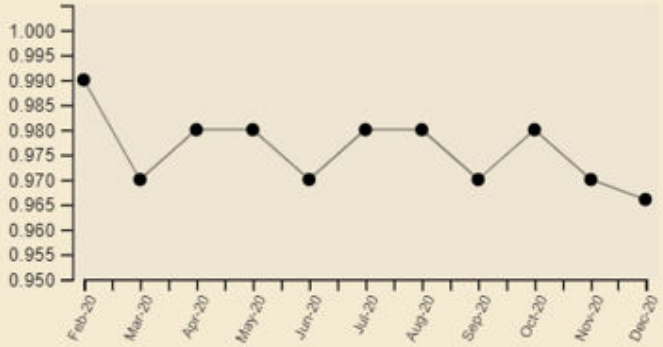
December 2020: 87.00%
Target: N/A

Performance by Domain
Effective: Performance Charts

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

M-10

**Stroke - Assessed F2F Diagnostic Bundle %



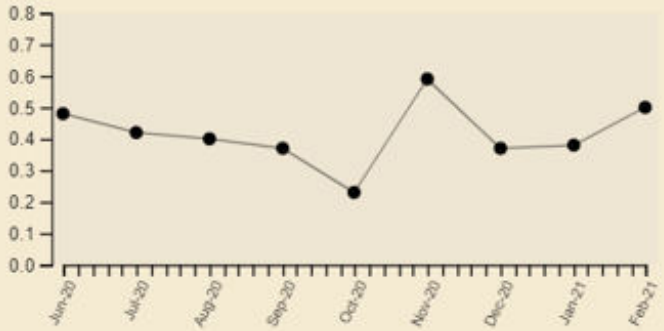
December 2020
96.60%
Target
N/A

Performance by Domain
Caring: Performance Charts

Our staff involve and treat our patients with compassion, kindness, dignity and respect

QS-10

Proportion of Complaints Relating to Crew Attitude %



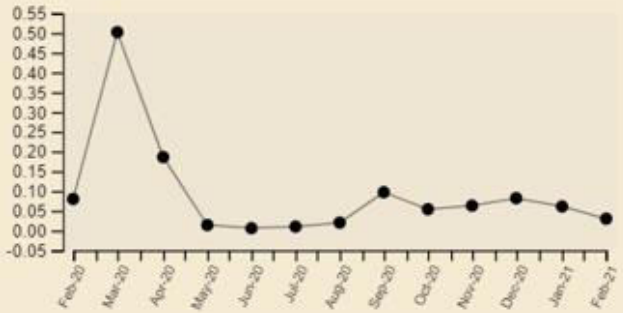
February 2021
50.00%
Target
N/A

Performance by Domain
Responsive: Performance Charts

Our services are organised so that they meet our patient's needs

111-3

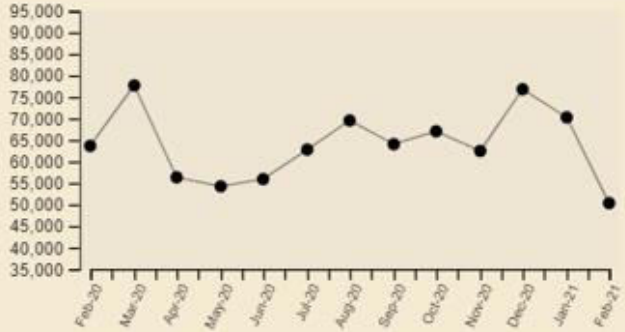
111 Calls Abandoned - (Offered) After 30 Seconds %



February 2021
3.00%
Target
6.00%

999-10

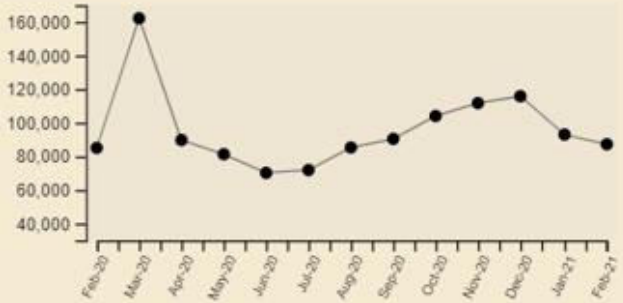
999 Calls Answered



February 2021
50316
Target
N/A

111-1

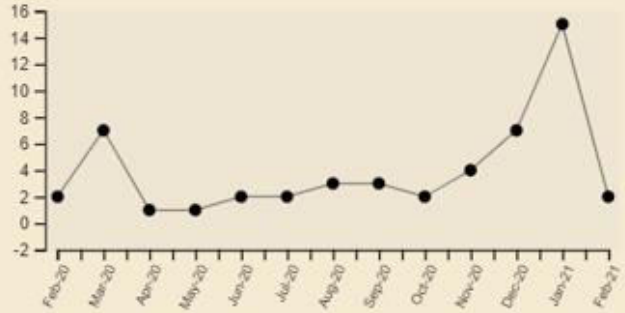
111 Calls Offered Actual



February 2021
104059
Target
N/A

999-1

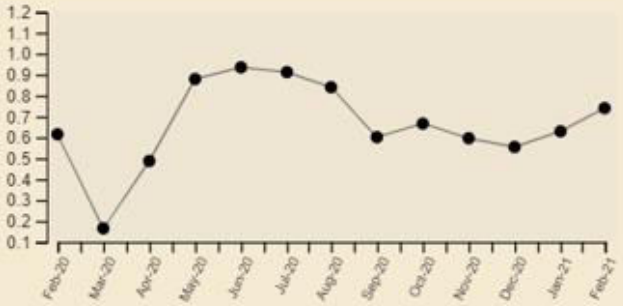
999 Call Answer Mean



February 2021
00:00:02
Target
00:00:05

111-1

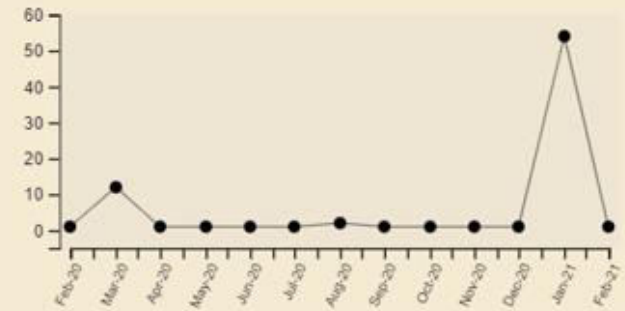
111 Calls Answered in 60 Seconds %



February 2021
74.00%
Target
95.00%

999-1

999 Call Answer 90th Centile



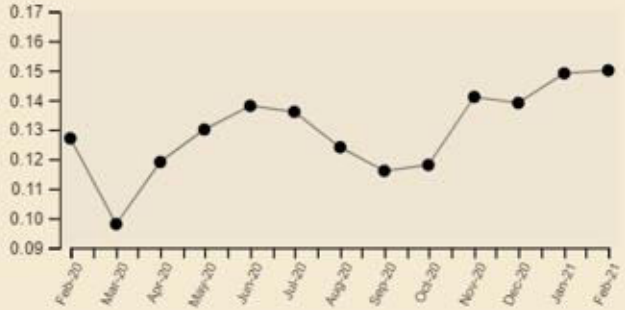
February 2021
00:00:01
Target
00:00:10

Performance by Domain
Responsive: Performance Charts

Our services are organised so that they meet our patient's needs

111-4

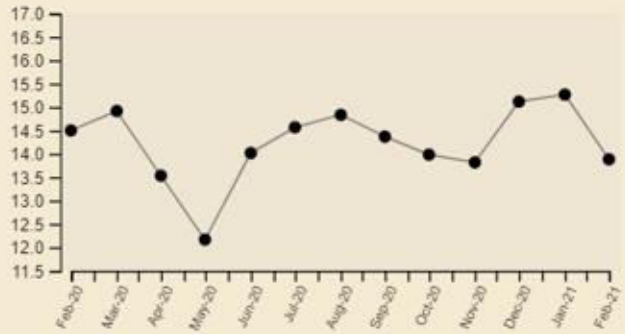
999 Referrals (Answered Calls) %



February 2021
15.00%
Target
N/A

999-2

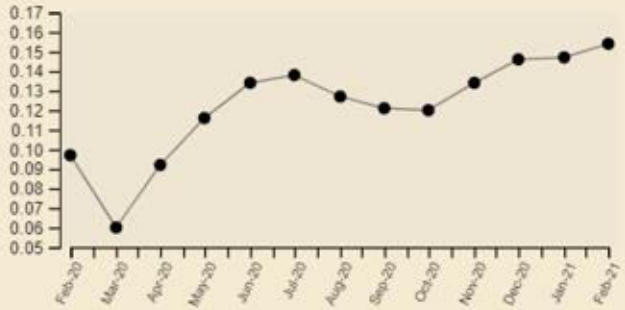
Cat 1 90th Centile



February 2021
00:13:53
Target
00:15:00

111-5

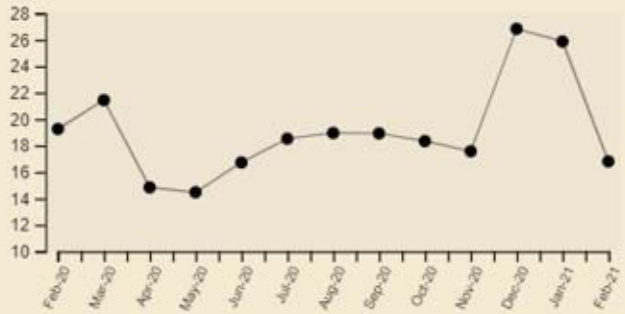
A&E Dispositions %



February 2021
15.40%
Target
N/A

999-4

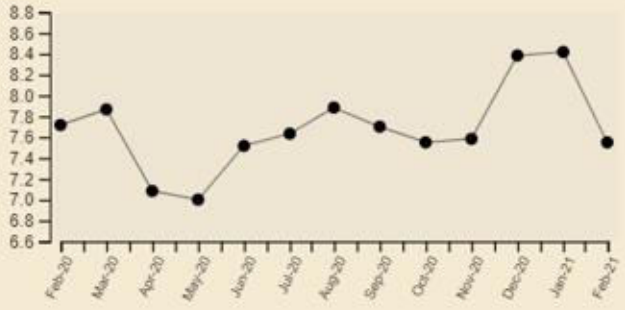
Cat 2 Mean



February 2021
00:16:48
Target
00:18:00

999-2

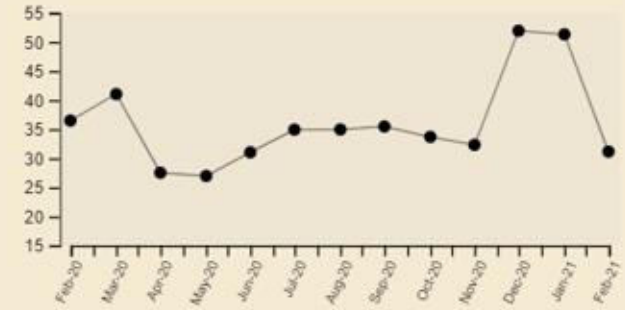
Cat 1 Mean



February 2021
00:07:33
Target
00:07:00

999-4

Cat 2 90th Centile



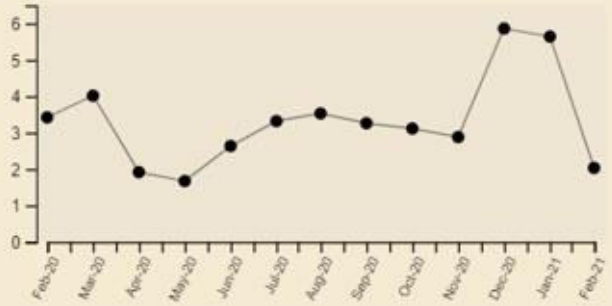
February 2021
00:31:09
Target
00:40:00

Performance by Domain
Responsive: Performance Charts

Our services are organised so that they meet our patient's needs

999-5

Cat 3 90th Centile

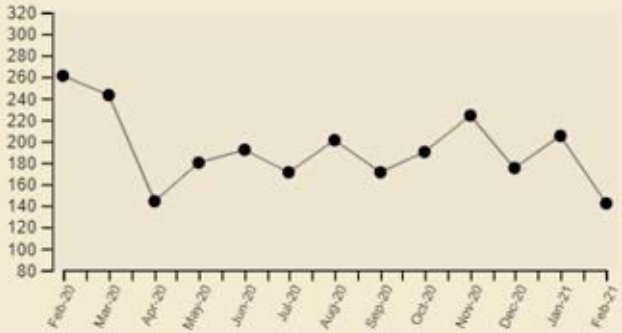


February 2021: 02:01:52

Target: 02:00:00

999-10

Fire First Responder Attendances

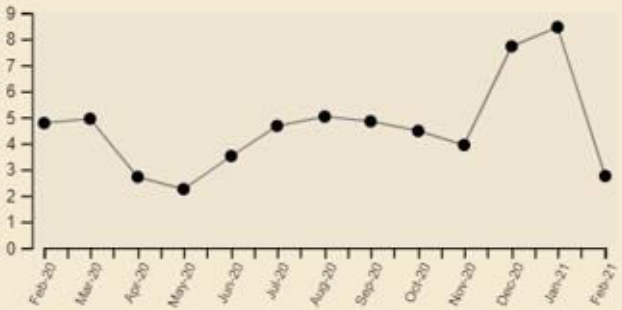


February 2021: 142

Target: N/A

999-6

Cat 4 90th Centile

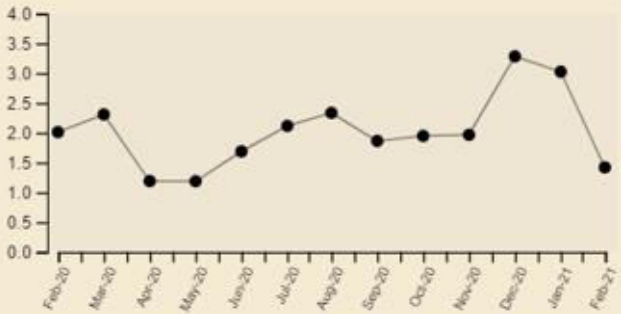


February 2021: 02:44:51

Target: 02:14:44

999-7

HCP 3 Mean

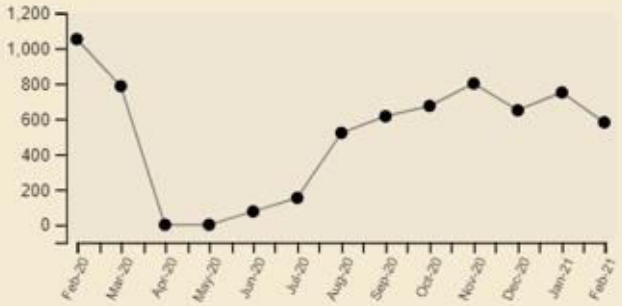


February 2021: 01:25:11

Target: N/A

999-10

Community First Responder Attendances

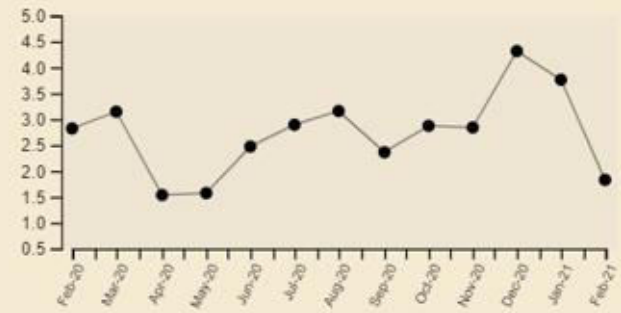


February 2021: 580

Target: N/A

999-7

HCP 4 Mean



February 2021: 01:49:46

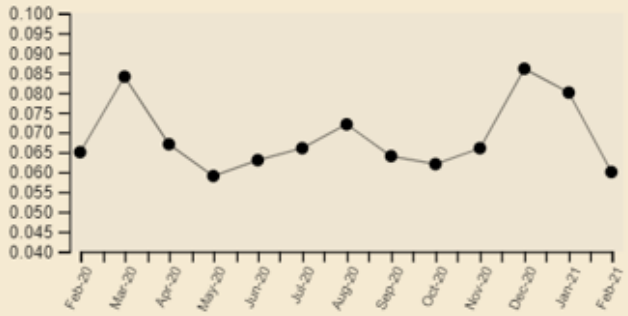
Target: N/A

Performance by Domain
Responsive: Performance Charts

Our services are organised so that they meet our patient's needs

999-9

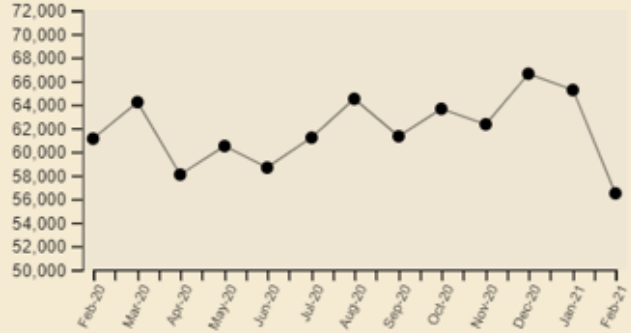
Incident Outcome Hear & Treat %



February 2021
6.00%
Target
N/A

999-10

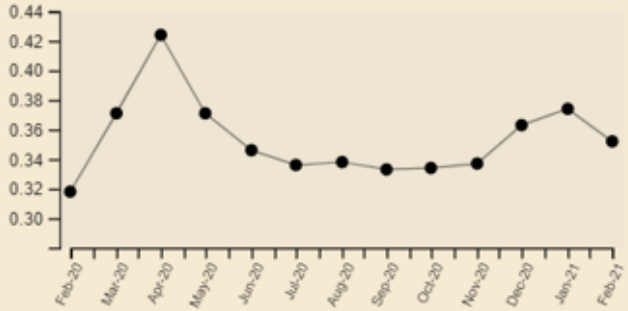
Incidents A7



February 2021
56470
Target
N/A

999-9

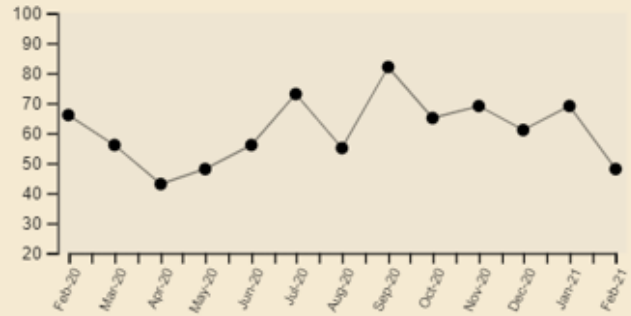
Incident Outcome See & Treat %



February 2021
35.20%
Target
N/A

QS-5

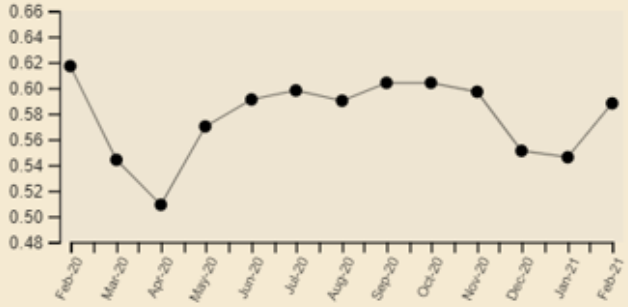
Number of Complaints



February 2021
48
Target
N/A

999-9

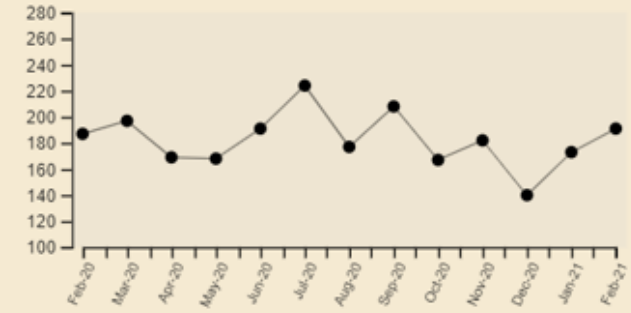
Incident Outcome See & Convey %



February 2021
58.80%
Target
N/A

QS-6

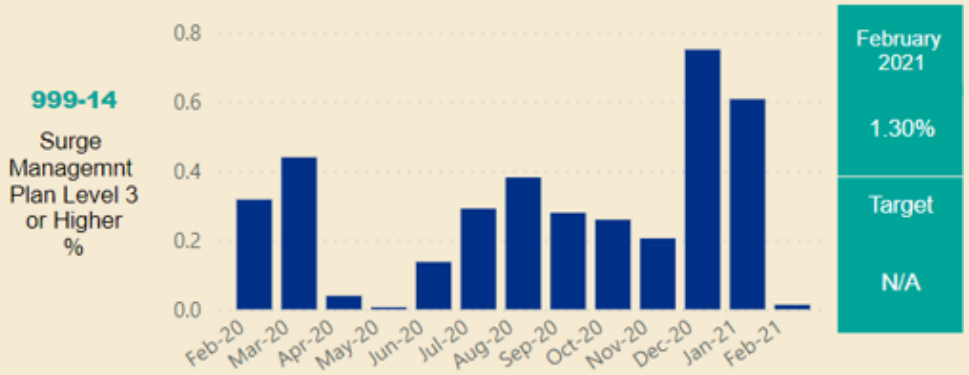
Number of Compliments



February 2021
191
Target
N/A

Performance by Domain
Responsive: Performance Charts

Our services are organised so that they meet our patient's needs



Performance by Domain
Well-Led: Performance Charts

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

F-1

Income Actual Month

February 2021	Plan
£26134.50	£21725.70

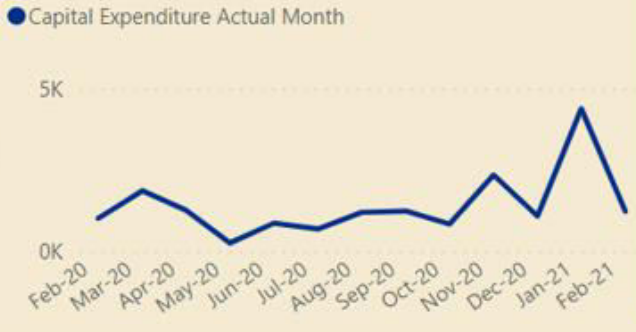
F-2

Operating Expenditure Actual Month

February 2021	Plan
£24952.70	£21725.60

F-3

Capital Expenditure Actual Month



February 2021	Plan
£254.00	£2621.41

F-4

Cost Improvement Plan (CIP) Actual Month

February 2021	Plan
£478.00	£508.00

F-6

Surplus/Deficit Actual Month

February 2021	Plan
£1181.80	£0.10

F-7

Cash Position Actual Month

February 2021	Plan
£51441.00	£43848.00

Performance by Domain
Well-Led: Performance Charts

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

F-8

Agency Spend (£000s) Month

February 2021	£-80.27
Plan	£210.00

WF-8

Annual Rolling Sickness Absence %

February 2021	7.30%
Target	5.00%

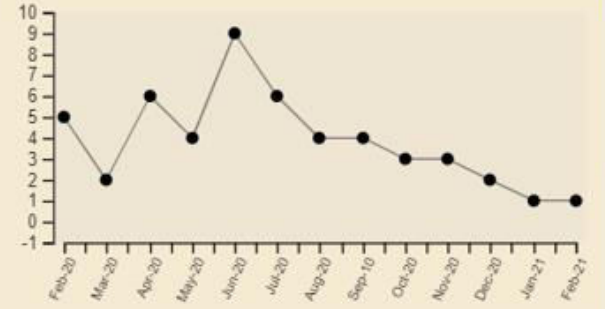
WF-5

Objectives & Career Conversations

February 2021	45.70%
Target	80.00%

WF-9

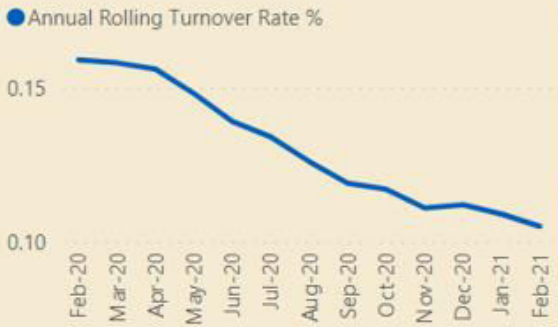
Disciplinary Cases



February 2021	1
Target	N/A

WF-7

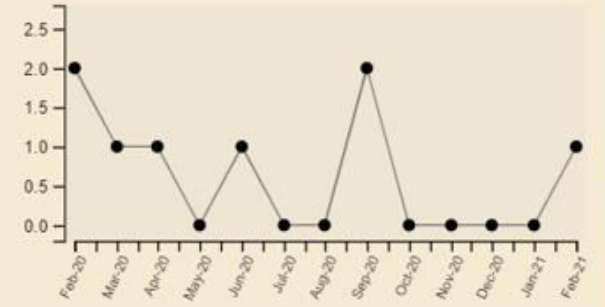
Annual Rolling Turnover Rate %



February 2021	10.50%
Target	N/A

WF-11

Collective Grievances



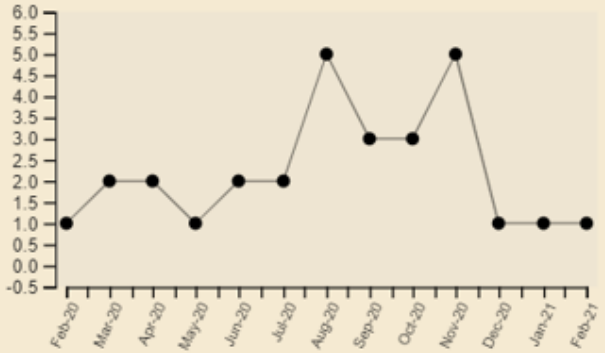
February 2021	1
Target	N/A

Performance by Domain
Well-Led: Performance Charts

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

WF-12

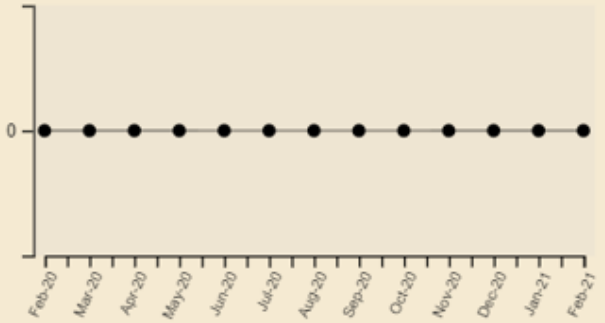
Bullying & Harrassment Internal



February 2021
1
Target
0

WF-13

Whistleblowing



February 2021
0
Target
N/A

Appendix 2

Glossary

A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ED	Emergency Department
F2F	Face to Face
FFR	Fire First Responder
HCP	Healthcare Professional
ICS	Integrated Care System
Incidents	AQI (A7)
JCT	Job Cycle Time
MSK	Musculoskeletal conditions
NHSE/I	NHS England/Improvement
OmniceII	Secure storage facility for medicines
PAD	Public Access Defibrillator
RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations
ROSC	Return of spontaneous circulation
SI	Serious Incident
STEMI	ST-Elevation Myocardial Infarction
Transports	AQI (A53 + A54)
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
TIA	Transient Ischaemic Attack (mini-stroke)
WTE	Whole Time Equivalent (staff members)

Appendix 3

Symbol Key

PD	Performance Direction		
▲	Improving performance	+	Outperformed target
▼	Deteriorating performance	-	Underperformed target
●	No change	=	On target
■	Aspirational metric	-	Data not provided

Ambulance Call Categories (Ambulance Response Programme)

Category	
Cat 1	Calls from people with life-threatening illnesses or injuries – such as cardiac arrest
Cat 2	Emergency calls – serious conditions such as stroke or chest pain
Cat 3	Urgent calls – conditions which require treatment and transport to hospital
Cat 4	Less urgent calls – stable cases which require transport to hospital or a clinic

Chart Key

Data Point	This represents the value being measured on the chart.	AVG	This line represents the average of all values within the chart.	Above UCL Below LCL	When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.
Target	The target is either an internal or National target to be met.	Upper Control Limit Lower Control Limit	These lines are set two standard deviations above and below the average.	Run of 8 improving against average Run of 8 deteriorating against average	These points will show on a chart when the value is above or below the average for 8 consecutive points. This is seen as statistically significant and an area that should be reviewed.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meeting	18 March 2021
Overview of key issues/areas covered at the meeting:	**Operational Performance** There was a detailed review of performance and the current trends. In summary, things are closer to normal than they have been in terms of activity and delivering hours, and APR performance is improving. We still have much reliance on overtime which as the committee has highlighted before, is not sustainable. The director of operations took the committee through the efficiency metrics, which led to the committee concluding that there needs to be greater focus on what the data and information is telling us about what we need to do to manage our resources more effectively over the coming months. For example, to improve the ratios between hear and treat, see and treat, and see and convey. There was also a good analysis of 111 CAS performance and, linked to the review of 999, the committee noted the efforts to ensure patients are treated at the right place/time. Overall, the committee is assured that during this very challenging period we have done our very best to keep people safe. Forecasting will be key going forward as will getting the best out of our 111 CAS so that as we work through the shape of our operating model, we ensure we are set up as efficiently as possible to deliver safe and effective services. **Information Technology** A really helpful paper was received that set out a very impressive list of Digital / IT deliverables during the past year, along with the resourcing and budgetary summaries. Our structure appears to be similar to others although the committee noted that it is not very easy to benchmark as some have different services. The committee discussed the size of the digital support team based on what we need to do and how our platforms are configured. It explored how far we are from a series of platforms that optimise a level of support, for example more cloud based systems will lead to a lower overhead. It noted we are only halfway in our journey having been focussed over recent years predominantly on network infrastructure. There has also been much investment in the Microsoft estate and roll out of hardware. The next challenge is to look at our disparate systems and this will inform the strategy. The committee is assured with what we have in place and gave special thanks to the IT team for their efforts, especially over the past 12 months of the pandemic. **Commissioning Contracts** A report was received updating the Trust's NHS commissioned contracts and services. This helped to provide assurance that we have effective contract management and an early alert system for potential issues, risks and opportunities that may arise.

	Budget Update 2021/2022 / Financial Performance There continues to be a lack of certainty about the system's financial framework. We are however well engaged with our partners to ensure we gain as much clarity as possible. Internally, the only significant outstanding issue relates to the desk top evaluation of our estate. An impairment is expected. The current headline numbers are as follows: ▪ The month 11 deficit of £3.3m is £2.5m better than plan ▪ The year to date deficit is £4.2m, which is £2.3m better than plan ▪ The full year forecast is a deficit of £4.2m, favourable to plan by £2.2m ▪ The Trust has received some Covid-19 funding and funding is expected for the additional annual leave carry over The committee discussed the main risks, which include the rollover of block contracts into 2021/22 perpetuating the funding gap, and the funding gap for 111 First. In summary, the committee is content with the financial position, in the context of the pandemic. Specifically, the committee does not think the expected deficit is due to sub optimal financial management, nor does it think the underlying position has deteriorated. That said, while some things are not within our control, the committee reinforced the need to understand what we can control like our cost improvement programme, as we must be as efficient as possible. The committee will closely monitor the planning for next year as more certainty emerges and will hold extraordinary meetings, as necessary. **Procurement** There was a really good presentation setting out the approach to procurement. The overarching aim is to establish a robust procurement business partner model to ensure best value for money and improved contract management. The committee supported the approach and asked that we ensure greater prominence of environmental sustainability / anti-slavery etc. as it applies to the supply chain.
Any other matters the Committee wishes to escalate to the Board	**Replacement of iPads** A fully funded business case was supported, and this will be coming to the Board in part 2 due to the commercial sensitivities.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	9 | 242/20

Name of meeting	Quality & Patient Safety (QPS) Committee
Date	Friday 26 February 2021
Name of paper	Cervical spine and immobilisation guideline update
Responsible Executive	Dr Fionna Moore - Executive Medical Director
Author	Dr Magnus Nelson - Assistant Medical Director
Synopsis	This paper provides oversight of the current position and background to the SECAmb Immobilisation guidelines 2020.
Recommendations, decisions or actions sought	The narrative describes process and scrutiny of the guidelines introduced to SECAmb in July 2020 with regard to C-Spine assessment and immobilisation It is recommended that a follow up report is provided at 24 months looking at the national progress on adoption and internal performance of the guideline.

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**

Cervical spine and immobilisation guideline update

1. Background

1.1. C-spine assessment and immobilisation is a topic that has for many years been an area where the literature has shown no clear evidence of benefit. The American Advanced Trauma Life Support (ATLS) version of triple immobilisation with hard (semi rigid) cervical collar, head blocks and tape has been the international standard. The absence of an alternate view has been a factor in slow changes that have occurred in the last 7 years because the only doctrine that has been widely taught follows the ATLS model.

1.2. Since 2014 there have been a number of new pieces of work which have attempted to review historical academic literature and investigate new methods for the assessment and immobilisation of patients. Several of these have led to the delivery of new national and regional guidelines overseas.

2. Development

2.1. Since 2018 SECAmb has spent time working with local Trauma Networks, expertise from within the region and international colleagues to develop a set of C-spine assessment and immobilisation guidelines that reflect the current best available international evidence and significant changes of international pre hospital practice from settings such as Scandinavia and Australasia.

2.2. Our process culminated in 2020 with SECAmb guidance being reviewed by a Joint Royal Colleges Ambulance Liaison Committee (JRCALC) subgroup as a forerunner to being adopted as national guidance as well as going live within the Trust in July 2020. A training package had been developed and delivered as part of Key Skills to ensure that staff were familiar with the Trusts new approach to immobilisation which was well received.

2.3. Following the JRCALC review process very little was changed to create a draft guideline of UK Ambulance best practice for beyond 2020.

2.4. On final review at National Ambulance Service Medical Directors (NASMed0 in late 2020 it became apparent that there were a number of individuals involved in the JRCALC process who had not recognised the need to declare a role in a potential upcoming National Institute for Health Research (NIHR) grant application for research surrounding this topic. Therefore, the request to JRCALC was that this guideline was not adopted at the current time until the status of the grant application and research was finalised. This process may take a number of years to complete.

2.5. This series of events means that currently SECAmb is operating a set of guidance that whilst based heavily on best evidence and international practice, sits outside of the current JRCALC guidance on spinal immobilisation. It is not unusual for Trusts to work to their own guidance on some elements of care and process but given the historical position of C-spine management it is appreciated that this may be felt to hold a degree of organisational risk.

2.6. During the guideline development the Trust has worked through all of the elements required to ensure the guidance is in line with creation of best practice and this is reflected by the favourable feedback from JRCALC and absence of significant change in the guidelines that were to be adopted.

3. Oversight

3.1. In light of the delay in adoption nationally there is a need to ensure organisational support and oversight for this element of care continuing to be delivered by SECAmb.

3.2. The development process has been shown to be robust and we have sought feedback from the Trauma Networks that we convey patients to who were also involved in the early phases of development. In all cases they have confirmed they are supportive of our management of patients in line with our 2020 guidance and are not aware of any significant issues since the transition to the new format.

3.3. We have liaised with the Chief Executive of Aspire, the national association for spinal cord injury patients, whose response has also been positive.

3.4. We have also conducted a review of DATIX and legal proceedings in order to ensure that practice to date has not highlighted any clear patterns of a reduction in the quality of care delivered.

3.5. The review of DATIX using the terms SPINAL/SPINE/IMMOBLISIATION for the period post introduction revealed 46 incidents which on review led to 5 relevant DATIX to the area of consideration. 3 related to failure of equipment with no impact on the patient. 1 related to a failure of documentation on the Electronic Patient Clinical Record (ePCR) and 1 related to a failure to follow the new guidance, but with no patient sequelae.

3.6. A review of current and pending legal cases revealed none relating to the time since the introduction of the new immobilisation guidance.

4. Summary

4.1. SECAmb has undertaken an evidence-based consensus approach to the generation of new C-spine assessment and immobilisation guidance. The guidance delivered has had positive reception from JRCALC and many others including the staff. Due to circumstances outside of the Trust's control it has been delayed in being implemented nationally but is actively supported by our regional Network partners as being in line with current practice followed by them. A review of our own incident reporting has not revealed any evidence of concern or poor-quality care in the time since the instigation of the guidelines in 2020.

5. Recommendation

5.1. It is recommended that the Trust continue to use the 2020 C-Spine and immobilisation guidance and perform a further review at 24 months post go live including the status of the national guideline process.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**11 March 2021**
Overview of issues/areas covered at the meeting:	The meeting started with a review of a ***management response*** relating to an issue escalated to the Board in January about the completion of the learning for AAPs. This relates to 63 AAPs with outstanding learning/assignments and progress reviews with each individual has been taking place through March. The aim is to use this to identify those engaging and on track; those engaging and require support to ensure completion of the requirements, with revised timelines; and then those that are either not engaging or are asking to withdraw. The committee confirmed that if any of these individuals wished to withdraw then we would work with them to ensure they are redeployed. No redundancies are planned or expected. The committee sought reassurance that this delay in our pipeline for clinical staff had been accommodated in our workforce planning. By the time of the Board meeting, we should have a clearer picture. The meeting then focussed on the following areas: **HR Process Performance Update** The committee received updates on progress against some of the HR/management processes and controls. This will remain a standing item until the committee is assured they are all established and working effectively. <u>E-Timesheets</u> The roll out from January went ahead as planned. The engagement from staff has been positive, although as expected there has been a high number of queries, which appear to have been managed well. Some issues have been identified, including some submission errors, data issues and pay, all of which are being addressed. The committee heard that the February pay run saw fewer issues, using the learning from January. The committee acknowledged the huge effort that has gone into this to make it work. It has shone the light on some historical anomalies with how hours have been claimed, which are being looked in to ensure staff are clearer about how to follow the rules. This should remove one source of tension between staff and their line managers. The committee reflected on this work, between HR specialists and line managers, and feels this has been an example of good matrix management and cross organisational learning.

E-Expenses

The roll out has been delayed due to recent operational pressures. Some trial sites have systems fully embedded and are using them well, and this will help the full roll out. The remaining issues linked to car insurance is close to resolution.

P-Files

The numbers of outstanding returns is continuing to reduce and is not circa 400. There are a small number of OUs that require specific focus with more targeted engagement to ensure this project is completed over the coming few weeks. This led to a discussion about how in our broader reporting, we are able to show local managerial 'hotspots', in addition to looking at indicators trust-wide.

Driving Licences

There are now just over 250 outstanding checks for operational staff. Additional resource has been allocated to work through these individuals more directly, in a similar way we are focussed the final push for P Files. The committee clarified that to-date no issues have been identified as a result of either P Files or driving license checks. In risk terms, the likelihood of staff driving our vehicles unlicensed was low but the consequences would be extremely damaging

Payroll Provider

The draft Business Case and Service Specification has been drafted, with the final specification to be agreed by April 2021. The go-live has been pushed back to ensure a safe transition.

Corporate Affairs

The committee had a good discussion on this, based on a paper setting out how we do corporate affairs currently. The Board will recall that this issue was referred to the WWC at a recent Board meeting. Our approach is currently a broad and uncoordinated one involving several different departments and directorates.

Philip led this discussion and the committee agreed with him that there is work to do to ensure we are more coordinated. For example, the Board Strategy Advisory Group should have a role in ensuring strategic messages are developed, agreed and managed by the Board This would require clearer management and accountability arrangements to join up the different leads and ensure better shared intelligence and a consistency of external messaging which will be important to SECAmb fulfilling its purpose in the future.

The committee acknowledged this is a complex piece of work that requires time to work through. However, although achieving change should be given time to ensure it is done properly the committee will ask for an options paper on the organisation and management of Corporate Affairs to ensure that momentum on this important issue is maintained.

Wellbeing Strategy

The committee reflected that in recent times it has focussed more on workforce than wellbeing and so as part of this will ensure there is better balance going forward.

A verbal update was provided confirming that the executive had recently requested a deeper review of our strategy. This will explore the costs and benefits of to explore what and how we deliver in the context of what has become more widely available both regionally and nationally in the NHS since our Wellbeing Hub was established. The committee was pleased to learn that, the executive is establishing a group to work through the more immediate need to ensure we plan for the post pandemic people recovery.

The committee welcomed the appointment of Tom Quinn as the Trust Wellbeing Guardian, which is a national requirement of the NHSE/I to hold the Board to account in areas related to looking after our people. This links to what metrics are reported to Board as part of the IPR. The committee reviewed and accepted all the requirements. The committee felt that it was important that SECAmb met the NHSE/I requirements as part of its own wellbeing work rather as a separate 'programme'.

Increasing workforce diversity

While acknowledging the scale of this challenge, the committee concluded that we must do more. NHS England has set itself an aspirational target of meeting its overall workforce ethnic diversity of 19% across all pay bands by 2025, and a focus on leadership diversity is also a key action within the NHS People Plan. The committee asked that when the executive works through what our target should be it should be both stretching and achievable, particularly in the context of the diversity challenge across the country for the paramedic workforce. It was noted that 'diversity' involved more than ethnicity and gender.

Update on the WRES plan

The committee noted that many of the actions haven't progressed as much as we would have liked during the past 12 months, but this is against the background of the pandemic. There were some 'green shoots' however, with greater focus on diversity with Board appointments and the decision to offer placements from 1 April to two NExT Directors; this is the scheme led by NHSE/I to support senior people from groups who are currently under-represented on trust boards with the skills and expertise necessary to take that final step into the NHS board room. It was noted that this needed to be matched by a similarly focussed programme of management and career development for our managers and clinicians.

Staff survey results / next steps

The committee received an update from Philip on the staff survey results which have since been published. It noted that the results have not identified anything surprising or unexpected, and reinforced that the staff survey provides really helpful indicators and feedback but must be seen alongside the other sources of information. Taken across the

	three year period there is not much change; some indicators are slightly better and some slightly worse. The committee agreed with Philip that it is disappointing that these results aren't demonstrating more progress. It also agreed that all the things we decided a couple of years ago as priorities remain so, but with even greater focus and effort needed. For example, in the development of our approach to education training and development across our entire workforce. Some of these areas will require longer to show impact and the committee will monitor this over the coming year. The next two areas considered by the committee are both on the Board agenda. **Gender pay gap** This paper provides assurance that the Trust is meeting its legislative duties in publishing its annual Gender Pay Audit. It also provides detail and analysis of the audit as well as the actions to be undertaken to help address the disparity. The committee welcomes the recent launch of the new gender network, which helps provide focus on ensuring better gender balance. Emma Williams in the Chair of this network and she highlighted the imbalance there is within the operational leadership, for example, and the need to understand why more females are not applying, getting shortlisted, and/or appointed. **Amin Abdullah recommendations** This paper provides assurance that the Trust has completed a review of all current disciplinary cases in line with the instructions from NHS England and Improvement following the investigation and review by Verita into the death of Amin Abdullah. It confirms the identified areas for focus in the review of our own disciplinary practices in line with the learning from the Verita report. The committee noted the actions to be taken forward in SECAmb as response to the risks identified in the paper. It reinforced the need for robust and timely investigations and asked particularly that the executive review whether we sufficiently cover in this our approach to when we refer staff to professional bodies.
Any other matters the Committee wishes to escalate to the Board	There was a discussion at the start of the meeting under matters arising, related to the significant risk to our ability to meet targets of losing paramedics to other parts of the health system, in particular primary care. The executive is well engaged with system partners on this and the committee will consider this in detail at its next meeting. The Board asked the committee to review the actions being taken to mitigate the incidents of violence and aggression to staff. This was scheduled for the meeting but was deferred to the next meeting, to take account of the recent development linked to the pilot of body worn cameras. There has been frequent reference to the need for assurance that SECAmb has sustainable establishment levels. Even without the effects of Covid, there was concern

	that training, development, appraisal of our colleagues could not be properly conducted because the level of 'abstractions' required would have an adverse effect on performance. This links to the work under case or change and the need to ensure we are adequately funded to meet the development needs of our workforce. Overall, the committee felt it was a good meeting and noted the good quality papers.

SECAMB Board

Summary Report on the Audit & Risk Committee

Date of meeting	11 March 2021
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting were ▪ External Audit Plan ▪ Progress with the Internal Audit Plan ▪ Counter Fraud ▪ Response to COVID / BCI ▪ Preparation of the Annual Governance Statement ▪ Effectiveness of IPR ▪ Risk Management Framework and BAF Risks
External Audit	The committee is assured with the progress being made for the end of year audit. The Board will be aware that this year there is greater emphasis on the assessment of value for money. There is currently no issues to escalate.
Internal Audit Plan	The Internal Audit reports continue to provide good assurance. During the year only one review has provided negative assurance. The draft Head of Internal Audit Opinion was considered and the committee supports this broadly positive opinion. Two Management Letters were provided to the committee, one related to a Q-volunteering grant. This found that the money was spent in line with the terms agreed, but not in accordance with project plan. The issues identified have been mitigated and the committee confirmed that there has been appropriate communication with the affected parties. The second Management Letter related to the procurement of powered hoods and specifically the circumstances whereby these were known to be becoming discontinued. The committee did not think this was a failure of governance, but rather an override of management controls; hence why the review was commissioned. There is some positive learning about procurement training and raising general awareness, as well as the need to circle back to the business case process when significant changes are made. Much better progress is being made with closing the management actions. However, some still remain overdue and the committee was particularly keen that those related to the (workforce) partial assurance report are closed and asked the Executive to ensure this is the case by the time of the next meeting in May.
Counter Fraud	The committee is assured with the work of counter fraud and agreed the workplan for 2021/22. It received positive assurance following the benchmarking report on gifts and hospitality, and noted the actions agreed to further improve the controls around secondary employment. Linked to a report from early 2020, an update was provided on the actions taken to improve the controls for self-rostering. The committee will check the extent to which these controls now in place are working effectively, later in the year.

COVID-19	The committee receives updates on the governance for the response to COVID and continues to be assured. It clarified that there are no issues with the provision of PPE and that there are steps being taken to plan for a potential next wave.
Effectiveness of the IPR	At least once a year the committee will test the effectiveness of the IPR, for the Trust Board. There was good support for the evolution of the current version, which some members felt is the best we have ever had. As part of the development process, feedback was provided to management who will reflect this in the next iterations. For example, including more SPC charts and ensuring the summary really clearly draws out the key issues.
Risk Management / BAF	The committee supported the planned alterations to how we approach the management of risk. While it reinforced the improvements in this area over recent years, there are still some things that require more work. For example, the committee still thinks there are too many risks, and some of this is being clear about the difference between risks and management issues. But overall, there is a relatively good risk management process in place. There was also a review of the BAF risks. The Board will recall that it challenged the executive to review these risks to ensure they were more long term/strategic in nature. The committee supported the revisions that were proposed.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Item No	83/20

Name of meeting	Trust Board
Date	25 March 2021
Name of paper	Gender Pay Gap
Executive sponsor	Ali Mohammed, Executive Director of HR & OD
Author name and role	Asmina Islam Chowdhury, Programme Manager, ED&I
Synopsis	This paper has been considered by the Workforce and Wellbeing Committee and provides assurance that the Trust is meeting its legislative duties in publishing its annual Gender Pay Audit. The paper also provides detail and analysis of the audit as well as details of actions to be undertaken to help address the disparity.

Gender Pay Gap Report for Inclusion Working Group as at 31st March 2020

1. Introduction

1.1. The Gender Pay Audit (GPA) obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. All organisations that employ more than 250 people and listed in Schedule 2 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, must publish and report specific information about their gender pay gap annually.

1.2. Since March 2017 Public sector organisations were required to take a "snapshot" of their workforce as of 31st March each year. The resulting data must be published along with a written statement on their public-facing website. It must also be reported to the government via the gender pay gap reporting service by 30th March.

1.3. A high gender pay gap can indicate there may be a number of issues to deal with, and the individual calculations may help us to identify potential causes. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of inequality in the workplace, female and male participation, and how effectively talent is being maximised.

2. What does the audit cover?

2.1. The gender pay gap report provides a comparison on the pay of male and female employees and shows the difference in the average earnings (mean and median). This is expressed as a percentage of men's earnings e.g. women earn 15% less than men do.

2.2. The gender pay audit is different to equal pay, which looks at the pay differences between men and women carrying out the same jobs, similar jobs or work of equal value. Any potential equal pay issues are addressed by adherence to Agenda for Change terms and conditions and pay framework, and a robust and objective job evaluation process. Gender pay gap figures are affected by differences in the gender composition across our job grades and roles.

2.3. The audit requires us to make six calculations covering the following:

- **Mean gender pay gap in hourly pay** – adding together the hourly pay rates of all male or female full-pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.

- **Median gender pay gap in hourly pay** – arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of the range.

- **Mean bonus gender pay gap** – add together bonus payments for all male or female employees and divide by the number of male or female employees. The gap is calculated by subtracting the results for females from the results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.

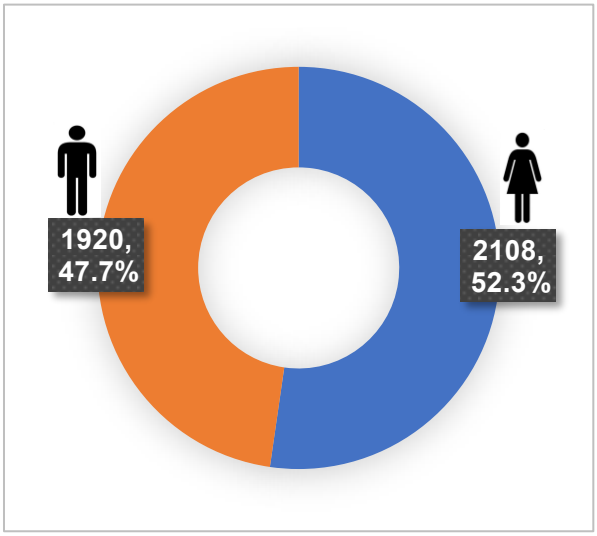
- **Median bonus gender pay gap** – arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

- **Proportion of males and females receiving a bonus payment** – total males and females receiving a bonus payment divided by the number of relevant employees.

- **Proportion of males and females in each pay quartile** – ranking all our employees from highest to lowest paid, dividing this into four equal parts (quartiles) and working out the percentage of men and women in each of the four parts.

2.4. This information along with a written statement, confirming the accuracy of their calculations must be published on both the Trust's website and on a designated government website.

3. Our Gender Pay Gap data

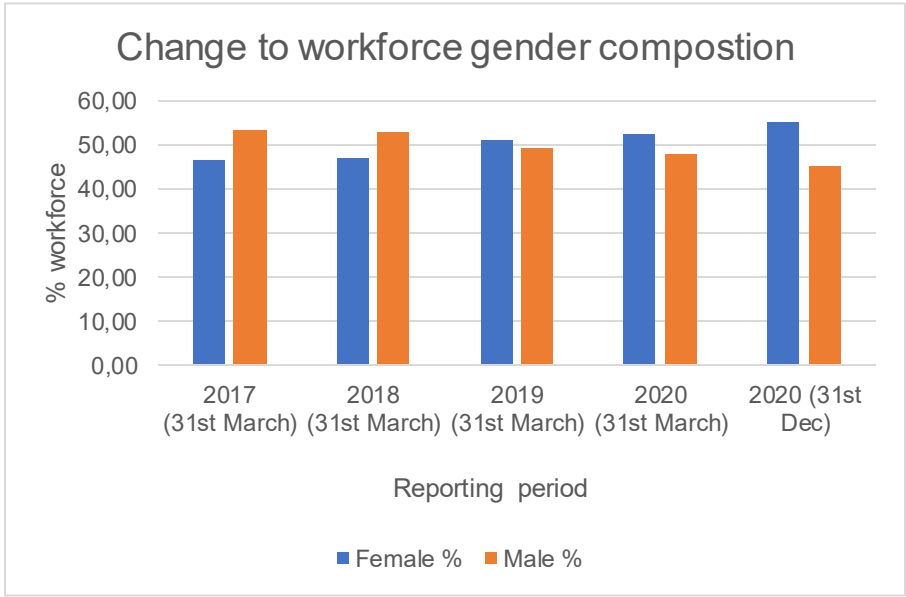


3.1. Our data for this submission is **as at 31st March 2020**, when the Trust workforce consisted of 2,108 females (52.3%) and 1,920 males (47.7%), totalling 3,733 employees.

3.2. There was a 7.8% increase in our workforce between 31st March 2019 and 31st March 2020. In the same period, the Trust had 11.2% increase in the number of women in the organisation overall compared to 4.2% increase for men. A move towards a predominantly female workforce overall was first observed in 2019 data and is also apparent in the latest workforce figures for the Trust.

In March 2019, the workforce profile by gender was 1,892 females (51%) and 1,841 males (49%), totalling 3,733.

To provide further context, our latest workforce figures as at December 2020, show the workforce gender profile as 2,387 (54.9%) female, and 1,958 (45.1%) male.



3.3. **Mean and median gender pay gap in hourly pay**

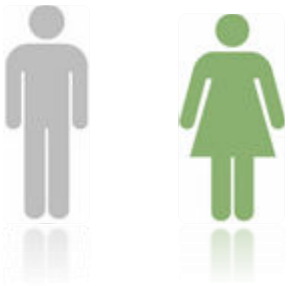
The table below shows the difference in the mean and median hourly rates, and the pay gap as a percentage for 2018 to 2020. This shows a small increase in the mean hourly rate resulting in an increase of SECAmb's gender pay gap. However, there is a slight decrease in the mean (average) hourly rate of pay, but it is unknown whether this change is statistically significant overall.

Gender	31st March 2018		31st March 2019		31st March 2020	
	Mean Hourly Rate	Median Hourly Rate	Mean Hourly Rate	Median Hourly Rate	Mean Hourly Rate	Median Hourly Rate
Male	£13.80	£13.28	£14.52	£13.71	£15.78	£14.85
Female	£12.52	£11.60	£13.22	£11.96	£14.37	£13.17
Difference	£1.29	£1.68	£1.30	£1.75	£1.42	£1.68
Pay Gap %	9.00%	12.62%	8.95%	12.77%	8.99%	11.30%

Table 1: Gender Pay Gap for 2018 to 2020

All Trust Staff - Overall Mean vs. Median average hourly rate - 31/03/2020

Mean average hourly rate

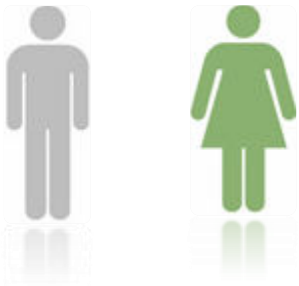


8.99% difference

£15.78 **£14.37**

This means that in 2020 **women earned 91p** for every **£1** that men earnt when comparing mean hourly wages.

Median average hourly rate



11.30% difference

£14.85 **£13.17**

This means **women earned 87p** for every **£1** that men earnt when comparing median hourly wages.

Proportion of males and females in each pay quartile

3.4. The figures below show a ranking of our employees from highest to lowest paid, dividing this into equal quartiles and providing a percentage breakdown of the number of males and females in each of these.

The highest variances for the quartiles continue to be in the upper pay quartile, where there is a 19.6% difference for a second consecutive year. However, the increase in the number of employees in upper quartile is equitable and did not contribute to any increases in disparity, therefore maintaining the status quo from 2019. The percentage of males in the upper quartile continues to represent 31% of all males in the overall workforce, in comparison to 19.2% of all females in the organisation.

3.5. The percentage increase in females in the lower two quartiles continues to grow. This difference in the gender split of the lower pay quartile also increased for a second year to 18.4% from 15.6% in 2020 A similar difference is also seen in quartile two (lower middle pay) with an 18.1% in favour of females from 15.88% in 2019. These figures are believed to have been as a result of a sizeable increase in the number of fulltime Health Advisors and EMA's (AFC pay band three) within 2019/20 financial year.

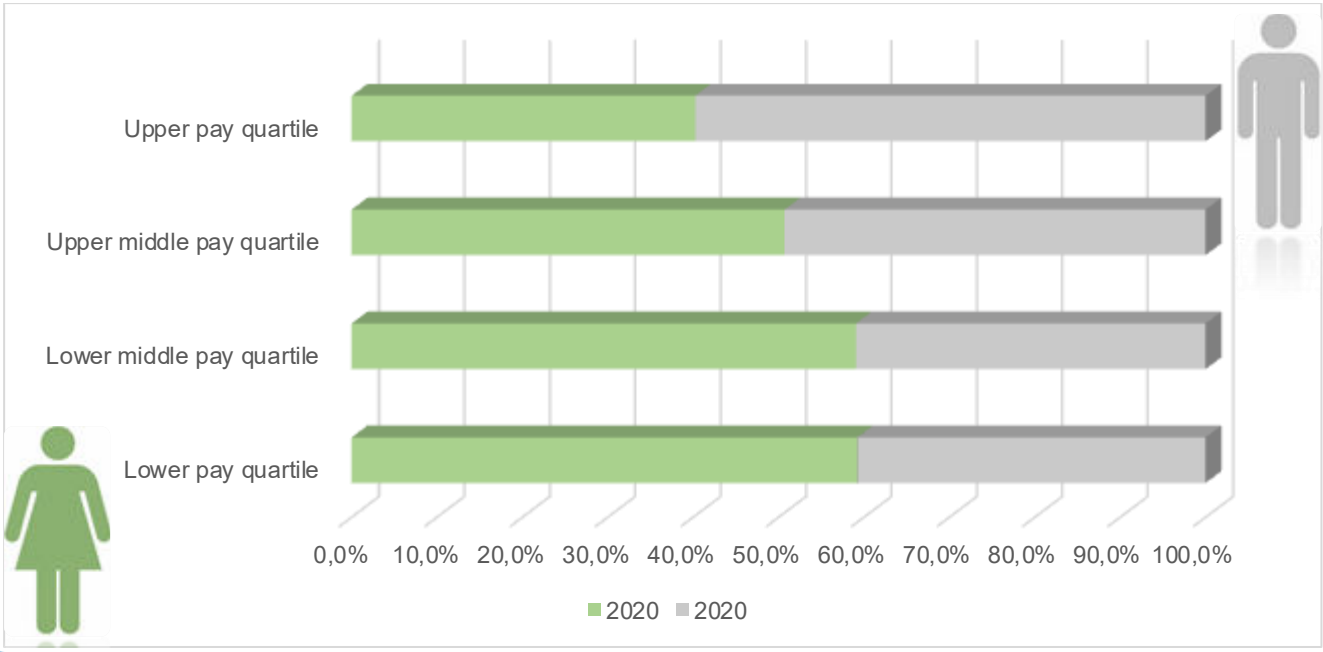
There has also been a further increase in the number of women in the upper middle quartile (quartile 3), bringing the percentage of women in this group to 50.7%. This is linked to an increase of female Newly Qualified Paramedics (AFC pay band five) who have joined the organisation.

3.6. Despite the continuing increase of females at lower pay bands, the equitable increase in men and women in the upper pay (quartile 4) quartile and increase of females in the upper middle (quartile 3) have prevented any further increase to our current gender pay gap.

	2018				2019				2020			
Quartile	Female	Male	Female %	Male %	Female	Male	Female %	Male %	Female	Male	Female %	Male %
1- Lower pay quartile	477	369	56.38	43.62	512	374	57.79	42.21	595	410	59.20	40.8
2- Lower middle pay quartile	432	411	51.25	48.75	551	400	57.94	42.06	594	412	59.05	40.9
3 - Upper middle pay	390	459	45.94	54.06	443	493	47.33	52.67	510	496	50.70	49.3
4 - Upper pay	312	533	36.92	63.08	386	574	40.21	59.79	405	602	40.22	59.7
Total	1611	1772	47.00	53.00	1892	1841	51.00	49.00	2104	1920	52.28	47.7

Table 2: Gender pay Gap by quartile, 2018 to 2020

All Trust Staff - Proportion of males and females in each pay quartile - 31/03/2020



3.7. The detailed analysis undertaken to produce the audit shows that the Trusts' Non-Executive Directors (NEDs) are recorded on the Electronic Staff Record (ESR) system as full time. However, they actually work four days a month, equating to a whole time equivalent (WTS) of 0.13. This significantly impacts the reported hourly rate for NED's and possibly has a small impact on the quartile distribution and overall mean and median hourly rates.

To provide further context around composition of the quartiles, our workforce data for 31st March 2020 shows that approximately 95% of our employees were within pay bands two and seven. The GPA quartiles do not align with specific bands. As such, due to the GPA methodology and our workforce make up, the upper quartile will also contain a proportion of employees at band six, and therefore in planning actions to make improvements, it is important that we consider the GPA results alongside workforce breakdown by pay band and gender.

3.8. Where staff members have signed up to a salary sacrifice scheme such as childcare vouchers or Tusker cars, guidance advises that the remaining gross salary once these deductions are made is used to calculate their hourly rate. This may also further impact the overall hourly rates which are then used to calculate the mean and median pay gaps.

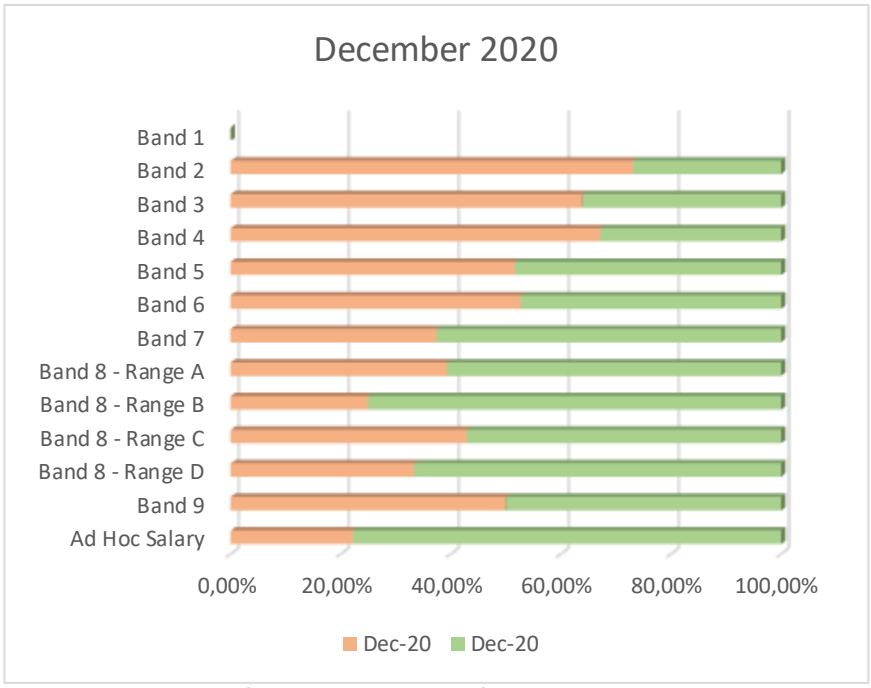
Mean and median bonus gender pay gap.

3.9. The only bonus payments made by the Trust are to eligible staff who apply for the Clinical Excellence Awards (CEAs), which can be awarded nationally or locally. Due to the small numbers of bonus payments made in 2020 potentially rendering recipients identifiable if published, the Trust will not be publishing any data for this part of the Gender Pay Gap report. Bonus payments are awarded in recognition of excellent practice over and above contractual requirements.

Gender by pay band

3.10. Although Agenda for Change (AFC) ensures that we are proving equal pay for equal work, we can see discrepancies in the ratio of males to females within pay bands. The table below shows a greater number of men than women in posts within pay band 7 and up. This is an improvement on 2019, when the discrepancy began at pay band 6. There is also a positive increase in the number of females at all bands at 7 and above, bar band 8b and those on an ad-hoc salary (shown in table 3 and 4, below).

Staff counted within Ad-hoc figures are outside of both AFC pay bands, and include Very Senior Managers (VSMs) and colleagues on external secondments whose salaries are controlled by the receiving organisation.



	Dec-20		Difference % from 2019
	Female	Male	Female
Ad Hoc Salary	22.22%	77.78%	-11.11%
Band 9	50.00%	50.00%	25.00%
Band 8 - Range D	33.33%	66.67%	11.11%
Band 8 - Range C	42.86%	57.14%	4.76%
Band 8 - Range B	25.00%	75.00%	-2.91%
Band 8 - Range A	39.33%	60.67%	4.19%
Band 7	37.38%	62.62%	4.24%
Band 6	52.66%	47.34%	5.18%
Band 5	51.72%	48.28%	-0.05%
Band 4	67.20%	32.80%	11.00%
Band 3	63.89%	36.11%	4.25%
Band 2	73.08%	26.92%	1.15%
Band 1	0.00%	0.00%	0.00%

Table 3: Workforce by Pay band and Gender, December 2020

	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Ad Hoc Salary
Female Total 2019	0.00%	71.93%	59.65%	56.20%	51.77%	47.48%	33.13%	35.14%	27.91%	38.10%	22.22%	25.00%	33.33%
Male Total 2019	100.00%	28.07%	40.35%	43.80%	48.23%	52.52%	66.87%	64.86%	72.09%	61.90%	77.78%	75.00%	66.67%
Female Total 2020	0.00%	73.08%	63.89%	67.20%	51.72%	52.66%	37.38%	39.33%	25.00%	42.86%	33.33%	50.00%	22.22%
MaleTotal 2020	0.00%	26.92%	36.11%	32.80%	48.28%	47.34%	62.62%	60.67%	75.00%	57.14%	66.67%	50.00%	77.78%

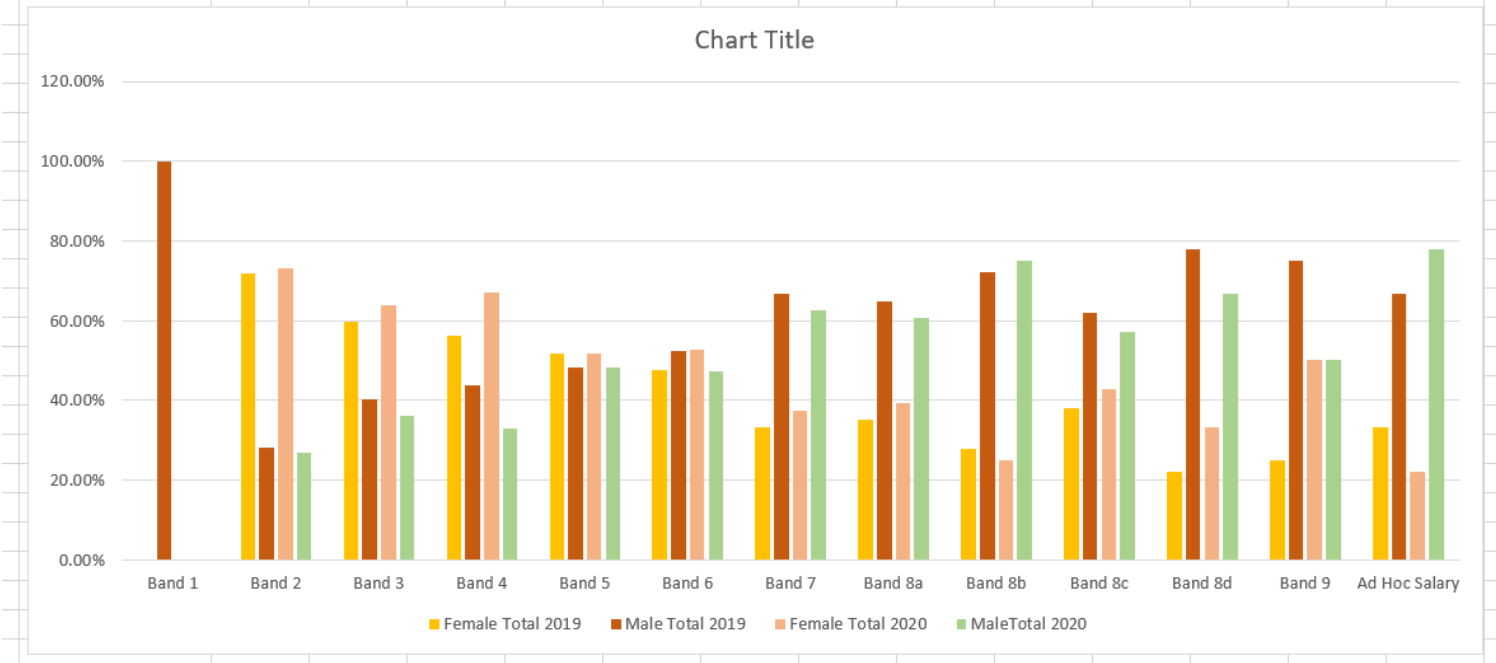


Table 4, workforce by gender and pay band, 2019 and 2020

3.11. It is encouraging to see moves towards greater equity at pay bands 8a, 8c, 8d and 9.

3.12. The workforce gender profile below, also identifies the largest areas of discrepancy to be bands 8 and above in Field Operations and 111 in favour of males. However, it should be noted that both Field operations and EOC made improvements in senior level gender representation at band 8+ in comparison to the previous year.

	2019		2020	
All Staff	Female %	Male %	Female %	Male %
Bands 1-4	59.86%	40.14%	61.76%	38.24%
Bands 5-7	45.72%	54.28%	44.87%	55.13%
Bands 8+	33.82%	66.18%	35.83%	64.17%
Ad hoc	31.25%	68.75%	27.43%	72.57%

	2019		2020	
Operations	Female %	Male %	Female %	Male %
Bands 1-4	50.69%	49.31%	53.22%	46.78%
Bands 5-7	43.41%	56.59%	44.57%	55.43%
Bands 8+	20.45%	79.55%	26.24%	73.76%
Ad hoc	0.00%	0.00%	0.00%	0.00%

	2019		2020	
111	Female %	Male %	Female %	Male %
Bands 1-4	70.23%	29.77%	68.64%	31.36%
Bands 5-7	84.48%	15.52%	71.78%	28.22%
Bands 8+	25.00%	75.00%	0.00%	100.00%
Ad hoc	0.00%	0.00%	0.00%	0.00%

	2019		2020	
Emergency Operations Centre	Female %	Male %	Female %	Male %
Bands 1-4	78.37%	21.63%	75.63%	24.37%
Bands 5-7	67.38%	32.62%	66.33%	33.67%
Bands 8+	27.27%	72.73%	38.46%	61.54%
Ad hoc	0.00%	0.00%	0.00%	0.00%

	2019		2020	
Support Staff	Female %	Male %	Female %	Male %
Bands 1-4	53.85%	46.15%	72.29%	27.71%
Bands 5-7	39.52%	60.48%	33.60%	66.40%
Bands 8+	46.75%	53.25%	39.30%	60.70%
Ad hoc	31.25%	68.75%	27.43%	72.57%

Table 5: Employee Gender Profile information as of 31st March 2020 by service

3.13. Comparative data against the other ambulance Trusts for the 2021 audit publication is not yet available. However, the published data for the 2020 submission (based on 31st March 2019) shows SECAmb jointly had the highest mean pay gap with North West Ambulance Service at 8.9% and were second to South West Ambulance Service in relation to the median pay gap. London Ambulance and East of England Ambulance did not submit their 2020 GPA due to the COVID19 pandemic.

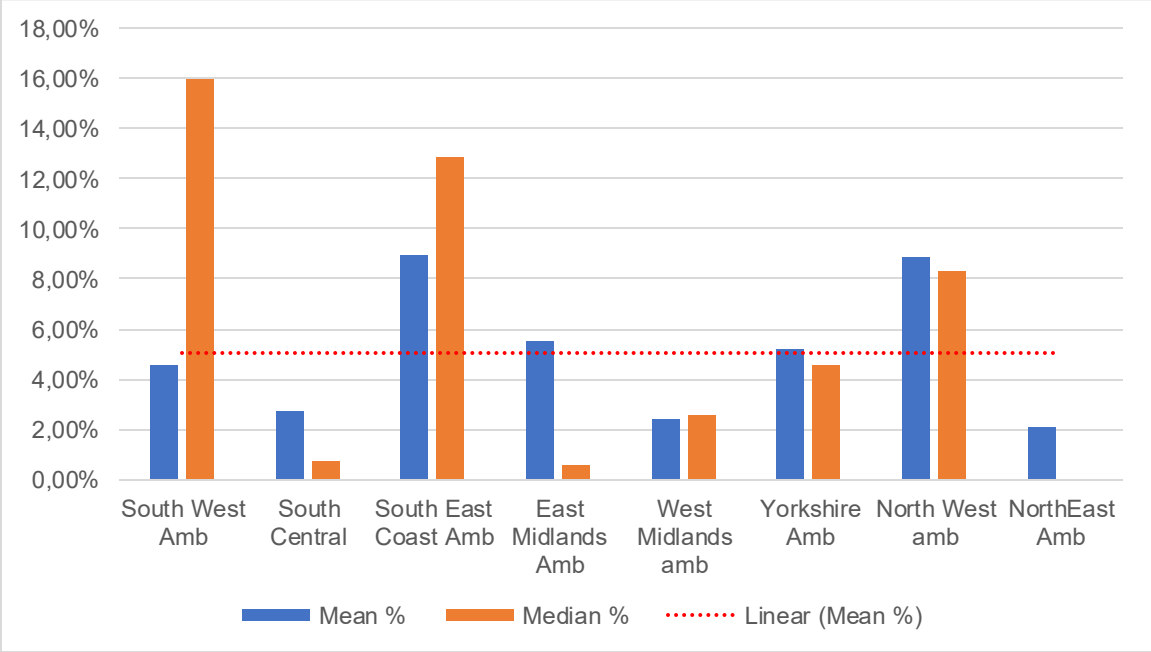


Table 6: Ambulance sector comparison of mean and median pay gap as at 31st March 2019

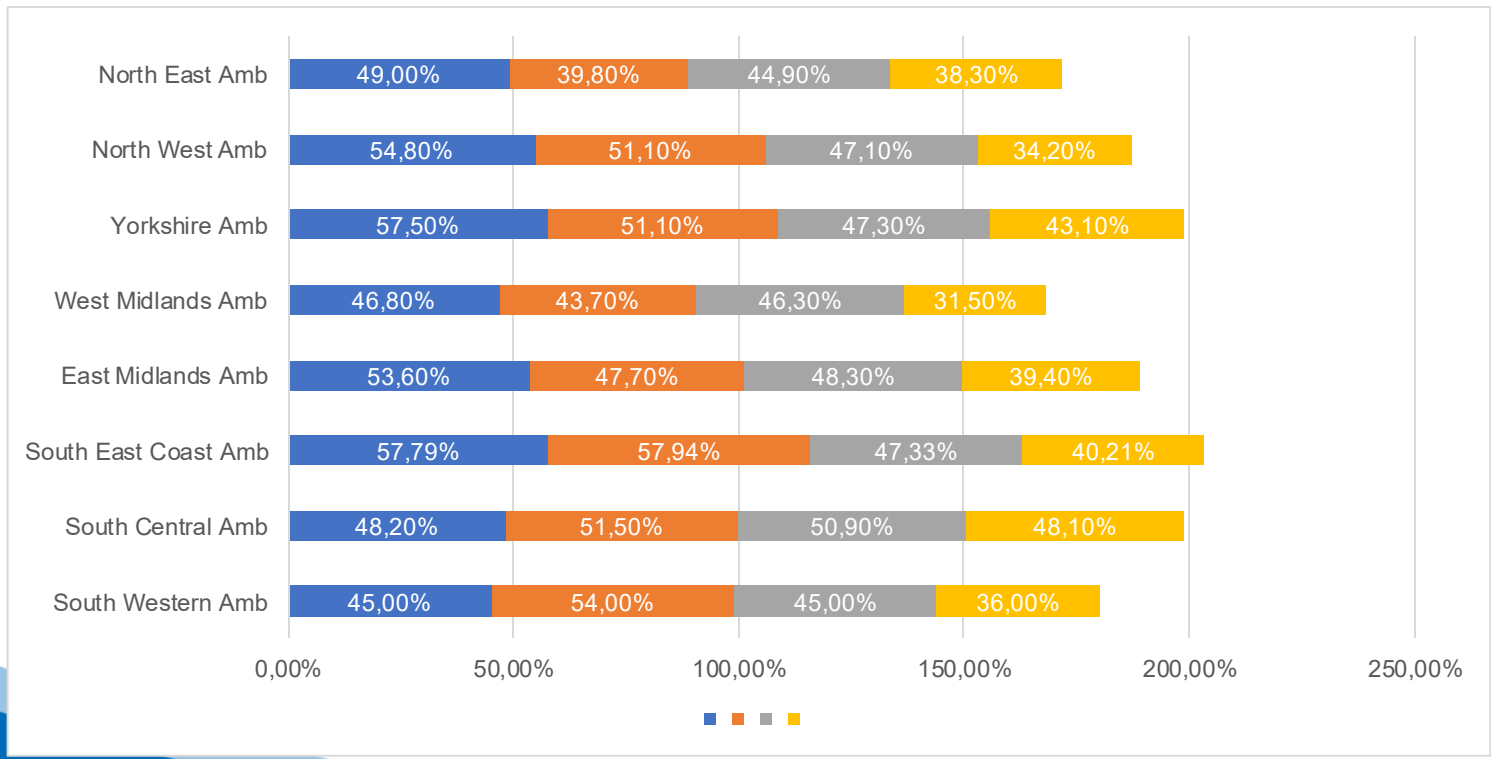


Table 6: Ambulance sector comparison of by quartile as at 31st March 2019

3.14. Based on the comparative data across the sector, it appears that SECAmb has a higher proportion of females in the workforce than in other Trusts. Whilst this is positive and more reflective of the NHS workforce overall, the disproportionately higher concentration in the lower quartiles will result in an overall higher gender pay gap for the Trust.

4. Conclusion

4.1. There was a 0.04% increase in SECAmb mean gender pay gap which is not considered to be significant, and a 1.47% improvement in our median pay gap. The latest workforce data shows positive improvements towards greater equity in some of the higher pay bands.

4.2. Whilst we do not have an equal pay issue, pay gender pay gap in SECAmb does remain and work to reduce this must be ongoing and include exploring best practice across the sector and beyond. The breakdown by service area highlights that there is a need to identify any underlying factors as to why there is such a gender imbalance within the Operations, 111 and the Emergency Operations Centres, and the need for possibly targeted support within 111 in relation to interview and shortlisting processes.

What have we done to date?

4.3. Implemented Agenda for Change and developed a robust job evaluation process for all jobs. However, it is recommended that job evaluation panels should reflect a gender balance.

4.4. Training has been delivered to a number of senior managers in interview skills to support senior management recruitment and we have increased the number of trained interviewers.

4.5. Development and launch of menopause guidance in recognition of the potential negative impact on career progression this has.

4.6. Increased the frequency of diversity reports by demographics to the Inclusion Working Group and to the Board via the Integrated Performance Reports, on a quarterly basis for scrutiny and discussion.

4.7. Developed and implemented processes and training to ensure that all interviews are undertaken by trained panel members.

4.8. Planned the revised launch of the Gender Equality Network for 8th March 2021 following postponement in 2020 due to the COVID pandemic.

4.9. Received organisational commitment to ensure gender diverse interview panels for **all roles** at band 8 and above.

4.10. Received commitment from EMB for a 2.5% increase in women at band 7 on an annual basis based on the current size of the organisation. This will be reviewed in line with organisational growth on an annual basis.

4.11. Commenced recruitment for a first cohort of the Springboard Women's development programme.

Next steps:

4.12. That we develop a range of activities over the next 12 months to advance gender pay, these include:

4.12.1. To provide assurance that once the GPA submission is made for 2021, we will be fully compliant with the duties placed upon the Trust with regards to publishing the Gender Pay Audit.

4.12.2. Extending our commitment to having gender diverse interview panels to **all roles at band 7 and above from April 2021.**

4.12.3. To provide access to support in conjunction with L&OD to colleagues applying for a promotion within the organisation or preparing for interview.

4.12.4. Continue to explore opportunities for more flexible or alternative shift working across the organisation, including how this could be introduced into a wider range of operational roles.

4.12.5. Submission of the Trust GPA results to the government portal ahead of 31st March 2021 and publish the data to our public facing website as per the requirements of the Equality Act 2010.

South East Coast Ambulance Service NHS Foundation Trust

Item No	84-20

Name of meeting	Trust Board
Date	25 March 2021
Name of paper	Disciplinary review
Executive sponsor	Ali Mohammed, Director of Human Resources and Organisation Development
Author (s) name and role	Asmina Islam Chowdhury, Programme Manager, Equality Diversity and Inclusion in collaboration Karen Lavender, HR Policy and ER Manager.
Synopsis	This paper has been considered by the Workforce and Wellbeing Committee and provides assurance that the Trust has completed a review of all current disciplinary cases in line with the instructions from NHS England and Improvement following the investigation and review by Verita into the death of Amin Abdullah. The paper also provides detail of identified areas for focus in the review of our own disciplinary practices in line with the learning from the review.

Disciplinary review

1. Executive Summary

1.1. The independent investigation into the death of Amin Abdullah highlighted that Imperial College Healthcare NHS Trust (ICHT) disciplinary procedures against Mr Abdullah were "weak and unfair".

1.2. Subsequently, all NHS Trust leaders were asked by Prerana Issar, Chief People Officer NHS England and Improvement to 'honestly reflect' on their disciplinary procedures. Trusts leaders were also asked to "commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed or minuted at a public board or equivalent."

1.3. The HR BP and ER team were asked to review all current disciplinary cases in January 2021 against five questions set by NHS England and Improvement to ensure that our processes stand up to scrutiny and identify areas for improvement as well as good practice. A total of 26 cases were reviewed as part of this process, and the key findings from this are outlined in section 4 of this paper.

1.4. The review identified variation in the investigation and management of disciplinary cases within the Trust. Although good practice was identified, and the policies meet Advisory,

Conciliation and Arbitration Service (Acas) guidelines, under the new leadership of the HR Directorate it is agreed that there is a need for an urgent review of both the Trust Disciplinary policy, procedure, management guidance notes.

1.5. This paper also sets out a number of recommendations for consideration in the development of the above and to support our commitment to meeting our strategic objectives of focussing on our people (ensuring everyone is listened to, respected and well supported), and delivering quality (we listen, learn and improve).

2. Background

2.1. Mr. Amin Abdullah died in February 2016 after setting himself on fire outside Kensington Palace while awaiting a hearing to appeal his dismissal from his job. He had been a band 6 nurse and deputy ward manager working at Charing Cross Hospital, part of ICHT. He had no previous history of depression or mental illness. An independent investigation into Mr Abdullah's death was ordered by the government in 2017 after Mr Skitmore (his partner) took the case to the then Secretary of State for Health.

2.2. The subsequent independent investigation by consultancy firm Verita found that Mr Abdullah had been treated unfairly and had not been given the support he needed throughout the process. It determined that the charges held against Mr Abdullah by the Trust were unjustified and that his case was subjected to excessive and unwarranted delays. Following the report, ICHT admitted that Mr Abdullah should not have been dismissed and pledged to carry out a full review of its disciplinary processes and procedures.

2.3. Following this, all NHS CEO's received communications Dido Harding, Chair NHS Improvement on 24th May 2019. The letter lists the guidance and questions that Trust's should ask themselves when considering any formal action against staff, prompts all NHS Trusts to look seriously at how they manage incidents and disciplinary proceedings (as well as other people based processes such as capability etc), and asks NHS Trusts to review their policies in line with the recommendations. The letter contained a number of questions that Trusts were asked to consider as part of this review to help inform what corrective action is required to bring our policies in line with the national best practice. It also highlighted the seven themes identified by the new national guidance on NHS disciplinary processes and the need to ensure these were implemented as part of any review to ensure Trusts treat people fairly and protect their wellbeing.

The five questions Trusts were asked to use to review all current and future disciplinaries and the seven themes are provided in Appendix A.

2.4. A further letter from Prerana Issar, Chief People Officer NHS England and Improvement, was received on 1st December 2020 asking Trusts to complete the review outlined in May 2019. It also asked that Trusts reflect on the findings in the context of the NHS People Plan and NHS People Promise, **to ensure that our people practices are inclusive, compassionate, and person-centred, with the overriding objective being the safety and wellbeing of our people.**

NHS organisations were asked to commit to undertaking an annual review with a discussion on our own disciplinary procedures against the recommendations at a Public Board meeting or equivalent by the end of the 2020/21 financial year.

A copy of ICHT's revised policy was also shared as best practice and where changes to policies are required, Trusts are asked to consider this as an example of good people practice when reviewing their own policy and procedures.

A recommendation that Trusts publish their current disciplinary policy on our public website by the end of the 2020/21 financial year was also made.

3. Review process

3.1. The HR Employee Relations and Business Partnering team were asked to undertake a review of all current disciplinary cases in line with the five questions from Dido Harding to help identify areas of good practice, and areas of improvement. The work was led by Karen Lavender, HR Policy and Employee Relations Manager.

3.2. There were 26 open disciplinary cases which were reviewed as part of this process.

The HR Business Partners and HR Advisors were asked to review all their cases against the five questions (Appendix b) and invited to participate in a feedback meeting with HR Policy and ER Manager, Senior ER Advisor, and Programme Manager Equality Diversity and Inclusion (ED&I). Areas of learning and key themes have been collated for this paper to inform next steps and priorities moving forward.

4. Key findings

The key findings have been grouped under the seven national themes (Appendix A) within the guidance on NHS disciplinary processes.

4.1. Adhering to best practice

4.1.1. The Acas code of practice sets out main areas of consideration as follows:

- That the basic principles of fairness and transparency are promoted by developing and using rules and procedures for handling disciplinary and grievance situations. These should be set down in writing, be specific and clear. The following elements should be considered in order to ensure fairness;
    - Employers and employees should raise and deal with issues promptly and should not unreasonably delay meetings, decisions or confirmation of those decisions.
    - Employers and employees should act consistently.
    - Employers should carry out any necessary investigations, to establish the facts of the case.
    - Employers should inform employees of the basis of the problem and give them an opportunity to put their case in response before any decisions are made.
    - Employers should allow employees to be accompanied at any formal disciplinary or grievance meeting.
    - Employers should allow an employee to appeal against any formal decision made.

- Employees and, where appropriate, their representatives should be involved in the development of rules and procedures. It is also important to help employees and managers understand what the rules and procedures are, where they can be found and how they are to be used.
- Where some form of formal action is needed, what action is reasonable or justified will depend on all the circumstances of the particular case.

4.1.2. The Trust has a disciplinary policy (V5.00) and investigation guidelines which adhere to Acas guidelines. This policy is due for review by May 2021. However, the Trust Investigation guidelines have not been formally ratified and were produced as a draft version in 2016 (v0.01).

4.1.3. The case review exercise identified the following;

- Neither the Disciplinary Policy nor the Investigation Guidelines outline the need for clear Terms of Reference (ToR) at the start of the investigation; however, these are produced as standard practice within the HR BP and ER team for all formal disciplinary investigations. Where the ToRs were breached, these were not regularly reviewed and updated in line with changes with the scope of the investigation or delays.

- There is a lack of clarity regarding the length of time a disciplinary investigation should take, bar one reference in the guidelines advising that the Investigating Manager (IM) complete their report within 28 days.
- It was identified that there needs to be greater clarity regarding what could constitute a conflict of interest. However, there were also positive examples of where potential conflicts of interest/ bias had been identified and resolved by reassigning the case to an alternative, suitable person.

- In multiple cases, it was identified there were additional delays to investigations by the movement of Operating Unit Managers that should have been planned for and resolved. There needs to be greater awareness of the impact of and the management of organisational change on the wider business of the Trust.

- There were issues regarding confidentiality of investigations. In one example given the employee under investigation learnt of the complaint and that they were under investigation from a family member who also works for the Trust. This was prior to their being formally notified of the investigation. In other cases, staff were observed speaking about the case openly despite being reminded that this was a confidential matter.

- The review identified missed opportunities to address wider issues in parts of the Trust relating to normalised inappropriate behaviours by looking beyond the individual case and considering the specific feedback from witnesses.

4.2. **Applying a rigorous decision-making methodology**

4.2.1. The Trust's disciplinary policy supports the use of informal resolution. However, these outcomes are not consistently captured within the Selenity system used for reporting. As a result, there is an incomplete picture regarding whether informal resolution was considered and / or how successful current informal resolution processes are within the Trust.

4.2.2. During this review of our disciplinary cases, all 26 cases had been assessed as requiring formal investigation and that the action being taken was a proportionate and justifiable response. However, it was found that there is no system in place to assure consistent decision making on whether formal investigation is the most appropriate route to resolution.

4.2.3. Concerns were raised by one member of the team that they were aware of a formal process being initiated without HR guidance or support being sought at an early stage, and that this could have led to an inconsistent approach.

4.2.4. Formal disciplinary sanctions are considered by a panel that includes a Human Resources representative.

4.3. **Ensuring people are fully trained and competent to carry out their role**

4.3.1. The Disciplinary policy states that all Managers involved in a disciplinary investigation must be trained. HR BP and ER team assign trained IM's who have demonstrated aptitude and competency. However, consistent application of this cannot be evidenced through internal training records.

4.3.2. It was not possible to identify how many of the current IM's and Commissioning Managers (CM) have had investigation training.

4.3.3. During the case review it was evident that there was variation in the way members of the HR BP and ER team manage their casework and utilised the Selenity system which is used to track ER cases.

4.3.4. There was variation in the utilisation of GRS to record completion of welfare calls for those who were absent from the workplace.

Where both Selenity and GRS systems are being utilised, the case handlers (HR Advisors) had a higher level of oversight of the progress of the investigation and assurance that employee wellbeing was being supported.

4.4. **Assigning sufficient resources**

4.4.1. Of the 26 cases reviewed for this report, the oldest case was 31 weeks old (217 days / 7.5 months since mid-April 2020) and the average time open for each case was at 19 weeks (133 days / 4.5 months).

The Verita report notes the excessive delay in the completion of the investigation in Mr Abdullah's disciplinary investigation, highlighting that the average length of time for the ICHT to manage disciplinary cases was 72 days. Mr Abdullah's case took 91 days to manage.

The National Social Partnership Forum (SPF) provided a statement on 1st April 2020 advising organisations to extend or pause employee relations cases including disciplinaries. The Trust implemented this from the end of April / beginning of May until the end of November 2020 and it is possible this may have contributed to some of the delays. During this time, cases which had both union and employee agreement were able to proceed.

4.4.2. In all cases reviewed, it was found that there is a consistent lack of adherence to the recommended investigation timescales. This was found to be due to:

- Inability to appoint an appropriate investigating manager (IM) in a timely manner.
- IM's not-confirming their ability to complete the investigation within the investigation timescales as set out in the ToR.
- Difficulties with shift rota patterns not aligning between colleague and IM, and meeting/ hearing dates.
- Lack of capacity as a result of the increased number of staff being absent from work due to ill health.
- Where it has been advised as a reasonable response to the Covid pandemic as a part of the NHS Staff Council Guidance or to REAP escalation.
- Where a grievance or bullying harassment complaint has been raised that relates to the misconduct allegation.
- Where parallel criminal investigations have resulted in delays to progression of internal investigations due to a lack of clarity about what aspects of the shared information should be included within the investigation.
- Where Police investigating the parallel criminal investigations have advised the Trust to pause the internal investigation/ hearing.

4.4.3. HR resources are allocated to each case to provide advice on conducting investigations in a fair manner and in line with the Trust Values and policy/ guidance.

4.5. **Decisions relating to the implementation of suspensions/exclusions**

4.5.1. Of the 26 cases reviewed, 13 resulted in the individual being placed on suspension. Two of these suspensions have since ended.

4.5.2. A risk assessment must be completed for all suspensions, restrictions in practice, or temporary adjustments as a result of a disciplinary investigation. The Risk Assessment form is reviewed from multiple perspectives prior to these being agreed. These include:

- Manager
- HR representative
- Union Rep
- Director of HR and OD
- Director of Operations

In addition, a member of the Safeguarding Team, Professional Standards/ Consultant Paramedic, the Directors of Nursing and Quality, and Medical may also review the risk assessment where necessary.

4.5.3. Approval for suspension is provided via an Executive Director level panel, who also review all cases on a bi-weekly basis to ascertain whether there should be a continuation of the suspension.

4.5.4. The case reviews highlighted that the approval for continuing suspensions and the associated extension letters were not always evident in the HR employee relations database. The Trust cannot be satisfied that all individuals have received timely correspondence in relation to extensions of suspension.

4.5.5. It was also found that the completed suspension risk assessment template was not readily available to HR after a decision to suspend / not suspend. As a result, it was found there were instances where those who handle / support the case were under informed.

4.5.6. Case review also identified cases where alternatives to suspension had not been fully explored and may have been avoided, enabling an employee to remain in the business albeit with adjustments.

4.6. **Safeguarding people's health and wellbeing**

4.6.1. Areas of good practice were found regarding the ongoing concern for colleagues' health and welfare. However, the case review identified that depth of support differed in both approach, frequency, and the documentation of support.

4.6.2. Template letters provide the details of the Wellbeing Hub and Trust Chaplain's for colleagues to self-refer. For those colleagues suspended from the workplace, named welfare contacts are assigned to them. Where individuals were absent from work due to their physical or mental health there was a good awareness and use of the Occupational Health service. This was not consistently evidenced for those still in the workplace. Where an individual requests a referral or intervention, the Trust provides a number of referral and support routes.

4.6.3. Regular welfare contact during an investigation was found to be inconsistent, with feedback from case handlers indicating that this was undertaken regularly in some cases, but sporadically with others.

4.6.4. Areas of good practice were demonstrated in regard to the Trust's Duty of Care to ensure the safety and wellbeing of colleagues, with a number of interventions in place, e.g. alternative work location, agile working, change of rota, alternative duties, and the provision of special leave.

There were good examples of wellbeing support in some areas where the HR Advisors had processes in place to support the welfare of all colleagues involved in investigation, including the complainant, the colleague subject to the process, and the IM. In contrast, it was identified that there were missed opportunities to support employee wellbeing when the complainant, and employee subject to the investigation work across more than one operational area due to instances of apparent silo working.

4.7. **Board-level oversight**

4.7.1. At present the Board receives a monthly update on the number of new disciplinary cases. This alone provides little context around behaviours and opportunities for learning as identified by the disciplinary process. The cases reviewed identified

missed opportunities to address poor behaviours which were described as “normal” by witnesses.

4.7.2. New processes have been put into place to ensure executive board members are involved in the approval of all suspensions and these are reviewed bi-weekly

5. Action taken to date

5.1. A number of processes have been updated to improve practice ahead of a full review of the current disciplinary policy.

5.1.1. Where there are delays in appointing a suitable IM, this is escalated within seven days with the relevant Executive Director (or nominated deputy) to assign an appropriate IM to the case. This action has been implemented with immediate effect and will be reviewed on a monthly basis with the Head of HRBP and ER.

5.1.2. If an IM is unable to complete within timescales, the case will be reassigned to an alternative IM.

5.1.3. Work has commenced with the Consultant Paramedic Team to integrate their knowledge of a “just culture” and learning outcomes for registered clinicians. This work will support improvements in the suspension risk assessment process and the assessment of whether allegations presented can be dealt with informally.

5.1.4. Comprehensive weekly and monthly reporting to the Head of HR BP’s and ER on disciplinary cases was introduced in September 2020 to enable increased oversight and targeted support to bring investigations / suspensions to conclusion in a timelier manner

5.1.5. Update of Suspension Checklist to understand what other options our managers have considered before suspension. 14- day review of all suspensions by Executive Director of HR and OD and Executive Director of Operations.

6. Learning outcomes and recommendations

6.1. An urgent review of both the Trust Disciplinary policy, procedure, management guidance notes, and draft Investigation Guidelines should be undertaken to integrate Acas guidelines with current NHS best practice and NMC and HCPC guidelines. Both documents should be reviewed with the intent of placing the employee at the centre of the process to ensure that all opportunities for learning are identified as part of the process and ensuring that the person who is the subject of an investigation or disciplinary procedure is treated with equity and fairness throughout the process.

The review of the disciplinary process must be co-designed with wide stakeholder and union engagement.

6.2. The introduction of a “Just culture” within the Trust would support a refreshed approach to disciplinaries. However, a just culture approach to disciplinaries alone cannot be successful and must link to other workstreams within the Trust to address organisational culture and poor behaviours.

Just culture approach is described as "the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability."

The development of a Just Culture approach within the Trust is being explored by several teams including Medical, Learning and OD, and the HR BP and ER team. However, at present this work appears to be disjointed.

The NHS resolution framework identifies the three central themes to be considered in the implementation of a just culture approach:

- To prioritise learning about how to minimise the conditions and behaviours that can underpin or lead to error rather than apportion individual blame.
- Build a consistent approach for all staff, no matter what profession or what background.
- A determination to avoid, wherever possible, inappropriate suspension, exclusion and disciplinary action unless there is wilful intent

It is recommended that Trust look to implement a single unified approach to the implementation of just culture in SECAmb, providing clarity of direction and intent.

6.3. The Trust should consider the following within the revised processes:

6.3.1. Increased focus on early and informal fact finding to assess whether there is the justification to manage an allegation formally.
6.3.2. Improved access to accredited mediators in the Trust.
6.3.3. Introduction of a reflective learning practice.
6.3.4. A multidisciplinary approach, led by HR, to review allegations of misconduct and assess the most appropriate route to resolution.
6.3.5. Introduction of a pathway and integration plan to enable all alleged misconduct issues to be captured onto the HR employee relations database to allow for consistent oversight of all cases
6.3.6. Aligning our core values and strategic principles with our HR processes, management systems and leadership behaviours.

6.4. The revised policy, procedure, and guidelines must include clear end to end agreed timescales for the completion of an investigation, with clear lines of reporting and accountability for when these are breached.

6.5. A template to support the development of TOR for an investigation outlining what the IM needs to do and how the investigation should be conducted should be integrated into the policy / investigation guidelines. These should also include key information relating to the roles of the different people involved and the agreed timescales to work to.

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6.6. Regular written updates must be provided to staff under investigation if their case is not dealt with within the agreed timeframe, utilising the available investigation template letters. Where necessary, the ToR must be updated and communicated to the colleague. This documentation must be uploaded into the Trust's ER database.

6.7. More proactive steps to support all staff going through a disciplinary process should be taken. A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated ToR.

The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; confidential and compassionate.

6.8. Review whether there could be an increased use of the accelerated hearing provision within the Disciplinary Policy for appropriate cases and where individuals fully understand and acknowledge the allegations against them. It would be beneficial to ensure that this is included in future investigation training for managers and as an option on the template letters.

6.9. Training must be provided to those who conduct investigations or are likely to conduct investigations in the future. This should include:

- Awareness on conflicts of interest
- Awareness and understanding of the impact of bias and equality, diversity and inclusion principles.
- Learn from areas of best practice to understand how this is achieved and what "good" looks like.
- Defining roles and responsibilities in the disciplinary process
- How to properly define allegations
- Where a grievance/ bullying and harassment complaint is raised that relates to the disciplinary investigation.
- Information governance and confidentiality
- Understanding of how to manage unacceptable workplace behaviours using either various informal approaches or formal investigation as appropriate,
- Awareness of and understanding of relevant legislation and our obligations as employers
- Familiarity with the relevant Trust policies and procedures,
- Ability to plan and conduct a fair and thorough investigation,
- understand how to analyse the evidence and write a clear and reliable investigation report.
- Upskilling Investigating Managers on the Trust Selenity Framework to provide better oversight on the current status of disciplinary investigations.

However, careful consideration needs to be given to who exactly should be undertaking disciplinary investigations, how many trained investigators are required by the Trust, and the need for additional specialist training when these relate to bullying and harassment cases. A move to a just culture framework should ultimately reduce the Trust's ER caseload.

6.10. The case reviews identified variation in case management within the HRBP and ER team, however, these also provided an important learning opportunity, and it is recommended that all cases going forward are consistently reviewed against the five questions from NHS England before being progressed to formal investigation going forward. The HR BP and ER team should also look to undertake case study reviews to share good practice and learning opportunities within the team. It is also recommended the HR Policy and ER Manager lead quarterly case reviews to ensure consistency of approach and identification of further good practice moving forwards.

6.11. HR BP and ER team must be adequately trained to deliver a fair and consistent approach, and thereby empowering them the to hold IM's and other supporting colleagues e.g. Welfare contact to account earlier in the process.

6.12. That an "Investigation pro forma" be introduced to assess if an IM / CM can;

- complete the investigation within the given timescales.
- establish if any conflict of interest may exist.
- whether they feel competent to undertake the task.
- if they have received formal investigation training within an agreed time period.

Where concerns are raised as to whether the investigation can be completed in a fair and timely manner the case will be reassigned.

6.13. The Suspension and Restriction in Practice Risk Assessment should be made available to HR colleagues who are involved in supporting the case throughout any investigation period. Extension to suspension letters must be sent to affected colleagues following the bi-weekly review. All documentation relating to a suspension should be captured on the HR Selenity system and confirmed to executive directors at the bi-weekly review.

6.14. During this review, anecdotal feedback was shared highlighting an increased focus on the employee wellbeing and improved partnership working when HR was viewed as a neutral party in the process by both the employee subject to the process and Union representative.

HR colleagues must always remain a neutral party within the disciplinary process and operate within the boundaries of the CIPD Professional Code of Conduct. The perception that HR's role is primarily to support manager's or as the punitive party needs to be addressed within wider workstreams in the directorate and across the Trust.

Consideration should also be given to the introduction of an "expectations meeting" with Union Representative, to help support colleagues who are invited to a disciplinary hearing and to reiterate HR's role as custodians of a fair and equitable process.

6.15. The Welfare Contact role and responsibility document should be formally integrated into the policy and / or the investigation guidelines as a tool to ensure support all staff subject to a formal disciplinary process are appropriately supported. Consideration should be given to ensuring a welfare contact is assigned to all employees subject to a formal disciplinary regardless of suspension.

The Trust should implement a duty of care form and Welfare conversations guide should also be developed to support managers in having appropriate wellbeing and duty of care conversations.

A consistent method of recording welfare conversations should also be agreed.

6.16. Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' and therefore an immediate independent investigation must be commissioned and received by the Board. Further, prompt action should be taken in response to the identified harm and its causes. Where concerns are raised about a potential serious harm this should be immediately raised with the senior manager and HR representative.

6.17. Mechanisms should be built within which comprehensive data relating to investigation and disciplinary procedures are collated, recorded, and regularly and openly reported at Board and committee level for oversight and scrutiny. Associated data

collation and reporting should include, for example; numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions / exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt; average formal investigation reporting to hearing completion time.

6.18. There is a need for increased transparency and reporting of ER case load and timescales to both the Joint Partnership Forum and Executive Management Board.

6.19. An annual review of disciplinary processes must be timetabled for discussion to ensure a process of continuous improvement.

6.20. Deputy Director of HR and OD will be accountable for ensuring HR BP and ER team are adequately trained to deliver a fair and consistent approach, and thereby empower them the to hold managers to account.

7. Conclusion

7.1. The disciplinary review has identified three main areas of focus in the way in which the Trust manages disciplinary cases. These are;

- An urgent revision of Disciplinary policy, procedure and associated documentation.
- Training; for members of the HRBP and ER team as deemed appropriate by the Deputy Director of HR; fit for purpose training for all managers involved in investigating, commissioning or hearing disciplinary cases.
- Increased transparency and reporting of ER case load and timescales at both Board and committee level for oversight and scrutiny.

7.2. Failure to address the recommendations made within this paper present multiple risks to the organisation:

- Poor employee experience and a risk that we fail to meet our duty of care to support their wellbeing.
- Procedural unfairness and inequity due to variation in training for those managing and investigating cases.
- Failure to meet the requirements of the NHS People Plan and NHS People Promise.
- Increased risk and cost of litigation and tribunals against the Trust, as a result of procedural failings.
- Risk of increased staff turnover due to variation in policy application and non-person centred practices.

All of the above will also contribute towards a risk to organisation reputation and our ability to attract and retain staff.

8. Next Steps

8.1. The HR Senior Management Team will review and prioritise the wider learning outcomes and recommendations made and propose actions to address these within clear timescales. This will be reported to EMB.

Appendix A: The seven dos of investigation and disciplinary procedures

The new national guidance on NHS disciplinary processes cover seven themes – implementing these across the NHS will contribute to ensuring we treat people fairly and protect their wellbeing.

1. Adhering to best practice

(a) "The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published)."

(b) "All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise)."

2. Applying a rigorous decision-making methodology

(a) "Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps."

(b) "In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone."

3. Ensuring people are fully trained and competent to carry out their role

(a) "Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles."

4. Assigning sufficient resources

(a) "Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing',

the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered."

5. Decisions relating to the implementation of suspensions/exclusions

(a) "Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, time bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction."

6. Safeguarding people's health and wellbeing

(a) "Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support."

(b) "A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate."

(c) "Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes."

7. Board-level oversight

(a) "Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt."

In addition, for cases currently being considered and all future cases, Dido Harding asked teams to consider five questions (and, where necessary take corrective action), as given below;

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable

response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Appendix B – Case review form

South East Coast Ambulance Service NHS Foundation Trust

A review of all current disciplinary cases as of 12-01-21

The five questions we should be asking ourselves as part of the review.

1. Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action? Detail Allegations as per Terms of Reference

2. Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
Detail of informal interventions considered & reasons for initiation of formal procedure
Detail alternatives to suspension considered

3. If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
Has IM confirmed availability & resources to complete within policy timescales?
Where an extension to investigation has been actioned, has the individual been updated (detail)?
Has CM confirmed availability & resources to complete within policy timescales?
Have policy timescales been breached (detail)
Are there any conflict of interests?
Have you reviewed the investigation report? Are you satisfied with the quality of the investigation?

Have you advised CM in relation to the investigation report?
Are suspensions being reviewed 2 weekly by Dir of HR & OD and Dir of Ops?
Have extension to suspensions been confirmed by Dir HR & OD and Dir of Ops been confirmed in writing every 2 weeks?
Have policy timescales been breached in regard to suspension? detail

4 a. What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Detail	
Wellbeing referral	
OH Referral	
Signposting to support	
Welfare Contact	
Reasonable adjustments	
Other	
Is this regularly/ continuously assessed?	

4 b How will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage. Detail

5. For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Outcomes			
	Action Required	**Next Steps**	**Learning Outcomes**
Point 1.			

Point 2.			
Point 3.			
Point 4a.			
Point 4b.			
Point 5.			