South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

29 July 2021
10.00-13.00

Via Video Conference

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
13/21	10.00	Welcome and Apologies for absence	-	-	Chair
14/21	10.02	Declarations of interest	-	-	Chair
15/21	10.02	Minutes of the previous meeting: 27 May 2021	**Y**	Decision	Chair
16/21	10.03	Matters arising (Action log)	**Y**	Decision	PL
17/21	10.05	Chairs Report	**Y**	Information	Chair
18/21	10.10	BAF Risk Report	**Y**	Assurance	PL
	10.20	Infection Prevention and Control Board Assurance Framework	**Y**	Assurance	BH
19/21	10.25	Chief Executive's report	**Y**	Information	PA
20/21	10.40	Operational Performance & Patient Safety	**Y**	Assurance	EW
21/21	12.10	Integrated Performance Report Incl. Committee Reports	**Y**	Information	PA
22/21	12.50	Amendment to the Trust Constitution	**Y**	Decision	PL
Closing					
23/21	12.55	Any other business	-	Discussion	Chair
24/21	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting After the meeting is closed questions will be invited from members of the public					

Date of next Board meeting: 30 September 2021

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 27 May 2021

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

Present:

David Astley	(DA)	Chairman
Philip Astle	(PA)	Chief Executive
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
Emma Williams	(EW)	Executive Director of Operations
Fionna Moore	(FM)	Executive Medical Director
Howard Goodbourn	(HG)	Independent Non-Executive Director
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Senior Independent Director
Michael Whitehouse	(MW)	Independent Non-Executive Director
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director / Deputy Chair
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Christopher Gonde	(CG)	Associate NED
Mamta Gupta	(MG)	Associate NED
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary

Chairman's introductions

DA welcomed members, those in attendance and those observing. He welcomed PB, CG and MG to their first meeting, and on behalf of the Board congratulated EW for her recent appointment.

01/21 Apologies for absence

There were no apologies

02/21 Declarations of conflicts of interest

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

03/21 Minutes of the meeting held in public 25.03.2021

The minutes were approved as a true and accurate record.

04/21 Action Log

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

05/21 **Board Story** [10.02 -10.15]
The film shown builds on the national coverage received last week regarding the roll out of iPads to ambulance staff. It highlighted the following:

- Our proactive stance in investing in iPads for frontline staff means we are ahead of most others
- How utilising technology can enable us to work with our system partners to improve patient care, at the point of delivery but also to avoid future issues and complications
- Improved care for patients but also supporting the wider NHS system; enabling patients to safely receive care in the community & avoiding unnecessary A&E visits & transfers
- The opportunities for us to work as an integrated part of the system on other care pathways

FM reflected that the film helped to demonstrate first class patient care with good outcomes and good working between us and specialist clinicians, which has evolved over the past couple of years. The implications for technology in the future are great and we need to review what other conditions we could use this to help treat. TQ agreed and is encouraged to see collaboration of care between patients

DA noted the role of the Quality and Patient Safety Committee to review how the evolving technology could be used to positively impact quality and patient safety.

06/21 **Chair's Report** [10.15 – 10.24]
DA summarised the key issues from his report and the activities of the Board since its last meeting in March. He explained that the NHS White Paper has prompted much consideration and review.

DA confirmed that the separate item on operational performance is the main focus of this meeting, and will be taken slightly out of order, immediately after the CEO report. He then reflected on where we are as a Trust with interesting challenges ahead with the evolving NHS structures and post pandemic recovery. DA reinforced the need to keep improving which will bring challenges.

LB announced that she will be joining University Hospitals Sussex in September as NED. The Board congratulated her on this appointment.

07/21 **BAF Risk Report** [10.24 – 10.37]
PL set out from the report the current view of what constitutes the principal risks to achieving the Trust's strategic objectives. He reinforced that the report is dynamic and so will be subject to ongoing change and explained that the main purpose of this report is not to necessarily scrutinise the detail of the risk, but rather to seek assurance that the Board is regularly reviewing how these risks are being managed.

Section 3 of the report confirms the extent to which the management of the risks have been tested by the Board, directly or via one of its committees. PL suggested that the Board could take assurance by the oversight there has been. In the detail of each risk, we have reflected the conclusions from the recent reviews, which confirms that in all but one (system leadership) the controls in place do not currently mitigate down the risk. PL felt that this is a fair assessment and a reflection of the nature of these risks and the point in time we are. However, if this continues to be the position over the next 3-6 months then it would potentially be a concern.

PL referred to the Board agenda (parts 1 and2) where there is good scrutiny of three of the five risks; 111 & 999 Performance; Financial Management; and System leadership. The other two risks are scheduled to be covered by the Workforce and Wellbeing Committee (WWC) at its next meeting in 24 hours' time.

DA opened to questions and there were some specific queries related to clarification. TQ noted an absence of staff wellbeing in the report, and with the expected issues related to trauma he wondered how we are approaching this risk. PL confirmed that there are related risks captured in the risk register, it is just about the extent to which this should be a BAF risk. AM added that we do provide good well-being services and we are in the process of evaluating this so it is an active item under consideration.

LM wondered if some risks are in fact reduceable at all and in the context asked whether we are we doing enough contingency planning, so that we have some options if risks materialise. He suggested we should think of the worst and plan accordingly. This would mean there is less focus on risk reduction and better planning for handling the consequences.

DA asked the executive to consider these comments.

08/21 Chief Executive Report [10.37 – 11.10]

PA introduced his report, starting by noting how positive it is for the Trust that DA has been re-appointed for a second three-year term. He then outlined his view on the current position with COVID, suggesting that there will very likely be a third wave, probably between July and September. The question is how severe will it be and how much will the vaccines protect us from the different variants. The plan is to close our vaccination centre in June and re open it when we have the booster vaccine, possibly in September.

With regards the paramedics risk covered in the BAF report, PA explained that he supports a broadening career, but we are not in a place where we can actively introduce a rotational system that places paramedics within primary care. This is because we simply don't have enough paramedics and so with the support of the system, we are trying to limit the appetite of PCNs, while we grow our workforce over the next 3-5 years. Only then can we support a rotational model. We remain in discussion with HEE NHSE and the ICSs, and there is good awareness of the risks and good engagement.

In light of the separate agenda item PA touched briefly on operational performance explaining that we were expecting a slow build of demand up to a 3rd wave, but in reality, demand has significantly increased when compared to the same period in previous years. The increase overall is 7% but hidden within this is a 19% increase in C1, which places a significant pressure on resources. C2 is also increasing and so we are seeing far more patients and of this number they are sicker. Keeping pace with performance has therefore been a real struggle. This is the same across all ambulance services and indeed other parts of NHS are seeing similar trends.

111 CAS are also experiencing challenges with demand. For example, yesterday we would expect 2,500 calls and received over 3,800. We are continuing to recruit and seeking the funding we require to help enable us to meet demand.

DA opened to questions.

LM agreed that allocating resources to grow paramedics is needed, but he asked confident PA is that the system understands the risk to us and therefore how constrained will they be in recruiting paramedics? PA responded that the PCN workforce plans suggested a call for 200 paramedics this year across region. Had we agreed to rotation we would need to put 200 through this from 1 April. We didn't do this and to-date the numbers leaving are relatively small. Everyone in authority understands the consequence to the ambulance service. We have felt listened to and confident we have been heard. NHS England however are not limiting the flow; as a sector we did ask for a cap on recruitment but this was declined. Instead, they referred the issue to local systems to manage.

LB acknowledged some of the great things we are doing, some of which were highlighted in the Board story, but with the increasing challenges PA refers to she asked about the immediate actions being taken to respond, noting the impact of the 21 June (lifting restrictions). PA confirmed that EW will cover this in the next item and reflected that he shares the concerns being expressed by the Board.

LB came back to ask whether we are expecting improvement in performance or will this continue. PA explained that if demand continues to rise then we will do well to hold the current level of performance. This is because we don't have much capacity to add resource (people) and so the things left will be managing non COVID sickness, which is too high, and control other abstractions. PA felt that demand will likely continue to rise probably up to September.

10/21 Operational Performance & Sustainability [11.10 – 12.01]

EW took the Board through the slides starting with the contingency planning and what is expected over the coming weeks. She explained how we optimise our planning over the 12 months of the year. The last 12-18 months been extraordinary and the impact on staff is being carefully considered as there is a level of fatigue and we must ensure staff take annual leave which will have an impact on performance.

EW outlined the primary reasons for non-delivery of performance which included:

- Dispatch complexities result in challenges in efficiency and consistency
- Variability and inconsistency in terms of the number of hours being produced across all dispatch desks
- Abstractions still high despite reduced level of annual leave abstraction and cessation of shielding – this is still requiring higher levels of overtime to backfill
- Contributory factors (e.g. handover time) not on track compared to target/max level
- Data analysis has focused on single metrics with current inability to triangulate across multiple metrics to be able to demonstrate a robust action-based cause & effect
- Inability to deliver predictive data to assist in planning for the future (near & far)

EW reflected on the assumptions we used to make that the provision of close to 9700 hours would achieve ARP performance standards, but the evidence not is not bearing this out so we need to both increase hours and make them more efficient. Our review with other ambulance services confirms there are very similar issues being seen across England.

EW outlined the short-term measures commencing now and will blend into a longer-term plan over the year. This includes:

- 'Grip and focus' on the basics
- Managing and monitoring the key metrics to improve performance
- Weekly review and oversight process by operational leadership to ensure course correction where needed
- Planning for summer pressures and continued release of lockdown

Longer term (commencing planning now and deployment from October 2021 onwards) includes:

- 'Better by Design' programme which commenced in April (planning phase) and will move into an implementation phase from October
- This will focus on the structural changes required in order to deliver ARP sustainably in the future

111 CAS also forms part of the plan and the actions/metrics included in the paper are the areas we are focussing on.

EW noted that this is high level summary and there are lots of detailed actions that sit underneath this, which the operational leadership team are held to account against.

For 21 June specifically, EW confirmed that we are looking at ways of increasing PAPs and optimising specialist paramedics and HART. Also, increasing hear and treat which was 9% last weekend and this is the sort of level we need to sustain, and increasing the hours provided by response capable managers. In addition, the strategic and tactical teams are more proactive, looking forward and working with systems to let ensure they understand the pressures and can support us, e.g. handover delays / diverts.

DH added that it is really important for assurance that we are focussing on the here and now with a 12-week forward view. We have as an executive been challenging to ensure actions /metrics are SMART. This bank holiday will be a good signal for how the summer will go. The whole system is planning for a challenging summer and so the focus needs to continue on keeping patients as safe as possible. The public communications is encouraging the public to use our services in the most appropriate way.

DA thanked EW and DH for this summary and opened up to questions, asking for directors to test their levels of assurance by the plans to manage demand over the short medium and long term.

HG asked about the extent to which we can amend employment contracts to ensure vaccinations are taken up. BH confirmed that this is something we and wider NHS is looking at.

MW understands what is being done, but felt that the Board should acknowledge that, as a Board, our focus should be on the strategic solutions. He asked for clarity on what the executive consider these to be. For example, PA confirmed earlier the likelihood of demand increasing, not just in the short term but annually, and as we go through later this year another spending round, we need an understanding of demand so we can be assured that have a reasonable expectation to be able to meet this. Currently, we possibly cannot reasonably have this expectation. We need to plan for the variance in demand and ensure clarity on the staffing level needed to ensure we are resilient in the longer term. Whatever the gap is will need to underpin our financial plan and call for funding from commissioners.

DH responded that we are working to ensure we are able to better predict demand. There is work behind scenes on a performance cell which will forecast future demand much more accurately and match this to hours and skill mix required. Then what the performance trajectory is likely to be. By the summer we will have part of this in place and while it will take some time to embed and get right, we will start using it to predict. In terms of matching workforce to demand this is unlikely to happen this financial year irrelevant of funding, given the pipeline and lead in times. However, we will use PAPs to close some of the gap and as EW explained, we then need to establish ways to use the resources we do have more efficiently.

Action
MW asked that we aim to get as soon as possible clarity on what the target establishment needs to be to give us the best chance of being resilient (meeting ARP standards) without putting inappropriate pressure on our people**.**

DH reminded the Board that we did this via the demand and capacity work, which gave a target demand and required workforce, but this has since been diluted by the current situation. The first presentation from the performance cell is on 3 June and we will bring this back to Board and from this we will establish the operating model for the next 12 months; Better by Design will then establish the longer-term model to ensure we are sustainable.

MW felt that we owe it to our workforce to give them some light at the end of the tunnel, acknowledging how unsustainable it is to expect them to work so much overtime. DA agreed and we also need to give assurance to our public that we are doing all we can to manage demand.

LM noted the need to suspend/minimise training and the careful balance of risk needed here given that education training and development is pretty fundamental. He confirmed that WWC will test the downside of reducing abstraction.

LB is assured that we have a plan in place and acknowledged the passion from EW, but given what has been said about what we can reasonably expect we must manage safety, e.g. welfare calls / tail audits. In response to this challenge EW set out what we are doing and the governance in place to flag things early. She confirmed that tail audits are robust. In terms of welfare calls, this needs some work and is part of the overall plan. We have regular conversations about quality, safety and performance. In terms of feedback via incidents and complaints BH added that this is about supporting operations to ensure learning is identified and action taken. There is more focus on making changes to ensure immediate impact. FM outlined some of the practical issues including improving comms between safety navigators, supervisors and PP Hubs. We are also piloting video conferencing and CCPs who do relatively few jobs are being asked to increase provision.

Looking to the future, TQ suggested a need to think strategically to really understand why demand is rising and how we link with public health colleagues. For example, what sort of conditions are resulting in the rise in demand and how do we work with data expert partners to more proactively address this constant rise. We won't have all the capacity to understand this so need to work with system partners. Only when we understand the reasons can we better manage it. FM agreed and explained that we are seeing unmet demand from the past year arising from primary care; this is seen across the country.

LM agreed we need to understand the demand side but not just about clinical condition, also how this is related to pathway partners. We need to engage locally with providers to work with them to develop pathways. How they behave is a function of what demand we get.

For assurance, DH confirmed that in the new performance cell we have a role for a data scientist. Once we interpret the data we can ask clinicians to find solutions. But the data must be the first part to our approach. This will enable us to look at conditions and demographics etc. to predict the likely kind of activity.

DA asked that as a Board we stand together to deal with the immediate pressure on the Trust and wider NHS. We are asking our staff to step up over the next few months after such a difficult year so we need to approach this as one team and keep staff tuned in so we are all working together.

PA added that this can only be delivered locally. We need to ensure we provide our OUs the resources we have available then plan to get the resources they need longer term. The rest is getting a shared understanding of the position and difficulty we are in.

DA summarised that there is a clear diagnosis of the current challenges. The immediate short-term plan aims to best manage demand accepting the challenges. There are some clinical systems in place to ensure we provide a safe service. The Board will oversee this to ensure it is maintained. We want to be assured further regarding comms and public messaging about what we can reasonably achieve over the coming weeks and months. We have a clear operating framework in place and while the Board remains concerned it is satisfied there is clear action.

[Break 12.01-12.10]

09/21 IPR /Committee Reports (12.10 – 13.14)

PA introduced the report which includes new metrics and continues to evolve to ensure it is as useful as it can be. DA then asked that executive directors to start by highlighting any specific areas. He confirmed there will then be questions before asking the committee chairs to introduce their escalation reports.

Operational and Financial Performance / Finance and Investment Committee

Operations

DA asked if there is anything to add to the item discussed already. EW felt the key issues have been covered.

Finance

The Board noted that the IPR includes detail about year end and month 1 and that the year end position is covered in part 2. DH confirmed that we ended the year in deficit and explained this was related to a technical accounting issues whereby an estate valuation exercise resulted in a financial impairment of £7.8m. The underlying position however remains at a breakeven.

Next year we have a control total deficit target of £5m. At month 1 we are on target for this. In part 2 we will need to explore how when we go back to normal cost and volume and how we manage the shortfall in income.

The Board explored the risk to our cash position, from the planned £5m half-year deficit, and sought assurance that the finances won't impact patient care. DH provided assurance and confirmed the work we are doing within the system to ensure we continue to be financially sustainable.

FIC report

HG highlighted the key issues as set out in the report, with the main focus on performance having already covered in detail here. He also went through the detail of the finances as DH has just described. The two business cases will be covered in part 2.

There were no questions.

Quality and Patient Safety / QPS Committee

FM highlighted two issues from the care bundles. Firstly, with regards stroke, we have always performed well but the downward trend is worrying. We have done some work on this and of the non-compliant cases we were missing the patients' blood glucose and so corrective action is being taken. Secondly, on STEMI this relates to the use of analgesia and specifically use of paracetamol that is not considered sufficient, although this guidance might soon change. It is therefore not as bad as we thought and was covered in detail at QPS committee.

BH highlighted one issue related to risk reviews. There are a high number that are overdue review and this is a combination of Datix simply not being updated and a lapse in some of the grip and focus over past few months. The executive discussed this recently and he IPR sets out three main things we are doing to address this. In addition, the revised risk management process will help too.

HG is unclear how we identify unwarranted variation and how we use national guidance to implement locally as in the example of STEMI we seem to be adopting a different approach to the guidance. FM explained that there is good compliance with 3 of the 4 aspects of the bundle. But there is debate about the best form of pain relief for patients with chest pain. Paracetamol is equivalent to 10mg of morphine so is being increasingly accepted as acceptable analgesia; the guidance is likely to be revised to reflect this.

SS asked BH when we can expect to see improvement with the issue related to risk management. BH explained that a paper is coming to EMB soon that sets this out and will be reflected in the IPR going forward.

LB refereed to compliance with NHSP audits and asked what the consequences of this are. FM explained that this relates to call audits; the data is skewed as random audit of calls we target where we have complaints or SI which tend to be lower so brings the audit down. We are now moving to a 'side by side' audit position.

LB asked about the measures to push on hand hygiene; we are close to target but not quite there. She asked what more we can do. BH explained we have struggled with balancing the need for audit versus abstractions. But we should be meeting IPC targets especially with COVID. EW added that we do monthly performance and governance meetings which include IPC. There is much greater focus on general infection control, but she accepted we need to get back to making the audits happen and understand how we get consistency across the patch.

QPS Committee
TQ then outlined the focus of the most recent QPS meeting as set out in his report to the Board, including some of the issues, further actions to be taken, and levels of assurance obtained.

The Board noted the **Learning from Deaths Report** and FM outlined some of the findings. This helpful report will continue to be received by the Board each quarter.

BH took the Board through the **Safeguarding Annual Report** outlining the main findings which as QPS reflected is an excellent report. In high-level terms the Board acknowledged what a busy year it has been for the safeguarding team, with the rise in activity. This is seen positively in terms of reporting concerns. On behalf of the Board DA thanked the team and staff for their work. DA specifically noted the commitment demonstrated at QPS was very assuring.

FM commended the excellent **Research & Development Annual Report** to the Board reflecting on the work of what is a very small team. This highlights the impact of the pandemic. FM confirmed that one of our research paramedics has a fully funded fellowship, one of only a few across the country. FM then outlined some of the outputs of some of the reviews.

LM reflected on the R&D team being a very powerful intellectual resource that can help improve our position to use evidence in discussion with partners. He felt it is very clinically based and asked whether we could use it to apply to other issues that aren't narrowly clinical. For example, could we commission R&D support to provide rigorous evidence to justify what we do, such as body worn cameras. FM agreed that this is a good challenge and explained we do try and engage so we don't just focus on one area. We are involved in a number of national studies, e.g. crash 4 study. This requires quite a lot of planning and FM will take forward to ensure we don't focus too narrowly.

The Board was assured by these three reports.

<u>Workforce and Wellbeing</u>
AM highlighted concern about the high level of sickness and staff affected by COVID. Also, we have seen a recent increase in employee relations activity and have regular meetings to deal with issues before they escalate. On partnership work with unions, AM reflected that we engage very well now with unions on all these issues.

<u>Audit & Risk Committee</u>
MW outlined the key areas of focus for the committee which was the most important meeting in the calendar as it considered the annual report and accounts. He reflected a positive picture. A key component is the annual governance statement which gives assurance that we are manging resources effectively. This is signed off by Chief Executive and is consistent with internal audit. The overall opinion is positive. External auditors are indicating a positive opinion too, and we will pick this up in part 2.

MW explained that the auditors are required to give value for money opinion which gives assurances about how well we mange resources. The strong indicator from KPMG is that this will be a positive opinion.

The meeting also considered two new internal audit reviews with moderate assurance. There is scope for improvement in clinical education and in payroll and actions are in place to improve these areas. Another positive aspect is the improvement in the closure of management actions.

Finally, we reviewed license self-certifications and recommend to the Board that it signs these off in part 2.

MW thanked DH and his team for finalising the accounts in such a short period of time. And to PL and his team for the work on the annual report.

11/21 AOB
None

12/21 Review of meeting effectiveness

There being no further business, the Chair closed the meeting at 13.15

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
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	2021/22	Board	c	Considered at the June development session
27.05.2021	10 21	MW asked that we aim to get as soon as possible clarity on what the target establishment needs to be to give us the best chance of being resilient (meeting ARP standards) without putting inappropriate pressure on our people.	DH	30.09.2021	Board	IP	Work progressing via the performance cell

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	18-21

Name of meeting	Trust Board
Date	29.07.2021
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.

In the weeks since the last Board meeting, we have experienced enormous challenges in being able to consistently respond in a timely way to the needs of our patients. I know as a Board we are deeply concerned about this. The main focus of this Board meeting, therefore, is to seek assurance on the measures being taken to provide as safe a service as is reasonably possible.

I acknowledge the importance of allocating resources to ensure ongoing safety, and so the primary assurance relates to the *immediate* steps being taken. However, the Board must also seek assurance that the Executive is allocating sufficient resources to ensure the *longer-term* strategic solutions. This builds on the discussion we had at the Board development session in June when we explored some of these solutions, such as the critical path for the Better by Design programme; performance cell; and workforce (scheduling and production).

While the Quality and Patient Safety Committee will, on behalf of the Board, continue to assure aspects of safety, we have established a new Operational Performance Committee (the inaugural meeting is scheduled for next month) to assure the Board on the impact of the actions to maximise the efficiency of our resources to improve operational performance.

It is important for context to recognise that our pressures are being experienced throughout the ambulance sector. As Philip sets out in his Chief Executive's Report, this is acknowledged by NHS England and NHS Improvement and the additional funding it recently announced is welcome. I commend the action Philip is taking with his peers in the sector to seek alternative support from other agencies. Given the challenges we must explore every option.

I would like to take this opportunity on behalf of the Board to thank the extraordinary work of our 111, EOC, ambulance crews and CFRs who in the face of adversity are doing all they can to provide a good service. I can assure all our colleagues that the Board is determined that our contingency measures make a difference to patient care and in turn support to our staff.

Finally, this is scheduled to be the last formal meeting of the Trust Board for both Lucy Bloem and Terry Parkin. Both have provided great service to SECamb and have been valued members of the Board over the past 6-8 years. They will be greatly missed.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	18-21

Name of meeting	Trust Board
Date	29 July 2021
Name of paper	Board Assurance Framework Risk Report
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic priorities and sets out the controls, assurances, and actions. It is used by the Board and its committees to inform the areas it needs to focus, when setting agendas. At its meeting on 15 July, the Audit & Risk Committee challenged the executive to think more about the contingency plans so that we are better placed to respond should these risks materialise. Through the Executive Management Board time will be provided in the coming weeks to consider this so that the controls and planning is more robust.
Recommendations, decisions or actions sought	The Board is asked to review the report and note how the risks have been considered by the Board and its committees. It is also asked to note that the controls for the majority of the BAF risks currently provide limited risk mitigation, which reflects the nature of these risks.

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

Board Assurance Framework (BAF) Risk Report

1. Introduction

The BAF risk report is regularly considered by the Executive to ensure the risks reflect the current position. Specific risks are also scrutinised by the relevant Board committee.

Should the Executive consider it necessary to add or remove a risk, it will make a recommendation to the Trust Board, directly or via the relevant Board committee, for decision. No changes are recommended in this version.

2. Structure of the BAF Risk Report

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

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

The **Risk Radar** provides an illustration of the risk score (with controls) against each strategic priority. This also confirms where there has been movement in score since the previous report.

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

Board / Committee	Agenda Item	BAF Risk
Finance and Investment June	111 & 999 Operational Performance Financial Planning	2 5
Workforce and Wellbeing May	Clinical Education Improvement Plan & Internal Audit Review Paramedic Workforce / PCNs	3 1
Board Development Session April & June	Paramedic Workforce Risk ICS / NHS White Paper Operational Performance	1, 2 & 4

The Board agenda has been arranged to ensure there is specific focus on operational performance and maintaining patient safety, which is linked to a number of the BAF risks, and most directly risks 2 and 3**.**

4. Management Review & Recommendation

As set out in Appendix A, each risk has a nominated scrutinising forum, where the subject matter experts consider the risk, and update accordingly. Where the forum is not EMB, it will make recommendations to EMB about any changes to the risk. When applicable, EMB will recommend removal and / or an addition of a BAF risk(s).

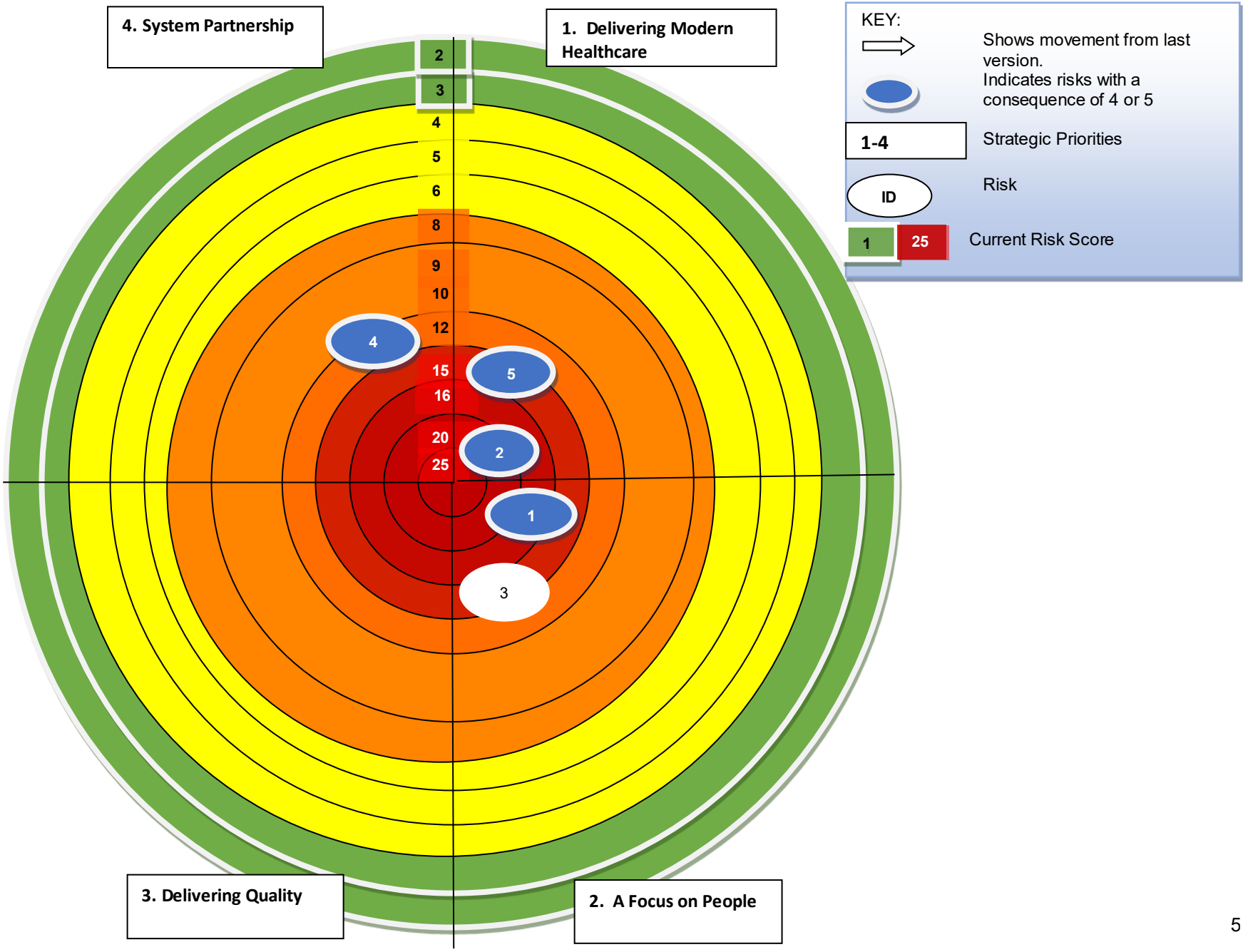
5. Conclusion

The Executive believes that the BAF risk report is sufficiently focussed on the right high-risk areas that affect the Trust's ability to meet its strategic goals. The BAF risk report will continue to be used by the Board and its committees to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

Over the coming weeks the Executive will review each of the risks in light of the challenge from the Audit & Risk Committee, to ensure clearer and more robust contingency plans.

Dashboard

Link to Priorities	Risk ID / Theme	BAF Dashboard	Initial Score	Current Score	Target Score	Target Date	Board Oversight
1 & 3	Risk ID 2 111 & 999 Performance	Risk that our operating model is not suitably designed to ensure efficient and effective management of demand and patient need.	20	20	08	March 2022	FIC / QPS
2	Risk ID 1 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.	16	16	08	March 2023	WWC
1 & 3	Risk ID 5 Financial Management	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.	16	16	04	March 2022	FIC
2 & 3	Risk ID 3 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	15	15	06	March 2023	WWC
1 & 4	Risk ID 4 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.	16	12	04	March 2022	Board


4. System Partnership
1. Delivering Modern Healthcare
3. Delivering Quality
2. A Focus on People
2
3
4
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6
8
9
10
12
15
16
20
25
4
5
2
1
3
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Priorities
ID
Risk
1
25
Current Risk Score

Appendix A

Priority 2	**BAF Risk ID** 1 Workforce	**Date risk opened:**

Underlying Cause / Source of Risk:	**Accountable Director**	Chief Operating Officer
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.	**Scrutinising Forum**	EMB
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Work in partnership with six higher education institutions (HEIs) for pre-registration paramedic education programmes As at April 2021 supporting 649 Student Paramedics (557 direct entry and 92 in-service) across all elements of their degree programmes Workforce Plan - aims to reduce the shortfall in paramedics by circa 150 by March 2022

Gaps in Control

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Shortfall of over 500 paramedics (-) Additional Roles Reimbursement Scheme could lead to a potential increased attrition of 230 paramedics by March 2024 (-) Retention of paramedics	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Working with the Regional Leads and PCN's to limit the recruitment from the Ambulance service whilst the issue is collectively addressed. Working with HEE to understand how the pipeline and supply side issues of new recruits can be addressed. The Trust working with partners to mitigate the constraints outlined in the paper around internal and external training pathways Workforce Plan - to reduce the shortfall in paramedics by circa 150 by March 2022	

Last management review	Executive Management Board	**Last committee review**	28.05.2021 Workforce and Wellbeing Committee

Priority 1 & 3	**BAF Risk ID** 2 111 & 999 Performance	**Date risk opened:**

Underlying Cause / Source of Risk:	**Accountable Director**	Chief Operating Officer
Risk that our operating model is not suitably designed to ensure efficient and effective management of demand and patient need.	**Scrutinising Forum**	Organisation Change Group
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**20** (Consequence 4 x Likelihood 5)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Operational Performance and Sustainability Plan – focus on key actions to improve processes / use of resources Better by Design – a programme to establish the most effective delivery model. Progress to date: Board engagement and vision developed; Senior leadership workshops and defined projects; procured forecasting and planning tools. Moved to REAP 4 in early July

Gaps in Control
Establishing the best care delivery model.

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Overall performance in 111 CAS & 999 (-) Increasing demand (-) REAP 4	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Operational Performance and Sustainability Plan Development of the new Performance Cell BBD Programme to review the care delivery model	The plan is in place and being monitored weekly by EMB Demand led planning (performance and predictive analytics) introduced in June Q2 - outputs of workshops developing better by design projects in all workstreams

Last management review	Executive Management Board	**Last committee review**	10.06.2021 Finance and Investment Committee

Priority 2 & 3	**BAF Risk ID 3** Education Training & Development	**Date risk opened:**

Underlying Cause / Source of Risk: 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. .	**Accountable Director**	Director of Operations
	Scrutinising Forum	Senior Management Group
	Initial Risk Score	**15** (Consequence 3 x Likelihood 5)
	Current Risk Score	**15** (Consequence 3 x Likelihood 5)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**06** (Consequence 3 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Key Skills delivery programme Management development programme

Gaps in Control
Education, Training and Development (ETD) Strategy Management plan for additional annual leave carried over from 2019/20 Insufficient funding for the actual level of activity and abstractions

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Operational pressures / REAP 4 (-) Additional abstraction (carry over of leave due to the pandemic)	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Clinical Education and wider ETD strategy being developed	

Last management review	Executive Management Board	**Last committee review**	28.05.2021 Workforce & Wellbeing Committee

Priority 1 & 4	**BAF Risk ID 4** System Leadership	**Date risk opened: 13.09.2018**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Nursing & Quality
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.	**Scrutinising Forum**	Strategic Partnership Board
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Internal Strategic Partnership Board established Board Strategy Advisory Board Existing engagement approach

Gaps in Control
Differences across the three ICSs in our region Approach to corporate affairs

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Board's test of the Trust strategy against the emerging system design/approach	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Plan to ensure a more joined approach to corporate affairs Establishing the Strategic Partnership Board	In progress – some scenario testing to be arranged Has met twice and still in the forming phase

Last management review	Executive Management Board	**Last committee review**	28.05.2021 Workforce and Wellbeing Committee

Priority 1 & 3	**BAF Risk ID 5** Financial Management	Date risk opened:

Underlying Cause / Source of Risk:	**Accountable Director**	Chief Operating Officer (Director of Finance)
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.	**Scrutinising Forum**	Executive Management Board
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Block contract in place Interim financial arrangements have been extended by NHSE to Sept 2021 2021/22 budgets set Capital Plan

Gaps in Control
Funding agreed only for the first half of 2021/22 Potential deficit could result in a cash shortfall that may affect future capital plans ICS capital limits

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Working with the ICS and NHSE&I	The clarity on the funding arrangements from October are not expected until September.

Last management review	Executive Management Board	**Last committee review**	10.06.2021 Finance and Investment Committee

Appendix B
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

Appendix C

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Negligible	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)

Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non- critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim	Complaint possible Litigation unlikely Claim(s) <£10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100-£1m	High profile complaint(s) with national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of moral within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days' coverage e.g. front page, headline Regulator concern	National Media <3 days' coverage Regulator action	National media >3 days' coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	18-21

Name of meeting	Trust Board
Date	29.07.2021
Name of paper	IPC Board Assurance Framework
Executive Lead	Executive Director of Nursing & Quality
Synopsis	The Infection Prevention and Control Board Assurance Framework was introduced last year by NHS England, to support providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The framework helps to assess the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards. Using this framework is not compulsory, however, SECAmb has been using it for the past 12 months. Some changes have been made since the version last seen by the Board and these are highlighted in yellow.
Recommendations, decisions or actions sought	For assurance.

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

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: o a review of the effectiveness of the ventilation in the area; o operational capacity; o prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; • when an unacceptable risk of	Ambulance specific hierarchy of controls are being drafted to match the ambulance setting. To be completed once document is approved All patients that call 999 are triaged using NHS Pathways and clinicians record patient history on the trusts Electronic Patient Clinical Report form, which is sent to the receiving hospital.	Still in draft format to be approved at National Ambulance IPC Group None	SECAmb IPC Team are leading on the draft version of the document

transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;	Guidance for PPE compliance is available to all staff and reviewed regularly in line with any national changes.	None	
• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative;	N/A		
• that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;	N/A		
• resources are in place to enable compliance and monitoring of IPC practice including: ○ staff adherence to hand hygiene; ○ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:	Local Managers are responsible for monitoring compliance to PPE guidelines and report any breaches via the Trusts DATIX incident reporting system. The IPC Team along with local IPC Champions visit local hospital sites to undertake spot checks for PPE compliance.	Due to operational pressures this is not always possible and breaches have been reported. These are dealt with locally following notification via the IPC Team.	

▪ a) clinical; ▪ b) non-clinical setting; ○ monitoring of staff compliance with wearing appropriate PPE, within the clinical setting; • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered; • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace; • additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team; • training in IPC standard infection control and transmission-based precautions is provided to all staff; • IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training; • all staff (clinical and non-clinical) are trained in: ○ putting on and removing PPE; ○ what PPE they should wear for	N/A All Trust staff, including contractors, students and volunteers have been offered Lateral Flow Test kits in line with national guidance. Outbreak Management Framework in place to deal with any local issues The IPC Team attend all virtual training sessions for new staff and this year's level 2 IPC Key Skills session also provides with staff with up-to-date guidance for Covid-19 and all other infections.	Not all staff have taken up the offer for LFD testing None	

each setting and context; • all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance; • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace; • IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way; • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted; • risks are reflected in risk registers and the board assurance framework where appropriate;	All staff have access to the ZONE where guidance is provided for PPE and when to wear it including donning and doffing procedures All sites and vehicles have PPE to the levels and type of PPE required for the setting A range of posters have been developed and are displayed at all sites The Trust review all updates to national guidance on a weekly basis, or as and when changes are published. Staff are informed of changes via the 16-00 calls and by email of required. The Trusts internal website also has a dedicated section for all Covid-19 related guidance and communications, which staff can access remotely All risks related to the pandemic are managed at the Covid Management Group (CMG)which meets weekly and the Chair of the group will escalate any concerns to the	None None None None	

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens; • the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep; • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board; • the Trust Board has oversight of ongoing outbreaks and action plans; • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	Board The IPC Team continue to assess any risks associated to all infections and pathogens that are of concern. Regular reviews of IPC procedures and practices continues within the Trust and an IPC Team representative attends national and regional IPC Forums. N/A The Head of IPC updates the Board Assurance Framework and forwards to the Trust Board for approval and comment Daily sit-reps are sent to the Board and outbreak action plans go via the CMG The CMG membership and ToR's cover this need	None None None None	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas; • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas; • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance; • assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; • cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution	N/A N/A N/A N/A The Trusts cleaning contractor for both the vehicles and environment follow the national guidance for all cleaning	None	

at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses;	products. The Trusts IPC Team hold regular weekly and monthly meetings with the contractor where any compliance concerns are discussed, and actions put in place to mitigate these.		
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance;	As above	None	
• a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance;	Our enhanced schedule for cleaning includes a focus on all frequently touched surfaces and staff are also remined of the responsibility for regular cleaning to be adhered to	None	
○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails;			
○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards;	As above, with a real focus on our Call Centers and staff clean all surfaces at the start and end of shifts as well as before and after taking a break.	None	
○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal	Trust staff will doff PPE at the hospital site or in the vehicle if the patient is not transported. Vehicles will then be decontaminated in line with	None	

by groups of staff;	guidance.		
• reusable non-invasive care equipment is decontaminated: o between each use o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing or repair equipment;	Staff are instructed to follow decontamination procedures as described in the Trusts IPC Manual for Procedures. This includes repair and servicing decontamination processes	None	
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken;	Trust staff dispose of any linen at the hospital and use a one for one exchange in line with the local SOP	None	
• single use items are used where possible and according to single use policy;	Fully compliant	None	
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk;	All reusable equipment is decontaminated following national guidance	None	
• cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment;	Regular site visits and monthly audits are carried out at all Trust sites and any issues are raised at the monthly cleaning contractor meeting for actioning.	None	

• where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	All sites have been provided with guidance under the Working Safely in Ambulance Settings COVID-19 Guidance	None	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements for antimicrobial stewardship are maintained • mandatory reporting requirements is adhered to and boards continue to maintain oversight	The Trust doesn't have a mandatory reporting requirement for antibiotics. However, we do review all antibiotic use via our internal Medicines Team and PGD Group meetings.	None	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • national guidance on visiting patients in a care setting is implemented; • areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have	N/A N/A		

restricted access; information and guidance on COVID-19 is available on all trust websites with easy read versions;	The Trust internal website has a dedicated section for Covid-19 related guidance and communications.	None	
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved;	Receiving hospitals use our EPCR to gain patient history before arrival and this will include any Covid-19 risks.	None	
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	The Trust is unable to use posters in vehicles to provide patients and escorts with advice / guidance, but our staff will inform them of the required guidance that they are required to adhere to.	None	
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	The Trust have an IPC Improvement Plan in development which will include all of the latest guidance and tool kits available.	None	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people - Not Applicable to Ambulance Services			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance; • staff are aware of agreed template for triage questions to ask; • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible; • face coverings are used by all outpatients and visitors; • individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room			

isolation; • clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative; • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly; • there is evidence of compliance with			

routine patient testing protocols in line with Key actions: infection prevention and control and testing document; • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.			
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas;	Trust staff follow local hospital guidance when on site.	None	
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe;	All staff have access to the latest guidance and continue to complete level 1 and 2 IPC annual training via a workbook.	None	
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on	As above	None	

and remove it; • a record of staff training is maintained;	Monthly training figures are shared with managers from our HR Directorate.	None	
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk;	IPC audit tools include PPE compliance and are carried out at hospital sites by local managers, IPC Team and IPC Champions.	None	
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters; ○ good respiratory hygiene measures; ○ staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care; ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public	Newly developed posters, banners and email signatures are available and reviewed by the IPC Team on a regular basis to ensure they are providing the latest Covid-19 guidance. They cover all the areas shown opposite.	None	

health guidance outside of the workplace; ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas; ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. • staff regularly undertake hand hygiene and observe standard infection control precautions;	Latest audit results provide assurance that staff are compliant.	None	
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance;	All vehicles use paper towels as part of the hand hygiene procedure.	None	
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas;	Posters displayed at all Trust sites in the toilets and kitchen areas.	None	
• staff understand the requirements for uniform laundering where this is not provided for onsite;	A poster was introduced last year providing staff with further	None	

	guidance on returning home and removing uniform in a safe zone before entering their house.		
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms;	Regular communications and Action Cards cover this issue.	None	
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals);	The Trust review the community data weekly and provide advice to all staff during the 16-00 calls.	None	
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported;	Internal staff monitoring is in place and an Outbreak Management Framework is in place.	None	
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	All documents are in place and have been recently reviewed considering national guidance changes.	None	

7. Provide or secure adequate isolation facilities – Not Applicable to Ambulance Services			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff; • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas; • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate; • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance; • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.			

8. Secure adequate access to laboratory support as appropriate – Not Applicable to Ambulance Services			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals; • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance; • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); • screening for other potential infections takes place; • that all emergency patients are tested for COVID-19 on admission; • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission; • that sites with high nosocomial rates		

should consider testing COVID negative patients daily; • that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge; • that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • staff are supported in adhering to all IPC policies, including those for other alert organisms;	The Trust constantly remind staff to look for all infections during the pandemic and report on any local surveillance of these via Public Health England daily reports.	None	

• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff; • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance; • PPE stock is appropriately stored and accessible to staff who require it.	The trust also identifies any national changes via the National Ambulance Services IPC Group as well as PHE. All procedures and policies are in line with the national guidance and monitored via the IPC Sub Group. Central store and Standard Load List in place and working well.	None None None

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported; • that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff;	All risk assessments have been carried out for staff and are reviewed on a regular basis or as and when guidance changes nationally. HR Directorate lead on this and record all risk assessments centrally as well as assisting local managers with any individual concerns.	None None	

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally; • staff who carry out fit test training are trained and competent to do so; • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used; • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation; • those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods; • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options	All staff went through training and Fit testing and were provided with the appropriate FFP3 mask. The Trust has now rolled out Powered Hood respirators which provide all staff with protection including those that were unable to Fit Test to a re-useable or single use mask and anyone with a beard. Fully Compliant The Trust now use Powered Hoods as the first line of defence Fully Compliant where required Fully Compliant Fully Compliant	None None None None None None	

commensurate with the staff members skills and experience and in line with nationally agreed algorithm;			
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health;	Fully Compliant	None	
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record;	Fully Compliant	None	
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	Fully Compliant	None	
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance;	Not applicable to ambulance services.		

• all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas;	Working Safely During Covid-19 in Ambulance Settings is fully embedded across the trust.	None	
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;	As above with risk assessments carried out at all Trust locations.	None	
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas;	Not applicable to ambulance services.		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing;	Monitored through the Trust Covid-19 Management team as well as local manager. All staff training is now completed virtually.	None	
• staff who test positive have adequate information and support to aid their recovery and return to work.	Welfare for staff comes from the Covid-19 Management Team as well as their local managers.	None	

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	19/21
Name of meeting	Trust Board		
Date	29.07.21		
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 June 2021 and July to date. Section 4 identifies management issues I would like to specifically highlight to the Board.

2 Recognising the current operational pressure the Trust is under, this Report will reflect only the key issues affecting us at present.

A. Local Issues

3 **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.

4 As part of its weekly meeting, the EMB regularly considers quality, operations (999 and 111) and financial performance. It also regularly reviews the Trust's top strategic risks. In addition to the main weekly meeting, we also hold regular Executive 'huddles' to ensure that there is a frequent opportunity for issues to be raised and discussed and action taken.

5 The key issues for EMB during this period have been operational performance and patient safety, however, other issues overseen include:

- Introduction of the Performance Cell
- Review of structures to ensure they are right-sized and well aligned to operational delivery
- Agreed approach to improving staff experience

6 EMB have also discussed and agreed the following investment decisions:

- Body Worn Cameras trial
- Performance Cell Transformation
- Make Ready Service and Building Cleaning Contracts

7	**Engagement with stakeholders and staff** During recent weeks, I have continued my on-going programme of spending time at our Trust locations, including both EOCs, Worthing, Guildford and Polegate, although this has been somewhat curtailed due to the growing operational pressures that the Trust is under.
8	I have been working with all of our Integrated Care Systems (ICSs) as they firm up their plans to become Statutory bodies next year.
	B. Regional Issues
9	**Appointment of new Executive Director of Planning and Business Development** On 15th June 2021, we announced the appointment of David Ruiz-Celada as the new Executive Director of Planning and Business Development.
10	The new role comes with an extensive portfolio including system forecasting and planning to ensure the Operations Directorate has the right level of resources to deliver timely patient care as well as the delivery of Information Management, logistics and Fleet.
11	David will join SECAmb in September after a decade of working in the aviation industry. His most recent role has seen him lead a number of key areas including developing forecasting and modelling capability at London City Airport and delivering a number of improvement initiatives using technology and process changes to increase capacity.
12	I would like to formally welcome him ahead of his arrival in September and look forward to working closely with him in future; I am confident that his experience will prove hugely beneficial to SECAmb.
13	**Departure of Executive Director of Nursing & Quality** On 23rd July 2021 we announced that sadly, Executive Director of Nursing & Quality, Bethan Eaton-Haskins, has decided to take up a new role outside of the NHS.
14	Bethan has made a significant contribution to the Trust during her time with us, taking forwards the quality agenda and has been and remains instrumental in our organisational response to the COVID pandemic. She will be a loss to SECAmb but I am sure you will all join me in wishing her well in her new role.
15	The Appointments & Remuneration Committee (ARC) have begun the process of recruiting a permanent replacement and interim arrangements will be put in place in the meantime.
16	**Queen' Ambulance Medal for Dr Fionna Moore** I am delighted to report that it was announced on 11th June 2021, that our Executive Medical Director, Dr Fionna Moore, had been named in this year's Queen's Birthday Honours to receive the prestigious Queen's Ambulance Service Medal, (QAM).
17	Fionna has enjoyed a distinguished and lengthy career in the ambulance service spanning more than 20 years and was one of just six recipients to receive the medal in this announcement. During her time at SECAmb she has overseen work to raise clinical standards including exemplary work on medicines governance which was subsequently hailed by the

	CQC as outstanding.
18	I know that she is held in the very highest regard among our staff and the wider ambulance service, both nationally and internationally and I am really pleased that Fionna's dedication and career has been marked with her receiving such a prestigious honour.
	C. National Issues
19	**COVID-19 outbreak** As the pandemic progresses, we are continuing to monitor the situation closely:
20	Governance**:** The COVID Management Group (CMG), chaired by Bethan Eaton-Haskins, our Lead Director for COVID-19, continues to meet, ensuring that all decisions and actions related to COVID are considered appropriately. In light of the changes in national restrictions and the current situation, we have increased the frequency of the meetings.
21	Lifting of national restrictions: CMG is carefully considering the impact of the national changes made on 19th July 2021, when the majority of COVID restrictions were lifted, especially the impact on our staff as well as on operational demand (see below).
22	It's important to note that the actions we put in place earlier on in the pandemic – working from home where possible, social distancing and IPC requirements in both clinical and non-clinical settings – remain in place, as Public Health England (PHE) has instructed for NHS organisations.
23	Impact on staff numbers: We are continuing to see the impact of the pandemic on our staffing levels in a number of different ways, including staff needing to self-isolate, staff with COVID symptoms or confirmed COVID and the on-going impact on staff of long COVID.
24	We are continuing to work through the recently-announced process for NHS staff needing to self-isolate to understand how this could work safely in an ambulance setting.
25	**Trial of body worn cameras** At the beginning of July 2021, we went live with the trial of body worn cameras by ambulance crews to establish if the technology can act as a deterrent against aggression and violence and aid future prosecutions, following our successful application for funding from NHS England and NHS Improvement.
26	The trial will involve approximately 400 body worn cameras being used by crews across five areas covered by the Trust – Thanet, Medway, Gatwick, Brighton and Guildford.
27	The trial also forms part of a wider trust approach to tackle violence and aggression against staff which includes close working with police services to ensure all incidents are robustly managed alongside conflict resolution training for staff. The trial will feed into wider national

	work already under way to ensure the Trust benefits from trials which are already taking place elsewhere in the country.
28	**Additional national funding for ambulance services** On 14th July 2021 NHS England announced an additional £55million of funding for the ambulance sector to cover the winter.
29	The funding is specifically designed to increase the number of 999 call handlers; put additional crews on the road; provide additional clinical support in control rooms; extend the availability of hospital ambulance liaison officers (HALO) at the most challenged acute trusts and increase the number of emergency ambulances available for the winter.
30	The funding will be made available to ambulance Trusts following sign off of their individual plans covering how it will be used to increase capacity and improve performance.
	D. Escalation to the Board
31	**Operational Performance** For a number of reasons, including the impact of lockdown restrictions being released, major events including the football and the recent hot weather, demand for our 999 and 111 services has been far higher recently than we would expect to see at this time of the year.
32	We are also seeing this increased demand at a time when the resources we have available to respond to patients, both on the road and in our control centres, is being significantly impacted by the numbers of staff affected by various COVID-related issues, a busy annual leave period and high sickness levels.
33	The combination of increasing demand and pressure on our operational resources, is leading to an extremely challenged operational situation for us, where we are seeing some patients wait far longer than we would like. This position is replicated nationally amongst our fellow ambulance Trusts, as well as within the wider health system.
34	As a result of the challenging situation, we moved to REAP Level 4 on 2nd July 2021 and declared a Business Continuing Incident (BCI) on 16th July 2021, which remains in place at time of writing. Both of the actions were taken to ensure we are able to take all possible steps to maximise our operational performance as far as possible in these challenging times.
35	My team will cover this separately on today's agenda. Emma Williams, our Executive Director of Operations, continues to lead on the on-going delivery of an over-arching plan to improve our operational performance, supported by David Hammond as Chief Operating Officer. Through our quality and safety governance framework, we also continue to closely monitor the impact of any delays on our patients and ensure we are taking all steps possible to maintain safety. We have significantly stepped up the work in the Emergency Operations Centres to keep patients safe whilst they are waiting and increased our harm reviews proportionately.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	20/21

Name of meeting	Trust Board
Date	July 2021
Name of paper	Operational update – June 2021
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Emma Williams, Executive Director of Operations

Synopsis	A summary of operational delivery and performance covering:
	• Kent, Medway & Sussex 111 service
	• 999 service
	  ○ Emergency Operations Centres
	  ○ Field operations
	  ○ Specialist services (including HART, CFRs, and specialist paramedics)

Recommendations, decisions or actions sought	• For the Trust Board to review and consider the contents of the paper provided in line with contractual/delivery requirements and the current operating environment.

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

Contents

1. Overview of the operating environment

June 2021 was an increasingly difficult month for the Trust seeing an overall worsening position against operational performance requirements. Key contributing factors to this included a more challenged staffing situation due to a significant uplift in annual leave being taken in combination with increase absences due to sickness (both Covid and non-Covid related).

The Integrated Care Systems (ICSs) across the South-East region also felt more pressure, as was demonstrated through an increased hospital hand-over time, and reports of increasing hospital metrics indicating greater challenges in patient flow across all areas.

As a result of the deteoriating position regarding operational performance across June, a decision was made to move the Trust to REAP (Resource Escalation Action Plan) level 4 on Friday 2nd July. At the time of decision, SECAmb was the fourth ambulance Trust to move to this position – at the time of writing, 9 out of the 10 English mainland ambulance services have declared REAP 4.

It is predicted that these challenges for both SECAmb, the wider South-East region and nationally, will continue to grow, requiring continued enhanced engagement with local and system partners, our staff and union colleagues, and consideration of additional, extraordinary actions to be taken (in line with and above those in the REAP guidance document).

2. Performance Improvement Plan (PIP)

In early April 2021, following discussions within the Executive team, a decision was made to commence a focused programme of work whose fundamental intention was to improve the efficiency and effectiveness by which the services are provided within the financial envelope

The intention of the actions and activities within this Performance Improvement Plan (PIP) was twofold, and based on using the existing resources more efficiently:

- Initial shorter-term focus to stabilise current performance to mitigate the risk of deteoriation, particularly over the forthcoming summer months and the implications of the national lifting of lockdown restrictions.
- Building on the above, over a longer time (across the 2021-22 financial year) improve the overall service performance against all required key performance indicators (KPIs), national and contractual targets.

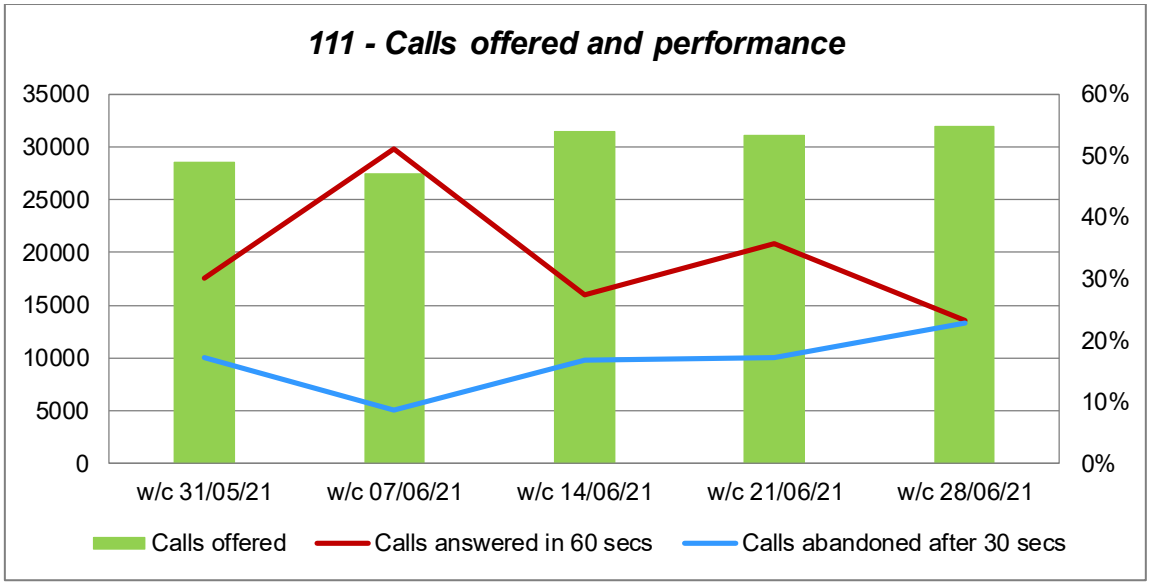
Whilst the intention of the plan is an initial 12-week focus, the foundations within the plan will provide the basis of an ongoing, longer term programme of actions focused

on achieving a consistent, sustainable high-quality service. As the plan has evolved additional actions have been identified and are being added to the plan. It has been essential to baseline metrics and ensure the ability to report on each of them – and where this has not been possible immediately, engaging with relevant parties to enable facilitation as a priority

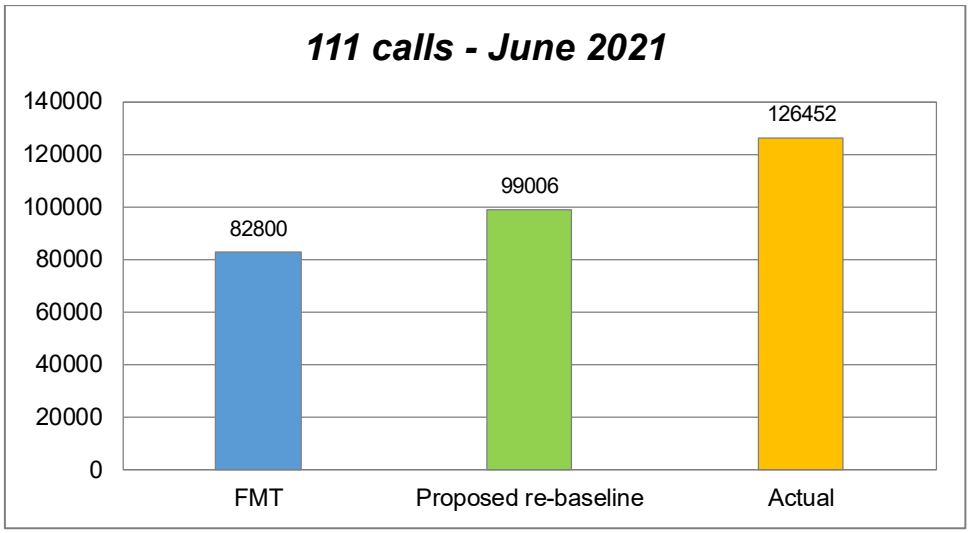
3. KMS 111 services

- 111 performance against the primary metrics of call answering and abandonment rate has been significantly off target for several months, primarily due to the increased demand being seen.

Performance metric	***June 2021***
Calls answered in 60 secs	33.96%
Calls abandoned after 30 secs	15.97%
Referral rate to 999	9.66%
Referral rate to Emergency Dept	17.76%



- The KMS 111 service continues to experience significantly higher demand than contracted for – this being a pattern seen across all 111 providers nationally, however noting that the South East region has seen an increase that is above that which would have been expected due to population proportion.



Note: FMT stands for Financial Model Template – the volume of calls planned within the original agreed contract which was mobilised in October 2020. The re-baseline level was proposed in February 2021.

- Whilst 111 is included within the Trust PIP, there is a more detailed plan which has been developed in collaboration with the Sussex and Kent commissioners, and which is linked to the wider range of metrics within the 111 – Integrated Urgent Care (111-IUC) contract.
- The referral rate to 999 is closely monitored, with a requirement for a high level of validation before the call is passed across. For the month of June 2021, 90.46% of 999 referrals were validated with 39.76% of these calls being passed to 999. Of these 62.01% were for the C2 category and 27.39% being C3 calls.
- The 111 KMS service has also been delivering the 111 First service, and within this, 1451 patients in June were booked into Emergency Departments, 226 into GP out-of-hours services and 442 into Primary Care services.

4. 999 – Overview

- There has been deteoriation seen across all ARP performance metrics in June
- National data for all ambulance services is provided monthly, and for June 2021, the national average position for all ambulance services showed that only the C1 90th centile target was met. The SECAmb position is:
    - Worsening call answer performance (bottom quartile)
    - C1: Improvement in mean position (mid-table), no change in 90th centile (bottom quartile)
    - C2: Improved position – 3rd overall for mean and 90th centile
    - C3 and C4 90th centile performance: bottom quartile for both, no change
- An increase in the numbers of call received was seen (1600 more than May), however a decrease in the number of incidents (1997 less than May)
- Due to the challenges in resource provision, the Trust has spent an increased amount of time spent at high levels of surge

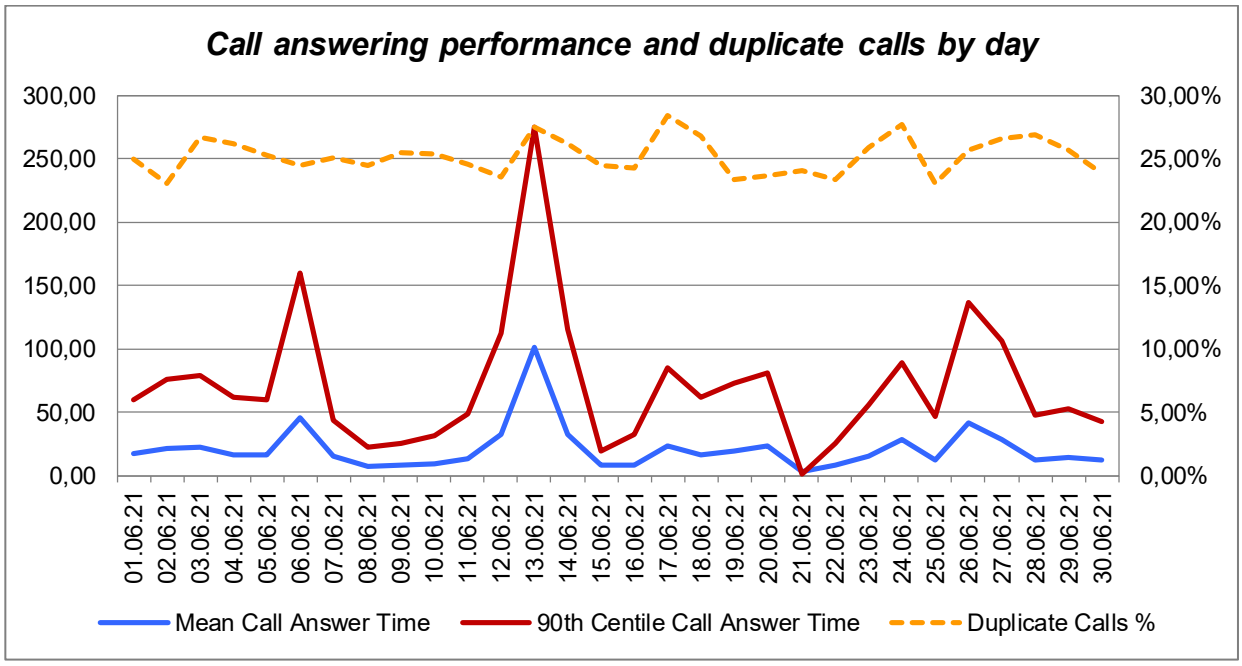
- The proportion of incidents closed via a 'hear and treat' proportion has increased with a slight reduction in proportion closed via a 'see and convey' route
- Staffing levels remain challenged in all areas due to high levels of annual leave being taken, and increasing sickness levels, including those causes that are Covid-related (Covid-confirmed, symptomatic or where the staff member is in self-isolation)

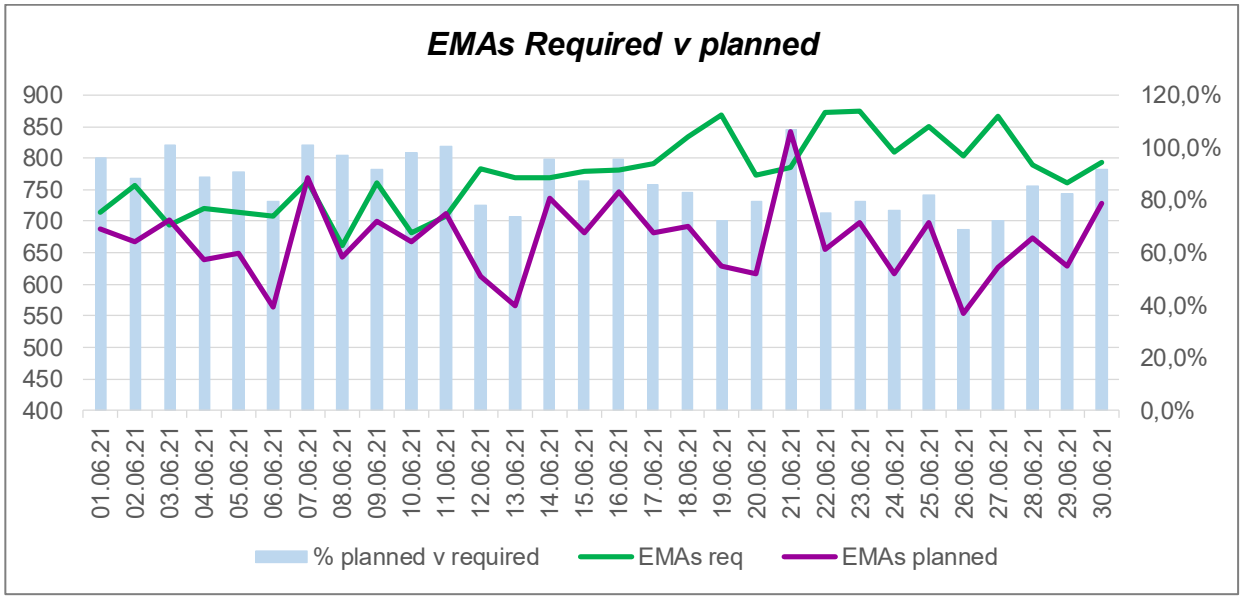
	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	4826	00:08:18	00:15:08
C1T	00:19:00	00:30:00	3139	00:10:24	00:19:14
C2	00:18:00	00:40:00	36459	00:26:11	00:50:55
C3		02:00:00	15414	02:35:15	05:39:49
C4		03:00:00	358	03:11:44	07:21:02
HCP 3			1059	03:25:24	06:56:26
HCP 4			749	04:22:49	08:01:15
IFT 3			534	03:42:27	08:05:25
IFT 4			100	04:26:58	08:27:18
ST	All Incidents		20503	31.26%	
SC	All Incidents		38954	59.39%	
HT	All Incidents		6132	9.35%	
Count of Incidents			65589		
Count of Incidents with a Response			59457		
999 Mean	Call Answer Target 00:05		80008	00:22	
999 90th	Call Answer Target 00:10			01:18	
Trust EOC 999 Abandoned Calls			851	1.1%	
A0	EOC All Calls		79357		

5. 999 – Emergency Operations Centres

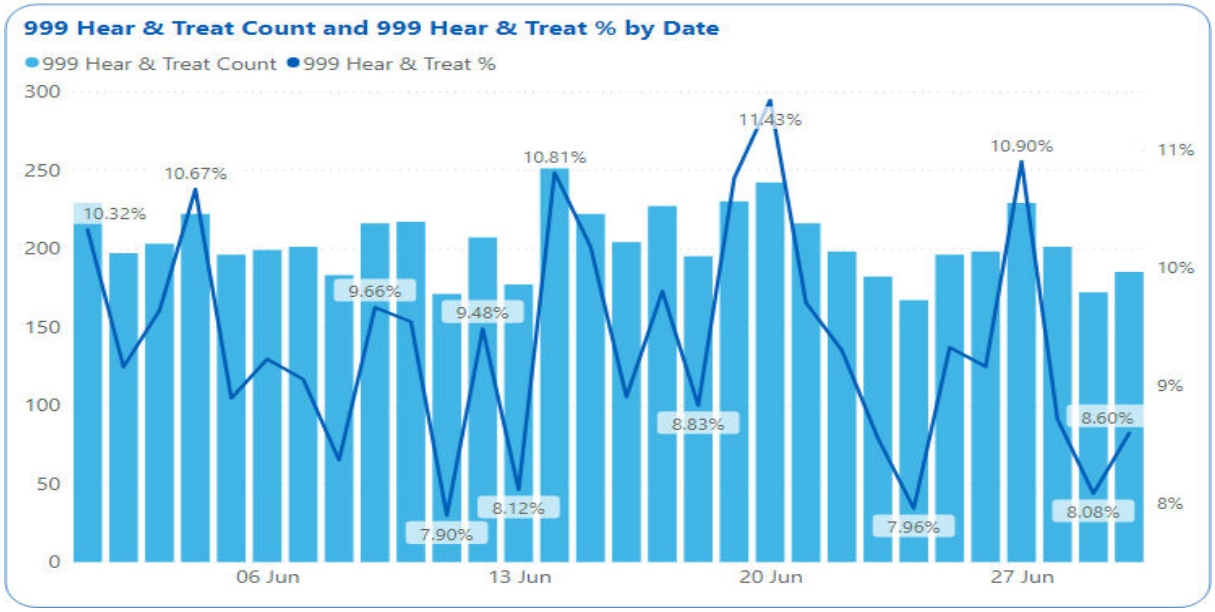
- Significant performance fluctuations have been seen across the month, with the provision of Emergency Medical Advisors (EMAs) having a direct impact on the call answering performance delivery on day
- During June, the total number of calls increased compared to May 2021, with the level of duplicate calls increasing to an average of a over 25% with a maximum of 28% (compared to 22% during Q1 2019-20)
- Whilst the overall *required* number of EMAs has increased to meeting the additional calls being received, the *actual* number of hours produced each day has reduced, creating a greater differential between the two
- Training of new EMAs continues with courses being run during the day and evenings, however with the re-opening of other local businesses, turnover has

begun to increase as some staff are looking to return to their original career choices (e.g. the airline industry)

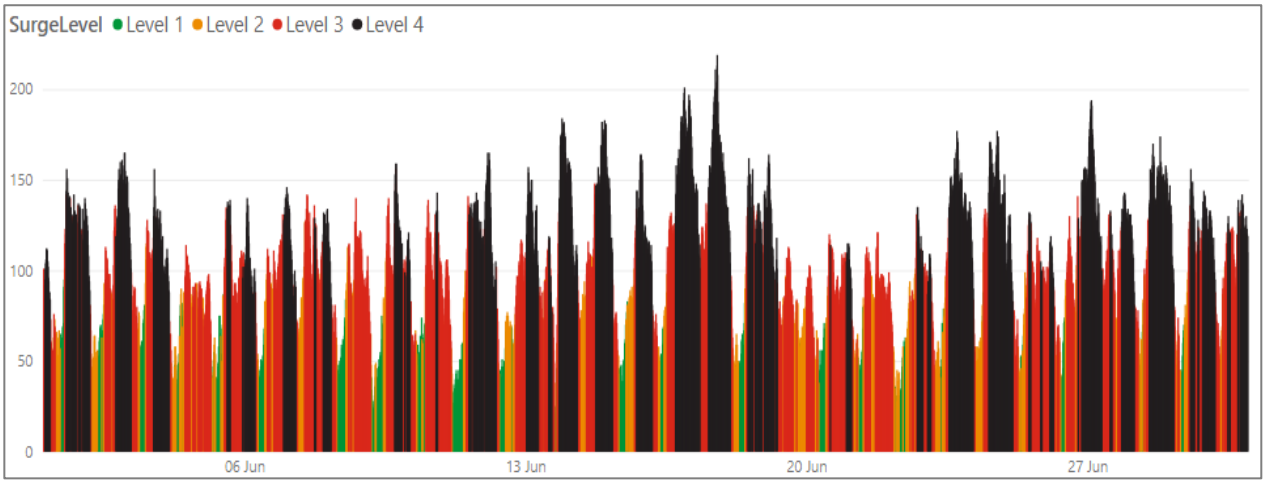




- Dispatch and clinical staffing were in a stronger position overall, but the coherence (consistency across each hour) is fluctuating to a greater extent
- Hear and treat as an outcome has shown improvement during June – this will have been positively influenced by the Cat 3 & 4 validation pilot that went live on the 25th May 2021

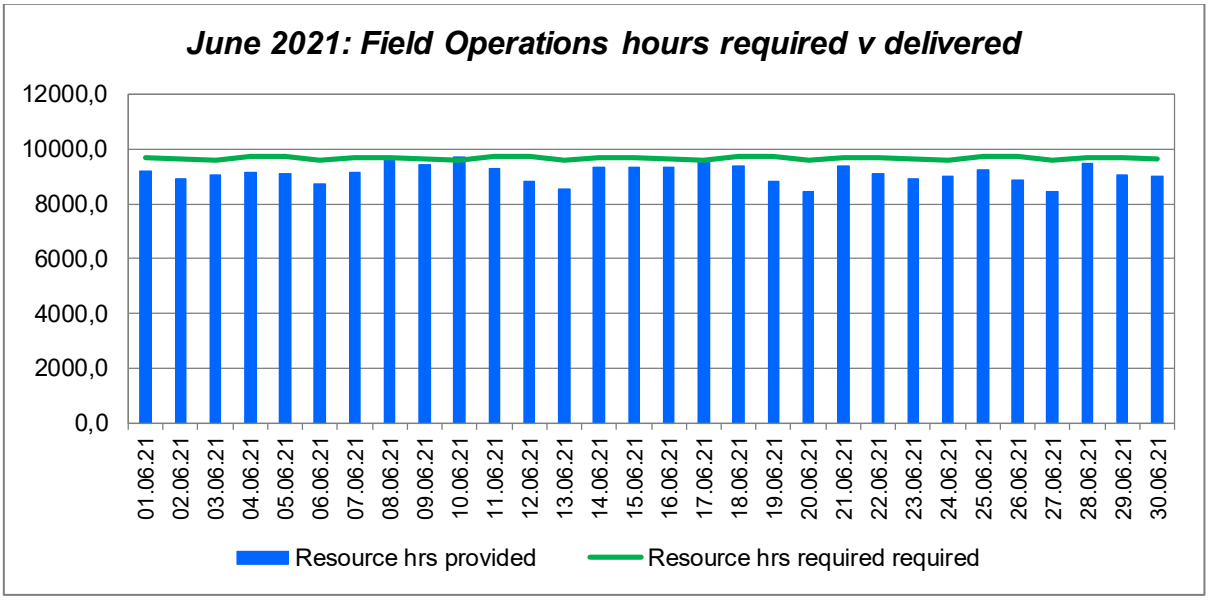


- Efficiencies:
    - EMA calls per hour remaining above the target of 4 per hr – a positive position
    - Resources per incident (RPI) at 1.09 for the month – meeting the agreed target set
- Due to the volumes of calls being received, and the increasing difficulty in reaching those through ambulance response, the Trust has seen a consistently high-level surge level across the month; 33.7% of the time was spent at SMP 4 (the maximum level), with only 31.0% of the time being at SMP 1 or 2. Surge levels are clearly defined and relate to the number, type and duration of calls being held by EOC prior to dispatch.



6. 999 – Field Operations

- A deteoriation in performance across all ARP categories was seen, when compared to previous months.
- Whilst overall calls increased from the previous months, incidents with a response decreased from May (59,457 from 62226 – a reduction of 4.4%).
- Across the month, on only one day did the hours produced meet/exceed the required level. The primary cause for this (as it was for EMAs) was an increased level of abstraction – a significantly higher number of staff were taking leave and increasing sickness was being seen (Covid and non-Covid related).



- Additional requests have been submitted to the current Private Ambulance Providers (PAPs) that have contracts with SECAmb to increase their hours provision to assist with the staffing challenges described – unfortunately this has not been forthcoming as they themselves are experiencing similar staffing issues, and are working hard to maintain the current contracted levels
- Within the PIP, one of the key workstreams for field operations has been a focus on job cycle time through three main areas:
    1) Hospital hand-over time (target 15mins – see below)
    2) Wrap-up time (target 15mins)
       Local management teams are supporting this area of work and have seen a reduction from 17min 42 sec in April to 17min 28sec in May.
    3) Long on-scene times
       Crews may remain on scene for a prolonged time for several reasons, and through the oversight of the east and west Tactical Hubs, where this is seen, crews are pro-actively contacted to see what additional assistance may be required, and/or if the delays are waiting for crew call-backs which could be expedited with assistance.
- Hospital handovers continue to be an area of significant issue:

- In June 2021, the average handover time was 18mins 40secs, and increase from 17mins 12sec in the previous month – only 47.9% of handovers were completed within the required 15mins.
- In total 5202.48hrs were lost at hospital due to handover delays with 658 (1.9%) taking more than 60 mins in total.
- The most significant proportion of these delays at handover occurred at Medway Maritime, where 10.1% of those patients (324 in total) conveyed there had a 60min or greater wait to be handed over, and the Royal Sussex County Hospital, where 7.5% (184 patients) experienced this level of delay
- A focus on ensuring staff get meal breaks continues, although with the increased pressure, and at escalated levels of surge, there has been an increased need for staff to take a break at the nearest possible location – this often not being their originating dispatch desk/base station/MRC. In June, 98.37% of front-line crews had a meal-break, with 85.82% of these on their own dispatch desk.

7. 999 – Specialist Services

HART

- HART continue to undertake their duties and assist general operational delivery
  - HART specific incidents attended: 153
  - Additional incidents attended in support to Operations: 142
- As part of the HART specification requirements, the team are measured against several other standards including those to do with resourcing levels and deployment speed:
  - Resources:
    - Against a minimum of 5 per team, 91.5% achievement
    - Against a minimum of 6 per team, 69.0% achievement
    - Both standards have been impacted by the same issues as in the other operational service lines, i.e. high levels of annual leave, and increasing levels of sickness (Covid and non-Covid). With HART team members being the only ones able to cover each other when shift vacancies occur, this naturally impacts their ability to be resilient at time of high pressure.
    - All training at this time is also considered carefully according to individual specific need – overall training has been deferred to a later date
  - Deployment against two standards:
    - 10min standard – 100% achieved
    - 15min standard – 91% achieved

CFRs

- The Community Frist Responder Team continues to focus on optimising delivery by increasing the number of hours produced to actively contribute to delivering good, timely clinical care.
- During June, CFRs attended 1,058 incidents (196 C1s, 798 C2s and 64 C3s)
- Of the C1 incidents, CFRs were first on scene for 125 incidents which contributed to a 16 second positive impact on C1 mean performance.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
July 2021

Data up to and including June 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 ****	4

* 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 additional IT metrics around critical system uptime and a new 111 dashboard (slide 10), mirroring the dates for the 999 dashboard, has been added.
- 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.

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 each month and we are improving and adding to the metrics, as set out on page 3. The aim of the report is to provide the key performance indicators and highlight to the Board through the exception reports the areas where the executive is most concerned. These are summarised on page 16.

While it is important to keep across all the areas within the IPR, by far the most significant issue now is operational performance and patient safety. I therefore propose that this should be primary focus of the Board this month.

The current challenges are so significant a separate paper is provided to describe the current position and the steps we are taking in the immediate and medium term to provide as safe a service as is possible. In light of this, I suggest the Board uses the IPR to help see from the metrics just how challenging it has been (for example, page 9 illustrates the time we have been at surge level 4 / black) and then the executive will set out the measures being taken under the separate agenda item.

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.

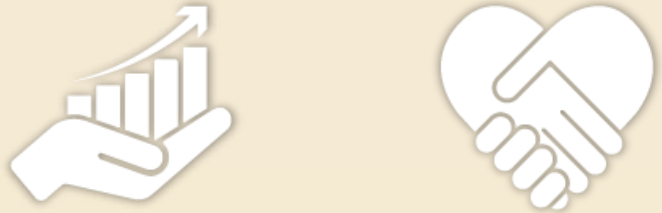
Our Priorities

- *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 (July 2021)

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

Safe

Metric	Jun-21	PD
999 Frontline Hours Provided %	94.30%	▼
Number of Incidents Reported as SIs	6	▼
Hand Hygiene Compliance %	95.00%	●
Violence and Aggression Incidents (Number of Victims - Staff)	87	▼
Medicines Management % of Audits Completed	98.70%	▲
DBS Compliance %	100.00%	●
Number of RIDDOR Reports	14	▼

Effective

Metric	Jun-21	PD
**Cardiac ROSC Utstein %	41.00%	▲
**Stroke - Assessed F2F Diagnostic Bundle %	96.00%	▲
**Sepsis Care Bundle %	85.00%	●
**Acute STEMI Care Bundle Outcome %	69.00%	▼
ECAL Mean Response Time	00:22:56	▲
999 Operational Abstraction Rate %	31.00%	▼
Statutory & Mandatory Training Rolling Year %	63.30%	▲

** April 2021 data

Caring

Metric	Jun-21	PD
Proportion of Complaints Relating to Crew Attitude %	31.00%	▲
End of Life Care Performance		■
Falls Performance		■
Complaints relating to privacy and respect %	0.00%	●
Dementia Performance		■

Responsive

Metric	Jun-21	PD
Cat 1 Mean	00:07:57	▲
Cat 1 90th Centile	00:14:54	▲
Cat 2 Mean	00:21:28	▲
Cat 2 90th Centile	00:40:51	▲
Cat 3 90th Centile	03:51:24	▲
Cat 4 90th Centile	04:39:46	▲
999 Call Answer Mean	00:00:08	▲
111 Calls Answered in 60 Seconds %	34.00%	▼
111 Calls Abandoned - (Offered) %	16.00%	▼
111 to 999 Referrals (Answered Calls) %	9.70%	▼
Complaints Reporting Timeliness %	96.00%	▼

Well-Led

Metric	Jun-21	PD
Disciplinary Cases	2	▲
Collective Grievances	1	●
Bullying & Harrassment Internal	1	▲
Annual Rolling Turnover Rate	12.10%	▼
Annual Rolling Sickness Absence	7.60%	▼
Absence Relating to Mental Health %	9.00%	▼
Absence Relating to MSK %	5.80%	▲
999 Frontline Late Finishes/Over-Runs %	53.40%	▲
Staff Successfully FIT-Tested %	69.90%	-

Symbol Key

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

Current Operational Performance
999 Emergency Ambulance Service (as of 20/07/21)

	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	3183	00:08:49	00:16:19	3183	00:08:49	00:16:19
C1T	00:19:00	00:30:00	2048	00:10:54	00:20:02	2048	00:10:54	00:20:02
C2	00:18:00	00:40:00	23810	00:30:26	01:00:07	23810	00:30:26	01:00:07
C3		02:00:00	8870	03:18:45	07:24:35	8870	03:18:45	07:24:35
C4		03:00:00	155	03:10:33	06:58:17	155	03:10:33	06:58:17
HCP 3			589	04:23:08	09:21:07	589	04:23:08	09:21:07
HCP 4			458	05:11:35	09:58:14	458	05:11:35	09:58:14
IFT 3			280	04:10:44	09:36:37	280	04:10:44	09:36:37
IFT 4			54	05:24:42	10:06:14	54	05:24:42	10:06:14
ST			13257	32.21%		13257	32.21%	
SC			24095	58.55%		24095	58.55%	
HT			3803	9.24%		3803	9.24%	
Count of Incidents			41155			41155		
Count of Incidents with a Response			37352			37352		
999 Mean	Call Answer Target 00:05		54329	00:57		54329	00:57	
999 90th	Call Answer Target 00:10			02:54			02:54	
Trust EOC 999 Abandoned Calls			2542	4.5%		2542	4.5%	
A0	EOC All Calls		51344			51344		

Current Operational Performance
999 Emergency Ambulance Service (28/06/2021 – 18/07/2021)

CAT 1

	28/06	05/07	12/07	Last 13 Weeks
Mean	00:08:34	00:08:21	00:09:12	
90th Centile	00:15:25	00:15:12	00:16:57	
RPI	1.49	1.51	1.49	
Count of Incidents	1176	1107	1143	

CAT 1T

	28/06	05/07	12/07	Last 13 Weeks
Mean	00:10:53	00:10:21	00:11:00	
90th Centile	00:19:11	00:18:36	00:20:32	
RPI	1.48	1.51	1.52	
Count of Incidents	761	704	748	

CAT 2

	28/06	05/07	12/07	Last 13 Weeks
Mean	00:28:42	00:28:47	00:31:28	
90th Centile	00:56:24	00:56:51	01:02:55	
RPI	1.06	1.07	1.06	
Count of Incidents	8708	8652	8492	

CAT 3

	28/06	05/07	12/07	Last 13 Weeks
Mean	03:13:57	03:06:02	03:18:50	
90th Centile	06:57:16	06:53:33	07:34:50	
RPI	1.05	1.06	1.05	
Count of Incidents	3292	3149	3329	

CAT 4

	28/06	05/07	12/07	Last 13 Weeks
Mean	03:38:44	03:53:41	03:51:54	
90th Centile	08:33:21	07:28:09	08:29:24	
RPI	1.03	1.11	1.02	
Count of Incidents	37	37	49	

Demand/Supply

	28/06	05/07	12/07	Last 13 Weeks
999 Call Volume	19378	18871	19868	
Incidents	15059	14804	14917	
Transports	8882	8785	8672	
Staff Hours Provided Vs 67635 target	91.7%	91.8%	90.4%	

999 Call Handling

	28/06	05/07	12/07	Last 13 Weeks
Mean Call Pickup Time (Seconds)	36	25	82	
Call Pickup Time 90th Percentile (Seconds)	125	93	246	
Call Pickup Time 95th Percentile (Seconds)	173	139	397	
Call Pickup Time 99th Percentile (Seconds)	288	214	779	
Average Call Length (seconds)	365	366	349	
Abandon Rate	2.67%	1.10%	7.51%	
Staff Hours Provided Vs 5842 target	83.6%	88.6%	72.0%	

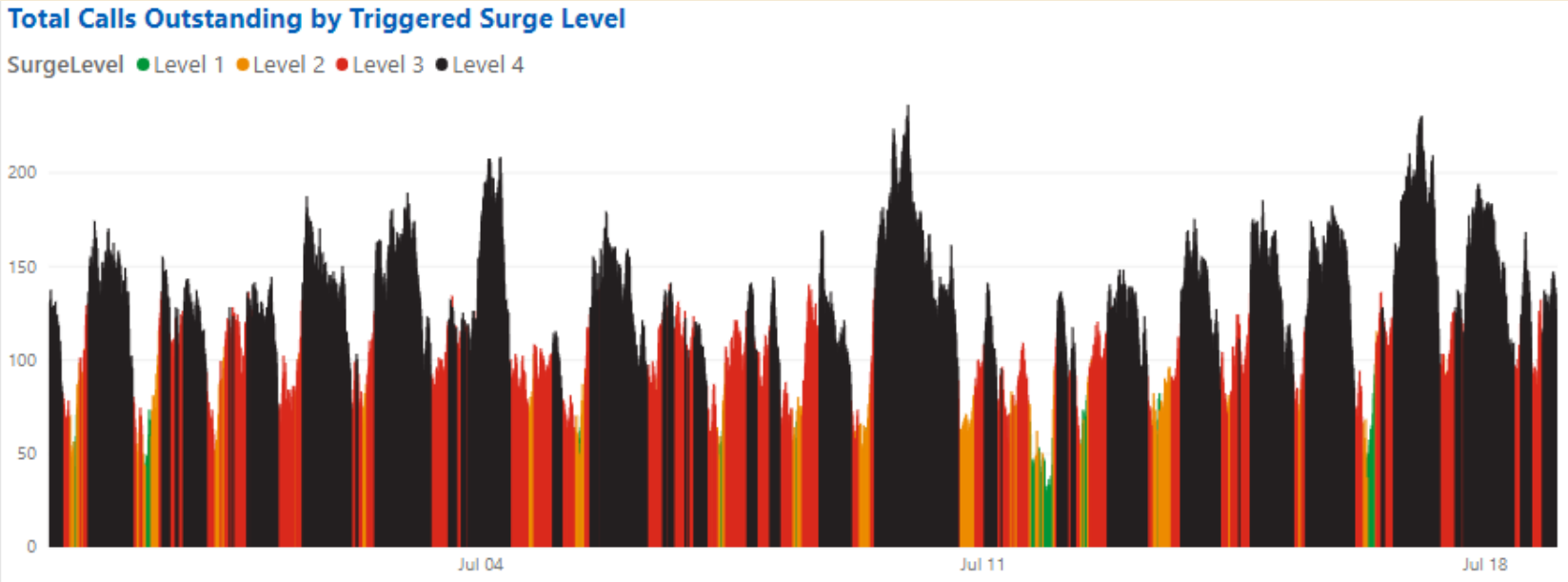
Incident Outcome

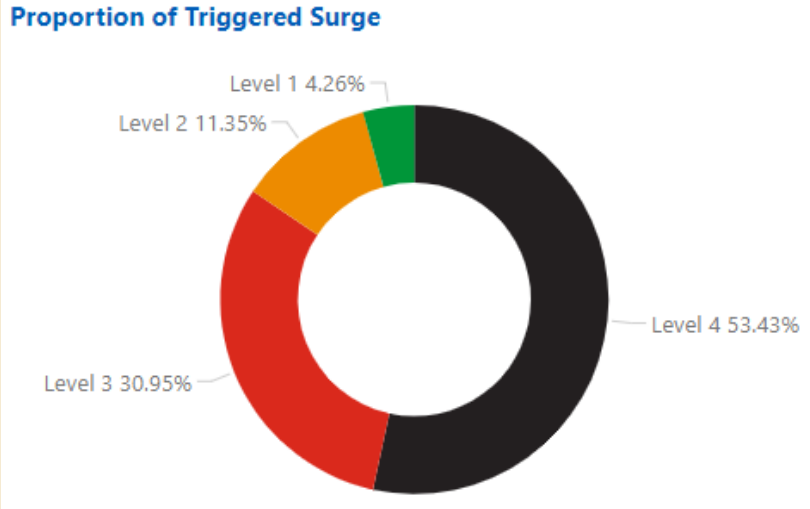
	28/06	05/07	12/07	Last 13 Weeks
See and Convey	59.0%	59.3%	58.2%	
See and Treat	31.8%	31.4%	32.6%	
Hear and Treat	9.2%	9.3%	9.2%	

Call Cycle Time

	28/06	05/07	12/07	Last 13 Weeks
Clear at Scene	01:16:48	01:18:03	01:18:22	
Clear at Hospital	01:52:09	01:51:31	01:53:26	
Hours Lost at Hospital	1371	1336	1483	

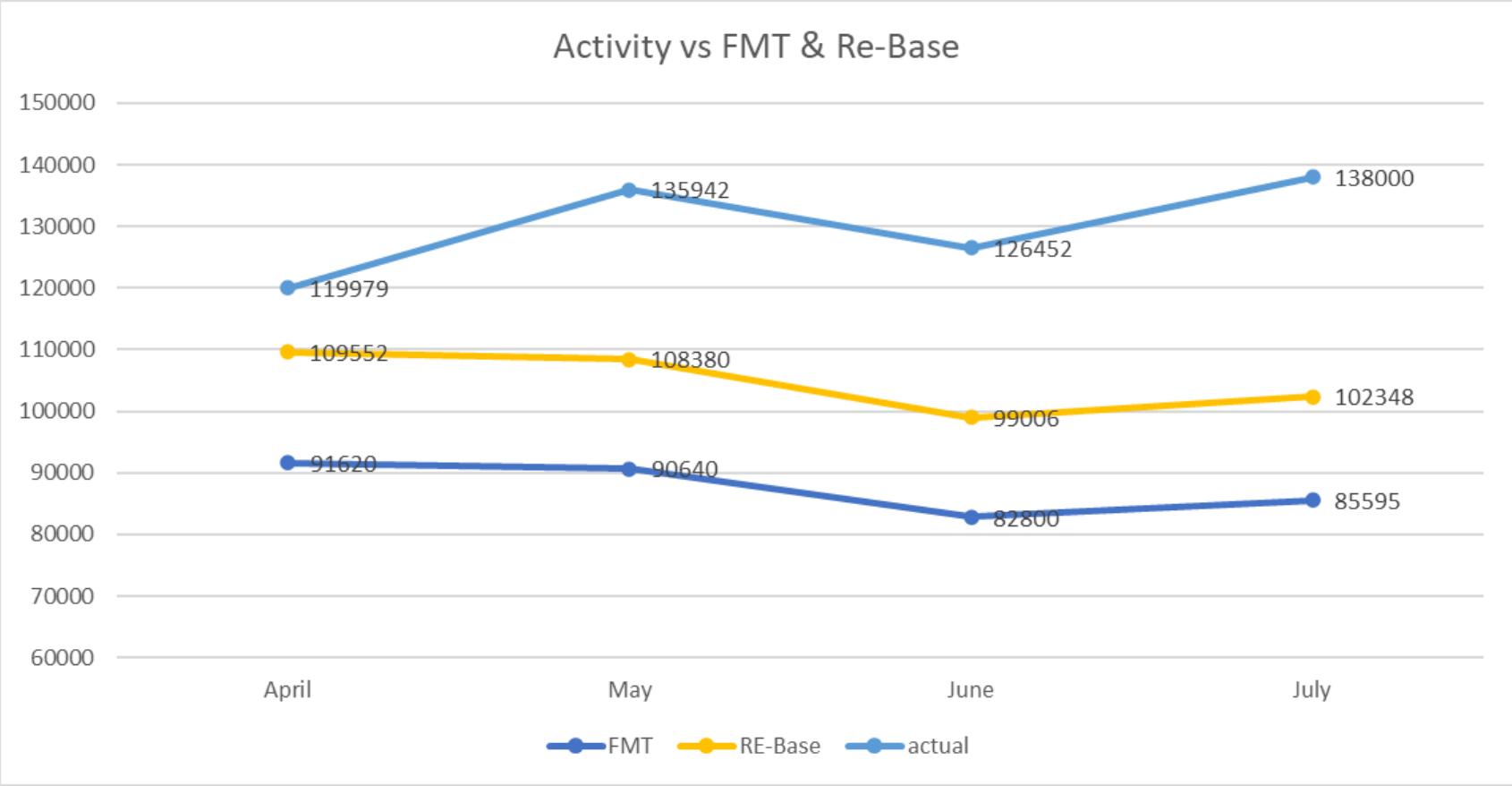
Current Operational Performance
999 Emergency Ambulance Service (28/06/2021 – 18/07/2021)





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**

Current Operational Performance
NHS 111 CAS Service – 111 Activity



Update on current situation

- July activity estimated to be circa 138,000 if current trend continues (+35% vs. proposed re-based contractual volumes)
- WTE required increased to 305 from 204 Finance Modelling Template (FMT – or original commissioned activity) and 244 Re-Base (proposed) – currently 236 WTE HA's

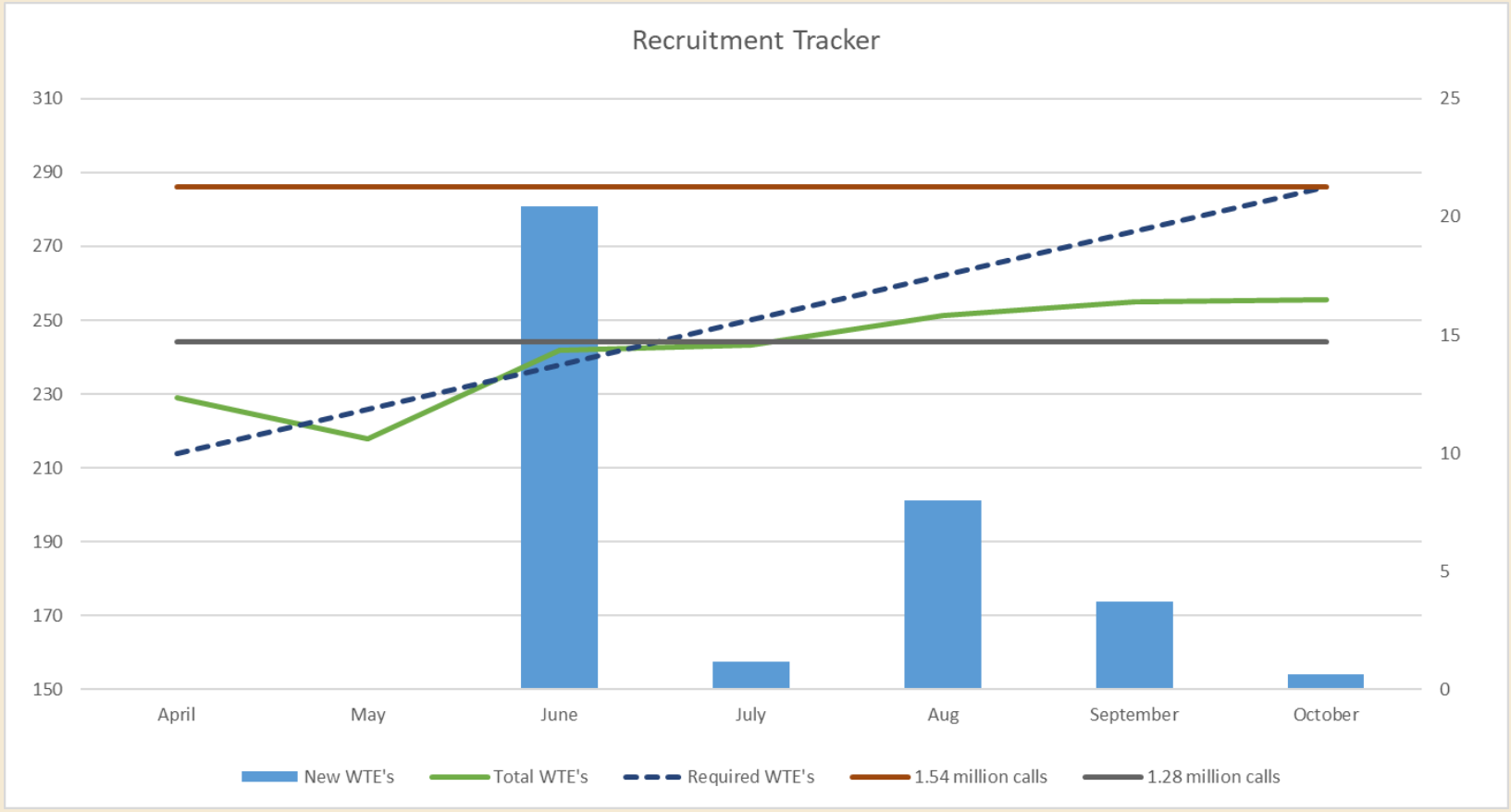
Causes

- Demand in Primary Care
- Patient behaviours change as a result of COVID
- Think111 campaign increased public awareness of 111
- 15 months of lockdown with latent health issues now presenting

Actions

- Ongoing liaison and collaboration with NHS England, Commissioners, systems partners and stakeholders
- Increased recruitment
- Targeted "quick-wins" via Performance Optimisation Plan (POP)

Current Operational Performance
NHS 111 CAS Service – 111 Staffing



Update on current situation

- Current staffing 244 WTE HA's
- Sickness & Attrition running at 36.69%

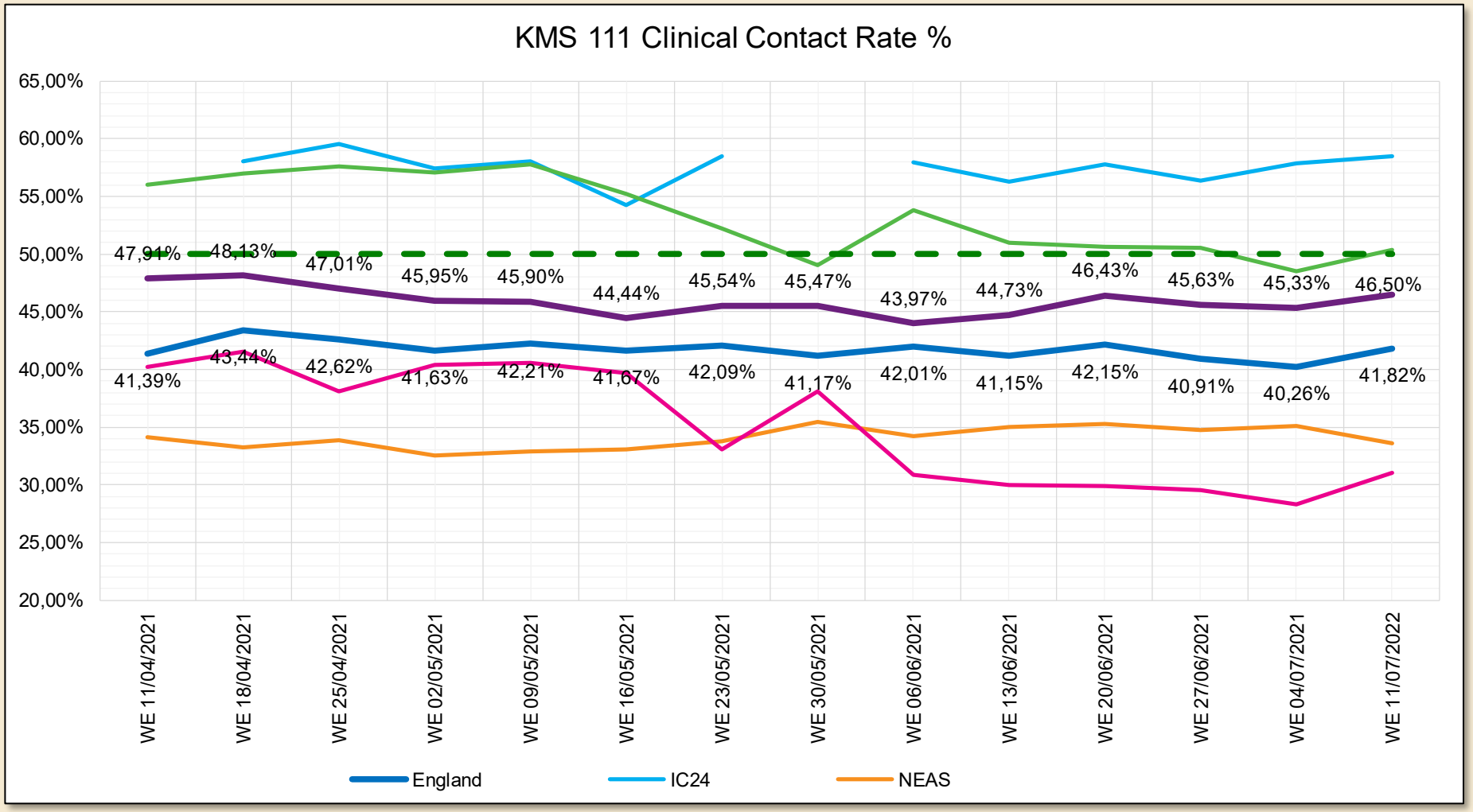
Causes

- Increased sickness due to:
  - work pressures including stress
  - late arrival of winter illnesses
  - rising COVID abstraction, esp. self isolation
- Low vacancy uptake & long recruitment times – 16wks

Actions

- Mental Health drop in sessions
- Staff engagement
- IPC re-inspections
- Increased recruitment
- Review how candidate compliance is managed to fill courses
- Work with HR/Finance to explore use of agency HAs

Current Operational Performance
NHS 111 CAS Service - 111 CAS Activity



Update on current situation

- Latest week Clinical Contact rate 46.50% (target 50%), being 9,707 cases to the CAS last week.
- National avg. currently circa 41% Clinical contact, with KMS Q1 average approx. 46%

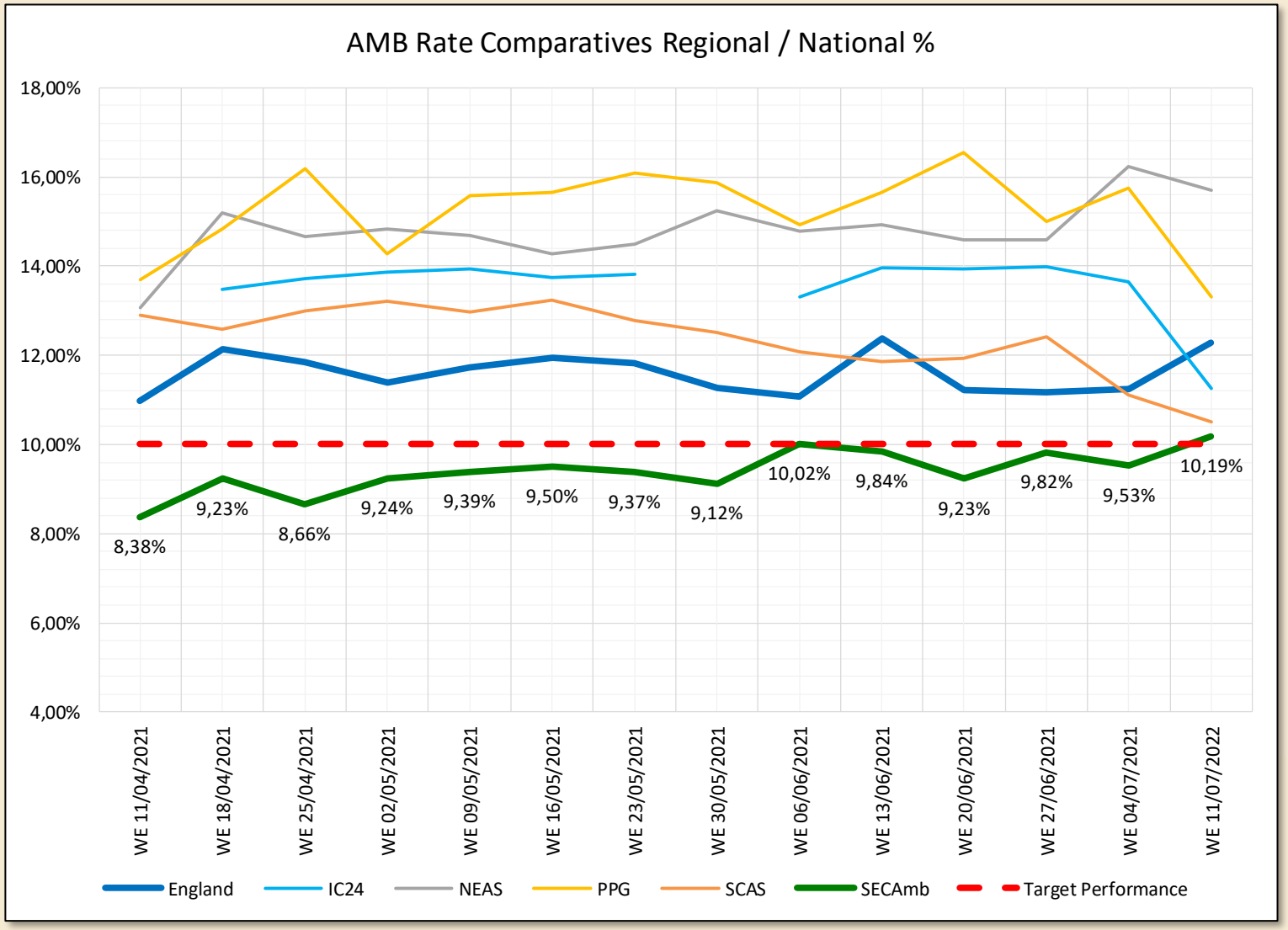
Causes

- Meeting 50% clinical contact national challenge and contractual expectation. Predominant rationale related to primary care increased activity being re-directed back to primary care in hours

Actions

- Liaison with Commissioners weekly updating on current position and included in POP meetings.
- Implementing NHS 111 on-line ED Validation in progress

Current Operational Performance
NHS 111 CAS Service – 111 Ambulance Referrals



Update on current situation

- Ambulance referral rates continued to increase in line with national trend with 10.19% of triaged cases resulting in referral to 999

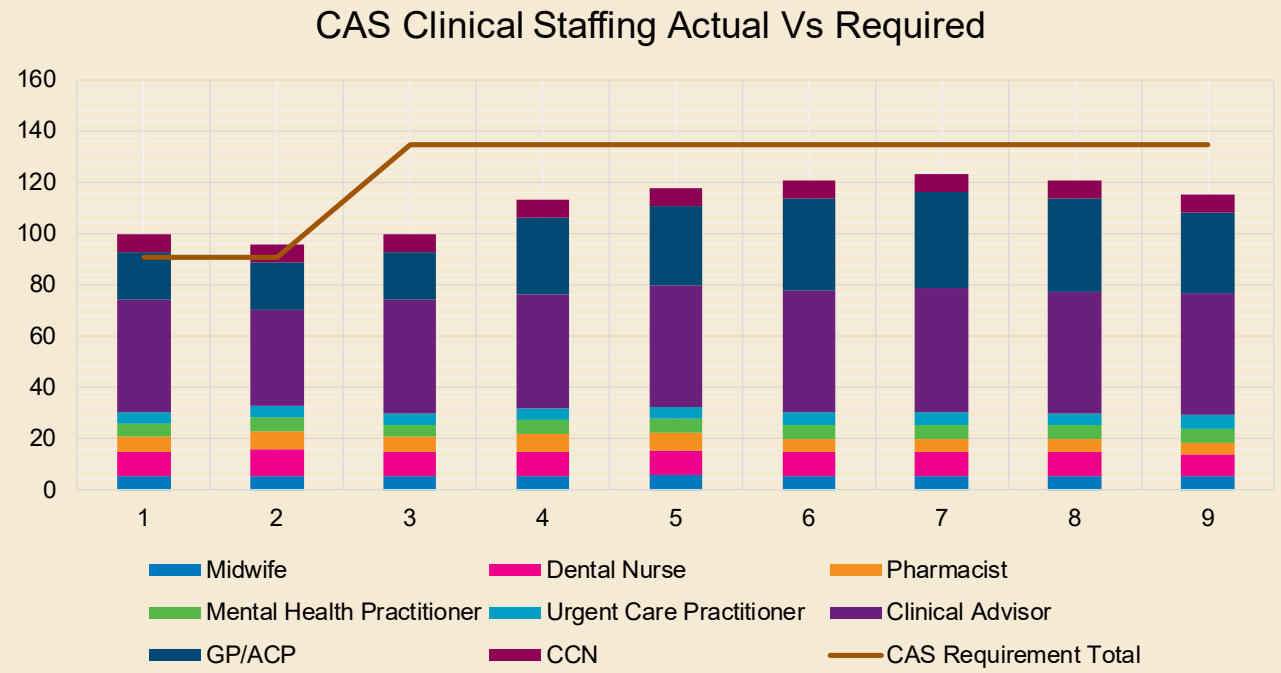
Causes

- C2 remains highest ARP Category of referral nationally (60%+), NHS P V26 update (14.7.2021) being assessed to determine possible C2 reduction, as alighted to NHS E/P by SECAmb.

Actions

- Ongoing validations W/E 18/7 94.7% validations completed with 63.95% standown.
- HA facilitated Bulletin for patients to refuse and MOW (Make Own Way to ED)
- Better engagement with Field Operations in relation to the benefits that 111 makes to 999

Current Operational Performance
NHS 111 CAS Service – CAS staffing



Update on current situation

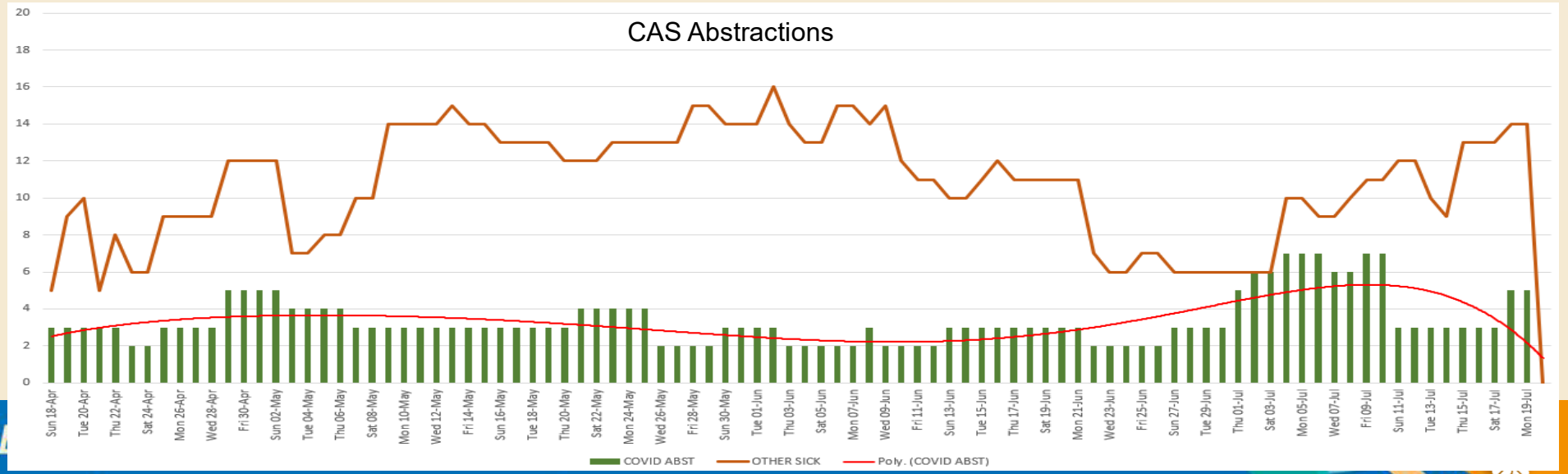
- CAS Clinical Staffing - June total 115.1 WTE against 134.45 WTE required (85%)

Causes

- Staffing requirement continuing to increase in-line with demand/activity.
- Productivity currently not able to be evaluated, with modelling at 3.5-4 cases per hour / actual estimate circa 3 cases per hour
- Abstractions – Tracked daily with recent increases in Covid related and Stress, Anxiety and Depression sickness. All training (excluding NHS Pathways / PaCCS) has been postponed

Actions

- Power BI reporting on productivity
- Considering medical leadership and additional staff to support clinical admin and Electronic Prescription Service
- Considering additional recruitment incentives



Trust Overview:
Summary of Performance Highlights

Domain	ID	Performance Highlight
Safe	QS-1 Number of Datix incidents	The Trust has seen an uplift in incidents reported year on year for May and June 2021 with a 1.2% uplift in May and 1.3% improvement in June. This demonstrates the resilience of the Trust's culture of reporting and learning from incidents, despite operational pressures.
Safe	QS-17 Outstanding actions relating to SIs, outside of timescales	Following an increase in April, a good number of actions were completed in May. The Board should note that all longstanding actions from 2018 are now completed, with a target of completion for all actions from 2019 to be completed by the end of July. However, a pragmatic approach is being taken due to operational demand.
Effective		Nothing new to report.
Caring		Nothing new to report.
Responsive	999 various indicators	In the context of the worsening position on many 999 metrics, it is worth noting that we are meeting our Cat 1 90th centile, and Cat 1 transport mean and 90th centile. All Cat-1 indicators improved May to June as we continue to prioritise our most poorly patients. Our hear and treat rate remains strong, and CFR attendances are up compared to April. The percentage of meal breaks taken remains high.
Well-led		Nothing new to report.

Trust Overview:
Summary of Exceptions

Domain	ID	Exceptions
Safe	QS-3 Duty of Candour compliance	The Trust missed the completion date on one case within a cluster Serious Incident (SI) because no investigating manager was appointed.
Safe	QS-13 Violence and aggression incidents	A worrying increase in reported incidents in May and June, up in the 70s and 80s and with June (87 incidents) having the second highest figure in the past 13 months.
Safe	QS-17 Outstanding actions relating to SIs outside of timescales	The team continue to work through the large backlog of SI actions where no evidence of completion had been received. Progress slowed May to June.
Effective	WF-6 & WF-20 Statutory & Mandatory Training (YTD and Rolling YTD)	The overall completion of statutory and mandatory training is currently 36.87%, significantly lower than June 2020 (51.61%). The rolling year to date completion is 63.31% compared to 75.07% in June 2020. The decreases can be accounted for by the introduction of new courses in April 2021.
Caring		Nothing new to report.
Responsive	111 & 999 - multiple metrics	Performance in both services is seriously challenged due to demand outstripping available resourcing.
Well-led	QS-24 Organisational risks outstanding review	It continues to be challenging to ensure risks are reviewed in a timely way, not helped by the lack of Risk Lead within the Trust at present. Recruitment is underway to fill this position and the Executive have oversight.

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 compliance* Definition: *Percentage of cases falling under the Duty of Candour regulation that are compliant with its requirements*	We missed the completion date on one case within a cluster Serious Incident (SI). No investigating manager was appointed due to a new methodology being introduced. This SI relates to a theme of delayed C2 attendances and we have identified 3 index cases to review using this methodology. This new methodology is being used for the overarching investigation process, not just the Duty of Candour. The SI team has approached the Emergency Preparedness Resilience and Response Team (EPRR) to lead on this to facilitate a "Pre-Mortem" style workshop. EPRR will produce after-workshop reports which will be the basis of the SI investigation report, hence we have not appointed an Investigating Manager in the traditional way for an SI.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The SI Management Team will ensure that the deadlines are highlighted suitably early in the SI process.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: 31 July 2021

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-13	Standards: *Violence and aggression incidents* Definition: *Number of victims - staff*	In May, 773 violence and aggression incidents were reported by staff. 21 of the reported incidents resulted in staff being assaulted. In June, 87 violence and aggression incidents were reported by staff. 19 of the reported incidents resulted in staff being assaulted. The figures had dropped back to be regularly below 70 from a peak of 124 in October 2020, and so this return to higher numbers is notable, with 87 the second highest number of incidents reported in the past 13 months.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The Trust recently implemented body worn cameras at sites which have previously reported the highest number of violence and aggression incidents and is in the process of recruiting a Violence Reduction Support Officer to support body worn camera trials and to promote a proactive health, safety and security function across the Trust in order to reduce violence and aggression incidents.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: 31 January 2022

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-17	Standards: *Outstanding actions relating to SIs outside of timescales* Definition: *Number of actions outstanding*	The Trust had a large backlog of Serious Incident (SI) actions where no evidence of completion had been received. These related to SI actions due in 2018 onwards.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The SI team have worked closely with the teams in Emergency Operations Centres (999) and Integrated Urgent Care (111) and the Operations Quality and Patient Safety Group (QUAPS) to gain evidence and close actions. All 2018 actions are now completed, with a target to complete the remaining 36 2019 actions by the end of July. This will leave 76 remaining actions to complete, down from 320 in June 2020.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: 31 July 2021 (2019 actions only)

Performance by Domain
Effective: Exception Report

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

ID	Standard	Background
WF-6 & WF-20	Standards: *Statutory & Mandatory Training (YTD and Rolling YTD)* Definition: *The percentage of staff (year to date and over a 12-month rolling period) who have received appraisals and their manager has recorded the appraisal on Actus*	The overall completion of statutory and mandatory training is currently 36.87%, significantly lower than in June 2020 (51.61%). The rolling year to date completion is 63.31%, down from 75.07% in June 2020.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The decrease on the previous year can be accounted for by the introduction of a new course (Emergency Driver Training) in April 2021 and the requirement for all staff to complete Dementia Awareness training from April 2021, not just clinical staff as had been the case previously. The Learning & Organisational Development team continue to send monthly compliance reports to senior leaders and OU managers. All managers have access to Power BI enabling them to drill down to individual team member level compliance to take action as required.	Named person: Ali Mohammed Executive Director of HR and OD Complete by date: Ongoing

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999 & 111 multiple indicators	Standards: *999 Frontline hours provided, 111 calls answered & abandoned, 999 call answer, Cat 2, Cat 3 and Cat 4, Time spent in SMP 3 or higher, meal breaks outside window* Definition: *Various key 999 and 111 performance indicators*	Frontline, EOC and 111 performance is severely challenged. There are increased abstractions due to annual leave, non-Covid sickness increases and Covid-related self-isolation. This is combined with increased demand and call volume, the latter exacerbated by duplicate/repeat calls due to lengthy response times. In 111 it is worth noting that national contingency measures (where we take calls on behalf of others who are experiencing long delays) have been activated multiple times in June, which means we have been taking calls on behalf of other providers while struggling with our own increased demand. Providers have been marking themselves as unavailable on the Directory of Services which has knock-on effects. The time spent in Surge Management Plan level 3 and higher is an indicator of the pressures across the whole system. Meal breaks being taken outside the window is another clear indicator of the level of demand versus resources available. We do not have enough resources to meet demand.

Action Plan

Actions being taken to mitigate issues:

The whole health system is experiencing severe difficulties. We are in regular calls with regional and local commissioners and providers and these are positive in that the challenges are clearly recognised and the local system is working together as best it can to maintain the safest possible service to patients. However, there is no capacity anywhere to aid other parts that are struggling. As internally, our regional system is struggling to find remedies for the inability to meet demand.

The Trust has its own Performance Improvement Plan and Optimisation Plan, and weekly Performance Assurance meetings have been established by the Executive so that the senior Operations Team can request assistance, identify blockages and for the Executive to gain assurance that we are doing all we can to maintain safe services. There is a real impact on patient care that is being monitored through Serious Incident and harm review processes.

Alongside patient care, staff wellbeing is everyone's concern: we do not see that the challenges will ease in the coming months, particularly as lockdown restrictions are lifted in July. All our operational staff are dedicated to delivering the service, however are fatigued through the intensity of work with increased levels of stress and anxiety due to the continuation of the impact of the Covid pandemic on the Trust and their personal circumstances. The team will continue to look to balance patients' needs with the need to keep our people healthy in these extraordinary times.

Accountable Executive

Named person:
Emma Williams
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
QS-24	Standards: *Organisational risks outstanding review %* Definition: *Percentage of organisational risks that have not been reviewed and updated on Datix within agreed timescales*	Ensuring risks are reviewed in a timely way continues to be challenging; this is made worse by the lack of resource to monitor and support risk leads.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The lack of progress has been escalated to the EMB and executives are taking up with their teams. The Risk and Incident Lead role is currently advertised and is expected to be recruited to this time due to the increase in banding. The new post holder along with a new incoming risk process will support better oversight and ownership by principal risk owners. A review of how unreviewed/static risks can also be escalated is also being undertaken.	Named person: Bethan Eaton-Haskins Executive Director of Nursing & Quality Complete by date: Ongoing

Performance by Domain
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-1	Number of Datix Incidents	905	940	861	952	1342	1470	1751	1595	1070	1149	1051	1175	1253					▼
QS-2	Number of Incidents Reported as SIs	9	10	5	2	4	9	8	6	7	1	7	3	6					▼
999-12	999 Frontline Hours Provided %	93.80%	89.30%	92.50%	91.20%	94.60%	99.40%	95.10%	96.10%	103.20%	96.90%	99.10%	99.30%	94.30%	100.00%		-		▼
QS-3	Duty of Candour Compliance %	100.00%	100.00%	100.00%	100.00%	100.00%	84.00%	80.00%	67.00%	100.00%	75.00%	100.00%	67.00%	100.00%	100.00%		=		▲
QS-7	Hand Hygiene Compliance %	92.00%	82.00%	97.00%	93.00%	99.00%	95.00%	96.00%	94.00%	93.00%	95.00%	94.00%	95.00%	95.00%	95.00%		=		●
QS-8	Safeguarding Training Completed (Children) Level 2 %	60.20%	67.10%	69.90%	72.70%	74.90%	74.90%	78.20%	79.40%	82.00%	90.40%	88.70%	87.00%	87.30%	95.00%		-		▲
QS-13	Violence and Aggression Incidents (Number of Victims - Staff)	68	69	75	66	124	74	70	53	60	60	65	73	87					▼
MM-1	Number of Medicines Incidents	111	146	103	89	162	141	125	125	142	173	152	171	118					▲
MM-3	Single Witness Signature Use CDs Omnicell	0	0	14	0	3	0	6	5	9	4	3	2	3	0		-		▼
MM-4	Single Witness Signature Use CDs Non-Omnicell	0	0	0	0	0	0	3	1	1	1	0	0	0	0		=		●
MM-5	Number of CD Breakages	17	16	14	14	17	9	25	21	10	27	16	16	19					▼
MM-7	Medicines Management % of Audits Completed	99.00%	99.00%	99.00%	98.00%	98.00%	94.00%	94.00%	93.00%	88.00%	95.00%	95.00%	98.00%	98.70%	100.00%		-		▲
WF-1	Number of Staff WTE (Excl bank and agency)	3784	3793	3806	3859	3888	3967	3956	3959	3968	3974	3945	3952	3957					▲
WF-2	Number of Staff Headcount (Exc bank and agency)	4141	4154	4173	4231	4271	4354	4345	4353	4358	4367	4335	4342	4350					▲
WF-3	Finance Establishment (WTE)	3905	3800	3816	3818	3880	3925	3950	3951	3956	3946	3946	3946	3946					●
WF-4	Vacancy Rate %	3.10%	0.20%	2.60%	-1.10%	-0.20%	-1.10%	-0.20%	-0.20%	-0.30%	-0.70%	0.10%	-0.20%	-0.30%					▲
QS-9	Number of RIDDOR Reports	6	11	8	7	16	5	9	9	12	8	10	11	14					▼
WF-16	DBS Compliance %	100.00%	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		=		●
M-20	Compliant NHS Pathways Audits (Clinical) %	84.00%	95.00%	95.00%	83.00%	96.00%	94.00%	92.00%	93.00%	90.00%	93.00%	92.00%	92.00%	87.00%					▼
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%	96.00%	103.00%	105.00%	83.00%					▼

▲ 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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-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%	85.00%	83.00%	84.00%	84.00%	100.00%		-		●
M-23	Required NHS Pathways Audits Completed (Clinical) %				85.00%	85.00%	94.00%	100.00%	100.00%	97.00%	100.00%	102.00%	102.00%	102.00%					●
QS-17	Outstanding Actions Relating to SIs, Outside of Timescales	320	288	248	172	158	127	111	126	112	117	141	114	112					▲
QS-19	Deep Clean Compliance %	105.00%	103.00%		92.00%	95.00%	86.50%	82.50%	72.80%		94.90%	95.00%	85.00%	82.00%					▼
QS-20	Health & Safety Incidents	43	42	35	42	37	35	22	35	33	31	29	59	47					▲
WF-24	Current licence details held for Operational Staff %			79.30%	88.80%	88.50%	88.10%	86.40%	89.50%	90.40%	92.40%	96.10%	96.10%	96.00%	100.00%		-		▼
QS-22	Manual Handling Incidents	22	46	30	26	29	26	24	29	32	22	17	43	28					▲
QS-25	Flu Vaccine Compliance (Winter 2020-21)					58.00%		78.80%		79.80%	80.10%				90.00%				-

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

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\- 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

ID	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-11	JCT Allocation to Clear at Scene Mean	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	01:19:00	01:18:57	01:14:38	01:17:12					▼
999-11	JCT Allocation to Clear at Hospital Mean	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	01:49:29	01:49:30	01:50:58	01:49:19					▲
M-1	**Cardiac ROSC Utstein %	45.00%	32.00%	46.00%	45.00%	44.00%	47.70%	40.90%	40.00%	48.50%	40.00%	41.00%							▲
M-2	Cardiac ROSC ALL %	24.00%	15.00%	24.00%	29.00%	27.00%	21.50%	15.70%	16.30%	23.70%	22.00%	23.00%							▲
M-12	**Sepsis Care Bundle %	81.00%	87.00%	88.00%	87.00%	85.00%	85.40%	87.00%	84.20%	86.30%	85.00%	85.00%							●
M-3	Cardiac Survival Utstein %	31.00%	8.00%	19.00%	23.00%	20.00%	23.80%	15.90%	25.70%	33.30%	18.00%								-
M-4	Cardiac Survival ALL %	9.00%	4.00%	7.00%	10.00%	12.00%	7.60%	4.20%	5.10%	9.10%	8.00%								-
M-11	Cardiac Arrest - Post ROSC %	74.00%	80.00%	79.00%	78.00%	72.00%	79.70%	85.50%	75.30%	61.60%	78.00%	81.00%							▲
M-5	**Acute STEMI Care Bundle Outcome %	64.00%	64.00%	68.00%	67.00%	64.00%	62.20%	65.60%	64.10%	63.90%	74.00%	69.00%							▼
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 %	97.00%	98.00%	98.00%	97.00%	98.00%	97.00%	96.60%	96.90%	95.80%	95.00%	96.00%							▲
M-13	Sensitivity of Cardiac Arrest Detection During Telephone Triage %				96.00%	91.00%	94.30%	93.30%	87.00%	93.40%	82.00%	82.00%							●
M-14	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %				79.00%	81.00%	75.10%	73.80%	74.30%	79.30%	79.00%	78.00%							▼
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%	5.70%	4.90%			9.00%	4.00%					-

▲ Improving performance
▼ Deteriorating performance
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■ Aspirational metric

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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

ID	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-13	ECAL Mean Response Time	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	00:24:20	00:23:43	00:23:31	00:22:56					▲
999-12	999 Operational Abstraction Rate %	32.50%	32.50%	32.60%	38.40%	38.30%	32.70%	35.30%	36.00%	32.50%	33.30%	25.20%	25.80%	31.00%	28.00%		-		▼
WF-6	Statutory & Mandatory Training Rolling Year %	75.10%	76.10%	75.90%	75.40%	75.00%	74.30%	76.10%	75.60%	76.20%	78.70%	67.10%	60.80%	63.30%	100.00%		-		▲
999-17	Responses Per Incident	1.10	1.12	1.12	1.08	1.08	1.08	1.08	1.08	1.09	1.00	1.01	0.99	1.01	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	00:17:36	00:23:22	00:18:10						-
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			00:06:04	01:43:52	03:48:17	00:22:29	00:23:57					▼
999-20	ePCR Usage	94.70%	93.80%	95.30%	93.70%	94.80%	96.10%	96.40%	96.20%	96.10%	96.70%	97.00%	91.00%	95.70%	95.00%		+		▲
999-24	Number of Hours Lost at Hospital Handover	1916	3610	4202	3958	4435	3358	5426	4583	2296	2237	2271	3249	2614					▲
999-25	Hours Lost at Handover as a Proportion of Provided Hours %	0.70%	0.20%	1.50%	1.40%	1.60%	1.20%	1.90%	1.60%	0.80%	0.80%	0.80%	1.10%	1.00%					▲
WF-23	Recruitment: Advert to Start Date														100.00%		■	■	■
M-24	ClinEd: Course Capacity Utilisation Associate Ambulance Practitioner %							96.00%	93.00%	93.00%	93.00%	93.00%	93.00%	92.00%					▼
M-24	ClinEd: Course Capacity Utilisation Transition to Practice %							65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%					●
M-25	ClinEd: Students at Risk of Not Obtaining Qualification %							40.00%		39.00%	44.00%	46.00%	45.00%	39.00%					▲
M-26	ClinEd: Course satisfaction score																■	■	■
WF-34	Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	31.50%	31.90%	31.40%	30.80%	30.80%	31.30%	31.40%	31.20%	31.60%	31.40%	31.40%	31.30%	31.70%	32.10%		-		▲
WF-35	Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	22.70%	22.80%	20.50%	20.20%	19.10%	18.60%	18.60%	18.90%	18.80%	19.00%	19.00%	19.10%	18.80%	23.20%		-		▼
WF-36	Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	45.80%	45.30%	48.10%	49.00%	50.10%	50.10%	50.00%	49.90%	49.60%	49.60%	49.60%	49.60%	49.50%	48.30%		-		▲

▲ 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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-12	Complaints relating to privacy and respect %												0.00%	0.00%					
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%	56.00%	31.00%	33.00%	31.00%					
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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
111-1	111 Calls Offered	70230	71925	85338	90438	104059	111727	115809	93018	87249	110294	119979	135942	126452					-
111-2	111 Calls Answered in 60 Seconds %	93.50%	91.20%	84.00%	60.10%	66.60%	59.60%	55.40%	62.90%	74.00%	73.10%	53.40%	36.50%	34.00%	95.00%		-		▼
111-3	111 Calls Abandoned - (Offered) %	0.60%	1.00%	2.00%	9.70%	5.40%	6.30%	8.20%	6.10%	3.00%	3.50%	7.70%	14.90%	16.00%	6.00%		-		▼
111-4	111 to 999 Referrals (Answered Calls) %	13.80%	13.60%	12.40%	11.60%	11.80%	14.10%	13.90%	14.90%	15.00%	13.40%	8.70%	9.10%	9.70%	13.00%		+		▼
111-4	999 Referrals	8443	8407	8864	7943	11110	12276	12384	11903	11064	12058	8188	8901	8805					▲
111-5	A&E Dispositions %	13.40%	13.80%	12.70%	12.10%	12.00%	13.40%	14.60%	14.70%	15.40%	15.60%	15.20%	15.00%	16.00%	9.00%		-		▼
111-5	A&E Dispositions	8161	8544	9102	8320	11350	11718	12925	11683	11349	14047	14261	14571	14472					▲
111-7	Clinical Contact %										48.10%	48.20%	45.20%	45.00%	50.00%		-		▼
111-8	Ambulance Validation %										95.40%	95.30%	95.10%	90.60%	85.00%		+		▼
999-10	999 Calls Answered	55915	62772	69541	64025	67031	62456	76806	70262	50316	60200	61386	77074	71529					-
999-10	Incidents	58653	61196	64489	61313	63644	62332	66615	65239	56470	62648	62845	65474	67474					-
999-1	999 Call Answer Mean	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	00:00:04	00:00:05	00:00:22	00:00:08	00:00:05		-		▲
999-1	999 Call Answer 90th Centile	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	00:00:02	00:00:02	00:01:19	00:00:22	00:00:10		-		▲
999-2	Cat 1 Mean	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	00:07:37	00:07:32	00:08:18	00:07:57	00:07:00		-		▲
999-2	Cat 1 90th Centile	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	00:14:14	00:13:56	00:15:08	00:14:54	00:15:00		+		▲
999-3	Cat 1T Mean	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	00:09:02	00:09:20	00:10:24	00:09:36	00:19:00		+		▲
999-3	Cat 1T 90th Centile	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	00:16:46	00:17:13	00:19:13	00:17:38	00:30:00		+		▲
999-4	Cat 2 Mean	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	00:18:37	00:18:54	00:26:11	00:21:28	00:18:00		-		▲
999-4	Cat 2 90th Centile	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	00:34:46	00:34:58	00:50:55	00:40:51	00:40:00		-		▲
999-5	Cat 3 90th Centile	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	02:49:03	02:58:41	05:40:07	03:51:24	02:00:00		-		▲
999-6	Cat 4 90th Centile	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	03:29:30	04:28:40	07:21:59	04:39:46	03:00:00		-		▲
999-7	HCP 3 Mean	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	01:39:18	02:02:40	03:25:11	02:32:00					▲
999-7	HCP 3 90th Centile	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	03:23:05	04:00:25	06:56:27	05:08:05					▲
999-7	HCP 4 Mean	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	02:01:07	02:44:10	04:22:49	03:20:43					▲
999-7	HCP 4 90th Centile	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	04:28:16	05:11:59	08:01:14	06:21:05					▲
999-9	Hear & Treat %	6.30%	6.60%	7.20%	6.40%	6.20%	6.60%	8.60%	8.00%	6.00%	6.90%	6.90%	9.40%	7.90%	7.80%		+		▼

▲ 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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-9	See & Treat %	34.60%	33.60%	33.80%	33.30%	33.40%	33.70%	36.30%	37.40%	35.20%	32.60%	32.10%	31.30%	31.60%	35.00%		-		▲
999-9	See & Convey %	59.10%	59.80%	59.00%	60.40%	60.40%	59.70%	55.10%	54.60%	58.80%	60.50%	61.00%	59.40%	60.50%	57.20%		-		▼
999-10	CFR Attendances	75	152	520	614	673	800	648	749	580	1034	1089	1337	1219					▼
999-10	FFR Attendances	192	171	201	171	190	224	175	205	142	316	260	364	241					▼
QS-4	Complaints Reporting Timeliness %	95.00%	95.00%	96.00%	83.00%	88.00%	95.00%	69.00%	95.00%	64.50%	88.00%		98.00%	96.00%	95.00%		+		▼
QS-5	Number of Complaints	56	73	55	82	65	69	61	69	48	64	68	72	116					-
QS-6	Number of Compliments	191	224	177	208	167	182	140	173	191	187	208	159	162					-
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	1.06	1.11	0.09	0.16					▼
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	3.91	3.69	0.21	0.23					▲
QS-14	Learning from deaths: Number of Structured Judgment Reviews	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 %	13.70%	29.10%	38.10%	27.90%	25.90%	20.50%	75.00%	60.70%	1.30%	12.10%	15.40%	36.10%	69.00%					▼
C-2	Number of BCIs	2	2	3	1	2	1	7	3	2	0	0	1	2	0		-		▼

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▼ Deteriorating performance
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Performance by Domain
Well-Led: Performance Dashboard

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ID	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
WF-5	Appraisals YTD	22.90%	28.20%	31.70%	34.10%	36.70%	39.70%	41.60%	43.20%	45.70%	52.20%	3.40%	7.00%	9.10%					▲
WF-40	Appraisals Rolling Year %										52.20%	48.90%	40.90%	36.80%	80.00%		-		▼
WF-7	Annual Rolling Turnover Rate	13.90%	13.40%	12.60%	11.90%	11.70%	11.10%	11.20%	10.90%	10.50%	10.30%	10.80%	11.50%	12.10%					▼
WF-8	Annual Rolling Sickness Absence	6.00%	5.90%	6.00%	6.10%	6.20%	6.30%	7.40%	7.10%	7.30%	7.10%	7.10%	7.40%	7.60%	5.00%		-		▼
WF-9	Disciplinary Cases	9	6	4	4	3	3	2	1	1	4	9	8	2					▲
WF-10	Individual Grievances	8	7	5	10	11	8	9	8	5	8	10	8	8					●
WF-11	Collective Grievances	1	0	0	2	0	0	0	0	1	0	1	1	1					●
WF-12	Bullying & Harrassment Internal	2	2	5	3	3	5	1	1	1	6	5	4	1	0		-		▲
WF-13	Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0	0					●
QS-27	Freedom to Speak Up: Total Open Cases											31	33	36					-
QS-27	Freedom to Speak up: Open cases re possible patient safety issues												3	3					-
QS-27	Freedom to Speak up: Cases Closed in Month With Resolution											0	0	1					-
QS-27	Freedom to Speak up: Cases Closed in Month Without Resolution											2	2	1					-
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%	3.10%	2.90%	2.90%	2.80%					▼
WF-37	Diversity: Disability - declared %				3.40%	3.40%	3.40%	4.00%	4.00%	4.00%	4.20%	4.20%	4.20%	4.30%					▲
WF-38	Diversity: Disability - declined to declare %				46.30%	46.30%	47.90%	10.00%	10.00%	10.00%	7.80%	7.80%	7.80%	7.50%	0.00%		-		▲
WF-39	Diversity: Ethnicity - BAME %				5.30%	5.30%	5.30%	5.50%	5.50%	5.50%	5.60%	5.60%	5.60%	5.60%					●
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%	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%	6.70%	6.70%	8.40%	9.00%					▼
WF-19	Absence Relating to MSK %	4.60%	2.80%	3.60%	3.60%	4.20%	3.60%	3.10%	2.80%	8.10%	4.50%	8.30%	6.20%	5.80%					▲

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

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Performance by Domain
Well-Led: Performance Dashboard

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ID	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
WF-25	Number of Wellbeing Hub Referrals		112	104	112	124	98	112	95	96	115	111	138	125					▲
WF-30	Time from referral to offered wellbeing appointment (days)					14	14	14	14	14	14	14	14	14	14		=		●
999-27	% of Meal Breaks Taken										99.20%	91.00%	98.50%	98.60%					▲
999-28	% of Meal Breaks Outside of Window										49.90%	51.10%	54.90%	59.40%					▼
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%	52.40%	51.90%	60.20%	53.40%					▲
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	00:40:17	00:44:03	00:47:33	00:43:27					▲
999-16	Staff Successfully FIT-Tested %		93.90%	88.30%		90.50%		91.30%		91.30%		91.30%		69.90%	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%	0.30%	0.40%	0.60%	0.70%					▬
999-21	Provided Overtime Hours %	7.40%	7.90%	8.10%	9.30%	9.10%	10.40%	9.10%	11.50%	15.40%	14.60%	9.10%	8.70%	10.40%					▬
999-21	Provided PAP Hours %	9.10%	6.80%	7.20%	6.50%	6.40%	6.40%	5.80%	5.90%	6.10%	6.30%	4.30%	4.90%	4.60%					▬
999-22	999 Remaining Annual Leave FY			42.50%	44.90%	50.70%	48.00%	45.00%	33.00%	27.00%	20.00%	53.00%		84.00%	83.30%		-		▬
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%	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%	11.30%	15.80%	17.40%	29.00%	0.00%		-		▼
QS-24	Organisational Risks Outstanding Review %			14.00%	10.00%	18.00%	21.00%	14.00%	59.00%	57.00%	52.00%	59.00%	81.00%	73.00%	0.00%		-		▲
IT-1	CAD System Uptime %												98.90%	99.50%					▲
IT-2	Telephony System Uptime %												99.20%	100.00%					▲
IT-3	ePCR System Uptime %												97.70%	100.00%					▲
IT-4	Number of Calls to IT Service Desk	974	1105	1168	1265	1310	1537	916	279	1436	1924	1324	1442	1214					▲
IT-5	Marval IT Requests Raised - IT Service Desk	1697	1702	1834	1764	1607	1870	1359	1561	1559	1847	1638	1705	1503					▲
IT-5	Marval IT Requests Raised - Critical Systems Team	549	523	451	480	668	523	480	539	694	724	728	757	765					▼
IT-6	Missed Calls to IT Service Desk	162	225	294	389	433	410	201	95	460	624	586	456	378					▲

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Performance by Domain
Well-Led: Performance Dashboard

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ID	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£22393.60	£22042.20	£22557.10	£22396.50	£22430.00	£22133.40	£23376.60	£23858.00	£26134.50	£35076.00	£23241.00	£23340.80	£23325.10	£23214.00	£111.10		
F-9	Income (£000s) YTD	£67058.20	£89100.40	£111657.50	£134054.00	£156484.00	£178617.40	£201994.00	£225852.00	£251986.50	£287063.00	£23241.00	£46582.10	£69907.20	£69863.00	£44.20	£275167.60	£205304.60
F-2	Operating Expenditure (£000s) Month	£22393.70	£22052.20	£22558.80	£22399.30	£23020.10	£23093.50	£24451.80	£25312.10	£24952.70	£38485.00	£23947.00	£24554.20	£24345.40	£24349.76	£-4.36		
F-10	Operating Expenditure (£000s) YTD	£67058.20	£89110.40	£111669.20	£134068.50	£157088.60	£180182.10	£204633.90	£230346.00	£255298.70	£293784.00	£23947.00	£48503.60	£72849.00	£72944.97	£-95.97	£285673.10	£212728.14
F-3	Capital Expenditure (£000s) Month	£861.53	£686.74	£1195.86	£1237.16	£834.38	£2343.59	£1080.59	£4378.10	£1223.15	£4138.00	£1618.00	£987.96	£983.67	£1109.00	£-125.33		
F-14	Capital Expenditure (£000s) YTD	£2377.53	£3064.27	£4260.13	£5497.30	£6331.68	£8675.27	£9755.85	£14138.03	£15361.18	£19499.00	£1618.00	£2605.91	£3589.58	£2946.00	£643.58	£140.00	£-2806.00
F-4	Cost Improvement Plan (CIP) (£000s) Month	£1022.00	£252.48	£147.52	£681.00	£71.00	£673.00	£8.00	£522.00	£478.00	£709.00	£0.00	£0.00	£150.00	£378.00	£-228.00		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£1022.00	£1274.48	£1422.00	£2103.00	£2174.00	£2847.00	£2855.00	£3790.00	£4268.00	£4977.00	£0.00	£0.00	£150.00	£378.00	£-228.00	£5515.00	£5137.00
F-6	Surplus/Deficit (£000s) Month	£-0.10	£-10.00	£-1.70	£-2.80	£-590.10	£-960.10	£-1075.20	£-1454.10	£1181.80	£-3409.00	£-706.00	£-1213.40	£-1020.30	£-1135.76	£115.46		
F-7	Cash Position (£000s) Month	£43742.00	£46283.00	£46647.00	£46862.00	£48231.00	£46275.00	£46819.00	£41747.00	£51441.00	£40152.00	£36526.00	£36448.00	£35923.00	£27464.52	£8458.48	£27464.52	£0.00
F-8	Agency Spend (£000s) Month	£284.92	£210.65	£174.87	£259.01	£84.98	£81.95	£205.95	£106.34	£-80.27	£155.00	£169.00	£250.04	£107.24	£291.00	£-183.76		
F-16	Agency Spend (£000s) YTD	£586.27	£796.92	£971.79	£1230.81	£1315.79	£1398.74	£1603.68	£1710.00	£1630.00	£1784.00	£169.00	£418.90	£526.14	£886.00	£-359.86	£2638.40	£1752.40

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■ Aspirational metric

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Performance by Domain
Well-Led: Finance Dashboard

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Key Performance Indicators

Month							Year To Date						H1 Forecast (to September 2021)			
% PY Var	£000 Prior Year	£000 Plan	£000 Actual	£000 Variance	% Variance		£000 Plan	£000 Actual	£000 Variance	% Variance	£000 Prior Year	% PY Var	£000 Plan	£000 Forecast	£000 Variance	% Variance
4.2%	22,394	23,212	23,335	124	0.5%	**INCOME**	69,862	69,917	55	0.1%	67,058	4.3%	142,143	142,202	59	0.0%
(4.2)%	16,788	17,468	17,499	(31)	(0.2)%	PAY	52,513	52,350	162	0.3%	51,058	(2.5)%	105,942	106,320	(378)	(0.4)%
(48.6)%	4,581	6,733	6,808	(75)	(1.1%)	NON PAY	19,994	20,193	(199)	(1.0)%	15,821	(27.6)%	40,370	40,035	335	0.8%
(13.8)%	21,368	24,201	24,307	(106)	(0.4)%	**OPERATING EXPENDITURE**	72,507	72,543	(37)	(0.1)%	66,880	(8.5)%	146,312	146,355	(43)	(0.0)%
(194.8)%	1,025	(989)	(972)	18	(1.8)%	**OPERATING SURPLUS/(DEFICIT)**	(2,645)	(2,626)	19	(0.7)%	179	(1571.2)%	(4,169)	(4,154)	15	(0.4)%
68.1%	150	146	48	98	67.2%	FINANCING COSTS	436	315	122	27.9%	179	(76.3)%	873	750	123	14.1%
(216.3)%	876	(1,135)	(1,019)	116	10.2%	**SURPLUS/(DEFICIT)**	(3,081)	(2,941)	140	4.5%	0	-	(5,042)	(4,904)	138	2.7%
0.0%	2	1	(107)	(108)	(10800.0)%	ADJUSTMENTS TO SURPLUS/(DEFICIT)	22	(110)	(132)	(6)	7	1671.4%	25	(107)	(132)	(528.0)%
(228.3)%	*878*	*(1,134)*	*(1,126)*	*8*	*0.7%*	*ADJUSTED SURPLUS/ (DEFICIT) : CONTROL TOTAL*	*(3,059)*	*(3,051)*	*8*	**0.3%**	*7*	*(43685.7)%*	*(5,017)*	*(5,010)*	*7*	**0.1%**
% PY Var	Incidents Prior Year	Incidents Plan	Incidents Actual	Incidents Variance	% Variance	**A&E ACTIVITY**	Incidents Plan	Incidents Actual	Incidents Variance	% Variance	Incidents Prior Year	% PY Var	Incidents Plan	Incidents Forecast	Incidents Variance	% Variance
11.5%	58,709	65,083	65,449	366	0.6%	A&E ACTIVITY per Plan	198,740	195,722	(3,018)	(1.5%)	177,260	10.4%	396,811	391,444	(5,367)	(1.4%)
✓	1	3	3		✓	**USE OF RESOURCES RATING**	3	3		✓	1	✗	3	3		✓
	Prior Year	Plan	Actual	Variance			Plan	Actual	Variance		Prior Year		Plan	Forecast	Variance	
✗	1,022	378	150	(228)	✗	**CIPS**	378	150	(228)	✗	1,022	✗	2,871	2,871	0	✓
✓	862	1,109	984	(125)	✗	**CAPITAL**	2,946	3,590	644	✓	2,378	✓	7,785	9,173	1,388	✓
✗	43,742	27,465	35,923	8,458	✓	**CASH POSITION**	27,465	35,923	8,458	✓	43,742	✗	20,504	34,758	14,254	✓
✗	4,468	4,631	4,345	287	✗	**WTE**	4,377	4,405	(28)	✗	4,487	✓	4,385	4,362	24	✗
% PY Var	£000 Prior Year	£000 Plan	£000 Actual	£000 Variance	% Variance		£000 Plan	£000 Actual	£000 Variance	% Variance	£000 Prior Year	% PY Var	£000 Plan	£000 Forecast	£000 Variance	% Variance
62.4%	285	291	107	184	63.1%	**AGENCY STAFF**	886	526	360	40.6%	586	10.3%	1,731	1,052	679	39.2%
56.0%	1,191	1,084	525	560	51.6%	**PRIVATE AMBULANCE PROVIDERS (PAP)**	3,252	1,592	1,661	51.1%	3,188	50.1%	6,505	4,845	1,660	25.5%

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Performance by Domain
Well-Led: Gender Composition by Pay Band (June 2021)

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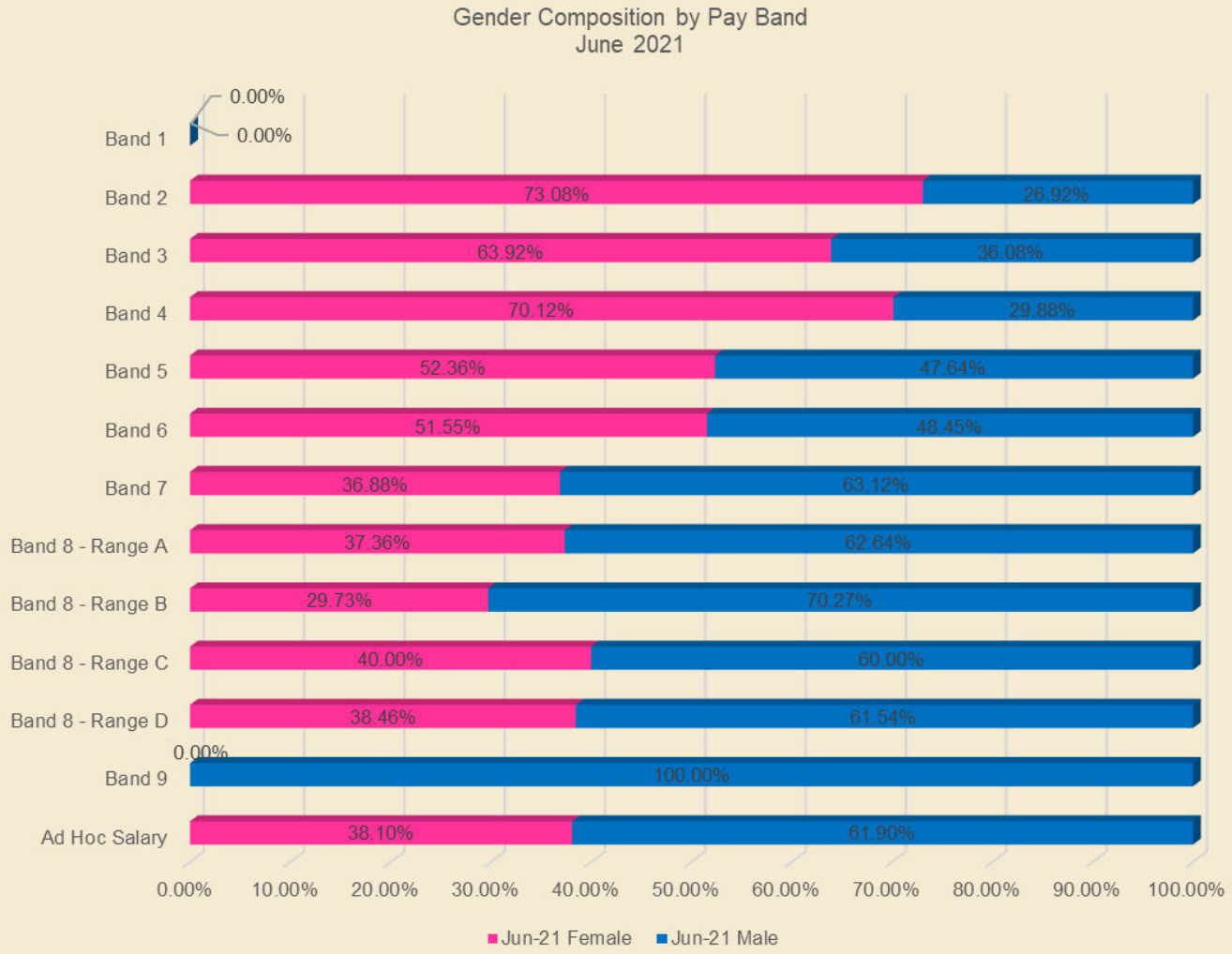


National Benchmarking
999 Emergency Ambulance Service (June 2021)

Key indicators at a glance for June 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	00:00:58	00:01:18	00:01:03	00:01:15	00:00:36	00:01:09	00:00:52	00:01:00	00:00:34	00:00:24	00:00:00	00:02:27
Calls Answered	892059	79815	86078	86693	1960	145870	39888	132491	52146	99511	103621	63986
Mean Call Answer Time	00:00:17	00:00:22	00:00:18	00:00:21	00:00:10	00:00:18	00:00:21	00:00:17	00:00:12	00:00:09	00:00:01	00:00:45

Incident Proportions (Over All Incidents)	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	783050	65423	80384	70400	2453	115589	37401	98404	57370	83285	99548	72793
C1 Incidents %	9.39%	7.38%	8.70%	10.41%	6.16%	8.10%	8.39%	12.66%	7.66%	11.61%	8.37%	9.41%
C2 Incidents %	54.35%	55.71%	59.99%	60.02%	45.58%	55.20%	55.98%	54.90%	44.32%	53.16%	49.38%	54.87%
C3 Incidents %	18.99%	23.53%	13.87%	12.78%	26.99%	17.20%	16.75%	13.57%	28.20%	19.90%	28.95%	15.66%
C4 Incidents %	0.70%	0.46%	0.39%	0.18%	1.59%	1.26%	1.01%	0.00%	2.02%	0.29%	1.25%	0.35%

Incident Outcomes	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	10.29%	9.34%	10.14%	11.71%	11.54%	14.83%	10.18%	9.06%	13.02%	7.85%	6.51%	10.26%
See & Convey %	52.60%	57.70%	54.43%	51.95%	57.97%	51.39%	53.11%	53.30%	48.81%	49.26%	51.73%	55.16%
See & Treat %	31.70%	31.28%	32.00%	30.95%	29.60%	29.50%	26.54%	29.98%	33.30%	38.50%	35.64%	26.62%

Response Performance	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:14:01	00:15:08	00:15:15	00:14:46	00:18:57	00:10:57	00:12:27	00:14:03	00:13:50	00:16:23	00:12:33	00:14:24
90th Centile Response Time: C2	01:03:29	00:50:55	01:06:48	01:25:55	01:03:38	00:58:18	01:07:39	01:17:58	00:39:34	01:18:22	00:37:26	01:04:34
90th Centile Response Time: C3	04:35:23	05:39:58	04:37:58	05:52:40	03:39:46	03:26:04	04:43:58	07:53:55	03:01:04	05:28:37	03:36:10	03:37:30
90th Centile Response Time: C4	05:42:57	07:37:44	06:17:47	06:11:21	03:00:02	07:19:43	04:31:04	00:00:00	04:10:24	07:08:29	04:48:07	05:36:12
Mean Response Time: C1	00:07:54	00:08:18	00:08:07	00:08:21	00:10:15	00:06:34	00:06:58	00:08:19	00:07:25	00:08:38	00:07:10	00:08:31
Mean Response Time: C2	00:30:42	00:26:11	00:32:03	00:41:26	00:29:14	00:27:20	00:33:23	00:38:15	00:19:52	00:37:14	00:18:38	00:30:04

Note

As of 22/07/21, 8 out of 10 Ambulance Trusts in England had moved to the highest level of escalation available (REAP 4) with several declaring a Business Continuity Incident (BCI) in the previous 7-days.

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 who had ROSC on arrival at hospital %	24.19%	23.56%	21.45%	22.71%	28.57%	23.45%	22.50%	29.57%	22.38%	34.95%	20.71%	22.68%
Proportion who had ROSC on arrival at hospital utstein %	50.96%	50.00%	50.00%	62.50%		50.00%	54.55%	50.00%	42.31%	64.71%	35.71%	51.52%

NB: NHSE's most recent publication of national clinical outcomes no longer includes 'proportion of cardiac arrests discharged live' metrics.

National Benchmarking
NHS 111 CAS Service (June 2021)

NB: National KPI data for June 2021 was not available at time of publication

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Appendix 1

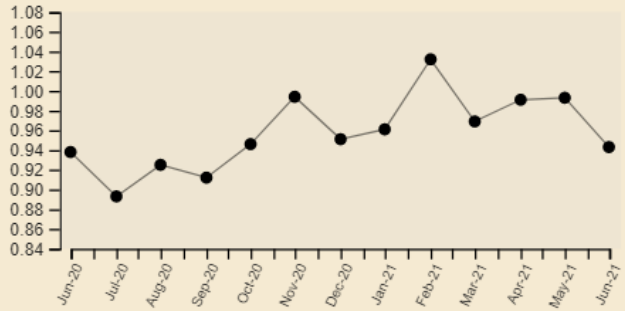
Performance Charts

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

999-12

999 Frontline Hours Provided %



June 2021

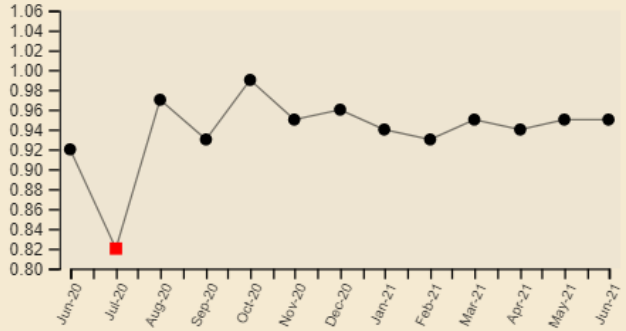
94.30%

Target

(Blank)

QS-7

Hand Hygiene Compliance %



June 2021

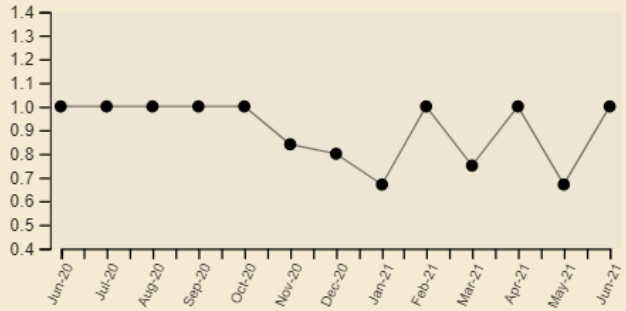
95.00%

Target

(Blank)

QS-3

Duty of Candour Compliance %



June 2021

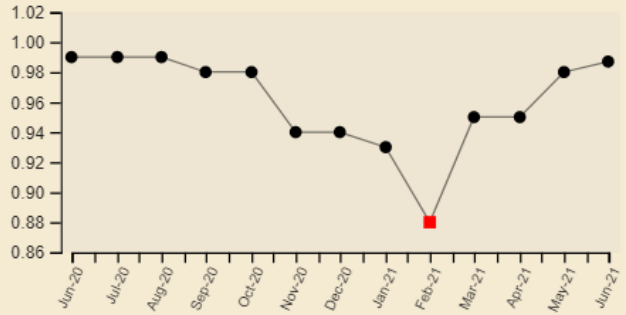
100.00%

Target

(Blank)

MM-7

Medicines Management % of Audits Completed



June 2021

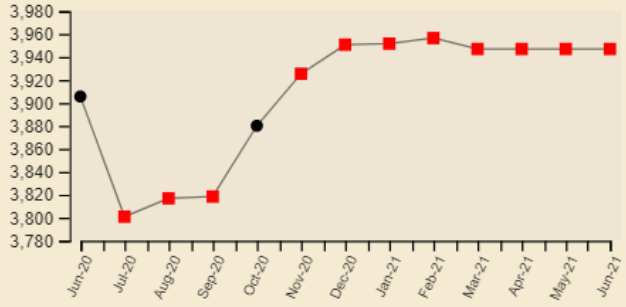
98.70%

Target

100.00%

WF-3

Finance Establishment (WTE)



June 2021

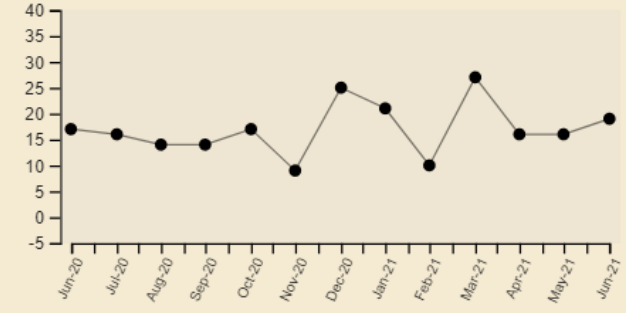
3946

Target

N/A

MM-5

Number of CD Breakages



June 2021

19

Target

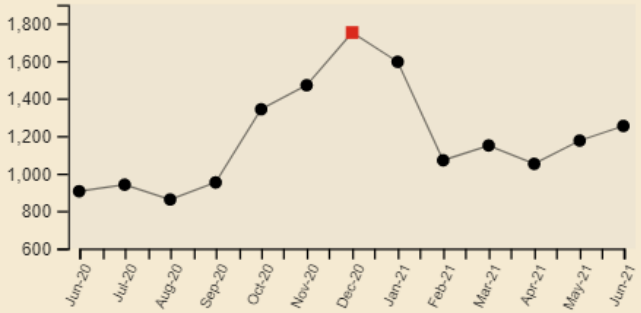
N/A

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

QS-1

Number of Datix Incidents



June 2021

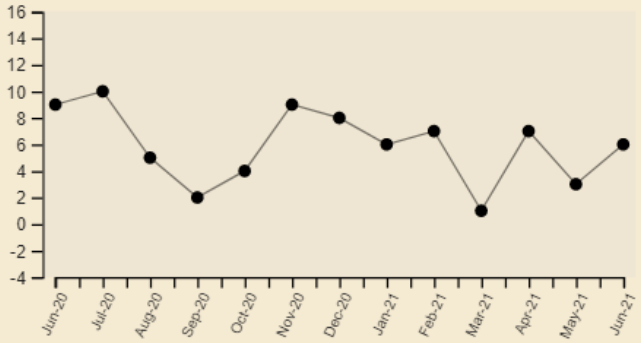
1253

Target

N/A

QS-2

Number of Incidents Reported as SIs



June 2021

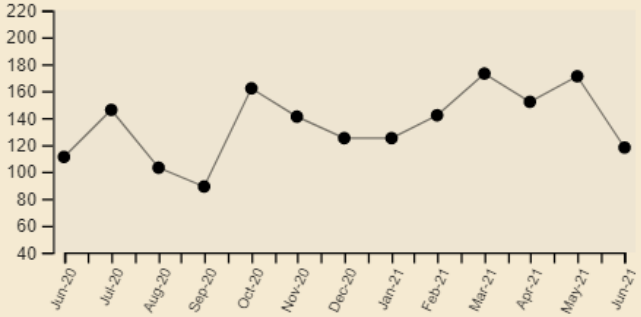
6

Target

N/A

MM-1

Number of Medicines Incidents



June 2021

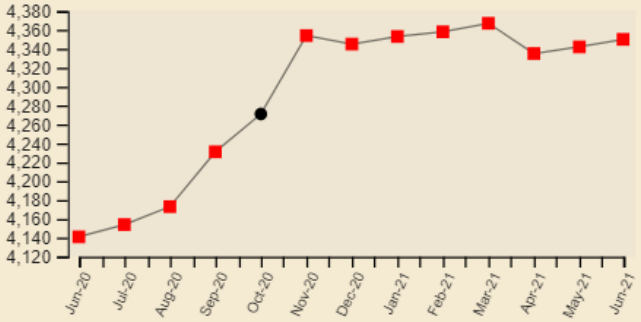
118

Target

N/A

WF-2

Number of Staff Headcount (Excl bank and agency)



June 2021

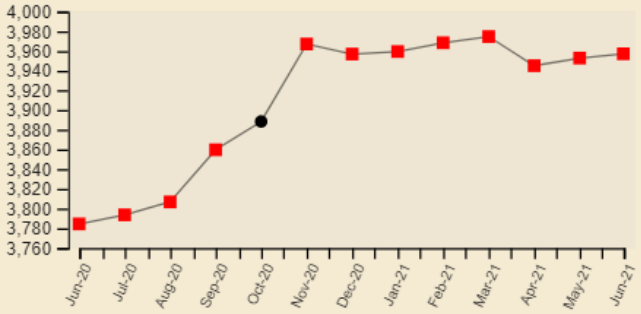
4350

Target

N/A

WF-1

Number of Staff WTE (Excl bank and agency)



June 2021

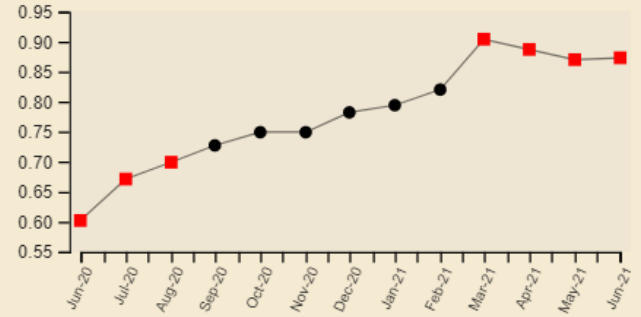
3957

Target

N/A

QS-8

Safeguarding Training Completed (Children) Level 2 %



June 2021

87.30%

Target

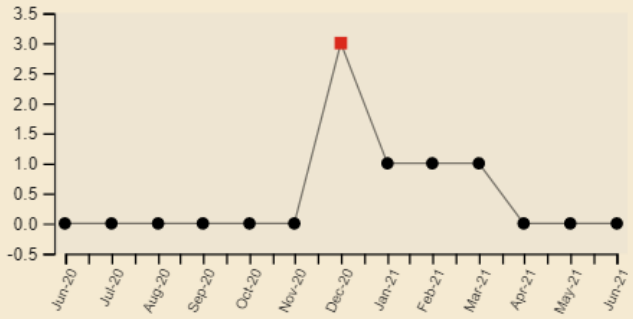
(Blank)

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

MM-4

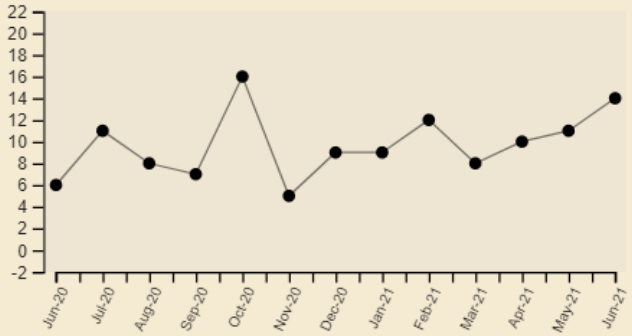
Single Witness Signature Use CDs Non-Omnicell



June 2021
0
Target
N/A

QS-9

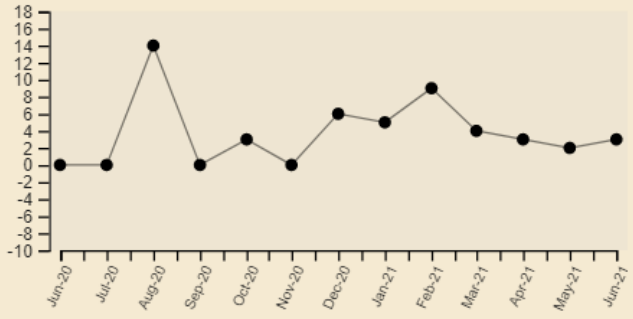
Number of RIDDOR Reports



June 2021
14
Target
N/A

MM-3

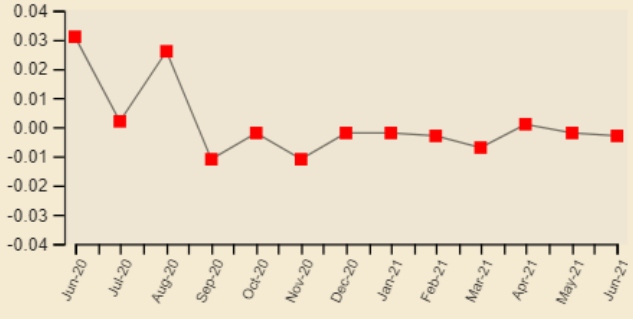
Single Witness Signature Use CDs Omnicell



June 2021
3
Target
N/A

WF-4

Vacancy Rate %



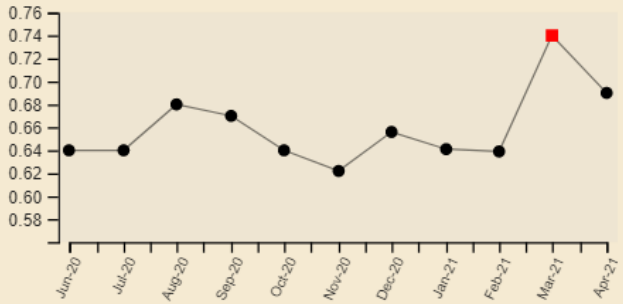
June 2021
-0.30%
Target
N/A

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

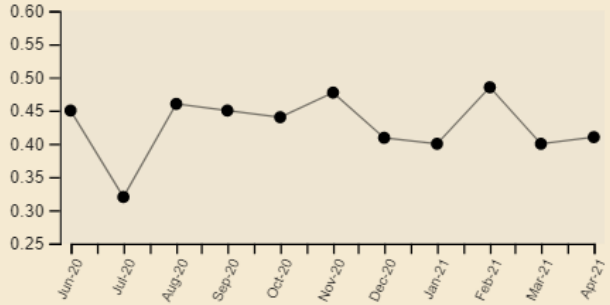
**Acute STEMI Care Bundle Outcome %



April 2021
69.00%
Target
N/A

M-1

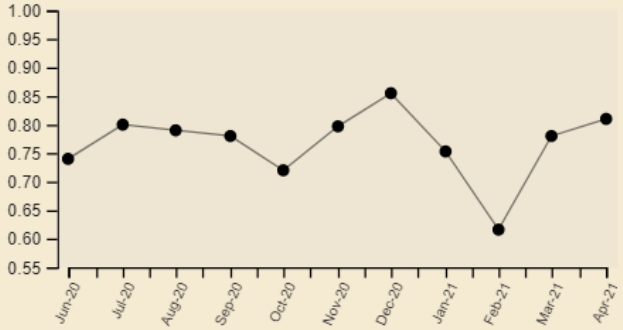
**Cardiac ROSC Utstein %



April 2021
41.00%
Target
N/A

M-11

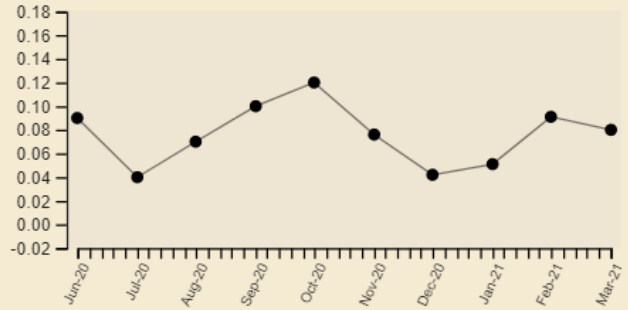
Cardiac Arrest - Post ROSC %



April 2021
81.00%
Target
N/A

M-4

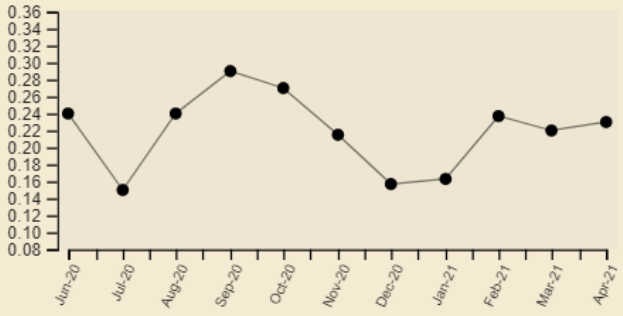
Cardiac Survival ALL %



March 2021
(Blank)
Target
N/A

M-2

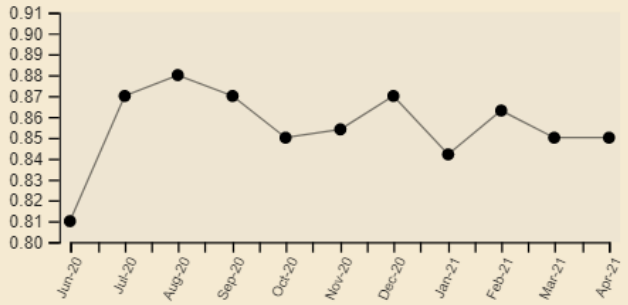
Cardiac ROSC ALL %



April 2021
23.00%
Target
N/A

M-12

**Sepsis Care Bundle %



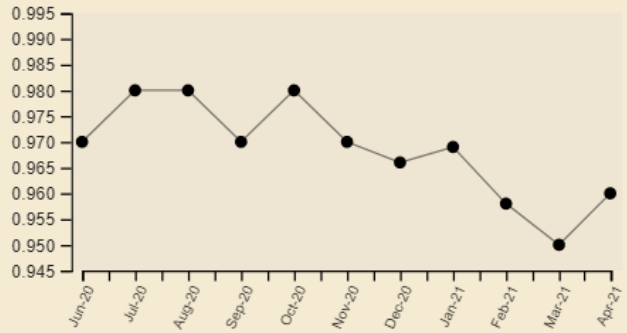
April 2021
85.00%
Target
N/A

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 %



April 2021

96.00%

Target

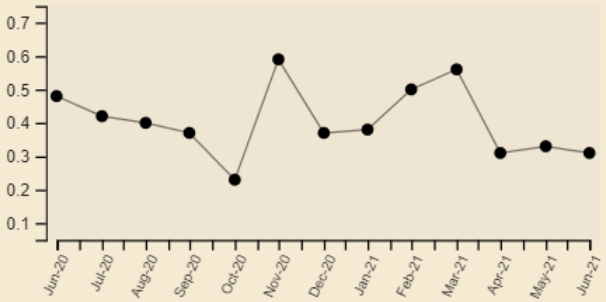
N/A

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 %



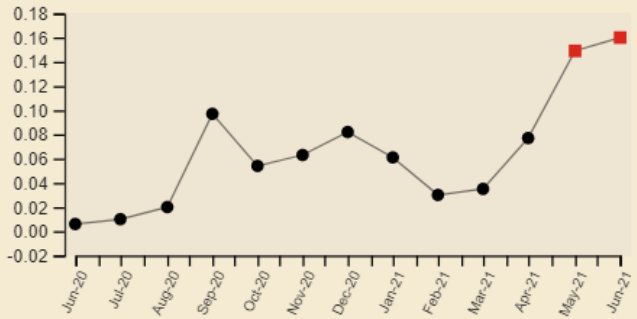
June 2021
31.00%
Target
N/A

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 %



June 2021

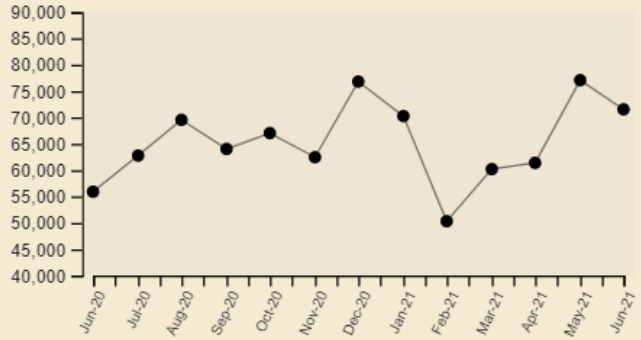
16.00%

Target

(Blank)

999-10

999 Calls Answered



June 2021

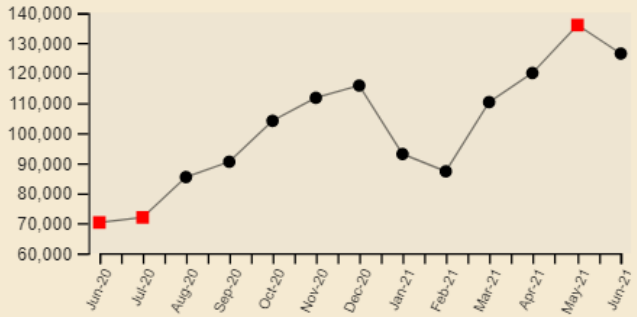
71529

Target

N/A

111-1

111 Calls Offered Actual



June 2021

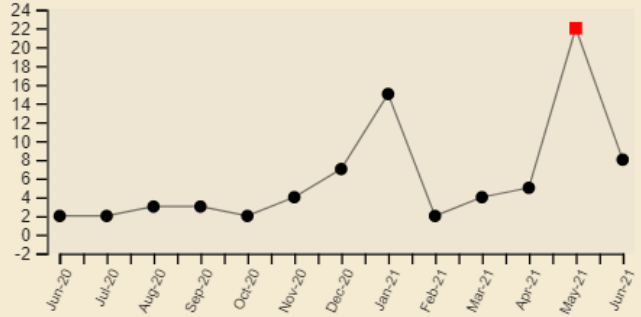
104059

Target

N/A

999-1

999 Call Answer Mean



June 2021

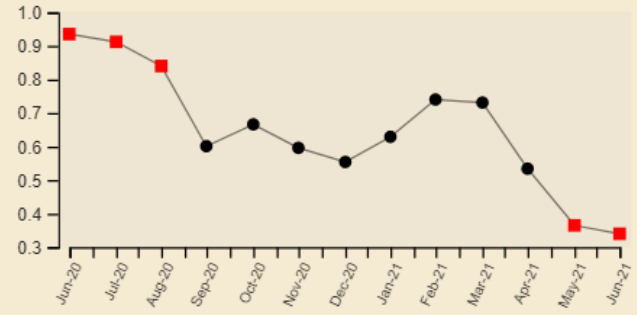
00:00:08

Target

(Blank)

111-1

111 Calls Answered in 60 Seconds %



June 2021

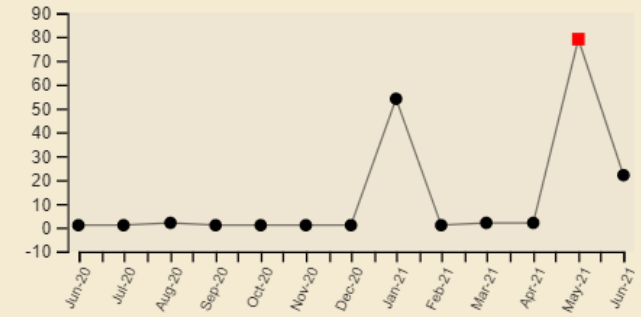
34.00%

Target

(Blank)

999-1

999 Call Answer 90th Centile



June 2021

00:00:22

Target

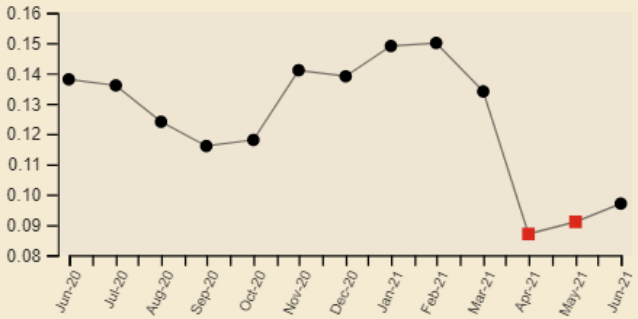
(Blank)

Performance by Domain
Responsive: Performance Charts

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

111-4

999 Referrals (Answered Calls) %



June 2021

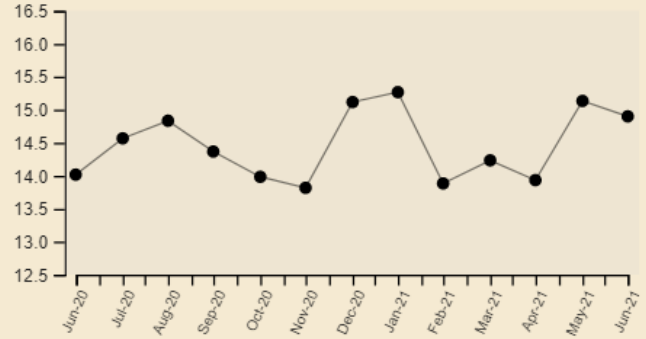
9.70%

Target

N/A

999-2

Cat 1 90th Centile



June 2021

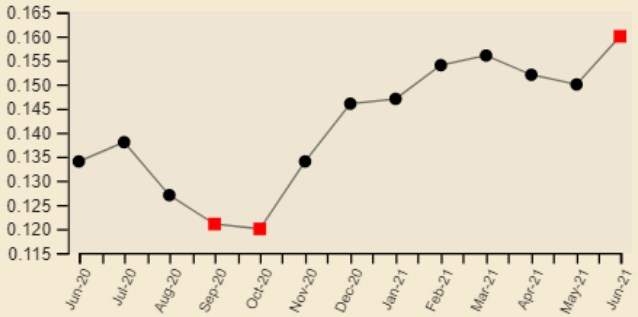
00:14:54

Target

(Blank)

111-5

A&E Dispositions %



June 2021

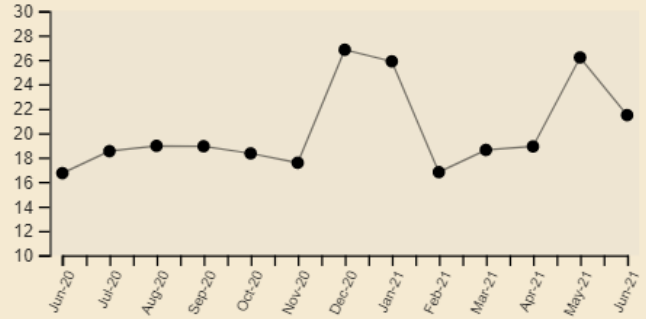
16.00%

Target

N/A

999-4

Cat 2 Mean



June 2021

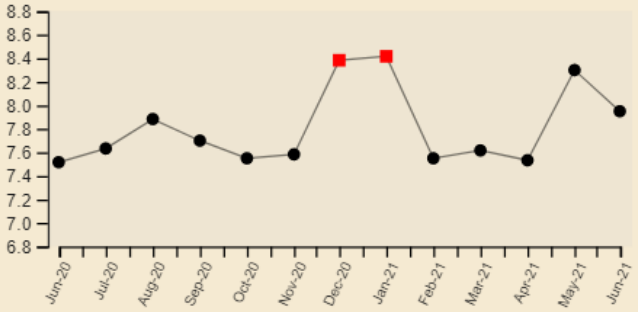
00:21:28

Target

(Blank)

999-2

Cat 1 Mean



June 2021

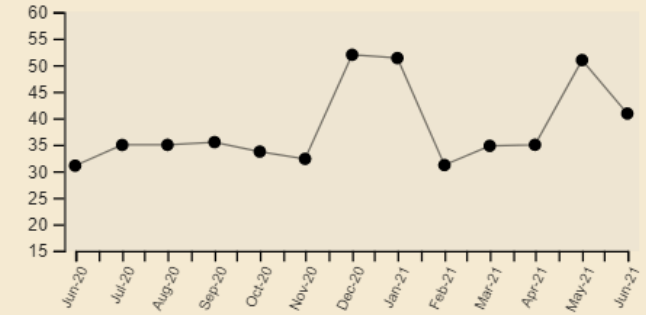
00:07:57

Target

(Blank)

999-4

Cat 2 90th Centile



June 2021

00:40:51

Target

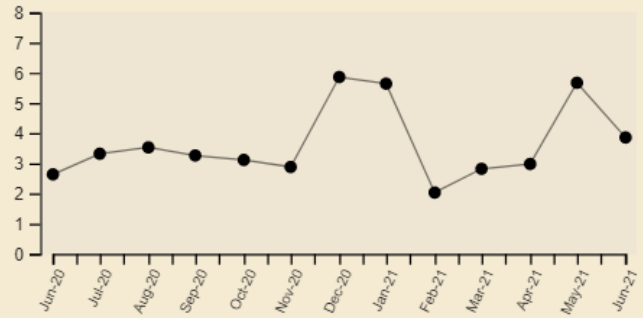
(Blank)

Performance by Domain
Responsive: Performance Charts

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

999-5

Cat 3 90th Centile



June 2021

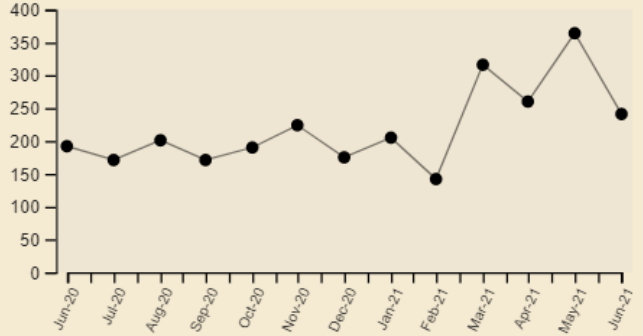
03:51:24

Target

(Blank)

999-10

Fire First Responder Attendances



June 2021

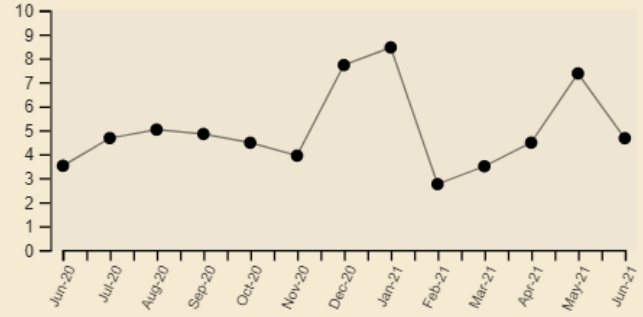
241

Target

N/A

999-6

Cat 4 90th Centile



June 2021

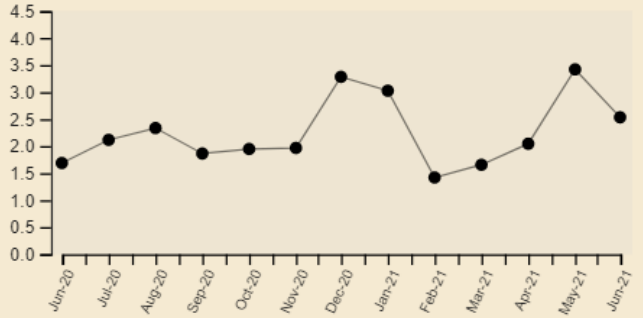
04:39:46

Target

(Blank)

999-7

HCP 3 Mean



June 2021

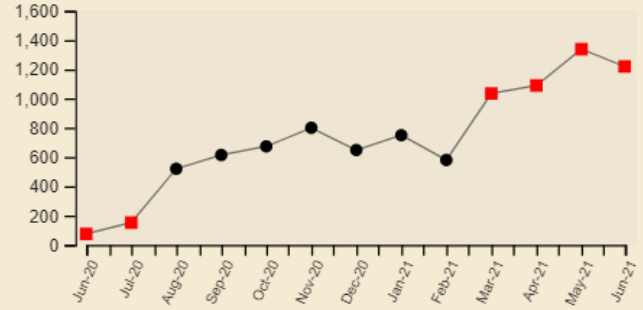
02:32:00

Target

N/A

999-10

Community First Responder Attendances



June 2021

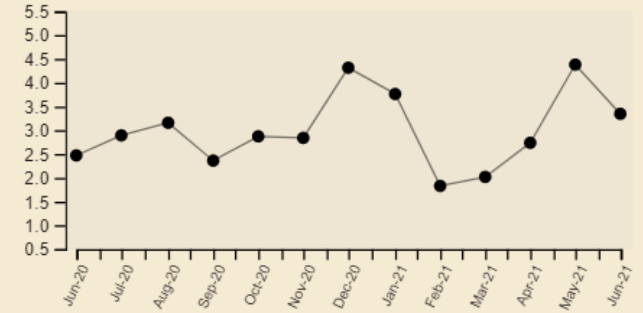
1219

Target

N/A

999-7

HCP 4 Mean



June 2021

03:20:43

Target

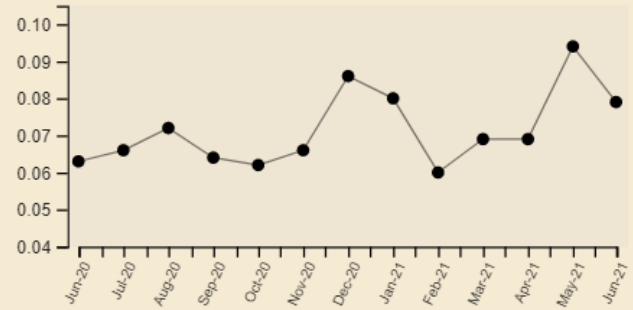
N/A

Performance by Domain
Responsive: Performance Charts

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

999-9

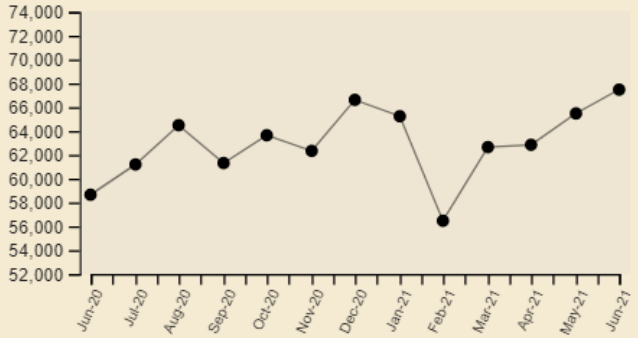
Incident Outcome Hear & Treat %



June 2021
7.90%
Target
N/A

999-10

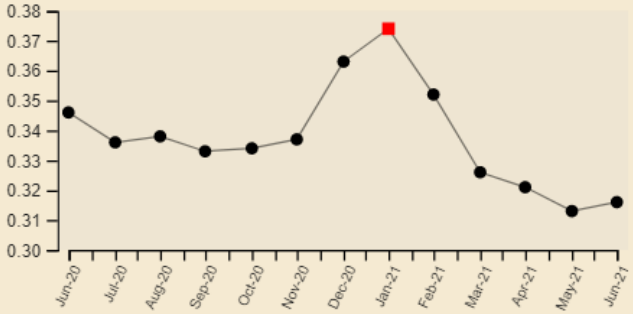
Incidents A7



June 2021
67474
Target
N/A

999-9

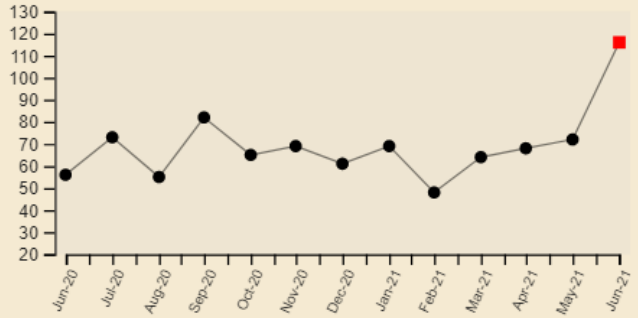
Incident Outcome See & Treat %



June 2021
31.60%
Target
N/A

QS-5

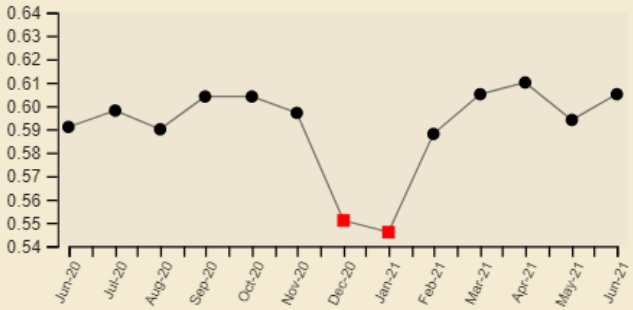
Number of Complaints



June 2021
116
Target
N/A

999-9

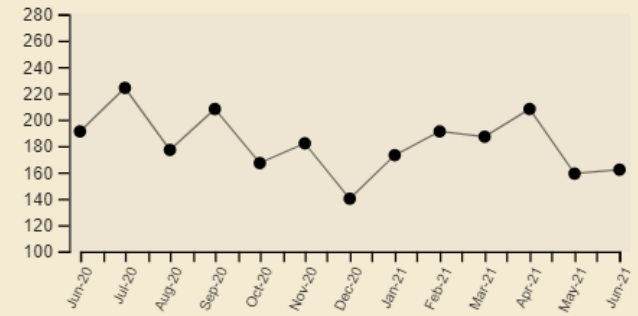
Incident Outcome See & Convey %



June 2021
60.50%
Target
N/A

QS-6

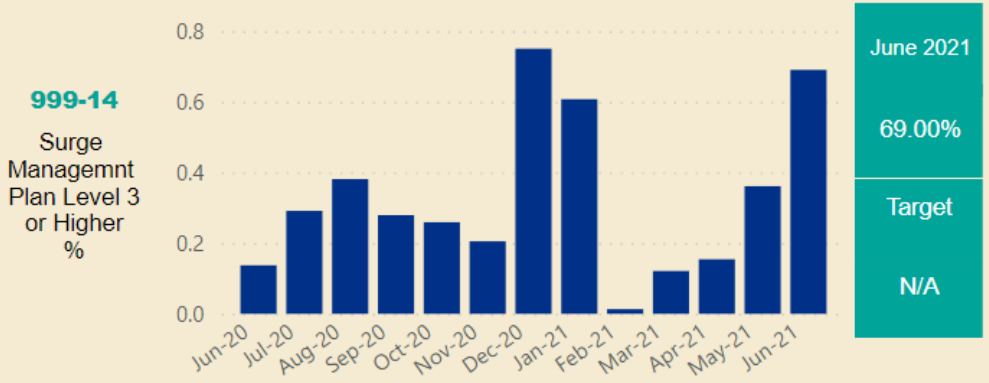
Number of Compliments



June 2021
162
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

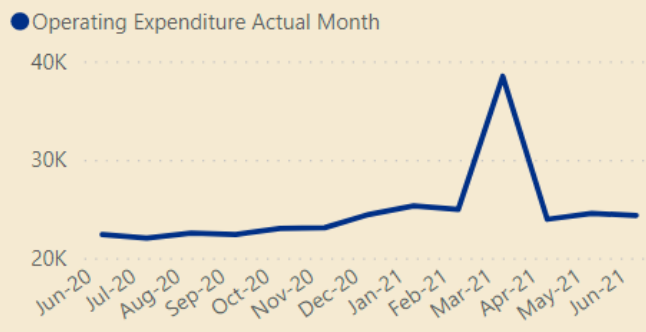
F-1

Income Actual Month

June 2021	Plan
£23325.10	£23214.00

F-2

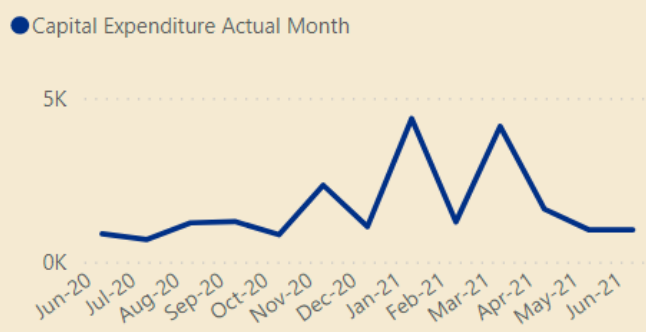
Operating Expenditure Actual Month



June 2021	Plan
£24345.40	£24349.76

F-3

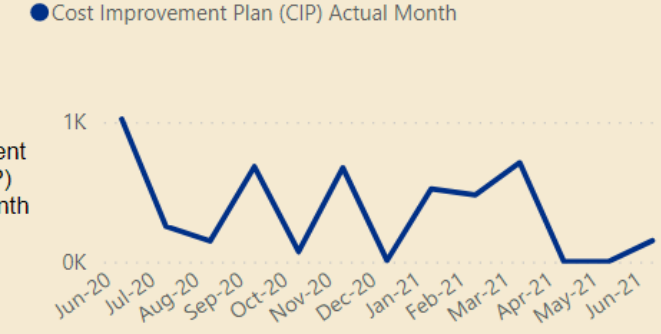
Capital Expenditure Actual Month



June 2021	Plan
£983.67	£1109.00

F-4

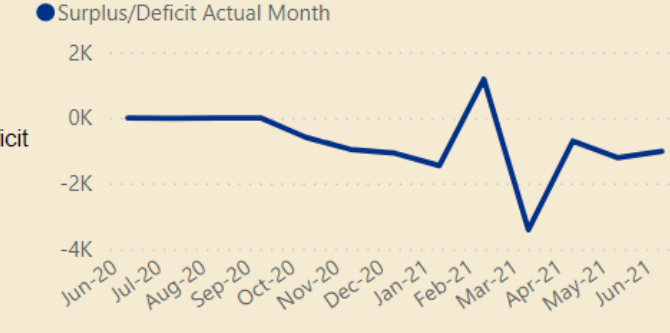
Cost Improvement Plan (CIP) Actual Month



June 2021	Plan
£150.00	£378.00

F-6

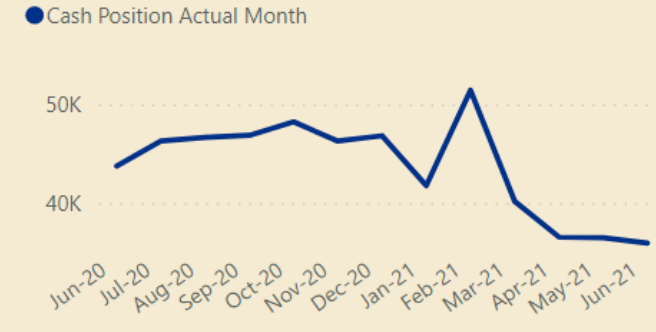
Surplus/Deficit Actual Month



June 2021	Plan
£-1020.30	£-1135.76

F-7

Cash Position Actual Month



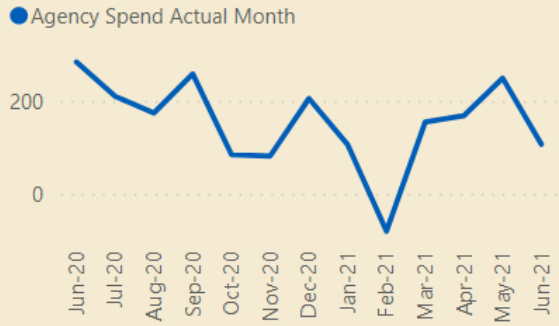
June 2021	Plan
£35923.00	£27464.52

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

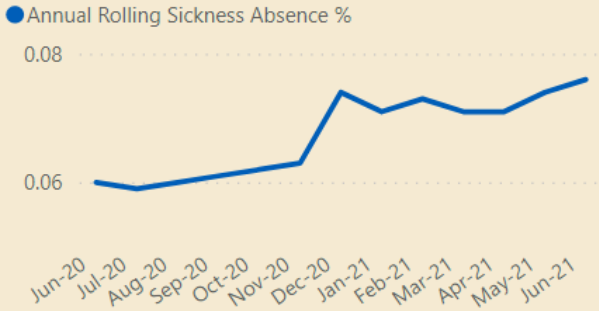
Agency Spend (£000s) Month



June 2021	Plan
£107.24	£291.00

WF-8

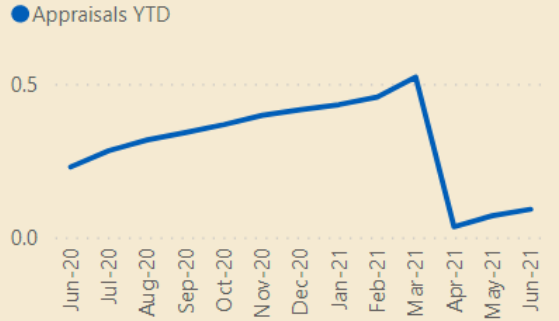
Annual Rolling Sickness Absence %



June 2021	Target
7.60%	5.00%

WF-5

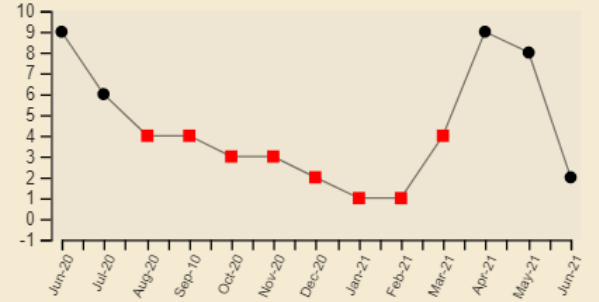
Appraisals YTD



June 2021	Target
9.10%	(Blank)

WF-9

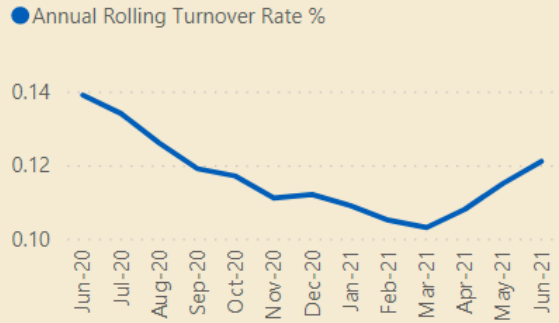
Disciplinary Cases



June 2021	Target
2	N/A

WF-7

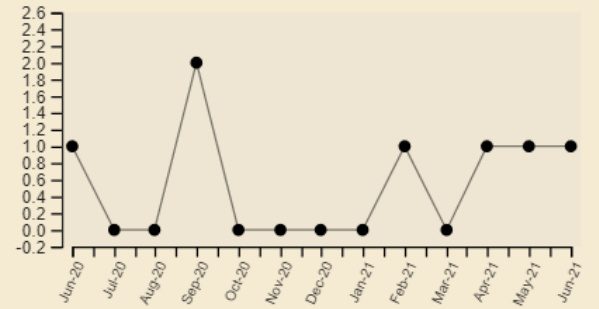
Annual Rolling Turnover Rate %



June 2021	Target
12.10%	N/A

WF-11

Collective Grievances



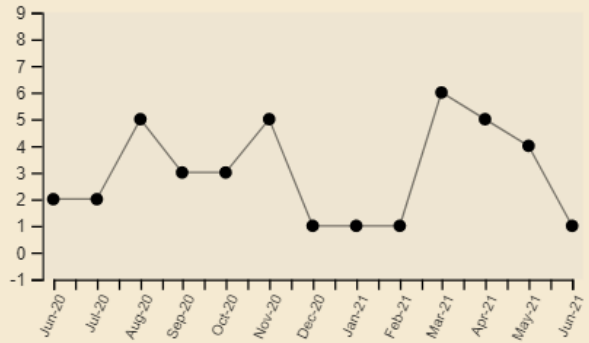
June 2021	Target
1	N/A

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

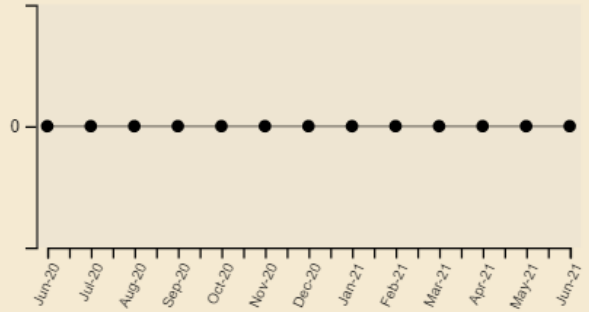
Bullying & Harrassment Internal



June 2021
1
Target
0

WF-13

Whistleblowing



June 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

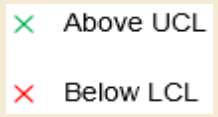
Ambulance Call Categories (Ambulance Response Programme)

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

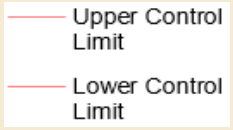
This represents the value being measured on the chart.

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

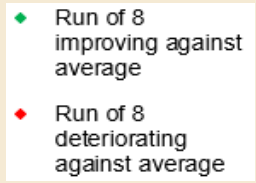


When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.

The target is either an internal or National target to be met.



These lines are set two standard deviations above and below the 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	10 June 2021
Overview of key issues/areas covered at the meeting:	**Operational Improvement and Performance Critical Path** The COO presented an overview of the Operational Improvement and Performance critical path which incorporated the Better by Design (BBD) Programme noting this is presently in the planning phase. Ultimately the critical path depicts an overarching story of when things will change and in what period, and ascertain what metrics are impacting adversely or positively. Between now and October the primary effort will be grip and focus and holding Senior Manager accountable in driving best use of the resources available. Abstractions continue to be high and will continue to be, due to uncertainty around lockdown release, and A/L/staycations. Performance is expected to broadly remain the same until October. It is expected that between April 22 and March 23 all change processes around it will be embedded. Members also received an introduction to the Performance Cell, which will give the ability to forecast future activity using an algorithm based on a series of inputs into a model which give forecast activity and thus required workforce, fleet, etc to meet demand. Members noted this was internally developed but based on learning from SCAS. Members encouraged the Executive to robustly align 'people' to the 'tools' so both component parts are in the correct place. The whole change process will require, simplicity, support and engagement with staff and Unions to ensure everyone is on board, and FIC welcomed and supported this diversity of methodologies moving forward, accepting that it was well overdue. **Operational Performance – 999/111** The Executive Director of Operations presented a detailed review of present activity and trends. May continued to be a difficult month with higher activity and a 20% uplift in C1 incidents. The position up to last week was showing that performance was not improving across any ARP levels, although hear and treat and see and conveyance remained stable. Activity remains high and resourcing remains challenging across both 999 and 111 – in particular 111 is 30% below resources for health advisors and clinicians. Members scrutinised the figures presented, which showed an increase in the ambulance referral rates and noted that nationally the position was sitting at 50% which indicated that callers are continuing to reach out to 111. Members challenged the activities underway to turnaround the current position, noting daily and weekly calls remain ongoing with system partners and the Operational Improvement Plan is being rigorously applied. Handover times remain delayed with the biggest area of concern being Medway. Detailed discussion took place around primary care, and the trend with people declining primary care dispositions when told to contact their GP, thus resulting in an increase in CAS.

	Overall, the committee is assured that despite this very difficult period, everything that can be done with the resources available is being done, and that the Better by Design Programme was now underway to address the medium /longer term performance challenges. **Make Ready & Strategic Estates Update** A report was received around the progress of the Banstead and Medway MRC's along with a general update on Strategic Estates. Banstead is progressing well, Medway was still subject to a minor delay due to the disconnection of utilities. Members were pleased to note that some planned collaboration was taking place around potential additional parking at Medway, noting parking had generated some concern amongst the staff affected by the move. FIC requested to see the Travel Plan associated with Medway once available. Detailed discussion took place around the Disposal programme and VFM, and members look forward to reviewing an updated paper around how the estate valuations are achieved noting the dip in land values this past year, and the need to release excess property no longer required. Ambulance Community Response Posts (ACRP's) were discussed versus impact on Operational performance, and the wider impact on strategic estate investment and how capital spend is prioritised, acknowledging that the Better by Design Programme will assist in aligning the Ops model to this. **Commissioning Contracts** Members were assured by the update paper on NHS commissioned contracts and services, and encouraged the Executive to widen their knowledge around PAP activity, using other Trusts and Providers to benchmark activity and costings. The Joint Commissioning Forum chaired by David Hammond is proving to be a successful and valuable meeting, which will promote continuous business development and align the Trust to the ICS's. Interfacility transfers require more scrutiny around contract versus delivery. Members noted the historical and legacy issues connected with the Air Ambulance contract. **Budget Update 2021/2022 / Financial Performance & Planning** The Associate Director of Finance presented an overview of the current financial position, which broadly depicted the Trust was on track at the end of Month 1. The planned deficit for the month was 700k and actuals were in line and still projecting a half year deficit of £5m. The cash balance remained healthy, due to some additional funding but this will start to decrease as the year progresses due to projects such as Banstead MRC. The Month 2 plan was a £1.2m deficit and there appears no change to that forecast. Members discussed the various cost pressures, noting the provision for the 'Flowers' case (recognition of holiday pay for overtime pay) which is estimated to be between £1m - £2m, with ongoing costs every year, noting the more use of overtime the more backlog of holiday pay will be accrued. Members agreed the Workforce Model needs addressing otherwise it will

	continue to increase the recurrent cost base significantly. COVID costs continue to be supported and the general view is that the methodology on COVID costs will be broadly the same as the previous year, and likely there will be no expectation to return any funding around it. Some underlying operational costs are being funded by COVID, so this could create an issue if indeed monies are withdrawn. Due to COVID, activity remains higher than the block contract. Members noted the risk around funding for the second half of the year being reduced, and urged the Executive to ensure they are prepared in respect of the Trust's own cost base to mitigate any surprises, and ensure the Board is sighted on any post COVID surge. Detailed discussion took place around 111 activity which was 39.4% higher than contracted, yet we continue to face call performance deterioration. As funding as not historically been available recurrently, this has gone at risk these past 18 months, but plans are approved to recruit more call handlers, which in turn will align and improve areas around average call time handling and calls completed per hour. CIP figures were reviewed to identify reducing cost base in certain areas, with a longer term trajectory for future structures applied. It was noted that half of the CIP's from the previous year were delivered non currently, and long term recurrent savings remain as the key focus. FIC challenged the Committee to review PAP activity, this was showing £519k against a plan of £1m, and this did not sit right considering the current pressures being faced. This could be down to reconciling or invoicing but needed to be reviewed. **Financial Planning** Members acknowledged the unknowns relating to the second half of the financial year, and challenged the Executives around accepting a £10m deficit and whether more could be done, particularly around being sighted on the ICS financials, and ensuring potential for over provision to position the Trust in the best place financially for the following year. The formal planning guidance expected out around mid to late June will help navigate some of these concerns, although it will remain a managed situation going forward. **Capital Programme** The current Capital Programme was submitted to NHSE&I in April 2021 and is a capital only submission in accordance with the national timetable. Members reviewed the five year capital plan presented noting the £35m investment for 2021/22. Changes to the overall ICS plan do not affect SECAmb in the current year, although there may be a need to rephase schemes in future years. Members were assured by the planned progress of Capital Investment. **Business Case Tracker** Members reviewed the planned BC's for the year ahead noting there was a 200% increase on the previous year, due to COVID, an increase in change

	activity and tighter controls generally. Members looked forward to receiving the Benefits Realisation from some of these cases which were planned for review at FIC later in the year. **Electronic Patient Prescribing (EPS)** Members noted the task and finish group surrounded the project had now ended as EPS had now been deployed into Cleric. Members were pleased to note GP prescribing is up and running. EPS now sits with the Operations Directors as BAU. Richard Quirk will continue to lead on non medical prescribing which is the background work to allow Pharmacists to prescribe. Members congratulated the team on the EPS project but challenged the Exec to capture the efficiencies, noting they will mature as the service embeds.
Any other matters the Committee wishes to escalate to the Board	The Exec are continuing to look at opportunities and research with other Trusts around how they are utilising Patient Transport Services with PTS leadership and what others are doing.

SECAmb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 22 July 2021
Overview of key issues/areas covered at the meeting:	**Management of Serious Incidents** The paper received provided the committee with an overview of the serious incidents (SI) the Trust had declared during May and June 2021. A summary of each case, and immediate actions, was included and this helped the committee get a much better sense of the issues. The majority of incidents related to delays, which reflected current operational pressures. There were six SIs declared in June and to-date this month there are already 14, some have been clustered reflecting the performance issues. In addition to the numbers increasing the level of harm identified is also increasing, which is a new trend. The committee reflected that the previous challenging period in December/January resulted in relatively few SIs, and the difference now is also that the pattern has changed as we are now seeing more incidents related to patients in category 2 (C2). This is because due to the current very significant challenges we are unable to consistently respond quickly enough to patients that are very unwell. The harm identified in patients in category 3 (C3) is relatively low despite some very long waits, reinforcing the shift in risk profile to C2. The committee acknowledged the current difficulty in matching resources with demand which is why the Trust is in the highest level of escalation, REAP 4, and why a Business Continuity Incident (BCI) was recently declared. It is understood that nearly every ambulance service in England is also in REAP 4. There was a good discussion about how we use our incident reporting and harm review processes such that in addition to identifying the issues and making recommendations resulting in actions, we also ensure a way to measure the impact of these. In other words, how do we know positive change has been made as a consequence? The committee welcomed the recent addition of including a measurement of effectiveness in the action plans and while it noted there is still some way to go, there is some progress which will be supported by the introduction of the new NHS l patient safety strategy. The committee will continue to seek assurance on this point. The committee is assured by the work of the Executive to ensure good incident reporting and identification of harm through the related harm reviews. In light of the increasing incidents and number of harm reviews needed, coupled with the need to ensure clinicians are in patient facing roles at this time, the Board should be aware that there will likely be an increase in the time it will take to conclude investigations. **Patient Safety in REAP 4** The focus here was on seeking assurance on the key actions being taken to keep patients safe while performance challenges persist. The daily harm reviews in place are focussing on C2 double breaches and 10% of C3 triple breaches. The committee acknowledges the distress and moral injury to staff that are tasked with undertaking these reviews, and to the staff in EOC and crews on the road for the impact on them from the current challenges that mean they are not always being able to ensure positive outcomes for patients, despite their very best efforts. In addition to the harm reviews looking back to identify ways to continually improve how we respond to patients the committee also explored the steps being taken in real time. There are a range of actions which include: • Optimising staffing, such as incentivising shifts. • Ensuring effective communication between clinicians in control rooms. There are routinely two clinical safety navigators (CSNs) who supervise groups of clinical

supervisors who in turn help manage the patients waiting for a response.

- A Strategic Medical Advisor joins all surge calls and flags specific issues to the CSNs from the calls waiting.
- Increased focus on C2 calls, highlighting to clinicians in EOC that the risk is shifted to C2s from C3s.
- When in sustained surge, consideration should be given to appropriate patients being advised to make their own way to hospital or to an urgent treatment centre.

The committee sought assurance that all the measures being taken is a careful balance of risk and uses the established governance including the quality impact analysis process.

The committee acknowledges that there are no simple solutions to these very unique challenges. While the measures supporting clinical decision making within the EOC will help ensure the most effective use of resources that ensures timely response to the most unwell patients, the fundamental reality is that the biggest positive impact will be from getting more staff back from sickness and self-isolation.

These very significant challenges are therefore likely to last several weeks if not months and so the committee will keep this under close review. We will schedule extraordinary meetings as and when needed, balancing the need for ongoing Board assurance with giving management the time to respond.

Bariatric Care

This was one of the routine scrutiny items and a very helpful paper was received that provided an overview of bariatric care including:

1. Details of vehicles & equipment
2. Activity – calls where the response involves the bariatric vehicles & equipment
3. Review of open SI actions and Datix incidents
4. Policy review & performance analysis

Although incidents requiring bariatric vehicles are infrequent (37 incidents a month on average) this is a very important service to those patients that need it. The committee heard about the difficulty in not always knowing which patients are bariatric and circumstances where non-bariatric vehicles / crews are used to ensure a timely response. The committee encouraged management to equip staff with the confidence to ask the sensitive questions needed to ascertain if a patient is bariatric. This will ensure better deployment and help mitigate some of the manual handling incidents that continue to occur.

It was encouraging to note the high number of safeguarding incidents reported, which demonstrates good staff awareness.

The paper listed a number of actions to improve the service, including a review of policies and procedures, and training, and the committee has asked for a management response to confirm they have been taken.

Medicines Management Review

Medicines management is a key area of quality and safety that the committee regularly seeks assurance on. A paper was received giving a helpful overview of the way we are managing medicines, highlighting the areas of good practice and where improvements are required. What the paper did not include was the actions being taken and so the committee has asked for a management response to set this out including timeframes. It will also use this opportunity to review the medicines strategy. This is being developed with some options around the continued use and development of the Omnicell. Linked to this will be consideration to what we should invest in and some of options will require not insignificant financial investment.

	In the meantime the committee is assured that we have a good and safe system of medicines management, albeit some processes are very time consuming. The audits completed demonstrate good levels of compliance. **Review of Clinical Services and Outcomes by Clinical Grade** The committee asked for a follow up paper related to the safety of discharge decisions made by the non-registered staff and Newly Qualified Paramedics (NQP) and the supporting mechanisms that govern these decisions. The paper was very clear, and management provided a frank assessment highlighting where there are gaps in assurance; specifically in whether this group of staff are consistently operating within their scope of practice. The committee supported the conclusion and the assessment of the actions that need to be taken. A paper will come back in September to quantify more clearly the risks and to set out the actions being taken. **Clinical Audit Annual Report** The Committee provided feedback on the draft report. It reflected that it is a good report and sets out helpful observations but lacks detail about what actions we are intending to take as a result that will make a difference. In response to the areas identified high risk we especially need to show what we plan to do, with an indication of timescales. The committee will receive an updated report at its next meeting.
Any other matters the Committee wishes to escalate to the Board	None.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**28 May 2021**
Overview of issues/areas covered at the meeting:	**HR Performance Update** The committee continues to oversee progress with a range of issues, with increasing levels of assurance. The summary from the committee is as follows: <u>E-Timesheets</u> These are now embedding and the committee will look at the benefits from this new system in six months' time. <u>E-Expenses</u> Operations go live from July; the trial went well with no significant issues identified. <u>P-Files</u> At the time of this meeting the numbers of outstanding was in single figures, with assurance sought that these would be complete imminently. The Board will know that this has been a long-standing issue, originally identified through the Audit Committee, and we are now in a really good position. Significantly, from this work no issues have been found with any member of staff. The executive self-reported this to the ICO last year and we have confirmed the conclusion of this with them. <u>Driving Licences</u> The numbers of returns from staff asked to re-submit copies of their driving licenses increases and the relatively small numbers are being managed by OU. Operations were prioritised but now there is focus on support services staff. <u>Payroll Provider</u> The business case was agreed by the Board in May and the plan is to go live with the new provider from 1 October 2021, with a 12-week transition period ahead of this. The committee will consider a post implementation review in early 2022/23. **Workforce Planning & Recruitment** As requested by the Audit Committee, the committee reviewed the management actions arising from the Internal Audit review, which concluded in 2020/21. A verbal update was provided and to provide assurance that the actions taken have achieved the expected outcomes an assurance paper will be received shortly.

Clinical Education Improvement Update

A good paper was provided that covered progress in the following areas:

- The Rectification Program that has been put in place to support AAP and ECSW internal learners to program completion.
- Learners on the program with Crawley College.
- The L6 Degree Apprenticeship at the University of Cumbria
- The findings and agreed actions from the Internal Audit Review which concluded in May.

The Internal Audit helped to reinforce the need to continue to progress the clinical education strategy. The committee heard that a working draft should be available by the end of Q1. The committee noted another finding about the lack of KPIs and supported the steps being taken to include qualitative metrics. As with the earlier review, the committee will seek assurance that the actions being taken achieve the expected outcomes.

The committee explored the support we are giving staff / learners in the context of the small cohort for Cumbria (commissioned for 30 and achieved 17). The committee noted the specific reasons for this and was assured that we did all we could to fill this course. Management expressed a good level of confidence that future courses will be better filled. However, an after-action review was completed and, in liaison with other ambulance services, some changes to the application process has been made, in addition to improvements in the provision of information to enable informed decisions for potential applicants. The committee welcomed this.

The issue of diversity was also explored. The executive acknowledged that we need to do better. The head of clinical education sits on the Inclusion Group and uses this group to help find ways the Trust can become the employer of choice for people of all backgrounds. Currently, our approach is too passive and it was accepted that we must be more focussed and proactive.

The final thing for the Board to note is that the committee was reassured by management that there are adequate resources available to deliver what is currently needed.

People Plan

An update was provided on the work that has been done in the past year, linked to the People Plan. The committee acknowledged the past year has been unique, but despite the challenges of the pandemic some really good progress has been made, in part due to our established processes prior to People Plan being published, such as in wellbeing and inclusion.

The committee agreed that there are too many actions and, in light of all the competing priorities, supported the review being undertaken by the Executive Management Board

to establish what is absolutely required and what is a nice to do, so that informed decisions can be made on what to prioritise. This will include how we measure and report

Retention
In early 2020 the Board approved the retention strategy, which was informed by our involvement in cohort 5 of Health Education England's 'Retention Programme' earlier in 2019. We initially aligned our strategy to deliver the national objective of improving retention by 1%, but then agreed a 'stretch target' of 30%. The paper considered by the committee summarised the actions taken to date and how far we have progressed against the 'stretch target'.

It is clear that retention in the past year has been helped by the pandemic. There is more work to do, therefore, to understand more deeply the impact of the initiatives taken. The committee also supported the view of the executive that we must ensure the initiatives that have not yet been implemented are done so at pace. Smaller and more localised retention plans are also being considered.

Acknowledging the link to the related BAF risk, the committee noted the data presented that confirmed an increase in paramedics leaving the service in April. It asked whether this was connected to the recruitment by PCNs but the data does not show this. An action was therefore agreed by the executive to establish how we can record if paramedics leaving the Trust are moving to other parts of the health system.

As retention is so critical to the delivery of services the committee sought assurance that we have sufficient resources to deliver the actions needed. The executive confirmed that we do and reinforced that fundamentally we need to ensure staff have positive experiences of working for the Trust.

BAF Risk – Paramedics and PCNs
The committee picked up the discussion from the May Board development session and will keep this as a standing item to track the extent to which this significant risk materialises and seek assurance that the right mitigating actions are being taken. This must include ensuring improvement in the flow of paramedics and consideration to other options to increase the workforce, such as use of other health professionals.

There was a good discussion about the pros and cons of a rotational model and more broadly how we ensure the right pathways for career advancement. Although we currently do provide a wider clinical portfolio than most if not all ambulance services, there are some roles such a paramedic practitioners with higher levels of attrition than we would expect. This is in part due to the offer from primary care.

The committee then reviewed the **workforce and wellbeing dashboard**. There were no specific escalations and the committee noted that via the development of the IPR, the committee dashboard will be improved as currently it is not as clear as it could be. The

	new dashboard will more readily highlight the staff wellbeing /welfare indicators, which the committee will be ensuring greater focus on. On ER cases the committee welcomed the work to establish a new tool using power BI to provide better information on the type and location of cases, including timeframes. This has enabled much easier visibility and therefore tracking of cases. The committee noted that there are still a high number that have been open a very long time. The HR team is using this new tool to focus on hotpots and ensure intelligent allocation of resources such as OD interventions to reduce issues in these areas. The committee was assured by this step in the right direction. Time was also spent reviewing the work to improve **staff experience**, using the feedback from the staff survey and other sources. The Executive Management Board is scheduled to agree in June the areas of primary focus and the metrics to be used to assess progress in improving staff experience. A management response was received related to the steps being taken to manage **incidents of violence and aggression against staff**. This arose from an earlier Board meeting and some indicators in the IPR. The paper helpfully set out the various measures being taken but did not go that step further to confirm the extent to which the executive believe more can be done. A further paper providing this assurance will come to the next meeting. The body worn cameras trial was discussed and the committee reinforced the need for a proper evaluation as there was concern that the evidence is not strong on these cameras providing value for money in terms of prevention. Finally, there was an update on **corporate affairs.** This followed up the discussion in March which concluded that there is lots going on but a potential gap in coordination, leading to an inconsistent approach and some duplication. A proposal was put forward about how we might amend our approach. This was explored and feedback provided to inform the ongoing rview, which will need to include consideration to how we link a head of corporate affairs, partnerships, and strategy. The committee suggested running some issues through to test how the structure responds. The committee will return to this at its next meeting.
Any other matters the Committee wishes to escalate to the Board	None

SECAMB Board

Summary Report on the Audit & Risk Committee

Date of meeting	**15 July 2021**
Overview of issues/areas covered at the meeting:	In light of the current operational position and level of escalation the Trust is in, the committee focussed its agenda to limit the impact on management time. The meeting covered the following areas: ▪ Internal audit progress report ▪ Counter Fraud ▪ BAF / Risk Management
Internal Audit	Two reviews were considered. **Data Security and Protection Toolkit –** Advisory Review This review helped to demonstrate a good level of accuracy in our self-assessment whereby 12 out of the 13 audit assertions were agreed, noting the further work included in the three management actions. RSM confirmed that this was a positive review and the areas it identified were not areas that will lead to non-compliance but rather more about improving compliance. The committee was assured that the focus on the mandatory items ensures good basic controls. It asked for a management response to come back to confirm the importance of the non-mandatory items and how we are taking these forward. **Station Visits –** Reasonable Assurance The committee was assured by the outcome of this review and by the feedback from RSM about how well-prepared staff were for this review. RSM also reflected on how management often points them to potential areas of concern, which they felt demonstrates a healthy learning culture. The one area of concern related to fire safety. The issue relates to some potentially ambiguous wording in the fire safety policy which led to some confusion about when the fire assessments needed to be renewed. The committee was assured these are reviewed regularly, and the renewals every five years is consistent with the regulations. However, the issue with how the policy is worded causes some concern about the robustness of the related controls, which the committee explored in some detail. Corrective action is being taken. There continues to be good and timely management follow up on the actions agreed from the internal audit reviews.
Counter Fraud	The annual report considered at this meeting demonstrates a positive (green) rating against the national standards. The committee's assessment is that we have a good counter fraud culture and the learning over recent years has led to tighter controls. RSM confirmed some changes to how savings arising from counter fraud are to be

	reported nationally and the committee asked that we reflect this clearly next year as there is likely to be a marked increase (in savings) due to the way this will be counted.
BAF / Risk Management	In the context of the BAF risks and the summary of risk profile within the risk register, the committee had a good discussion about our approach to risk management. The executive set out some of the issues that are being addressed, in part by a new risk management process. These relate to the timeliness of reviews; the way risks are described and the consistency of risk scoring. The committee has confidence that the executive will continue to make the necessary improvements in these areas. The committee challenged the executive to include more timeframes for risks, so it is easier to hold to account for delivery of the controls and related actions. It also challenged the executive to think more about contingency planning, because for those risks more difficult to mitigate, such plans will help ensure better management when the risks materialise.
Other matters	The committee also tested the governance arrangements in place for the **Better by Design Programme**. While it is assured by the current arrangements, it suggested taking a further view at the Board (possibly at the development session in August) to review the extent to which the overlaps with the purviews of some of the Board committees might lead to a slightly different approach to oversight. The committee also received a paper on **single tender waivers**. It reviews this at least annually and continues to be assured by the processes in place that significantly minimises its use.

SECAMB Board

Charitable Funds Committee Escalation report to the Board

Date of meeting	15 July 2021
Overview of key issues/areas covered at the meeting:	**Fundraising Activity** A detailed paper was shared around the fundraising that has taken place to July 2022 This includes donations received from members of the public, via the Just Giving page and the monies received from NHS Charities Together. Members were pleased to note these donations and equally pleased that the monies had been put to good use within the Trust, namely: - £41k to date spend by Directorates on items such as water bottles, gift vouchers, recreational equipment, garden accessories for stations. - £23k on wellbeing initiatives such as sleep workshops and online fitness and wellbeing classes - £27k earmarked for positive action training for BME colleagues - Use of the general fund to support hardship, serious illness and wellbeing requests. **TOR and Cycle of Business** Members scrutinised the TOR and cycle of business, and agreed it required some updating, the TOR need to contain the constitution and the charity objective, and members agreed that the strategy and stakeholder engagement needed to be included in the cycle of business to ensure direction of travel and to capture all current and proposed initiatives. **Financial Accounting** Members noted the year end accounts to 31 March 2021 and the summary accounts up to 31 May 2021. These displayed an overall balance of around £200k. Detailed discussion took place around recognising those immediate and urgent initiatives that can be dealt with at pace. Staff welfare and wellbeing were recognised as being key areas to support. **Volunteer Strategy** Members agreed that the present Strategy needs refreshing as it was originally written in 2018/19. The pandemic has created new ways of working and seen huge contributions for volunteers in ways not seen before in the Ambulance service. The Committee noted following a workshop with CFR teams earlier in the year that the process to procure goods/items could be improved. Members encouraged the Volunteer Services team to review processes and identify any improvements that can be made. **Summary** In summary, the committee is content with the financial position, in the context of the pandemic, and the resourcing currently available to promote the Charity. The Committee is assured with the financial accounts and fundraising activities which have taken place this past year and gave special thanks to Wellbeing, Finance, Operations and Corporate Governance Teams for their efforts in this area especially over the past 12 months of the pandemic.

	The Committee also encouraged the Executive to work at pace to consider recruiting a substantive person, with the relevant skills and charity experience, to manage and promote the activities surrounding the fund and the wider CFR fundraising going forward.
Any other matters the Committee wishes to escalate to the Board	The committee also wanted to ensure that the CEO was happy that the monies given during the COVID pandemic have been used in the best ways possible and will ask this at the Board meeting in two weeks.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	22-21

Name of meeting	Trust Board
Date	29.07.2021
Name of paper	Amendment to Trust Constitution
Author	Isobel Allen, Assistant Company Secretary
Synopsis	This is a proposal to make two changes to the Constitution. Firstly, to provide for a shorter term of office for some Governors elected in 2022, in order to better align the timing of elections. This is because, at present, there could be a change of up to two thirds of Governors in one election, which creates instability. The proposed change limits this risk to a maximum of one third. The second change is to add one additional Governor position to the Lower West constituency in 2022 to ensure equal representation based on population numbers for Lower East and Lower West. Both changes have been approved by the Council of Governors.
Recommendations, decisions or actions sought	As changes to the Constitution requires approval of both the Council of Governors and Board of Directors, the Board is asked to approve the two changes as proposed.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Board of Directors

Governor Election Proposals and Constitution Changes

1. Introduction

1.1. At the Governor Development Committee in August 2020 and then the Council of Governors in March 2021, discussion took place about potentially standardising election timings to create more evenly spaced-out annual elections. The discussion led to consideration of additional changes that might be made to improve the election cycle. Proposals were developed and refined by subsequent GDCs and approved by the Council of Governors. Changes to the Constitution requires the approval of both the Council of Governors and Board of Directors.

1.2. After discussion with NHS Providers' governance lead, there is no requirement to vote on the proposals at the Annual Members' Meeting, since the proposals do not have an impact on "the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)", which is the criteria for requiring such a vote.

1.3. The change proposed is aimed at realigning the timing of Governor elections and specifically, will result in some Governors elected in 2022 holding a term of two years rather than three.

2. Rotation of Governor vacancies

2.1. The Council of Governors wish to align Governor terms of office so that approximately one third of the Council is up for election every year. This necessitates changing the constitution (Annex 5) to enable the provision of some terms of office in 2022 being reduced to two years.

2.2. The detail of how this will work is set out in Appendix A.

2.3. Annex 5, section 9 of the Constitution is set out below with the proposed changes in red:

9. Terms of Office of Initial Council of Governors

9.1 Notwithstanding the prior provisions of this Constitution, those Governors who are elected to the Initial Council of Governors shall hold office initially for those periods set out in Table 1 of this Annex 5 below.

9.2 Those elected Governors who secure the greatest number of votes in their Constituency shall serve for three years and those securing fewer votes in their Constituency shall serve for two years where appropriate.

9.3 In the event that an election is not required because a Constituency is uncontested, the terms of the Governors will be determined by drawing lots.

9.4 In the event that there is a vacancy or vacancies after the initial elections are held, the number of Governors who shall serve two years will be reduced accordingly.

9.5 For the avoidance of doubt, this paragraph 9 relates only to the Initial Governors of the Council of Governors, any subsequent elected Governors shall serve for three years, save during elections in 2022 which shall be held in accordance with provisions 9.6 to 9.9.

Table 1

Constituency	Number of Governors who shall serve two years	Number of Governors who shall serve three years
Public - Brighton and Hove	0	1
Public – Medway	0	1
Public - West Sussex	1	1
Public - East Sussex	1	1
Public – Surrey (including certain wards of North East Hampshire and Berkshire identified in Annex 1)	2	
Public - Kent	2	2
Operational Staff	2	1
Non-Operational Staff	1	

9.6 The following paragraphs and Table 2 apply only to elections held in 2022, in order to achieve closer to one third of Public Governors and Staff Governors being elected in each year.

9.7 Those elected Governors who secure the greatest number of votes in their Constituency shall serve for three years and those securing fewer votes in their Constituency shall serve for two years where appropriate.

9.8 In the event that an election is not required because a Constituency is uncontested, the length of the terms of the Governors will be determined by drawing lots.

9.9 In the event that there is a vacancy or vacancies after the 2022 elections are held, the number of Governors who shall serve two years will be reduced accordingly.

Table 2

Constituency	Number of Governors who shall serve two years	Number of Governors who shall serve three years
Public - Lower East SECAmb	1	1
Public – Lower West SECAmb	1	1
Public – Upper East SECAmb	0	1
Public – Upper West SECAmb	2	1
Operational Staff	1	1
Non-Operational Staff	0	1

3. West Sussex representation

3.1. Discussion has previously taken place about increasing representation in Lower West SECAmb (West Sussex) by 1 seat as the population number equals that of the merged constituency of Brighton and Hove and East Sussex which has three Governors. The Constitution needs to be amended accordingly and Board approval of this change is sought.

3.2. The relevant section of the Constitution is Annex 3 and is set out below with the proposed change in red:

Composition of Council of Governors

Governors for the following Constituency classes shall be elected in accordance with this Constitution:

Public Constituency	
Lower East SECAmb	3
Upper East SECAmb	4
Upper West SECAmb (including certain wards of North East Hampshire and Berkshire identified in Annex 1)	4
Lower West SECAmb	~~2~~ 3

4. Recommendation

The Board is asked to approve the changes to the Constitution as set out to enable us to:

1. Hold a number of two-year term Governor elections in 2022 to enable approximately one third of Governor posts to be up for election each year

2. Add one additional Governor position to the Lower West constituency in 2022 to ensure equal representation based on population numbers for Lower East and Lower West

Appendix A:

In order to achieve as close as possible to one third of Governors being elected in each year, we need to select a number of posts that become two-year posts as a one-off.

See the table below as an illustration of what the full cycle could look like to address this issue.

The greying shows how these 2-year terms would enable the move to elections being held every year.

Year	**2 year term**	**3 year term**	**No. of Governors up for election each year**
2022	1 Lower East 1 Op Staff 1 Lower West – new position 2 Upper West	1 Lower East 1 Op Staff 1 Non-Op staff 1 Upper East 1 Upper West 1 Lower West	11
2023		1 Op Staff 1 Lower West 1 Upper West 3 Upper East 1 Lower East	7
2024		1 Lower East 1 Op Staff 1 Lower West 2 Upper West	5 (formerly 0)
2025		1 Lower East 1 Op Staff 1 Non-Op staff 1 Upper East 1 Upper West 1 Lower West	6