South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors Meeting to be held in public

3 March 2022 10:00-13:00 held online (MS Teams)

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Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
063/22	10:00	Chair's Introduction	-	-	David Astley (Chair)
064/22	-	Apologies for Absence	-	-	DA
065/22	-	Declarations of Interest	-	-	DA
066/22	-	Minutes from the previous meeting, action log and matters arising	Y	-	DA
Statutory duties: performance and holding to account					
067/22	10:10	Chief Executive's report	Y	To receive an update from the CEO	Philip Astle (CEO)
Statutory duties: member and public engagement					
068/22	10:30	Membership Recruitment and Engagement Report	Y	Information	Brian Chester (Public Gov. for Upper West)
Committees and reports					
069/22	10:35	Governor Development Committee Report	Y	Information	Brian Chester (Public Gov. for Upper West)
070/22	10:40	Governor Activities and Queries Report	Y	Information	Brian Chester (Public Gov. for Upper West)
Statutory duties: performance and holding to account					
071/22	10:45	Assurance from the Non-Executive Directors: - Integrated Performance Report (Nov/Dec data as presented to Board in January)	Y	To take as read – queries to NEDs to be taken under escalation reports	DA

072/22	10:50	Board Assurance Committees' escalation reports to include the key achievements, risks and challenges: Performance Committee - 06 January 2022 - Governor observation report Workforce and Wellbeing Committee - 9 December 2021 - Governor observation report Quality and Patient Safety - 13 January 2022 - Governor observation report Finance and Investment Committee - 20 January 2022 Audit Committee - 02 December 2021	**A-A2** **B-B2** **C-C2** **D** **E**	Holding to account, assurance and discussion	All Non-Executive Directors present
11:15	**Comfort Break**				
073/22	11:20	Better by design	**-**	Update	Philip Astle (CEO)
074/22	11:40	Board Committee scrutiny: Quality and Patient Safety Committee deep dive	**Y**	Information and discussion	Tom Quinn
075/22	12:10	Community Falls Team	**-**	Update	Andy Collen
General					
076/22	12:30	Any Other Business (AOB)	**-**	-	DA
077/22	12:45	Questions from the public	**-**	Accountability	DA
078/22	-	Areas to highlight to Non-Executive Directors	**-**	Assurance	DA
079/22	-	Review of meeting effectiveness	**-**	-	DA
		Date of Next Meeting: 6 June 2022	**-**	-	DA

Questions submitted by the public for this meeting will have their name and a summary of their question and the response included in the minutes of the meeting.

PLEASE NOTE: This meeting of the Council is being held in public using Microsoft Teams. The meeting will be video-recorded and made available for public viewing following the meeting. Anyone who asks a question gives consent to being recorded and the publication of their participation in the meeting.

There is a section of the agenda for questions from the public. During the rest of the meeting, attendees who are not members of the Council are asked to remain on mute with their video off in order to help the meeting run smoothly. *This is a strict rule and anyone not following this will be removed from the meeting.*

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 7 December 2021

Present:

David Astley	(DA)	Chair
Brian Chester	(BC)	Public Governor, Upper West
Micheal Tebbutt	(MT)	Public Governor, Upper East
Alison Fisher	(AF)	Public Governor, Upper East
Leigh Westwood	(LW)	Public Governor, Lower East
Harvey Nash	(HN)	Public Governor, Lower West
Marcia Moutinho	(MM)	Staff Governor (Non-Operational)
Nigel Wilmont-Coles	(NC)	Staff-Elected Governor (Operational)
Chris Burton	(CB)	Staff Governor (Operational)
Vanessa Wood	(VW)	Appointed Governor – Age UK
DCC Nev Kemp	(NK)	Appointed Governor – Surrey Police
Cllr Sinead Mooney	(SM)	Appointed Governor – Surrey County Council
Colin Hall	(CH)	Public Governor, Upper East

In attendance:

Philip Astle	(PA)	CEO
Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee, Chair of Operational Performance Committee
Laurie McMahon	(LM)	NED and Chair of Workforce and Wellbeing Committee
Subo Shanmuganathan	(SS)	NED
Paul Brocklehurst	(PB)	NED
Liz Sharp	(LS)	NED
Michael Whitehouse	(MW)	NED and Chair of Audit Committee and Senior Independent Director
Tom Quinn	(TQ)	NED
Peter Lee	(PL)	Company Secretary
Yvette Bryan	(YB)	Head of learning and organisation development
Benjamin Lazarus	(BL)	KPMG, Director, Public Sector Audit

Newly elected governors (observing):

Martin Brand	(MB)	Public Governor, Upper West
Andrew Latham	(AL)	Public Governor, Lower West
Linda Caine	(LC)	Public Governor, Upper East
Kirsty Booth	(KB)	Staff Governor (non-operational)
Nicholas Harrison	(NH)	Staff Governor (operational)
Patricia Delaney	(PD)	Public Governor, Lower East
David Romaine	(DR)	Public Governor, Lower East
Stuart Dane	(SD)	Staff Governor (operational)

Apologies:

Was Shakir	(WS)	Staff-Elected Governor (Operational)

Howard Pescott	(HP)	Appointed Governor – Sussex Community Trust
Nicki Pointer	(NP)	Public Governor, Lower East & Lead Governor
Nigel Robinson	(NR)	Public Governor, Lower West

Absent:

Chris Devereux	(CD)	Public Governor, Upper West
Amanda Cool	(AC)	Public Governor, Upper West
Sarah Swindell	(SS)	Appointed Governor – EKUHFT

Minute taker: Julie Harris – Assistant Company Secretary

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47. Introduction

47.1. DA welcomed everyone to the meeting including new starters.

47.2. He outlined the agenda for the day and set out the ground rules for the meeting.

48. Apologies

48.1. Apologies were noted as above.

49. Declarations of interest

49.1. No additional declarations of interest were made.

50. Minutes and action log:

50.1. The minutes were taken as an accurate record.

50.2. The action log was reviewed and updated.

50.3. Annual members meeting minutes were taken as an accurate record.

51. Chief Executive's report

51.1. PA provided an update regarding the Chief Executives Report which included Covid-19 (Delta/Omicron wave), indicating that we still don't know what the outcomes are, but people need to keep getting vaccinated as we are awaiting indications about how Omicron will behave over the next month or so. With regard to national performance, PA stated that all ambulance trusts in the UK have been on REAP4, unheard of which is why the increase of national press. He also added that there has a large impact on our patients. However regionally, PA stated that CAT2 which encompasses 70% of our patients, we were the best performing trust in the country. He further explained that there are two key factors affecting performance – demand (diversions from CAT3/4 to CAT 1/2) and supply (crew sickness, PTSD, stress). PA confirmed that we are giving good care to staff wellbeing and not discouraging leave.

51.2. For the benefit of the new members PA explained the definition of REAP and ARP (Ambulance Response Program).

51.3. PA explained the Integrated Care Systems which will be legal entities in April and stated that all systems went into OPAL4 (system equivalent to REAP). PA further indicated that the core problem is that people who are fit to be discharged but cannot be due to various reasons are taking beds, which leads to hospital handover delays. He indicated that it was an effort to answer on what

harm is being caused by hospital handover delays, that pressure is so great that hospital handover delays are still ongoing at all of our hospitals – due to blockage of not being able to get patients out of ED, not an easy fix.

51.4. PA provided an update on the statistics on where we are on vaccinations.

51.5. PA provided an update regarding the critical incident that occurred in November and indicated that an external investigation is underway to understand the root cause of the issue to ensure that it doesn't occur again. PA applauded the herculean efforts were done by all staff to mitigate the issues caused.

51.6. PA indicated that he was extremely proud to host our staff awards using a mixed system of in person as well as online receiving great feedback from everyone. PA also stated that he was pleased to see a new numbers of volunteers around the Trust.

51.7. Regarding engagement with stakeholders, PA advised that there have been several meetings have occurred with system leaders, regional MPs, ICS chief executive and ICS chairs.

51.8. PA informed that Robert Nichols will be joining us on February 15, 2022, the as the new director of quality and nursing.

51.9. DA offered his best wishes to Bethan after her distinguished service and wishes her well.

51.10. MM thanked the Trust for providing various opportunities to get booster vaccines.

51.11. HN provided his thanks for the increases in communications and indicates that one of the things that we would benefit from in the future is some insight on the background effort that is going on by the board. He also provided his appreciation to the great work of staff during the critical incident.

51.12. DA supported appreciative comments.

51.13. AF asked a question regarding what an integrated governor body will look like. PA responded that we have been discussing the governance of the ICSs but those discussions has only gone as far as the Non Executives Directors thus far, but we haven't gone as far as to discuss the governors come with foundation trust status – which is not required.

52. Membership recruitment and engagement report

52.1. BC introduced himself. He indicates that membership has dropped slightly due to difficulties in engagement surrounding Covid, focusing on MDC meetings including the staff engagement advisory group, the inclusion hub advisory group, patient experience group and voluntary services.

52.2. BC described the debate surrounding corporate communications, generated quite a bit of discussion and members were keen for the organisation to be as transparent as possible regarding current challenges being faced by the Trust.

52.3. BC indicated that he was much taken by the numbers and ability by the new governors coming forward and stated that he was looking forward to the contribution from the new elected governors.

52.4. BC spoke to the online Christmas event that is being organised and commends the initiative.

52.5. HN indicates that one of the things that came up at the GDC relating to the patients experience group, and stated HP wanted to raise to seek assurance from NEDS that the work from the patients experience group was supporting the NHS framework for improving the patient experience.

52.6. DA noted that we could comment and come back on the QPS on this issue later in the meeting.

53. Governor Development Committee (GDC) report

53.1. HN introduced the minutes and outlined the role and responsibilities of the GDC to advise and inform Council agendas, appraisal of NEDs, discuss Governor training needs, and recommend improvements to the way the Trust supports Governors to fulfil their role.

53.2. HN speaks to the importance of observing board meetings, provide appraisals of NEDS, induction, GDC attendance.

54. Governor activities and queries report

54.1. HN continued to note the report covered the sheer range of things that we question. Encourages all governors to ask as many questions as appropriate.

54.2. HN discussed the role of CFRs and advised that action is now being taken to ensure that CFRs are assisting on some of the ambulances and praises GK for keeping this front of mind to the board.

55. Assurance from the Non-Executive Director (NEDs)

55.1. DA noted that comments and queries would be taken under the escalation reports in the next item.

56. Board Assurance Committee's escalation reports

56.1. To include key achievements, risks and challenges. Reports included were from the following committees:

56.1.1. **Performance committee** – HG provided an update on the performance committee and advised that they focused on the Terms of Reference and objectives of the committee, overall governance and the understanding of the issues.

56.1.1.1. MM indicated that the biggest eye opener is the graph showing a funding gap and how are we addressing this funding gap. HG responded that recent extra funding has been provided (£6.8M). DA indicated that we have been able to increase staff with extra funding. HG added that 999 has received £4.3M extra funding to increase staffing. PA advised that extra funding was welcomed, however explained that there are three lines: one line that indicates what we were originally contracted to do, and that the £6.8M takes us above that line to a line that we agreed the demand was probably going to come. Unfortunately, he continued, the demand has grown beyond that line, so we are still not funded for the level of activity we are seeing. Although, he reiterates the £4.3M was specifically earmarked for 999 there is cross training occurring between 111 and 999 so we could use staff from both areas.

56.1.2. **Workforce and wellbeing committee** – LM introduced the report, focusing on the driving licences, HR processes, external review of health and wellbeing, sickness management, improving workforce diversity.

56.1.2.1. TQ shared that there is a lot of work being done to ensure the wellbeing of our staff, which will be reported to the WWC later this week.

56.1.2.2. LM further indicates that there is substantial work surrounding the training and development needs for the Trust (over a three-year period) being undertaken as well, including an early draft of the clinical education and career progression strategy that is to be presented at the WWC.

56.1.2.3. TQ indicated that he impressed with the progress done thus far.

56.1.2.4. Freedom to speak-up process concerns was also discussed by LM, and a strategy regarding employment relationships will be coming up at the WWC.

56.1.2.5. LM welcomed the governors' future attendance at the WWC meetings.

56.1.2.6. MM urged the NEDS at the WWC to challenge the Trust on how they communicate to support staff (they are feeling neglected). DA concurred with this assertion. LM confirms that all the strategies noted earlier included all staff – not just the clinical workforce. TQ confirmed the same and reflected what was just said.

56.1.3. **Quality and patient safety (QPS)** – TQ introduced the report, noting EOC/111 clinical safety, harm reviews, serious incidents, key skills programme, and public access defibrillators.

56.1.3.1. MM questioned if there was process in place to maintain the public access defibrillators sites. TQ assumed that all defibrillators will be on the British Heart national register and there will be prompts regularly if a PAD hasn't been checked. TQ admitted that he is unsure what the process is for Trust owned PADs. DA

56.1.3.2. SS added that a further update on patient harm due to the critical incident will be forthcoming and provided an update of the uptake of the flu vaccine 43% which is much higher due to mobile/roving units also doing boosters/vaccines.

ACTION – A note to be provided to confirm the process in place to maintain the public access defibrillator sites.

47.1.1.1. TQ concluded that more work must be done to ensure a positive patient experience. Such work would include mitigating delays, relationships with staff, and expect by the next QPS we would have a formal paper on patient experience and working with the patient experience group to achieve this. LS assured the governors that she has been following up with the patient experience team and although much work has been done, this has been side-lined due to the pandemic and will be ready to come back to the committee in the new year.

47.1.1.2. HN asked about the community falls team, what is happening, what is the process? PA confirmed that there are some community falls projects currently running, and some going through safety and

governance. LM advised that one of the falls projects in the system with AgeUK has provided with some funding to train their non-clinical volunteers to support our staff. VW advised that working with a third sector, working with community guardians as an example is the way forward.

ACTION – To provide an update on what progress is being made on the development of the Community Falls Teams.

47.1.2. **Finance and investment committee** – HG introduced the report.

47.1.3. **Audit committee** – MW introduced the report and raised the point regarding what does partial assurance means and gave assurance that we will be providing an EPR assessment in January and that the Trust's readiness is there.

48. Presentation of the KPMG annual audit report of the Trust

48.1. Ben Lazarus, KPMG director public sector audit, discusses the role of the external auditor, provided an unqualified opinion, and found that nothing material or significant needed to be raised. Did not identify any significant risks or significant weaknesses around the Trust's Value for Money circumstances and arrangements. BC credits the audit committee for the cleanliness of the report.

49. Board Committee scrutiny

49.1. **Audit committee** – MW gave a presentation describing the role of the committee, evidence used, composition of the committee, and frequency of meetings. MW further discusses highlights of 2021 including clear audit opinion covering both financial and value for money, positive assurance from internal audit, integrated performance report, risk, information governance, fraud control assurance, systemic issues (resilience, longer-term planning, leadership, people engagement, data led, clinical education, sustainability).

49.2. **Finance and investment committee** – HG provided context on the finance and investment committee including the committee structure, governance, terms of reference, purpose, memberships as well as key highlights/improvements and key ongoing challenges**.**

49.2.1. HG listed the key highlights/improvements over the year including the fact that we are in line with plan (£5M deficit) and forecasting slightly better by the year end, COVID-19 continuity of funding has been achieved, the initiatives surrounding better by design have addressed some of the deeper issues regarding operational performance, estates program remains a real positive for the organisation, implementation of the e-timesheets and new fleet information system (removing paper inputs), internal integrated planning, and the CAS111 implementation received extra funding.

49.2.2. HG listed the key ongoing challenges to include the overall deficit position (£10M) which has not been resolved with the ICS – we are funding a £9.6M deficit and although we are in a good financial position to fund this shortfall, it is not sustainable. Ongoing challenges include operational performance, better by design (danger that it is regarded as a panacea for

everything) where governance and engagement must properly picked-up, brief and recommendations coming out of the critical incident.

49.2.3. CB asked how confident is the board that ICS would be willing to take up the deficit. HG confirmed that it hasn't been resolved but needs to be resolved going forward. PA concurred with this assertion. DA confirms that it is very important to have a constructive relationship with all parties (including ICS directorships) and that we are watching the finances as an organisation and have laid down the risk. LM applauds the level of engagement between all four ICSs. DA confirmed that we cannot do this on our own and we need to encourage discussions between the non-executives and the ICSs, non-executive forums and formal management discussions when they can.

50. Any Other Business

50.1. There were none.

51. Questions from the public

51.1. Martin Grant, newly elected governor asked a question regarding ambulance (job) cycle time and shift overruns and its inclusion in the performance report. MG further discussed the impact of these issues to end of shift performance. PA advised that this is measured (and broken down into smaller chunks) in the performance approvement plan that is reported to the committees/board. PL indicated that there are two indicators that speak to the job cycle time. PA agreed that shift overruns are bad for the organisation and as such policies are being reviewed under the better by design program to address this. DA confirms that the better by design program focuses on staff welfare. TQ further indicated that there are 21 areas dealing with staff wellbeing (late finishes, meal breaks, etc) and are reported and addressed with the WWC.

ACTION – To provide additional context in terms of how job cycle time and shift overuns (and their impact) are reported.

52. Areas to highlight to the NEDs

52.1. DA summarised that he believed the areas to highlight to NEDS surrounded:

52.1.1. Corporate and public affairs particularly the communications to support staff

52.1.2. Implementation of agile working policy

52.1.3. Performance, its challenges and the need to improve into the future

52.1.4. Community falls projects

52.1.5. Clinical education

52.1.6. Financial sustainability

52.1.7. Job cycle time and shift overruns.

53. Review of meeting effectiveness

53.1. DA asked for Governors to comment about areas for improvement. The meeting was seemed to have been effective. DA thanked all participants and observers, particularly the outgoing members in which this is their last meeting

and hoped that the new members found the meeting valuable for their new governorship.

Signed:

Name and position: David Astley, Chair

Date:

Status Key Code: C- Complete, IP - In progress, S - Superseded

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST
Trust Council of Governors Action Log

Key
Closed
Due

Meeting Date	Agenda item	AC ref	Action Point	Owner	Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
20.09.19	33.2	268	Arrange a workshop briefing for Council on clinical performance and understanding the integrated performance report	IA	Jun.22	CoG	IP	This remains on the suggested items list that goes to the GDC. The IPR has now been revised and a session may come to the next Council meeting if Governors would like. 03.03.2022 - today's session has been postponed to the June22 meeting in order to draft necessary tools to ensure that the CoG receives full depth of understanding of the metrics as well as the IPR development plan.
04.09.20	28.22	290	Consider Council agenda item on training and education	CoG	Jun.22	CoG	IP	Was considered by GDC as an option, remains on potential agenda items list. Due to new person in post, suggest possible item for September or subsequent CoG meeting. 03.03.22 - To be considered at next GDC meeting.
03.09.21	40.1.31	303	TQ and LM, through their respective committees as appropriate, to consider the data around the root cause of complaints related to crew attitude, which was up to 59% of complaints, as detailed in the June IPR	TQ/LM	Dez.21	CoG	IP	Response on this due 07.12.21 meeting - TQ & LM will be picking this up at the WWC on Thursday - to understand better in our organisation (balanced approached).
09.11.17	123 (GDC)	304	Council to receive update on a review of the effectiveness of the Trust's internal and external communications by the end of 17/18 financial year.	PA	Dez.21	CoG	IP	This action was moved from the GDC action log to the Council action log for oversight on the 21.10.21 The WWC is working with the Executive on a review of the wider 'corporate affairs' function in the Trust. IA to seek timeline for completion from the Chief Exec. Update 19.08.21 If Governors have concerns then they can clarify what that is and test at COG through the NEDs to establish a) the extent to which this is a concern of the Board and b) its priority and therefore c) timeline for taking action. This action and it's origin date will be moved to the Council Action Log. PA indicates that we have taken a wider review of our corporate affairs, creating a new group (partnership group), taking it back to board via strategy group - ongoing piece of work. Re: comms the feeling is that we need to be louder to get into the front and inner pages of the press via our winter campaign for the next 6 weeks.
07.12.21	56.1.3.2	305	Council to receive an update to confirm the process in place to maintain the public access difibrillator sites	EW	Mär.22	CoG	C	03.03.2022 - A draft procedure has been submitted for consultation that deals with Public Access Defibrillators. It is proposed to have the Trust moved across to a national defibrillators network (NDN) run by the British Heart Foundation (BHF) known as 'The Circuit'. All Trust owned PAD sites will be registered with The Circuit which links with the Trusts Computer Aided Dispatch (CAD) system to ensure rescue ready status of all PAD sites.
07.12.21	47.1.1.2	306	Council to receive an update on what progess is being made on the development of the Community Falls Teams	EW	Mär.22	CoG	C	03.03.2022 - update to be provided in today's meeting. Agenda item 075-22.
07.12.21	51.1	307	Council to receive additional context in terms of how job cycle time and shift overuns (and their impact) are reported	EW	Jun.22	CoG	IP	03.03.2022 - to be included in the IPR training provided to Governors in June 2022

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	61-21
Name of meeting	Trust Board		
Date	27.01.2022		
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 December 2021 and January 2022 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 (assurance on current and forward planning) and patient safety, however, other issues overseen include:

- Our on-going response to the COVID pandemic including delivery of the Autumn Vaccination Programme and preparation for vaccination becoming a mandatory condition of deployment for patient-facing NHS staff
- Development of the Green Strategy & Clinical Education Strategy
- Improvements to both the risk management and appraisal policies, to be implemented for 2022/23
- Revisions to the management governance framework including the role of SMG

6 EMB have also agreed the following investment decisions:

- Medicines – improving the system for a single solution for electronic CD register and stock management at all sites
- 111/EOC – allocation of additional funding and establishment of a more robust

	training and development team • International recruitment of paramedics • Purchase of vehicles as permanent welfare vans
	Engagement with stakeholders and staff
7	On 22nd November 2021, I met with Ian Smith, the new Chair of Surrey Heartlands Clinical Commissioning Group (CCG) at Crawley HQ. It was an extremely useful meeting, and I was pleased that, as Chair of our Lead Commissioner, Ian was able to learn more about the ambulance service early on in his tenure.
8	On 26th November 2022, I was pleased to spend time at Thanet Make Ready Centre and join the retirement presentation for Paramedic and Team Leader Steve Green who had worked for SECAmb for an incredible 42 years.
9	On 17th December 2022, I was also very proud to hold a farewell meeting with our Joint Senior Chaplain, Reverend Francis Pole, who retired at the end of the year after an impressive 22 years' service with SECAmb & Sussex Ambulance previously.
10	Francis was one of the first Chaplains to join the then Sussex Ambulance Service and as he begins his well-earned retirement, I would like to thank Francis for his dedicated and devoted voluntary service over the years and wish him the very best for the future.
	Fatal collision involving an ambulance
11	On 5th January 2022, a road traffic collision occurred on the southbound carriageway of the A21 near Tonbridge between an ambulance and a cement lorry. Three members of staff were travelling in the ambulance at the time of the collision but were not conveying a patient.
12	Multiple crews attended the scene, including the air ambulance service alongside police and fire service colleagues but despite the best efforts of everyone involved, a female paramedic, 21-year-old Alice Clark, tragically died at the scene.
13	A male paramedic, who sustained serious multiple injuries, was airlifted to Kings College Hospital in London and a student paramedic, who was travelling in the rear of the vehicle, was taken to hospital with a head injury but fortunately was discharged shortly afterwards.
14	Alice was a newly qualified paramedic, who had only recently joined SECAmb having completed her paramedic training at the University of Greenwich. Her tragic loss has been very keenly felt by her colleagues at Paddock Wood as well as staff right across the Trust.
15	Our heart-felt sympathies remain with her family and friends during this very difficult time and I know that our thoughts are also with the other injured staff members as well as all of those who responded to the incident.
	Sentencing of two former staff members
16	On 11th January 2022, two former SECAmb staff members – Ruth Lambert and Jessica Silvester – received custodial sentences at Canterbury Crown Court after pleading guilty to

17	stealing medication from terminally ill patients. Their behaviour was a clear and targeted abuse of their position and does not reflect in any way the commitment and integrity of our staff. As soon as we became aware of the allegations, we took swift action to suspend and then dismiss both individuals, working closely with Kent Police during their investigation. We remain shocked and saddened at the lengths to which these former members of staff went to, to commit their crimes. Our thoughts remain with all those affected.
18	
	B. Regional Issues
19	**New Executive Director of Quality and Nursing** On 29th November 2022, we announced the appointment of Robert (Rob) Nicholls as our new Executive Director of Quality & Nursing.
20	A nurse since 1993, Rob has held several senior roles in the NHS, most recently in his current position as Director of Nursing Division of Medicine and Integrated Care at Imperial College Healthcare NHS Trust. He brings a great deal of experience with him across a variety of senior NHS roles, and I am certain this will be of huge benefit to SECAmb.
21	Bethan Eaton-Haskins, our previous Director, left SECAmb at Christmas and I would like to thank Bethan for her dedication since she joined us in 2018. She worked incredibly hard to strengthen our approach to quality and her expertise and leadership during the COVID pandemic was invaluable.
22	Rob will join us in February and ahead of this, Judith Ward is acting up as the Interim Director. I look forward to welcoming Rob to SECAmb and to working closely with him in the months and years ahead.
	C. National Issues
23	**COVID-19 outbreak** As the pandemic progresses, we are continuing to monitor the situation closely:
24	Governance**:** Following Bethan Eaton-Haskins' departure from SECAmb at the end of the year, the COVID Management Group (CMG) is now chaired by David Hammond, supported by Judith Ward. CMG continues to meet regularly, ensuring that all decisions and actions related to COVID are considered appropriately.
25	Impact on staff numbers: During this period, we have seen an increased impact on our staffing levels due to the prevalence of the Omicron variant, including seeing staff needing to self-isolate, staff with COVID symptoms or confirmed COVID and the on-going impact on staff of long COVID. We continue to work hard to support staff to access testing as needed and return to work safely when possible.

26	Conclusion of Autumn Vaccination Programme: Our Autumn Vaccination Programme closed on 17th December 2022, and I was very pleased to hear that, in the six weeks it was up and running, about 3,000 staff had received their COVID booster and flu vaccines through the Programme. Thank you to all those involved, who worked extremely hard to deliver the programme.
27	We are continuing to deliver the flu vaccine to staff through local clinics at sites across the Trust during January and into February.
28	Mandatory vaccines for patient-facing NHS staff: On 6th January 2022, legislation was passed in Parliament to make the COVID-19 vaccination a condition of deployment (and employment for new) healthcare workers. This will take effect on 1st April 2022.
29	In line with national processes, we are working through our records to identify those staff within scope who do not appear to have received their COVID vaccines and who will therefore be impacted by the new law.
30	We are working with these staff to ensure they are aware of the potential consequences to their employment of not having the vaccine, whilst respecting of course that it is their personal decision to make.
31	**NHS Staff Survey**
32	The NHS Staff Survey launched this year on 22nd September and closed on 26th November 2021. We worked hard this year to encourage as many staff as possible to complete the survey and our final return rate was 61%.
	The Survey results will be published in March 2022.
	Platinum Jubilee medal
33	To mark the HM The Queen's Platinum Jubilee in June, a special commemorative medal will be awarded to serving frontline members of the police, fire, emergency services, prison services and the Armed Forces.
34	The eligibility criteria to receive the medal, which includes a minimum of five years' service, have been set nationally. We have worked through our records and provided the number of eligible staff and volunteers to the Department of Health.
35	An alternative to include those staff and volunteers who are not eligible to receive the medal is being commissioned by the Association of Ambulance Chief Executives (AACE) and further updates on this will be provided shortly.

	D. Escalation to the Board
36	**Operational Performance** Although we saw some periods over Christmas and New Year where demand was higher than the same period last year, overall demand for our 999 and 111 services has not been consistently higher than expected during December and January.
37	However, even relatively brief spikes in demand have caused operational pressure for us, due to the resources we have available to respond to patients, both on the road and in our control centres, significantly impacted by staff absence due to a range of COVID-related issues and high sickness levels. We continue to work hard to support staff to access COVID testing as needed and to return to work safely and at the appropriate time.
38	As is evident from the national ambulance response time data published recently for December 2021, all ambulance services nationally remain under considerable pressure as does the wider NHS system. The impact of staff shortages on many NHS organisations has been frequently covered in the media in recent weeks.
39	We are continuing to work hard to ensure that we provide as responsive a service as possible, despite the resource constraints we have been experiencing. Overall, our 999 performance is stable although we need to continue to make improvements, especially to our Category 3 performance.
40	As a result of the on-going challenging situation, we remain at REAP Level 4 and with a declared Business Continuing Incident (BCI) in place. Both are reviewed regularly and are in place to ensure that we are able to take all possible steps to maximise our operational performance as far as possible in these challenging times.
41	Emma Williams, our Executive Director of Operations, continues to lead on the on-going delivery of 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.

South East Coast Ambulance Service NHS Foundation Trust

C - Membership Development Committee Report

1. Introduction

1.1. The Membership Development Committee (MDC) is a committee of the Council that advises the Trust on its communications and engagement with members (including staff) and the public and on recruiting more members to the Trust. The MDC meets three times a year. All Governors are entitled to join the Committee, since it is an area of interest to all Governors.

1.2. In this report, we focus on membership updates and summaries of the top items from the MDC meetings and those that report into the MDC (Staff Engagement Advisory Group, Inclusion Hub Advisory Group, Patient Experience Group and Voluntary Services). For a full picture of the important items discussed at these meetings and how staff and members are feeding in their views to the Trust, I recommend that you read the full minutes appended to this report where available.

2. MDC Meeting summary

2.1. The MDC met on the 21st of February 2022. The key areas of focus were:

2.2. The direction of travel for staff engagement in the organisation and how the MDC can support this work. It was flagged that there a lack of mechanism for support services to feed their views into the Trust.

2.3. Membership recruitment activity including proposed areas of focus. It was agreed to pause the refresh of the Governor Toolkit that enabled Governors to attend small events in person and focus on the large-scale event attendance with the support of the membership office this summer.

2.4. The Membership action plan was reviewed, and updates were provided. An action on connecting Governors to their local Operating Unit and Community First Responder Teams was in progress.

2.5. Further work on raising the profile of the Council and benefits of membership was discussed, with new ideas received from Governors in attendance.

2.6. The next MDC meeting is on the 20th June 2022.

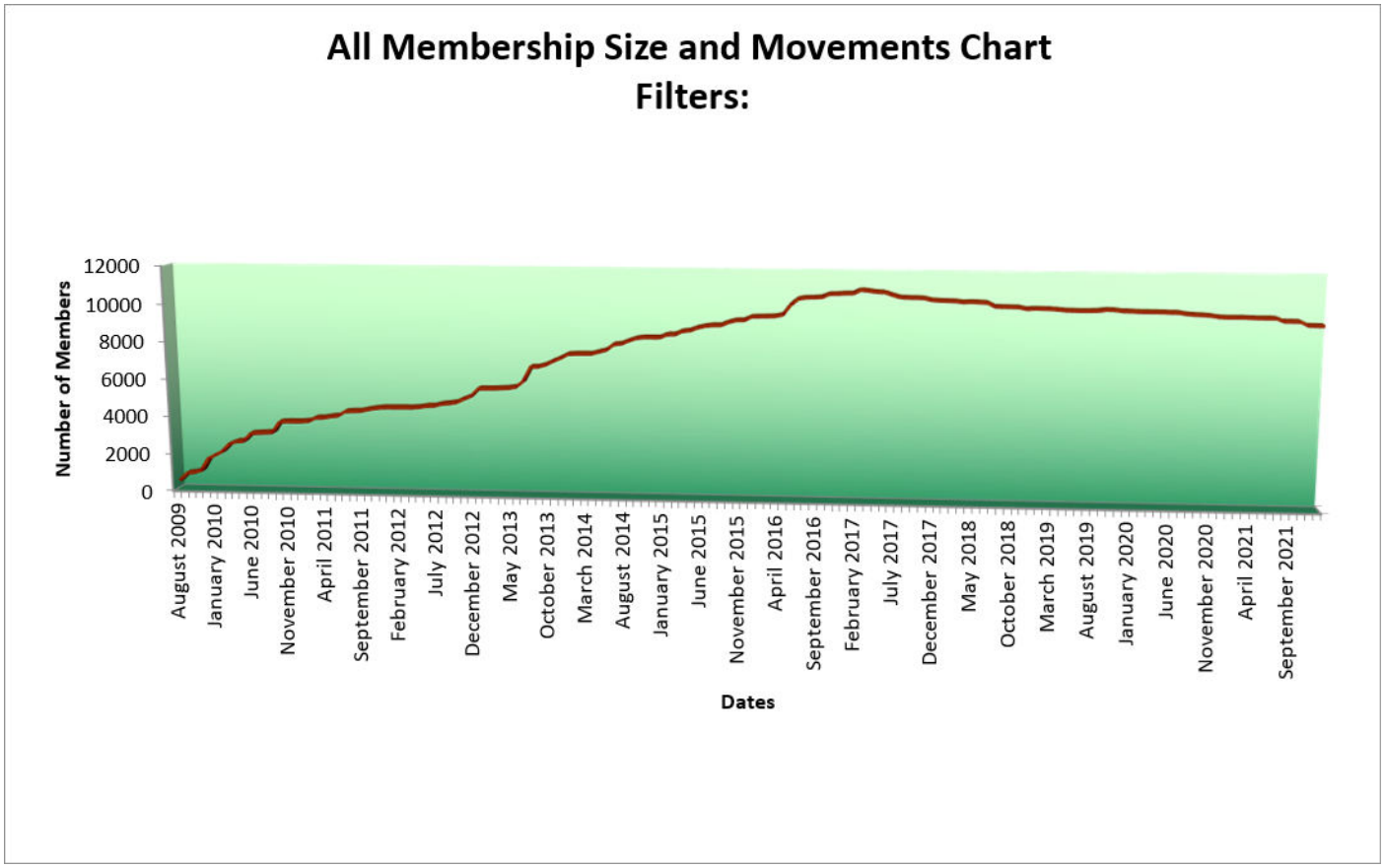
3. Membership update

3.1. The total staff membership including bank members as of 31.12.21 was 4,337.

3.2. Current public membership by constituency (at 03.02.22) is 9,483. Break down data provided as follows.

Constituency		Members	Population exc London	% of eligible population
Lower East SECAmb (East Sussex and Brighton)		1,909	848,414	0.24
Lower West SECAmb (West Sussex)		1,460	866,131	0.18
Upper East SECAmb		3,414	1,850,857	0.19

(Medway/ Kent/ East London)				
Upper West SECAmb (Surrey/ Hants/ West London)		2,295	1,386,062	0.17
Out of Trust Area		405	-	-
Total number of members		9,483		



3.3 Membership history report

This graph above shows membership stats from period of inception of Trust Foundation Trust status to date. Our inability to do wide scale member recruitment in its traditional format in 2020/21 has had an impact and we will look to rectify this as soon as we can. We maintain active contact with our current membership and have had good engagement on the recent election communications.

3.4 Membership recruitment update

3.5 We have always sought to maintain the membership numbers rather than dramatically increase them overall. Our approach for 2022 was proposed and agreed at the recent MDC meeting as follows:

- To attend one membership event in each constituency area to enable Governors to meet and sign-up new members within their area.

- Attend an additional large-scale event in West Sussex to develop membership numbers to bring them more in line with East Sussex figures as the populations are similar.
- Attend an additional patient/disability event to build patient membership numbers as these have been on a declining trend over the past few years. This can tie into any patient strategy plans for engagement.
- Consider developing youth membership representation by attending specific events and/or trialling participation in different types of events to the 'usual'.

Further online membership recruitment via social media will take place this year relating to wider health campaigns such as carers week as there is more capacity within the membership office now.

3.6 Membership Engagement Update

3.7 Our next member newsletter will be out in April 2022 and will focus on performance and an overview of the last year, Governor election results, new Make Ready Centre developments, Better by Design focussing on benefit to patients and staff and also some patient stories. Suggestions for content for future editions are welcomed.

3.8 Our membership survey will be refreshed with input from the MDC and issues in the latter part of 2022.

3.9 The elections proved popular with a contested election in all constituencies and a good overall level of interest from staff and public members. We adapted the election schedule to enable newly elected Governors to start their induction to the Trust earlier so they can observe the existing Council in action before commencing their term of office and prior to attending their first Council meeting as a Governor (in March 2022). I would welcome new Governors views on how this has worked for you.

3.10 We continue to make our Council and Board meetings held in public, accessible in real time via Microsoft Teams and promote this via social media and other platforms. The public, members and staff members are welcome to join events and watch live and ask questions at the end.

3.11 Thanks to those Governors who observed the recent Board meetings.

3.12 We will continue to make these meetings available to be viewed online in real time and advertise them to members. Recordings of the meetings are availiabel on our website.

4. Public Members' Views

4.1. The Inclusion Hub Advisory Group (IHAG) is a diverse group of our public Foundation Trust members who bring a wide range of views and perspectives from across the South East Coast area. SECAmb staff brief the group on plans and service changes and seek the group's advice on whether wider community engagement is necessary or simply gather the views of the IHAG to inform the Trusts' plans. This group are also able to feed information on issues of importance to them into the Trust.

4.2. **IHAG meeting summary:**

4.3. The IHAG January meeting was postponed due to our E&D Lead being needed to work on the preparations for mandatory vaccine rollout at the time. Meeting dates for the year are in the process of being set.
4.4. The IHAG took part in a joint online Christmas event with the Council where presentations were received from 111 and 999 colleagues. Attendees were given the chance to get to know each other a little better through interactive sessions as it was noted there had been a lack of opportunity to do this over the last two years.
4.5. A survey was issued to members of IHAG on membership representation and meeting formats. 60% of respondents noted that they missed the face-to-face meetings and the opportunity to get to know colleagues better and it was noted that a hybrid approach to some in person and some online meetings would be taken this year, guidance permitting.
4.6. 70% were pro a refresh of the IHAG membership, with a balance of retaining experience but bringing new voices to the group. They were keen to see the younger population represented within the group.
4.7. The inclusion strategy is due for a refresh - this currently brings together staff engagement, membership engagement and patient engagement together in one document. It may be that some of these items now sit within separate strategy's, but it is important to retain the involvement element at the core of the Inclusion strategy in the Trust's work going forward. Stakeholders would be engaged as this work progresses.

5. Staff Members' Views

5.1. Organisation Development and Engagement Advisors attend the MDC to provide an update on their work.
5.2. The Staff Engagement Advisory Group (SEAG) was the Trust's staff forum, which met quarterly. This has been on hold for a significant period of time whilst they review the purpose and aims of this group and direction of travel for this going forward.
5.3. A toolkit on employee engagement and experience had been developed to support improvement in this area and it is planned to be launched with the NHS staff survey results to support local action.
5.4. An Involvement toolkit was developed alongside this showing the value of engaging with different groups of people (employees, volunteers and public) and the groups available to facilitate this within the Trust.

6. Patient Members' Views

6.1. The Patient Experience Group (PEG) is a group of public, patient and staff representatives. Nigel Robinson and Anne Osler are the Governor representatives on this group. Our thanks to Harvey Nash for his previous attendance at this group.
6.2. Representation from the Patient Experience Team will provide updates on work at the PEG. Vicki Baldock attended in Graham Parrish's absence and gave an update.
6.3. The last two PEG meetings had been cancelled due to operational pressure.
6.4. The group had previously helped develop a patient and carer strategy for the Trust in 2019/20. Work to embed the strategy was delayed due to the need to manage the Trusts response to the pandemic.
6.5. Vicki noted that the group had not met as many times as they would have liked due to the operational difficulties of the last 2 years.
6.6. A patient friendly version of the strategy was developed to make the document more accessible.

6.7. Looking at patient data, gaps had been noted on the recording of characteristics in patient compliments and complaints, work was undertaken to rectify this and to be able to identify any trends.
6.8. A gap analysis on actions from the patient strategy is being undertaken and a prioritisation exercise will take place. A patient experience report is in development, more on this will come in due course.

7. Update from the Community Resilience Department

7.1. Sue Orchard Community Resilience Manager is part of the MDC as a representative from the Community Resilience Department.
7.2. SO was unable to attend the recent meeting but provided an update post meeting as follows:
7.3. <u>The Community Falls Team project</u>
This was finally now going live out of the Gatwick and Polegate / Hastings Operating Unit areas. Community First Responders (CFRs) have been trained in moving and handling patients who have fallen, plus extra clinical training has been undertaken to raise their awareness of conditions associated with falls. They will have direct support from the urgent care hubs and each incident will be followed up by an operational response. There will be an ongoing audit over the next 10 weeks to ensure the system is safe and of benefit to our patients who fall.

7.4. <u>British Heart Foundation - The Circuit</u>
The Circuit – the national defibrillator network, connects defibrillators to NHS ambulance services across the UK so that in those crucial moments after a cardiac arrest, they can be accessed quickly to help save lives.

7.5. The Trust has agreed to sign up to this programme for all our Public Access Defibrillators. Testing of both the Computer Aided Dispatch and associated systems has taken place and we are working towards a completion date of 23rd March 2022. All our PAD site guardians will also be asked to register their devices on The Circuit which is the National Data Base held by the BHF.

7.6. <u>Recruitment</u>
We have increased our recruitment numbers this year and plan to recruit over 100 new CFRs in to Secamb. We are now offering a First Responder on scene (FROS) course accredited by Future Quals. We have recruited so far to a course of 12 planned for Kent in April and a course of 24 planned for Sussex in May. The Surrey advert is currently live, and this will be for a June course.

8. Recommendations

8.1. The Council of Governors is asked to:
8.2. Note this report; and review any attached minutes for more detail.
8.3. Consider how best to encourage Governors to make use of such information, and to make use of the IHAG appropriately to help understand the perspective of public Foundation Trust members.
8.4. Encourage those they meet to become members of our Trust (it's free) at: Members receive our newsletter, 'Your Call', three times a year to keep them up to date with the Trust's activities. Members can vote or even stand in public & staff Governor

Elections to the Council.

Brian Chester
Upper West SECAmb Public Governor &
Membership Development Committee Chair

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

E – Governor Development Committee

1. Introduction

1.1. The Governor Development Committee is a Committee of the Council that advises the Trust on its interaction with the Council of Governors, and Governors' information, training and development needs.

1.2. The duties of the GDC are to:

- Advise on and develop strategies for ensuring Governors have the information and expertise needed to fulfil their role;
- Advise on the content of development sessions of the Council;
- Advise on and develop strategies for effective interaction between governors and Trust staff;
- Propose agenda items for Council meetings.

1.3. The Lead Governor Chairs the Committee and both the Lead and Deputy Lead Governor attend meetings.

1.4. All Governors are entitled to join the Committee, since it is an area of interest to all Governors. The Chair of the Trust is invited to attend all meetings.

1.5. The GDC met online on 10 February 2022. The minutes of these meetings are provided for the Council as an appendix to this paper.

1.6. Governors are strongly encouraged to read the full minutes from the GDC meeting.

1.7. The GDC meeting in February covered: feedback from the previous CoG, the agenda for the March CoG meeting, Governor communications/updating the posters, possibility to move to face-to-face meetings, and Governor training and development requirements.

2. Items of note

2.1. The full minutes are provided, and Governors are strongly encouraged to read them in full.

2.2. The GDC discussed the effectiveness of the pre-meeting and have agreed to have it a couple of days prior to the Council of Governor meeting. The objective of this change is to discuss (without major time constraints) what needs scrutinization from the reports submitted, noting occasions when the Council would not need to hear from specific NEDS to allow more time for other subject matter to be discussed at length.

2.3. The GDC discussed the current and changing environment for communications and felt that the current support was welcomed, however thought that a monthly bullet point summary document of what Governors needed to know would be helpful, as the volume of information could be overwhelming at times. In addition, a possible regular council update to the membership was discussed as well as the requirement to update the Governor poster – with a view to ensure that the posters show an approachable Governor group (less suits and ties).

2.4. Following a discussion on whether to return to face-to-face meetings, it was determined that the GDC is not in a position to currently go back to face-to-face meetings but will continue to re-evaluate.

2.5. Formal and informal development opportunities for Governors were presented. Governors noted that the NED committee observations were useful and discussed the possibility of increased attendance. The introduction of afternoon development sessions after the Council meeting was offered and accepted with keen interest for presentations from various areas of the business. The first of which was to be an overview of the Integrated Performance Report (IPR) on 3 March 2022, this has since been postponed.

3. Recommendations:

3.1. The Council is asked to:

3.1.1. Note this report; and

3.1.2. Read the minutes provided.

3.2. All Governors are invited to join the next meeting of the Committee on **14 April 2022 2-4pm venue TBC.**

Brian Chester (On behalf of the GDC)

See below for the minutes of the GDC meetings

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 10th February 2022

Present:

Brian Chester	(BC)	Upper West SECAmb Public Governor
Marica Moutinho	(MM)	Non-Operational Staff Governor
Harvey Nash	(HN)	Lower West SECAmb Public Governor
Leigh Westwood	(LW)	Lower East SECAmb Public Governor
Nigel Robinson	(NR)	Lower West SECAmb Public Governor
Chris Burton	(CB)	Operational Staff Governor
Julie Harris	(JH)	Assistant Company Secretary
Alison Fisher	(AF)	Upper East SECAmb Public Governor
David Astley	(DA)	Chair
Peter Lee	(PL)	Company Secretary
Waseem Shakir	(WS)	Operational Staff Governor
Amanda Cool	(AC)	Upper West SECAmb Public Governor

Minute taker:

Katie Spendiff	(KS)	Corporate Governance & Membership Manager

New Governors in attendance (term starts 1st March 2022): Ann Osler, Martin Brand, Linda Caine, Kirsty Booth, Patricia Delaney.

1. **Welcome and introductions**
   1.1 WS welcomed everyone to the meeting and asked new Governors to introduce themselves. WS noted he was Chairing the meeting in Nicki Pointers absence.

2. **Apologies**
   2.1 Apologies were received from Nicki Pointer.
   2.2 DA noted he had to depart at 15:00.

3. **Declarations of interest**
   3.1 There were no new declarations of interest.

4. **Minutes, action log and matters arising**
   4.1 The minutes were reviewed. KB noted her name was spelt incorrectly on the 1st page of the minutes. HN noted that Tom Quinn's role was mis-labelled and that he is a NED. HN noted that Howard Goodbourn was also Chair of the Operational Performance Committee, and this needed adding.

4.2 HN noted a rep for Patient Experience Group (PEG) was needed as his Governor term of office was coming to an end.
4.3 BC noted that he felt there was a lack of progress in the work of the patient experience group and was not confident this was being addressed amongst what he had heard on this at the Board.
4.4 NR noted he had been challenging the PEG on the lack of progress in the meetings for the last 18 months.
4.5 DA noted patient experience was on the radar of the Executives.
4.6 The action log was reviewed.
4.7 Regarding Governor opportunities to observe in 999/111 centres and go out on vehicles. JH in contact with Director of Operations about this. JH noting looking to do this from 1st April but reducing volume of people in attendance in one go and spreading the opportunities out over a period of time.
4.8 HN noted value of observing and attending large scale 999 events for learning purposes. HN noted Quality Assurance Visits had been good in the past for Governors getting out and about and questioned if they still took place. WS noted support of these QAV visits having experienced them himself.

ACTION: Find out if we are still doing Quality Assurance Visits and if Governors could participate.

4.9 PL noted a programme of learning would be developed for Governors. NEDs and Govs went out before Christmas to site venues and the intel was very useful.
4.10 DA noted feedback would be welcomed on these visits.

ACTION: Share overview of PEG purpose and opportunity for Governor to express an interest in the Governor vacancy on this group.

5. Feedback from December's Council meeting

5.1 WS noted it had been a productive meeting after reading the minutes.
5.2 MM noted the meeting had been useful and positive.
5.3 MM had since listened in to the Board meeting and noted a focus on support staff, alongside operational staff, the language now felt more inclusive after the points that were raised at the Council meeting.
5.4 MM had raised concerns about the process to register Public Access Defibrillator sites and the Trust's oversight of this. She was not assured on this matter at the meeting and was keen for another Governor to take on this to seek further assurance. KB noted she would pick this up when her term commenced.
5.5 JH noted a progress report on PAD site work would be useful to share with the Council.
5.6 PL noted good questions from the Council at this meeting. PL noted it was not easy to align the Councils areas of concerns and that the focus of the meeting could be more specific. Distilling the issues and creating an agenda that reflects this would be a good evolution of the Council.
5.7 MM noted importance of Governors challenging what they had read within the papers. PL agreed.
5.8 HN noted the GDC tended to precede the Council by a month and with the pace at which changes were happening in the health service and government, Governors needed to be able to ask pertinent questions in relation to the changing landscape.
5.9 WS noted his colleagues on the Council were incredibly hard working and were focussed on improving the organisation. WS thanked Governors for their commitment.

5.10 WS queried the 'unqualified opinion' statement in the audit report. BC noted in layman's terms this was actually a positive and meant it was a clean audit.

5.11 KS asked for feedback from new Governors on the meeting. KB noted passion came across within the meeting with challenge and discussion. Keen for this to be communicated outwards to members on what the Council do, and information on the challenges made at meetings.

6. Draft Council of Governors agenda for 3rd March meeting

6.1 JH noted there was a proposed agenda included within the pack that was up for discussion. JH gave an overview of the standard items that are included at every meeting.

6.2 JH noted QPS deep dive was proposed based on Governor feedback.

6.3 JH suggested specific focus and update on Better by Design and the Community Falls project and also an update on the PADs. Open to Governors to confirm what they would like to see on the agenda.

6.4 AF noted she was a new Governor. The agenda was focussed on reading and responding and didn't come across as an agenda created by Governors.

6.5 KB noted duplication of QPS deep dive on the agenda.

6.6 PL noted the need to not duplicate between Board and Council meetings. PL noted the Integrated Performance Report (IPR), and Board committee reports were received at the Board, and this did feel like it could be reframed with more specific focus. IPR and committee reports are there for information, the Council to pull out what they want to scrutinise from these reports.

6.7 BC noted the Council have a pre-meet to agree the areas of focus for the meeting to ensure questioning is effective and not duplicated. BC noted training for Governors was available – the focus of Council meetings is scrutiny.

6.8 HN noted the pre-meet was usually of value – the last one was not a good example of what usually happens. HN noted there may be occasions when we don't need to hear from specific NEDs, if there aren't questions arising in the pre meet we can take the escalation paper as read and then perhaps the NED does not need to talk to it.

6.9 NR noted that the pre meet could take place a few days before the Council to enable more time for Governors to discuss areas of focus and questions. These could then be shared with the NEDs in advance of the meeting.

6.10 PL noted some of the papers were available in advance as the Board committee escalation reports and IPR were available now as the Board was prior to Council.

6.11 DA noted that if there were specific areas of concern, these can be raised prior to the meeting. DA noted this needed to be balanced with spontaneity of being able to ask a question within the meeting on something.

6.12 MB noted he felt the pre-meet in its current format was a bit tight to achieve its goal.

6.13 MB felt all committee Chairs should be given the option to draw the Councils attention to a specific escalation.

6.14 HN noted this would be an additional meeting and an extra commitment. Suggested it be virtual to ease participation. HN seconded MB point. JH noted virtual for pre-meet would be useful. This could go to the Council as a vote re progressing.

6.15 DA noted the need to not run the Council meeting in private and keep a tight timing on it.

6.16 KB asked if the Quality Account themes and outcomes came to the Council for review. KS advised Governors were involved in selecting the themes.

6.17 The MDC agreed to a scrutiny item on the Quality & Patient Safety committee.

6.18 PL noted the Council meeting was prior to a QPS meeting, and that patient experience would be the focus of that QPS so it may be a touch premature. focus on patient safety rather than experience. Would it be better to move this to the June meeting (PEG aspect) and keep it as a general deep dive on QPS?

6.19 HN noted that Better by Design would be a fundamental part of the Trusts work going forwards, it would be good for Governors to understand the programme and its implications.

6.20 MB noted need to explain things in layman's terms and provide context as there was a whole new cohort of Governors. Presenters should be briefed that they have two audiences, those who know the history and those who don't.

6.21 CB keen to hear on Better by Design (BBD) and if the NEDs were comparing it to the 10-point action recovery plan for the NHS that was issued in September.

6.22 JH noted BBD could be included, DA noted this would be quite top level as it was still under development.

6.23 DA noted the community falls programme update would be good as it has been around for some time now.

6.24 HN noted a possible future agenda item for capturing could be on staff morale and engagement and how WWC have oversight of this. HN noted difficulties of working from home, sickness absence, performance pressure, reduced investment in training due to lack of available abstraction have all impacted staff morale. DA supported a focus on this.

6.25 NR noted need for evidence on staff welfare metrics and how they relate to patient experience metrics.

6.26 It was suggested there be a focus on a QPS deep dive, BBD, an update on the community falls project, and the PAD site work. Governors were also keen to hear about staff morale and support.

ACTION: JH to send voting email to Council to get a view on arranging virtual longer pre meets in advance of the CoG for Governors.

7. Governor communications / Updating the posters

7.1 JH noted opportunity to discuss communication mechanisms and what was or wasn't working for Governors.

7.2 NR noted level of support from the team was really welcomed. Perhaps a monthly bullet point document on what Governors need to know – a newsletter of sorts. Steer on things they need to know and what's coming up.

7.3 WS noted the quality of the information received was high, but so was the volume and this could be overwhelming sometimes.

7.4 KB was keen for the work of the Council to be communicated more widely to members.

7.5 WS noted from a staff Governors point of view they reached out to locally to staff.

7.6 JH noted KBs point about communicating role of Council and areas of focus and was keen to understand how this could be achieved.

7.7 HN noted perhaps a Council update to members would be useful from time to time. In person events were useful for feeding views back into the organisation.

7.8 KB noted that there is a large number of communications that go out regularly to staff and some messages can be lost. KB noted it would be good to discuss this more widely at Council meetings. A proposal on what we could do what be useful.

7.9 JH noted need to refresh Governor posters and website present. KS proposed a photographer to attend the next Council meeting to take headshots.

7.10 HN keen to see less suits and ties in images for the Council. Noted it should be possible for Governors to submit their own photos given current technology. The GDC agreed.

ACTION: Discussion on how to raise the profile of the Council and the work it undertakes to be held with full Council accompanied by a draft proposal on what could be done for context.

8. Should Council return to face-to-face or hybrid meetings?

8.1 PL noted the Board planned to take a hybrid approach alternating in person and virtual meeting. PL noted the March Council meeting may be too soon to do in person.

8.2 PL noted challenges of using two mediums at once in a meeting and was not sure it was the best option. HN noted meetings should be online or in the room not a mixture.

8.3 It was agreed that the March Council meeting would be online and then reviewed.

9. Governor training and development

9.1 KS gave an overview of formal and informal development opportunities for Governors and the progress made on this.

9.2 HN noted the NED committee observations were useful. HN queried it was only attending a few meetings, could we have less in attendance at more meetings.

9.3 KS noted a slight blurring of the line in scrutiny if attendance was increased. It's more to get a sense of performance.

9.4 NR noted the need to entrust NEDs to undertake their business.

9.5 KS noted that afternoon development sessions after Council meetings were available, and that Governors could suggest areas they want to learn more about.

9.6 NR noted re afternoon sessions, he would like to hear from an operational unit manager and the wellbeing hub on staff experience over the last 18 months. He also suggested an overview on the new reality of Integrated Care Systems. NR keen to hear from HR on their plans and pipe lines – a snap shot into their areas of business.

9.7 JH noted she was new in post and had found the IPR to be quite confusing, and she could have used an explanation of the metrics and what they meant when she started. She had suggested this would be of benefit for Governors to also learn about as it was one of the key documents that measured the Trusts performance, and she proposed this doe the first afternoon development session.

9.8 MB noted a session on the IPR would be very useful, especially understanding the interaction between the metrics.

9.9 MB keen to understand organisational structure and longer-term plans of the Trust.

9.10 MB noted updates from other Trusts on their work and how they interact with SECAmb would be useful.

9.11 KB keen to hear from the corporate teams on their role.

9.12 BC noted support for IPR session. BC noted re NED observations, this does help support providing feedback on NEDs for their appraisals.

9.13 PL noted joint Council and Board sessions provide interaction as do observation site visits.

10. Any other business

10.1 JH noted that photos of Governors for promotional use could be taken by herself at the upcoming training session.

10.2 BC thanked Governors HN, MM and WS for their participation in their Governor roles as it was the last GDC for them.

10.3 WS wished new Governors all the best in their roles. Keep asking questions and keep doing a great job.

11. Review of meeting effectiveness

11.1 The meeting was deemed to have been effective.

The next GDC meeting takes place on 14 April 2022 2-4pm venue TBC

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

E - Governor Activities and Queries

1. Governor activities

1.1 This report captures membership engagement and recruitment activities undertaken by governors (in some cases with support from the Trust – noted by initials in brackets), and any training or learning about the Trust Governors have participated in, or any extraordinary activity with the Trust.

1.2 It is compiled from Governors' updating of an online form and other activities of which the Assistant Company Secretary has been made aware.

1.3 The Trust would like to thank all Governors for everything they do to represent the Council and talk with staff and the public.

1.4 **The online form is being updated for the new cohort of Governors and will be shared in due course.**

Date	Activity	Governor
02.12.21	Governor Induction	David Romaine Patricia Delaney Linda Caine Martin Brand Ann Osler Matt Alsbury-Morris Andrew Latham Kirsty Booth Stuart Dane Nick Harrison
22.12.21	Council and Inclusion Hub Advisory Group Christmas Thank You event	Governors, Chair & IHAG members.
CURRENTLY In progress	Online form update (above noted form)	Administration
FUTURE 15.03.2022	Inhouse NHS Providers training for Governors	Kirsty Booth Nick Harrison Linda Caine Ann Osler Mike Tebbutt Stuart Dane David Romaine Martin Brand Colin Hall

		Alison Fisher Andrew Latham Howard Pescott Matt Morris Patricia Delaney

2. Governor Enquiries and Information Requests

2.1. The Trust asks that general enquiries and requests for information from Governors come via Julie Harris. An update about the types of enquiries received and action taken, or response will be provided in this paper at each public Council meeting.

15.11.21 – Harvey Nash

Question: The AACE report is concerning, but also worryingly revealing about the parlous state of hospital services in our patch. I was aware that hospital delays were causing ongoing operational / crewing issues for us but had not appreciated either the extent of direct patient risk this was incurring, nor that the problem for SECAmb is not only worse than for any other UK Ambulance service but worse by a considerable margin (cf pages 20 and 21 of report). It worries me that despite the 'delays' issue being not just aired but discussed at length at numerous meetings (CoG, WWC, QPS etc) the sheer scale unique to our patch has not been made known to Governors. If the AACE report had not been released to the press.....? This all echoes and reinforces the Governor disquiet about the openness of SECAmb public comms strongly voiced at the recent MDC.

I have raised previously the lack of MACA provision for SECAmb and this revelation makes its absence even more inexplicable.

Consequently, I have to raise the following Governor questions:

1. Were NEDs aware of the true impact of hospital delays on SECAmb's patients and that this was significantly worse than any other Ambulance service was experiencing? If so, why had that not been made overt in the many meetings involving Governors? If not, what action will they take to be assured that they and Governors are fully informed in future?

2. Are NEDs assured that they are fully informed on analogous business critical data and information?

3. Are NEDs assured that SECAmb is deploying the most timely and effective arguments to secure MACA support and to best serve its public regardless of political / comms strictures imposed by NHS HQ or others?

4. How do NEDs suggest Governors respond to enquiries as to why SECAmb had not made the extent and risks of local hospital delays public long ago?

Response (Tom Quinn): For context, it is worth highlighting that we had a discussion about the AACE report at yesterday's Part 1 Board. It was confirmed that the report focused on data collected on a single day, 4th January 2021, providing a snapshot of the national picture on handover delays. On that particular day, our Trust and partners were facing particular

pressures due to the emergence of the so-called 'Kent' (Alpha) variant of the coronavirus, and this is reflected in the data presented.

1: I can confirm that handover delays have been a well-documented issue for the Board over several years, with 'hours lost' one of the key performance indicators in the IPR. NEDs are assured that the Chair and Chief Executive have worked with system partners and regional leaders, and in some instances regulators, to raise concerns about handover delays, and to work creatively together to find solutions, reflecting the reality that handover delays are a system wide issue (from primary care through to social care).

2. Yes. NEDs receive, scrutinise and discuss very detailed reports at full Board and at Committees. For example, at QPS we have had detailed information on harm reviews at both regular and extraordinary meetings and received assurance both on management processes and some reassurance that, from thousands of reviews undertaken, the incidents of harm are very low (single figures, as mentioned at yesterday's Board). But we remain concerned about the impact on patient experience and will be looking at this in more detail in future meetings.

3. Yes. MACA support has been discussed regularly both at Board and in Committees. For example, the Escalation Report from the Performance Committee, presented at yesterday's Part 1 Board highlights that the Committee were assured that no reasonable options were completely discounted.

4. This is something that Governors may wish to pick up with the Head of Communications.

07.12.2021 – Marcia Moutinho

Question: Bought up again at CoG meeting and email received. I am just following up on my question yesterday about whether secamb has now a process in place to manage our PAD (public access defibrillators) sites. I know David said I would get an answer and I just want to let you know that I would very much like to receive an update on that.

As a society, we don't seem to agree on much these days but I am still to find someone that doesn't believe on the importance of PADs.

Response: A draft procedure has been submitted for consultation that deals with Public Access Defibrillators. It is proposed to have the Trust moved across to a national defibrillators network (NDN) run by the British Heart Foundation (BHF) known as 'The Circuit'. All Trust owned PAD sites will be registered with The Circuit which links with the Trusts Computer Aided Dispatch (CAD) system to ensure rescue ready status of all PAD sites.

3. Recommendations

3.1. The Council is asked to note this report.

3.2. Governors are reminded to please complete the online form after undertaking any activity in their role as a Governor so that work can be captured. The new form will be circulated in due course.

Brian Chester
Public Governor
(In the absence of a Lead Governor)

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
January 2022

Data up to and including December 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 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.

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

Philip Astle
Chief Executive

Welcome and thank you for talking the time to read our Integrated Performance Report. The aim of this report is to provide the Board with the key performance indicators and trends that the Executive is focussed on. On slides 5 and 6 you will find the operational scorecards containing an overview of our performance over the period across our 999, Field Operations and 111 Services. On slide 8 you can find a summary of the key areas where the Executive are concerned, followed by the individual exception reports that will provide you with more commentary into the causes and action plans in place to address the issues. Several new performance metrics have been added this month around our enabling services, and you can find a summary of those on slides 35-38. Finally, you can find all of the detailed data and trends in the Appendices from slide 50 onwards.

Operational Performance through November and most of December remained challenged due to sustained high levels of higher acuity demand combined with high levels of sickness, and protracted hospital handover delays. Towards the end of December and over the festive period, we experienced a reduction in demand, linked to a change in social behaviour due to the Omicron variant. This has meant that despite on-going system difficulties, we have been able to provide much improved response times to our patients, and this trend has continued into January. Whilst we are not yet providing the service we would like to provide to our patients, we continue to improve relative to the other English Ambulance Services, performing above the mean in the main response categories, and in particular sitting in the upper quartile for Category 2 – the largest group of seriously poorly patients. A focus over the last quarter has been to re-enforce our 999 call-handling team, where we have seen significant sustained improvement. Our efforts now are to maintain this positive trend and to support on our clinical and dispatch teams within to the control room. This will ensure we protect the higher rates of Hear and Treat we have been achieving, which will be a key success factor for when we see activity return in the coming months. We have seen similar trends in our 111 service, where our high validation rates continue to protect our core 999 activity by minimising referral rates. Performance in 111 however remains challenged due to the gap between funded levels and the activity we have seen in this service. We have remained in REAP 4 throughout the period.

Staff wellbeing continues to be a focus area for the Executive. We saw a peak in COVID-related sickness over the first week in January, but the numbers have since almost halved. Despite this, overall sickness remains high and our sickness management plan remains in place to support colleagues. Due to operational pressures, we also see an on-going challenge with completing appraisals and training, and whilst we are providing high levels of meal-breaks, over half are outside of the target window, and shift overruns remain unacceptably high. Our focus on workforce planning for FY 22/23 is to increase capacity, as well as better matching to demand at an hourly level, to increase our overall resilience.

Current Operational Performance
999 Emergency Ambulance Service – 13 week trend for the period of (18/10/21 – 16/01/22)

CAT 1

	27/12	03/01	10/01	Last 13 Weeks
Mean	00:08:25	00:08:24	00:08:13	
90th Centile	00:15:37	00:15:16	00:15:09	
RPI	1.53	1.60	1.56	
Count of Incidents	1179	1000	968	

CAT 1T

	27/12	03/01	10/01	Last 13 Weeks
Mean	00:10:35	00:09:56	00:09:58	
90th Centile	00:19:48	00:18:29	00:18:45	
RPI	1.54	1.63	1.53	
Count of Incidents	722	635	591	

CAT 2

	27/12	03/01	10/01	Last 13 Weeks
Mean	00:28:31	00:29:45	00:24:47	
90th Centile	00:56:52	01:00:44	00:48:07	
RPI	1.06	1.06	1.06	
Count of Incidents	8176	7558	7067	

CAT 3

	27/12	03/01	10/01	Last 13 Weeks
Mean	02:06:06	02:20:59	01:36:25	
90th Centile	04:40:04	05:27:50	03:30:58	
RPI	1.07	1.07	1.05	
Count of Incidents	3959	3627	3954	

CAT 4

	27/12	03/01	10/01	Last 13 Weeks
Mean	02:52:38	03:07:49	02:02:25	
90th Centile	06:16:23	08:22:09	04:07:05	
RPI	1.12	1.04	1.04	
Count of Incidents	67	69	83	

Demand/Supply

	27/12	03/01	10/01	Last 13 Weeks
999 Call Volume	17814	16369	14757	
Incidents	15243	14030	13680	
Transports	8810	8211	8249	
Staff Hours Provided Vs 67635 target	98.4%	91.4%	92.2%	

999 Call Handling

	27/12	03/01	10/01	Last 13 Weeks
Mean Call Pickup Time (Seconds)	17	17	5	
Call Pickup Time 90th Percentile (Seconds)	63	61	1	
Call Pickup Time 95th Percentile (Seconds)	109	110	21	
Call Pickup Time 99th Percentile (Seconds)	214	218	114	
Average Call Length (seconds)	421	394	393	
Abandon Rate	0.99%	0.75%	0.12%	
Staff Hours Provided Vs 4418.6 target	104.2%	105.6%	115.8%	

Call Cycle Time

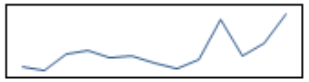
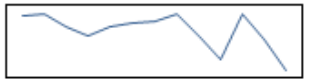
	27/12	03/01	10/01	Last 13 Weeks
Clear at Scene	01:21:05	01:20:01	01:20:45	
Clear at Hospital	01:54:40	01:57:42	01:53:36	
Hours Lost at Hospital	1680	1706	1206	

Incident Outcome

	27/12	03/01	10/01	Last 13 Weeks
See and Convey	57.8%	58.5%	60.3%	
See and Treat	33.3%	32.6%	32.2%	
Hear and Treat	8.9%	8.9%	7.5%	

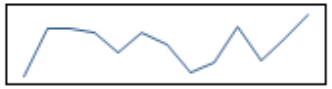
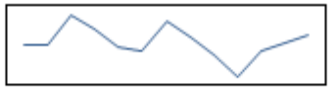
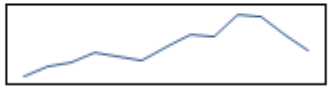
Current Operational Performance
NHS 111 Clinical Assessment Service – 13 week trend for the period of (18/10/21 – 16/01/22)

111 Demand/Supply

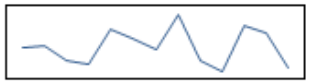
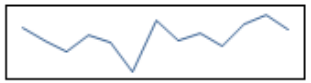
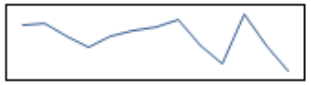
	27/12	03/01	10/01	Last 13 Weeks
111 Call Volume	39519	29765	22067	
Calls Answered	24765	21955	19292	
Calls Answered % of Volume	62.7%	73.8%	87.4%	
% Calls Answered in 60 seconds (> 95%)	21.5%	31.9%	57.0%	
% Calls abandoned after 30 seconds(< 5%)	31.8%	20.5%	7.1%	

** Note – contracted volume is 24,730/week*

111 Referal rates

	27/12	03/01	10/01	Last 13 Weeks
AMB referral rate % (<13%)	8.3%	8.8%	9.3%	
A&E referral rate % (<9%)	8.3%	8.5%	8.7%	
Clinical referral rate % (>50%)	54.5%	52.4%	50.5%	

111 Call Handling

	27/12	03/01	10/01	Last 13 Weeks
Triage Rate (% Calls Answered triaged)	98.0%	97.7%	96.0%	
Cat3/4 Validation Rate	97.8%	98.9%	97.2%	
Average Speed to Answer	00:15:43	00:08:13	00:02:26	

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Performance Highlights & Exception Reporting

Best placed to care, the best place to work

Trust Overview:
Summary of Performance Highlights

Domain	ID	Highlights
Safe	% Duty of candour compliance (QS-3)	Duty of candour compliance has increased to 100% from previous month. Reasons for the 100% compliance include the allocation of Investigating Managers to outstanding SI investigations.
Responsive	111 operational targets % 111 to 999 referrals (answered calls) (111-4) % A&E dispositions (111-5) % Clinical contact (111-7) % Ambulance validation (111-8)	In terms of clinical outcomes, the service continues to meet its contractual requirements and remains in the top quartile of national performance for 111 providers for both ED and 999 referral rates. In addition, the KMS 111 service currently has the highest % referral rate for Direct Appointment Booking (DAB) into Emergency Departments (EDs), which is a key component of the national 111 First initiative. This protection of the regional urgent and emergency care system is a key commissioner priority for this service. For the month of December, the service achieved the national and contractual, clinical contact target of 50%, with more than half of the patients triaged by KMS 111 having subsequent direct contact with a clinician. Further to this, KMS 111 also managed to clinically validate more than 96% of its 111 non-emergency CAT 3 and 4 ambulance dispositions, outperforming other 111 providers and the national 50% target.

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-3	Quality & Safety	Duty of Candour Compliance %	80.00%	67.00%	100.00%	75.00%	100.00%	67.00%	100.00%	100.00%	100.00%	75.00%	100.00%	80.00%	100.00%	100.00%	=	

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
111-4	Operations 111	111 to 999 Referrals (Answered Calls) %	13.90%	14.90%	15.00%	13.40%	8.70%	9.10%	9.70%	9.30%	9.30%	9.10%	8.90%	8.95%	8.51%	13.00%	+	
111-5	Operations 111	A&E Dispositions %	14.60%	14.70%	15.40%	15.60%	15.20%	14.90%	16.00%	9.10%	8.10%	8.90%	8.30%	8.70%	8.25%	9.00%	+	
111-7	Operations 111	Clinical Contact %				48.10%	48.20%	45.20%	44.90%	46.00%	46.00%	46.20%	48.00%	49.35%	52.17%	50.00%	+	
111-8	Operations 111	Ambulance Validation %				95.40%	95.30%	95.10%	90.60%	95.20%	93.60%	95.90%	95.60%	94.90%	96.86%	85.00%	+	

Trust Overview:
Summary of Exceptions

Domain	ID	Exceptions
Safe	Number of Datix incidents (QS-1)	The Trust has seen a downward trend on reporting incidents on Datix for November 2021 (7.5%) and December 2021 (11%).
Safe	Hand hygiene compliance % (QS-7)	IPC audit results are showing reduced levels of compliance for hand hygiene.
Safe	Safeguarding training completed (children) level 2 % (QS-8)	During 2021-22 L1&2 Safeguarding Training has only been on offer to new starters. Compliance for L1&2 Safeguarding training has been high for the past three years. Subsequently 2021-22 has focused on improving L3 compliance that has seen uptake of 65% since September 2021. A large number of staff who will have received level 2 training in previous years have received level 3 this year.
Safe	Violence and aggression incidents (number of staff victims) (QS-13)	The Trust has seen an increase in incidents of violence and aggression between November and December 2021.
Safe	Single witness signature use controlled drugs (CD) Omnicell (MM-3)	The Trust's Medicines Governance Team report on single sign outs of Controlled Drugs (CDs) on CD registers. This is where there is no witness available for the transaction in the CD register. The appropriateness of these single sign outs is determined by Operational Team Leaders (OTLs) via Datix investigation. This month there has been a delay in some of the OTLs getting this information to the Medical Team.
Safe	Outstanding actions relating to SIs (significant incidents) - outside of timescales (QS-17)	The impact of REAP 4 and wider operational challenges have resulted in a plateau in the number of outstanding actions. Additional risks include a significant sickness rate within the Significant Incident (SI) team. The Trust expectation is that SI actions are completed within timescales. Historically some timescales have not been realistic and there is focus on ensuring that all actions are SMART.
Safe	Flu vaccine compliance % (QS-25)	Since the discontinuation of the Covid booster programme across the organisation, a slowdown has been noted in the uptake of the annual flu vaccine by staff. Current uptake of 58% is broadly in-line with the other ambulance services but falls short of figures recorded at SECAmb over the past 2-3 years

Trust Overview:
Summary of Exceptions

Domain	ID	Exceptions
Effective	Job Cycle Times (JCT) JCT allocation to clear at scene mean (999-11) JCT allocation to clear at hospital mean (999-11)	Job cycle time is a key factor in overall service performance against ARP metrics. Unfortunately the Trust has seen significant increases in hospital handover times over recent months.
Effective	% Acute STEMI care bundle outcome (M-5)	The Trust reports to NHSE on its performance against STEMI care as part of the national audit programme. The most recent 2 months of audited data (September and October 2021) have seen a deterioration in the Trust's general performance. This has now just dipped below the usual fluctuations with a general tolerance of 5%.
Effective	% 999 operational abstraction rate (999-12)	Abstractions - particularly sickness (general plus Covid-19 related) – has been more difficult to manage over recent months. This has not only affected SECAmb but has also been reported by our system partners both locally and nationally. This has impacted the Trust's ability to deliver sufficient resource hours across all service lines to meet ARP or other contractual performance targets.
Effective	Number of hours lost at hospital (999-24) % hours lost at handover as a proportion of provided hours (999-25)	Handover times are generally not an indicator of activity in the ED alone, rather they are an indicator of overall patient flow across the whole hospital or even the ICP/ICS. Over recent months, all areas have reported a very significant increase in patients who are medically fit for discharge but who are unable to actually be discharged which has a substantial impact on patient flow, and hence handover times.
Effective	Clinical Education Students at risk of not obtaining qualification % (M-25)	As of December 2021, the Trust is reporting 24% of students are at risk of not obtaining their qualification. The nature of apprenticeship programmes, life or work events can lead to 'breaks in learning'. Processes are in place that offer 'submission dates' for work, these are at times missed. It is important therefore to recognise that % at risk will vary and for some there is a clear rationale.

Trust Overview:
Summary of Exceptions

Domain	ID	Exceptions
Responsive	111 operational targets % 111 calls answered in 60 seconds (111-1) % 111 calls abandoned (111-2)	The 111 calls offered continues to be significantly above the Trust's service contractual target, and higher than that which the Trust is funded to receive. As a result, the service is not achieving the operational call handling metrics such as calls answered in 60 seconds and the rate of calls abandoned.
Responsive	999 call answering performance 999 Calls Answered (mean and 90th centile) (999-1)	999 call answering, which has been a focus area for the Trust over the past quarter, continues to improve, underpinned by the successful delivery of the service's Q3 EMA recruitment plan. Overall, we have seen more than 80 EMAs trained, mentored and go-live prior to Xmas. It is important to note that the Trust has achieved the EMA trajectory, agreed with the NHSE central ambulance team and linked to the additional winter funding.
Responsive	999 ARP performance Cat 1 (mean and 90th centile) (999-2,) Cat 1T (mean and 90th centile) (999-3) Cat 2 (mean and 90th centile) (999-4) Cat 3 (90th centile) (999-5) Cat 4 (90th centile) (999-6) HPC 3 & HPC 4 (mean and 90th centile) (999-7)	The ARP performance framework is evidence-based in terms of both the target set, and the clinical implications of each target. Historically, since the start of the Pandemic, but more so during the 2021-22 financial year, the Trust has consistently failed to deliver against all metrics – this has primarily been as a result of challenges relating to resource provision, coupled with increased of demand and acuity.
Responsive	Complaints reporting timeliness (QS-4)	At the end of October 2021 there were a number of breached complaints regarding operational concerns. The Patient Experience Team (PET) worked closely with Operating Unit Managers to clear these, which resulted in the gradual drop in complaints responded within the 25 day response target. During the Covid Business Continuity Incident (BCI) it was agreed by the Executive Management Board (EMB) that target dates for responses can be extended to 35 working days.
Responsive	% Time spent in SMP 3 or higher (999-14)	Over recent months there has been higher proportions of time spent at the higher levels of Surge Management Plan (SMP) due to resourcing level challenges.

Trust Overview:
Summary of Exceptions

Domain	ID	Exceptions
Well-led	% Annual rolling turnover rate (WF-7)	Staff turnover has been impacted by the relentless nature of delivering services during COVID.
Well-led	% Annual rolling sickness rate (WF-8)	Due to COVID and long COVID, a not insignificant proportion of sickness cannot be effectively managed.
Well-led	% of meal breaks taken outside of window (999-28) % 999 frontline finishes/over runs (999-15)	With lower levels of resourcing in field-operations, crews are travelling further, which impacts the location where meal-breaks can be taken, as well as the distance required to travel back to base at the end of shift.
Well-led	% Policies and procedures outstanding review (C-1)	Due to COVID and REAP 4 levels, the chasing and updating of policies and procedures had halted at the end of 2020, where the policies and procedures outstanding review percentage was steady at approximately 11%. This caused said percentage to steadily grow since then.
Well-led	% Vehicles older than target age (FL-1)	As of December 2021, 41% of the Trust's operational fleet is older than the planned replacement target age. The Trust is currently working towards replacing operational vehicles to fall in line with the approved fleet strategy. The parameters have been set based on both the vehicles reliability at a certain age and the cost effectiveness to keep it on the road past this age against a replacement.

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-1	Standards: Number of Datix incidents	The Trust has seen a downward trend on reporting incidents on Datix for November 2021 (7.5%) and December 2021 (11%) decrease year on year. November did see a BCI declared on 17/11/21 when a number of systems went down due to server upgrades. Due to Datix being down for 24-48hrs over the period 17/11-18/11 this saw a decrease in incidents reported for November 2021. This has in turn made December's figures look higher compared to November 21. In reality, the Trust has seen a drop in reported incidents from December 2020 to that of December 2021.

Action Plan

Actions being taken to mitigate issues:
Analysis is being undertaken to understand whether this difference is related to the larger COVID peak in December 2020 to 2021 as the Kent variant emerged. This will also be discussed at Operations & 111/EOC QUAPS.

Accountable Executive

Named person:
Executive Director for Nursing & Quality

Complete by date:
January 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-1	Quality & Safety	Number of Datix Incidents	1751	1595	1070	1149	1051	1175	1253	1493	1397	1149	1070	1398	1652	N/A	N/A	

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-7	Standards: Hand hygiene compliance %	IPC audit results are showing reduced levels of compliance for hand hygiene. There are two main concerns: 1) non-compliance of bare-below-the-elbows; 2) hand hygiene before patient contact isn't being recorded correctly on the audit form. Both of these elements will be raised at Quality & Patient Safety Committee (QPS) and recommendations agreed.

Action Plan

Actions being taken to mitigate issues:

A paper was presented to the Quality & Patient Safety Committee (QPS) in January 2022 to discuss the issues and recommended actions for the IPC Improvement Plan. Progress has been delayed due to the challenges of the COVID pandemic. Improving compliance is a priority for the next three months.

Recommendations include:

- Improving day-to-day adherence to IPC standards
- Transforming IPC training & education
- Improving surveillance and audit of all IPC practice

Accountable Executive

Named person:

Executive Director for Nursing & Quality

Complete by date:

January 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-7	Quality & Safety	Hand Hygiene Compliance %	96.00%	94.00%	93.00%	95.00%	94.00%	95.00%	95.00%	92.00%	90.00%	95.00%	93.00%	84.00%	81.00%	90.00%	-	

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-8	Standards: Safeguarding training completed (children) level 2	During 2021-22 L1&2 Safeguarding Training has only been on offer to new starters. Compliance for L1&2 Safeguarding training has been high for the past three years. Subsequently 2021-22 has focused on improving L3 compliance that has seen uptake of 65% since September 2021. A large number of staff who will have received level 2 training in previous years have received level 3 this year.

Action Plan

Actions being taken to mitigate issues:

- Face to face delivery of L3 training to supplement safeguarding understanding across the Trust
- Approach taken by the Safeguarding Team on training has received support from commissioners
- Safeguarding referrals continue to see a year-on-year increase

Accountable Executive

Named person:
Executive Director for Nursing & Quality

Complete by date:
Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-8	Quality & Safety	Safeguarding Training Completed (Children) Level 2 %	78.20%	79.40%	82.00%	90.40%	88.70%	87.00%	87.30%	86.00%	86.20%	90.40%	82.00%	84.04%	84.27%	95.00%	-	

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 (number of staff victims)	The Trust has seen an increase in incidents of violence and aggression between November - December 2021. • November 2021 - 76 incidents of violence and aggression reported by staff. • November 2021 - body worn cameras were deployed 725 times within the trial locations. • December 2021 - 117 incidents of violence and aggressions reported by staff. • December 2021 - body worn cameras were deployed 834 within the trial locations.

Action Plan

Actions being taken to mitigate issues:

- Nationally, the Ambulance sector has seen a distressing increase in incidents of violence and aggression towards frontline staff, often associated with the inability to provide a timely response.
- The Trust's Health & Safety Manager has proactively worked with all of the police forces in our region on Operation Cavell. This is a commitment signed by our CEO and Chief Constables to robustly investigate and prosecute offenders consistently. We are also leading on this nationally.
- We have discussed with Clinical Education and Operations the requirement to train all frontline staff in conflict resolution. Unfortunately, partly due to the pandemic response, this has not yet happened. It is included in the plan to review our training requirements post pandemic.
- We are part of the national Body Worn Video (BWV) trial and are seeing cameras having a positive effect on de-escalating volatile situations and footage being used to improve prosecution rates. This will be evaluated Nationally using the NHSE criteria at the end of the trial.
- We are now in a position to recruit into a vacant Accredited Security Management Specialist which will enable increased traction in this area.

Accountable Executive

Named person:
Executive Director for Nursing & Quality

Complete by date:
Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-13	Quality & Safety	Violence and Aggression Incidents (Number of Victims - Staff)	70	53	60	60	65	73	87	91	99	60	60	76	117	N/A	N/A	

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
MM-3	Standards: Single witness signature use controlled drugs (CD) Omnicell	Single signatures on CD registers are not permitted at SECAmb. There is one exception to this, where the Paramedic is on a Single Response Vehicle (SRV) with no witness available (e.g. twilight hours on a quiet station). The Trust's Medicines Governance Team report on single sign outs of Controlled Drugs (CDs) on CD registers. The appropriateness of these single sign outs are determined by Operational Team Leaders (OTLs) via Datix investigation. This month there has been a delay in some of the OTLs getting this information back to us. Medicines has also historically asked if we can report retrospectively as time is needed to investigate and establish if this activity is appropriate or not.

Action Plan

Actions being taken to mitigate issues:

- The reason for the increase in incidents this month, is because there is a delay in the OTLs investigating and returning the appropriateness of these. This is because some of the incidents occurred at the end of December and this report was generated on the 04/01/22.
- The Medicines Governance Team are going to perform a deep dive on signal sign outs of CDs on all station sites and report into MGG. The OTLs will continue to monitor the appropriateness of these single sign outs in their weekly CD checks.
- OTLs require training around process of CD reconciliation and authorised activity at CD register. The Medicines Governance Team are currently reviewing this.

Accountable Executive

Named person:
Medical Director

Complete by date:
Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
MM-3	Medicines Management	Single Witness Signature Use CDs Omnicell	6	5	9	4	3	2	3	6	7	14	5	13	23	0	-	

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 Significant Incidents (SIs) - outside of timescales	The impact of REAP4 and wider operational challenges have resulted in a plateau in the number of outstanding actions. Additional risks include a significant sickness rate within the SI team.

Action Plan

As previously reported, the overall number of open actions are reducing as has the breached total, however this does not reflect when shown as a percentage figure.

Oversight of outstanding actions are scrutinised by the Serious Incident Group (SIG) and Clinical Governance Group (CGG).

Targeted work to reduce the breach rate is on-going and proving to be effective, however, as explained above, the percentage metric does not reflect this. It is proposed that both metrics are reflected in the IPR. Focus will be given to supporting individual governance groups to understand their outstanding actions and support to close them. This has proven to be effective in the past.

Accountable Executive

Named person:
Executive Director for Nursing & Quality

Complete by date:
Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-17	Quality & Safety	Outstanding Actions Relating to SIs, Outside of Timescales	111	126	112	117	141	114	112	116	117	117	112	129	130	N/A	N/A	

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-25	Standards: Flu vaccine compliance %	Since the discontinuation of the Covid booster programme across the organisation a slowdown has been noted in the uptake of the annual flu vaccine by staff. Current uptake of 58% is broadly in-line with the other ambulance services but falls short of figures recorded at SECAmb over the past 2-3 years.

Action Plan

Actions being taken to mitigate issues:

Current review led by the Nursing & Quality Directorate but involving all relevant directorates to reassess the current situation and consider options aimed at increasing uptake before the end of January 2022.

Options appraisal to improve uptake presented at Covid Management Group (CMG) was approved and is being implemented.

Accountable Executive

Named person:

Executive Director of Nursing & Quality

Complete by date:

January 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-25	Quality & Safety	Flu Vaccine Compliance	78.80%		79.80%	80.10%						80.10%	79.80%		58.00%	90.00%	-	

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

999-11	Standards:
	Job Cycle Times (JCT)
	JCT allocation to clear at scene mean
	JCT allocation to clear at hospital mean
	
	Definition:
	JCT starts from the time the call is allocated to a physical resource (DCA or SRV) to the time where the Trust resource completes the call and is available for a further call/response
		• Job cycle time is a key factor in overall service performance against ARP metrics.
		• Key components include:
		  • Time taken for the resource to travel from start point to the address of the call
		  • Time taken for the clinical patient assessment and associated decision making regarding required outcome/next steps
		  • Where appropriate, time taken to travel from the call address to the relevant clinical care setting for continuing care
		  • If the patient has been conveyed to a care setting, time taken to hand the patient over and for the crew to wrap-up at the end of the call

Action Plan

Actions being taken to mitigate issues:

Optimising resource levels - The distance travelled per call and cross-border activity (across operating units) is directly related to the overall resource level – with fewer resources, generally cross-border travel increases. Therefore a key component is managing resource levels to achieve optimal levels.

Improved support for on-scene decision making - There is a recognised correlation between relative ratio of 'see & convey' to 'see & treat' incidents against total on-scene times. Whilst the overall intention is to ensure only those patients who require further care in a local Emergency Dept or other location, in order to maximise 'see & convey' it is often recognised that additional time is required on scene to undertake a full assessment of the patient, and where appropriate liaise with other healthcare providers (e.g. the patient's own GP) to support decision making. The use of the PP hubs and GPs present in the Clinical Assessment Service (CAS), provides additional support.

Hospital handover & wrap-up times - These two components are managed through local management teams – through engaging with local and ICP.ICS level patient flow discussions and supporting staff to optimise wrap-up times. Unfortunately there has been significant increases in the hospital handover times seen across the Trust over recent months.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-11	Operations 999	JCT Allocation to Clear at Scene Mean	01:20:16	01:22:00	01:19:51	01:19:00	01:18:57	01:14:38	01:17:12	01:16:00	01:16:34	01:16:44	01:17:56	01:17:45	01:18:35	N/A	N/A	
999-11	Operations 999	JCT Allocation to Clear at Hospital Mean	01:57:53	01:57:24	01:51:48	01:49:29	01:49:30	01:50:58	01:49:19	01:52:57	01:53:43	01:54:04	01:55:44	01:55:40	01:57:04	N/A	N/A	

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
M-5	Standards: % Acute STEMI care bundle outcome Definition: The acute STEMI care bundle requires that all patients coded as having a STEMI have 2 pain scores recorded, and are administered Aspirin, GTN and appropriate analgesia, unless there is an exception	The Trust reports to NHSE on it's performance against STEMI care as part of the national audit programme. The most recent 2 months of audited data (September and October 2021) have seen a deterioration in the Trust's general performance. This has now just dipped below the usual fluctuations with a general tolerance of 5%.

Action Plan

Actions being taken to mitigate issues:

1) Analysis into the non-compliant cohort will be completed
2) In particular, we will look at the care bundle requirements that are most affecting performance and why
3) We will set up a panel of clinicians as a means of levelling non-compliance checks to ensure that local and national protocols are aligned

Accountable Executive

Named person:
Medical Director

Complete by date:
February 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
M-5	Medical	**Acute STEMI Care Bundle Outcome %	65.60%	64.10%	63.90%	74.00%	69.00%	60.30%	57.30%	60.60%	62.70%	54.00%	55.40%			64.70%	-	

NB: Please note M-5 is always reported 2-months in arrears

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
999-12	Standards: % 999 operational abstraction rate Definition: Abstraction rate is the proportion of total budgeted hours that are unavailable for use in service delivery. Types of abstraction include: annual leave, training and sickness	• Abstractions are budgeted to a specific level recognising the individual components and how they fluctuate across hours/days/years. • Many abstractions are managed via Trust policies (e.g. annual leave) with other components planned across a 12-month cycle such as training delivery. • Other abstractions are more difficult to plan and manage, particularly sickness over the past months where both general sickness and that related to Covid-19 has seen a marked increase not only with SECAmb but also on a local & national scale. This has resulted in a significant impact in the ability to deliver sufficient resource hours across all service lines to meet ARP or other contractual performance targets.

Action Plan

Actions being taken to mitigate issues:

Sickness management - This is being undertaken within local teams – supporting the well-being of staff through the appropriate processes as per policy. Complicating factors include:

- Staff who have had prolonged waits for treatment due to extended waiting lists
- Covid-related sickness levels which are strongly influenced by current pandemic trends in cases seen
- Complexities in the management of staff with Long-Covid

Annual leave management - This is being managed according to policy, however it has been complicated with the additional allowance in terms of carry-over from 2020-21 as per government guidance. In many cases, the use of annual leave has been more sporadic/inconsistent as staff have had to be able to respond quickly in terms of having the ability to travel abroad according to the current travel restrictions/requirements.

Training & education planning & delivery - An initial overview of the planning required for 2022-25 in terns of abstractions required for staff to undertake all components of training required was presented at Workforce & Wellbeing Committee (WWC) in December. Significant further work is on-going to quantify and plan abstractions for training for the new financial year. Within the remainder of the 2021-22 financial year, the Executive Management Board (EMB) agreed a formal approach to all training, particularly focused on operational service lines.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-12	Operations 999	999 Operational Abstraction Rate %	35.30%	36.00%	32.50%	33.30%	25.20%	25.80%	31.00%	33.10%	27.10%	34.70%	32.90%	30.82%	32.95%	28.00%	-	

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
999-24 999-25	Standards: Hours lost at hospital Number of hours lost at hospital (999-24) % hours lost at handover as a proportion of provided hours (999-25) Definition: Hospital handover time is that between the arrival of the patient at hospital under the care of a SECAmb clinician to when they are transferred both clinically and physically over to the care of the receiving unit/dept.	• Hospital handover times are a national target set at 15-mins. • Historically across the SECAmb footprint there has been a wide range of handover times ranging from a small number of Emergency Depts (EDs) where performance is much closer to the target, to those that have considerable handover times. • Handover times are generally not an indicator of activity in the ED alone, rather they are an indicator of overall patient flow across the whole hospital or even the ICP/ICS. Over the past months, all areas have reported a very significant increase in patients who are medically fit for discharge but who are unable to actually be discharged which therefore have a substantial impact on patient flow, and hence handover times.

Action Plan

Actions being taken to mitigate issues:

Strategic engagement at system level - On a daily and weekly basis, senior operational managers engage with and participate in ICS & regional calls with partners where current and predicted challenges to patient flow and handover times are examined and addressed. This ensures accurate and shared oversight of the issues and medium/longer-term planning discussions.

Real-time management - There are two main components:

- Local operational management – Where the relationships between local operational teams and the hospital management teams (particularly in EDs and site managers) enable improved shared risk management, and often works through local short-term challenges, preventing escalations of risk for all parties.
- Strategic oversight – The Trust command structure oversees live hospital handover times, and works with partners to support flow including the use of diverts where appropriate.

Conveyance rate - Through the delivery of an increased level of both 'hear & treat' and 'see & treat' this will result in fewer patients attending EDs via SECAmb which should be a factor in supporting improvements in handover times.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-24	Operations 999	Number of Hours Lost at Hospital Handover	5426	4583	2296	2237	2271	3249	2614	3898	3568	3838	4547	4404	4233	N/A	N/A	
999-25	Operations 999	Hours Lost at Handover as a Proportion of Provided Hours %	1.90%	1.60%	0.80%	0.80%	0.80%	1.00%	0.90%	1.40%	1.40%	1.50%	1.60%	1.64%	1.54%	N/A	N/A	

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
M-25	Standards: Clinical Education Students at risk of not obtaining qualification %	Learners are on an apprenticeship programme with Crawley College (ECSW and AAP), the learner journey fluctuates and is dynamic due to the nature of apprenticeship programmes, life or work events that can lead to a 'break in learning'. Processes are in place that offer 'submission dates' for work, these are at times missed. It is important therefore to recognise that % at risk will vary and for some there is a clear rationale.

Action Plan

Actions being taken to mitigate issues:

- Monthly governance/contract review meetings between Crawley College and SECAmb, attended by the Associate Director of Operations (ADO) and Consultant Paramedic for Clinical Education as the strategic leads and representatives of the Trust.
- Crawley College now maintaining a 'by cohort' dataset of learners at risk, broken down to individual and operational unit area – those at risk are now shared monthly with local Operations Managers as agreed by ADO (Ops) and Consultant Paramedic so that positive engagement from line management can be sought to ensure and support learner progress.
- Each Operating Unit has been asked to identify a named Operational Team Leader (OTL) who will be responsible for working with the College and learners supporting 'tripartite reviews' that occur as part of the apprenticeship standard so a proactive, multi-disciplinary approach can be adopted.
- At Risk learners are a standing agenda item on the monthly governance and contract review meetings. The Crawley College strategic lead is attending the next Workforce & Wellbeing Committee (WWC) meeting to present progress, challenges and mitigations of the programme for increased assurance.

Accountable Executive

Named person:
Medical Director

Complete by date:
Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
M-25	Medical	ClinEd: Students at Risk of Not Obtaining Qualification %	40.00%		39.00%	44.00%	46.00%	45.00%	39.00%	29.00%	25.00%	23.00%	19.00%	25.00%	24.00%	N/A	N/A	

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
111-1 & 111-2	Standards: % 111 calls answered in 60 seconds (111-1) % 111 calls abandoned (111-2)	The 111 calls offered continues to be significantly above the Trust's service contractual target, and higher than that which the Trust is funded to receive. As a result, the service is not achieving the operational call handling metrics such as calls answered in 60 seconds and the rate of calls abandoned.

Action Plan

Actions being taken to mitigate issues:

The service has embarked on a major recruitment drive and training plan for Health Advisor (HA) call handlers in Q4, with the Trust engaged in ongoing dialogue with commissioners and NHS E to secure the requisite funding to support this recruitment.

Accountable Executive

Named person

Executive Director for Operations

Complete by date:

Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
111-2	Operations 111	111 Calls Answered in 60 Seconds %	55.40%	62.90%	74.00%	73.10%	53.40%	36.50%	33.90%	29.10%	33.70%	27.10%	16.30%	23.19%	24.57%	95.00%	-	
111-3	Operations 111	111 Calls Abandoned - (Offered) %	8.20%	6.10%	3.00%	3.50%	7.70%	14.80%	15.90%	19.70%	15.50%	19.00%	30.20%	25.65%	25.48%	5.00%	-	

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999-1 to 999-7	Standards: 999 Calls Answered (mean and 90th centile) (999-1)	999 call answering, which has been under such intense scrutiny from the NHSE central ambulance team and NHSE overall continues to improve, underpinned by the successful delivery of the service's Q3 EMA recruitment plan, which has seen more than 80 EMAs trained, mentored and go-live prior to Xmas. It is important to note that the Trust has achieved the EMA trajectory, agreed with the NHSE central ambulance team and linked to the additional winter funding.

Action Plan

Actions being taken to mitigate issues:

Optimising resource levels - A focus on maximising the availability of all resources – call handling and EOC clinicians. In order to achieve this, sub-actions relating to a number of areas are being implemented:

- The management of abstractions such as sickness and annual leave
- Additional resource hours are being sourced via clinical managers and clinicians within other areas of the Trust.

Dynamic deployment of resources - In live-time Trust resources can be moved between areas/service lines to optimise response and mitigate risk. For example:

- Dual-trained call handlers and clinicians in 111 & EOC can work across either service line as required

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-1	Operations 999	999 Call Answer Mean	00:00:24	00:00:25	00:00:44	00:00:58	00:00:42	00:00:48	00:00:08	00:00:22	00:00:05	00:00:04	00:00:02	00:00:26	00:00:24	00:00:05	-	
999-1	Operations 999	999 Call Answer 90th Centile	00:01:29	00:01:28	00:02:29	00:03:03	00:02:22	00:02:34	00:00:22	00:01:19	00:00:02	00:00:02	00:00:01	00:01:28	00:01:30	00:00:10	-	

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999-1 to 999-7	Standards: Cat 1 (mean and 90th centile) (999-2,) Cat 1T (mean and 90th centile) (999-3) Cat 2 (mean and 90th centile) (999-4) Cat 3 (90th centile) (999-5) Cat 4 (90th centile) (999-6) HPC 3 & HPC 4 (mean and 90th centile) (999-7)	The ARP performance framework is evidence-based in terms of both the target set, and the clinical implications of each target. • Historically, since the start of the Pandemic, but more so during the 2021-22 financial year, the Trust has consistently failed to deliver against all metrics – this has primarily been as a result of challenges relating to resource provision, coupled with increased unpredictability of demand. • SECAmb performance is scrutinised within the Trust and more widely, including being reported within national ARP league tables for English ambulance services issued each month. In December 2021, SECAmb was generally in a favourable position being in the top 5 trusts for all measures apart from C4.

Action Plan

Actions being taken to mitigate issues:

Optimising resource levels - A focus on maximising the availability of all resources – field ops crews. In order to achieve this, sub-actions relating to a number of areas are being implemented:

- The management of abstractions such as sickness and annual leave
- Implementing a programme of incentives, and over the festive period an attendance allowance, to optimise additional hours
- Minimising on day lost hours through late starts, and day out-of-service reasons
- Additional resource hours are being sourced via clinical managers and clinicians within other areas of the Trust.

Dynamic deployment of resources - In live-time Trust resources can be moved between areas/service lines to optimise response and mitigate risk. For example:

- Private ambulance provision is reviewed daily in terms of the best geographical locations for the crews to work out of dependent on local SECAmb gaps in provision; Cross-border working for SECAmb crews, where they respond to the nearest higher priority call which may be in neighbouring dispatch desk areas

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-2	Operations 999	Cat 1 Mean	00:09:09	00:08:42	00:09:08	00:09:00	00:08:45	00:08:49	00:07:57	00:08:18	00:07:32	00:07:37	00:07:33	00:08:42	00:09:10	00:07:00	-	
999-3	Operations 999	Cat 1T Mean	00:11:06	00:10:43	00:11:15	00:11:07	00:10:51	00:10:54	00:09:36	00:10:24	00:09:20	00:09:02	00:09:01	00:10:43	00:11:06	00:19:00	+	
999-4	Operations 999	Cat 2 Mean	00:33:34	00:34:17	00:34:55	00:30:58	00:29:42	00:30:37	00:21:28	00:26:11	00:18:54	00:18:37	00:16:48	00:34:17	00:33:34	00:18:00	-	
999-5	Operations 999	Cat 3 90th Centile	06:14:03	06:21:14	08:06:05	07:12:42	06:17:02	07:21:23	03:51:24	05:40:07	02:58:41	02:49:03	02:01:52	06:21:14	06:14:03	02:00:00	-	
999-6	Operations 999	Cat 4 90th Centile	08:57:09	08:30:25	09:53:30	08:43:12	05:29:55	06:51:57	04:39:46	07:21:59	04:28:40	03:29:30	02:44:51	08:30:25	08:57:09	03:00:00	-	

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
QS-4	Standards: Complaints reporting timeliness	At the end of October 2021 there were a number of breached complaints regarding operational concerns. The Patient Experience Team (PET) worked closely with Operating Unit Managers to clear these, which resulted in the gradual drop in complaints responded within the 25 day response target. During the Covid Business Continuity Incident (BCI) it was agreed by the Executive Management Board (EMB) that target dates for responses can be extended to 35 working days.

Action Plan

- Actions being taken to mitigate issues:
  Figures in IPR Dashboard reflect breaches over 25 working days
- All complainants are contacted by the Patient Experience Team (PET) in the event that their complaint is likely to breach
- Information from the PET Manager confirm that a significant majority of breaches are less than seven working days

Accountable Executive

Named person
Director of Nursing & Quality

Complete by date:
January 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-4	Quality & Safety	Complaints Reporting Timeliness %	69.00%	95.00%	64.50%	88.00%	81.00%	98.00%	96.00%	87.00%	81.00%	88.00%	64.50%	84.00%	77.00%	95.00%	-	

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999-14	Standards: % Time spent in SMP 3 or higher Definition: SMP stands for 'Surge Management Plan' which contains 4 levels which indicate the pressure that SECAmb is under at any time. These levels vary on a minute/hour basis and are aligned to clear definitions based on the number, category and duration of calls being held awaiting a response.	• Normal 'business as usual' would be SMP1 and is seen when there is a balance between resource provision and call demand – where sufficient resources are available, then the number of calls awaiting dispatch/being held would be minimal. • Over the past months there has been higher proportions of time spent at the higher levels of SMP due to the resourcing level challenges as described elsewhere. • Within SMP there are specific actions that can be implemented at each level which are designed to manage clinical risk within EOC & field operations – these are also stood down as SMP levels de-escalate.

Action Plan

Actions being taken to mitigate issues:
Note: The actions for this are essentially the same as those for 999-1 to 999-7 as seen in the previous exception report (slide 27).

Review of the SMP - In conjunction with a move to a national ambulance framework to manage surge all ambulance services have been asked to review their surge plans to transition to a Clinical Safety Plan. This is an evolution of SMP with inclusion of additional actions at each level (actions and learnings from the past 12+ months) as well as consideration for additional clinical risk within clinical queues in EOC.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-14	Operations 999	Time Spent in SMP 3 or Higher %	75.00%	60.70%	1.30%	12.10%	15.40%	36.00%	68.90%	83.00%	70.70%	82.50%	86.20%	72.88%	72.57%	N/A	N/A	

Performance by Domain
Well-led: Exception Report

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

ID	Standard	Background
WF-7	Standards: % Annual rolling turnover rate Definition: Percentage of staff turnover on an annual rolling rate	Turnover has been impacted by the relentless nature of delivering services during COVID. VCOD represents a risk to retention of SECAmb colleagues and across the NHS and wider social care landscape.

Action Plan

Actions being taken to mitigate issues:
Sensitive implementation and communication of VCOD requirements, with engagement of union representatives

Accountable Executive

Named person:
Workforce (HR)

Complete by date:
January 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
WF-7	Workforce HR	Annual Rolling Turnover Rate	11.20%	10.90%	10.50%	10.30%	10.80%	11.40%	12.10%	12.90%	13.60%	13.90%	14.50%	15.18%	15.43%	N/A	N/A	

Performance by Domain
Well-led: Exception Report

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

ID	Standard	Background
WF-8	Standards: % Annual rolling sickness rate Definition: Percentage of staff sickness on an annual rolling rate	Work continues to support Operations in managing sickness absence, however, the Trust still operates under nationally set guidance for COVID and long COVID management. While this remains in place, a not insignificant proportion of sickness cannot be effectively managed.

Action Plan

Actions being taken to mitigate issues:
The sickness action plan is the mitigation – revised guidance is needed nationally on covid and long covid.

Accountable Executive

Named person:
Workforce (HR)

Complete by date:
January 2022

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
WF-8	Workforce HR	Annual Rolling Sickness Absence	7.40%	7.10%	7.30%	7.10%	7.10%	7.30%	7.50%	7.70%	7.90%	8.10%	8.30%	8.58%	8.57%	5.00%	-	

Performance by Domain
Well-led: Exception Report

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

ID	Standard	Background
999-28 999-15	Standards: % of meal breaks taken outside of window (999-28) % 999 frontline finishes/over runs (999-15) Definition: • Operational staff work shifts and therefore meal breaks are managed within specific 'windows' within each shift, generally somewhere around the mid-point. • Due to the nature of 999 work, it is very common for staff to end their shift off station – often at an ED having handed a patient over. Late finishes/over-runs occur where staff finish late as compared to their planned shift end time.	• Both of the standards within this exception report relate to staff well-being. • Meal-break compliance is measured against three components: whether it is taken or not, whether it is taken within the appropriate time window and whether it is taken within the geographical area/dispatch desk that the crew are based. • With greater challenges regarding field operations resulting in a lower level of resourcing, crews are travelling further which not only impacts the location where meal-breaks can be taken as well as the distance required to travel to get back to base at the end of shift.

Action Plan

Actions being taken to mitigate issues:

Optimising resource levels - A focus on maximising the availability of all. In order to achieve this, sub-actions relating to a number of areas are being implemented:

- The management of abstractions such as sickness and annual leave
- Implementing a programme of incentives, and over the festive period an attendance allowance, to optimise additional hours
- Minimising on day lost hours through late starts, on day out-of-service reasons
- Additional resource hours are being sourced via clinical managers and clinicians within other areas of the Trust.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-28	Operations 999	% of Meal Breaks Outside of Window				49.90%	51.10%	54.80%	59.30%	59.10%	58.70%	58.80%	60.70%	60.29%	59.56%	N/A	N/A	
999-15	Operations 999	999 Frontline Late Finishes/Over-Runs %	61.10%	59.50%	51.00%	52.40%	51.90%	60.20%	53.40%	50.60%	49.20%	51.90%	53.30%	50.78%	50.35%	N/A	N/A	

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
C-1	Standards: % Policies and procedures outstanding review	Due to COVID and REAP 4 levels, the chasing and updating of policies and procedures had halted at the end of 2020, where the policies and procedures outstanding review percentage was steady at approximately 11%. This caused said percentage to steadily grow since then.

Action Plan

Actions being taken to mitigate issues:
As of Q3, there has been more proactive support to policy authors to help ensure a reduction in those overdue for review.

Accountable Executive

Named person:
Chief Executive

Complete by date:
Ongoing

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
C-1	Corporate	Policies & Procedures Outstanding Review %	11.80%	11.80%	11.00%	11.30%	15.80%	17.40%	29.00%	32.00%	37.00%	36.50%	37.20%	40.78%	43.13%	0.00%	-	

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
FL-1	Standards: % Vehicles older than target age Definition: % of all Trust operational vehicles that are older than the planned replacement target age	This is the first time this metric has been reported in the IPR. As of December 2021, 41% of the Trust's operational fleet is older than the planned replacement target age. The Trust is currently working towards replacing operational vehicles to fall in line with the replacement parameters that have been set. The parameters have been set based on both the vehicles reliability at a certain age and the cost effectiveness to keep it on the road past this age against a replacement. Current replacement target ages are as follows: • Double Crew Ambulance (DCA) box conversion – 7 Years • Double Crew Ambulance (DCA) van Conversion – 5 Years • Single Response Ambulance RV – 5 Years

Action Plan

Actions being taken to mitigate issues:

- The Trust is due to start the commissioning process for 65 new Fiat DCA van conversions (January 22 – June 22), which will allow the decommission of 65 old DCA's
- The Trust is currently commissioning new SRV's for Paramedic Practitioners (PPs), Critical Care Paramedics (CCPs) and Operational Team Leaders (OTLs) and are on target to have them all replaced by the end of 2022
- A business case is in development for a standard recurrent vehicle replacement program

Accountable Executive

Named person:
Executive Director of Planning & Business Development

Complete by date:
On going as part of the Trust's vehicle replacement program

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
FL-1	Fleet	Vehicles Older Than Target Age %	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	36.00%	36.00%	36.00%	36.00%	41.00%	41.00%	0.00%	-	

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This period's new metrics

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This month's new metrics

Domain	ID	New Metric
Safe	Number of RTCs per 10k miles travelled (FL-2)	This dataset captures the frequency of Road Traffic Collisions (RTCs) per 10,000 miles travelled. This information will be reviewed monthly as part of the Driver Safety Forum led by the Trust's Driving Standards Manager and reporting to the appropriate Quality and Safety group within our governance. The group will identify in detail areas of outliers and liaise directly with local OUs for management action as appropriate. This high-level metric will include any form of RTC (i.e. cracked windshield, broken mirrors, would be included).
Safe	Planned vehicle services completed % (FL-3)	This is a new dataset which demonstrates the effectiveness of the Trust's planned vehicle maintenance and servicing function. As this is a relatively new dataset, it will be a couple of months before the Trust is in a position to identify any trends or agree performance targets/benchmarks.
Safe	Statutory estates compliance % (gas, water, electrical, asbestos, fire LOLER) (SE-1)	It is a legal requirement to provide a safe environment for our staff and visitors. Our compliance level across all requirements at the last reporting period of November 2022 was 94%. The slight drop in % was due to a delay in completing a small number of water risk assessments within the agreed timeframe - which has since been achieved.
Effective	Operations Support Desk (OSD) OSD vehicle movements achieved % (OS-1)	Current performance is good. Demand is well matched by supply and a monthly trend indicates the team are delivering 96% of moves within the timeframes required. This has remained constant throughout 2021 and has allowed the team to take on extra tasking from other departments e.g., Clinical Education. In addition, the team has been able to respond effectively to last-minute requests such as the mobilisation of PCR testing at remote hubs.
Effective	999 frontline hours compliance % (compliance by hour) (999-30)	Our hourly forecast planning tool provides a retrospective view of 999 frontline hours compliance (by hour of day). This will give a more meaningful picture of how the planning teams are performing and highlight the reasons for abstractions from the time of planning. This is an overall measure of effectiveness of our scheduling, and indicates how well we are fully matching demand to planned capacity, on an hourly basis.

This month's new metrics

Domain	ID	New Metric
Responsive	Reduction of Business Intelligence (BI) Marval request backlog (BI-1)	This metric is a count of how many requests have been completed during the month. The indicator provides a measure of productivity. During December 2021, there was a reduction in both requests being made and resource available from the Business Intelligence (BI) team members due to illness and planned leave.
Well-led	% Vehicles older than target age (FL-1)	As of December 2021, 41% of the Trust's operational fleet is older than the planned replacement target age. The Trust is currently working towards replacing operational vehicles to fall in line with the approved fleet strategy. The parameters have been set based on both the vehicles reliability at a certain age and the cost effectiveness to keep it on the road past this age against a replacement.
Well-led	% of DCA vehicles off road (VOR) (FL-4) % of SRV vehicles off road (VOR) (FL-5)	The Trust's operational vehicles can be "off the road" for a number of reasons e.g., planned maintenance, accident repairs, communication issues, specialist repairs or unplanned defects. The Trust has always recorded its average VOR percentage for Double Crew Ambulances (DCAs) and Single Response Vehicles (SRVs). However, from January 2022 onwards, the Trust will start reporting this data by specialist SRV e.g., Paramedic Practitioner (PP), Critical Care Paramedic (CCP), Operational Team Leader (OTL) etc. In addition, the Trust will also start to record VOR for its Hazardous Area Response Team (HART) vehicles. This measures the effective availability time of our fleet, as well as effectiveness of our maintenance team.
Well-led	Average miles between vehicle failures (FL-10)	The Trust carries out rigorous planned maintenance on its vehicles, however due to the nature of their use and the conditions they operate within, there are on occasions times when the vehicle may fail whilst in operation. This is usually due to either a mechanical failure, Road Traffic Collision (RTC) or tyre damage. This new data set will start to record the average number of miles between vehicle roadside failures so the Trust can review any trends and adjust planned servicing parameters if required.

This month's new metrics

Domain	ID	New Metric
Well-led	PAP shift fulfilment vs. contract % (999-29)	PAP shift fulfilment compliance against contract is usually above the 95% target. We saw a slight drop off in December for two main reasons: • Total contractual hours increased in December due to additional winter monies (December – End March 2022) • PAP providers experienced similar challenges to SECAmb and the rest of the health system regarding exceptionally high sickness absence rates. It is anticipated this situation will rectify itself to a large extent through January and we should expect compliance to have improved when next reported.
Well-led	Facilities Management (FM) performance against SLA % (SE-3)	The Trust has an outsourced Facilities Management (FM) provider to provide a 24/7 helpdesk for reporting all repair and maintenance issues. The Trust has an agreed SLA with the FM which provides Cat 1, 2 and 3 calls. The Trust monitors and manages performance against the SLA to ensure the provider is working effectively and providing best value for money. Current performance is at 97% overall in terms of how quickly calls are responded to and how effective the repairs have been such as first or second time fix.

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Appendices

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Performance Dashboards (by domain)

Best placed to care, the best place to work

Performance by Domain
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-1	Quality & Safety	Number of Datix Incidents	1751	1595	1070	1149	1051	1175	1253	1493	1397	1149	1070	1398	1652	N/A	N/A	
QS-2	Quality & Safety	Number of Incidents Reported as SIs	8	6	7	1	7	3	6	11	5	1	7	6	5	N/A	N/A	
999-12	Operations 999	999 Frontline Hours Provided %	95.10%	96.10%	103.20%	96.90%	99.10%	99.30%	94.30%	90.10%	86.90%	88.00%	89.50%	92.65%	91.61%	100.00%	-	
QS-3	Quality & Safety	Duty of Candour Compliance %	80.00%	67.00%	100.00%	75.00%	100.00%	67.00%	100.00%	100.00%	100.00%	75.00%	100.00%	80.00%	100.00%	100.00%	=	
QS-7	Quality & Safety	Hand Hygiene Compliance %	96.00%	94.00%	93.00%	95.00%	94.00%	95.00%	95.00%	92.00%	90.00%	95.00%	93.00%	84.00%	81.00%	90.00%	-	
QS-8	Quality & Safety	Safeguarding Training Completed (Children) Level 2 %	78.20%	79.40%	82.00%	90.40%	88.70%	87.00%	87.30%	86.00%	86.20%	90.40%	82.00%	84.04%	84.27%	95.00%	-	
QS-13	Quality & Safety	Violence and Aggression Incidents (Number of Victims - Staff)	70	53	60	60	65	73	87	91	99	60	60	76	117	N/A	N/A	
MM-1	Medicines Management	Number of Medicines Incidents	125	125	142	173	152	171	118	156	141	157	165	146	153	N/A	N/A	
MM-3	Medicines Management	Single Witness Signature Use CDs Omnicell	6	5	9	4	3	2	3	6	7	14	5	13	23	0	-	
MM-4	Medicines Management	Single Witness Signature Use CDs Non-Omnicell	3	1	1	1	0	0	0	1	0	0	1	1	0	0	=	
MM-5	Medicines Management	Number of CD Breakages	25	21	10	27	16	16	19	10	17	9	29	20	16	N/A	N/A	
MM-7	Medicines Management	Medicines Management % of Audits Completed	94.00%	93.00%	88.00%	95.00%	95.00%	98.40%	98.70%	98.10%	97.90%	94.10%	91.90%	98.40%	98.50%	100.00%	-	
WF-1	Workforce HR	Number of Staff WTE (Excl bank and agency)	3956	3959	3968	3974	3945	3952	3957	3936	3939	3949	3965	3957	3934	3996	-	
WF-2	Workforce HR	Number of Staff Headcount (Exc bank and agency)	4345	4353	4358	4367	4335	4342	4350	4327	4336	4344	4365	4350	4337	N/A	N/A	
WF-3	Workforce HR	Finance Establishment (WTE)	3950	3951	3956	3946	3946	3946	3946	4070	4060	4040	4033	3947	3996	N/A	N/A	
WF-4	Workforce HR	Vacancy Rate %	-0.20%	-0.20%	-0.30%	-0.70%	0.10%	-0.10%	-0.20%	3.30%	3.00%	2.20%	1.70%	-0.26%	1.55%	N/A	N/A	

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-9	Quality & Safety	Number of RIDDOR Reports	9	9	12	8	10	11	14	17	14	8	12	15	11	N/A	N/A	
WF-16	Workforce HR	`	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	=	
M-20	Medical	Compliant NHS Pathways Audits (Clinical) %	92.00%	93.00%	90.00%	93.00%	92.00%	92.00%	87.00%	97.00%	94.00%	95.00%	96.00%	96.00%	93.00%	N/A	N/A	
M-21	Medical	Required NHS Pathways Audits Completed (EMA) %	100.00%	98.00%	49.00%	96.00%	103.00%	105.00%	83.00%	53.00%	70.00%	78.00%	102.00%	99.00%	92.00%	N/A	N/A	
M-22	Medical	Compliant NHS Pathways Audits (EMA) %	92.00%	82.00%	83.00%	85.00%	83.00%	84.00%	84.00%	90.00%	82.00%	84.00%	84.00%	78.00%	96.00%	100.00%	-	
M-23	Medical	Required NHS Pathways Audits Completed (Clinical) %	100.00%	100.00%	97.00%	100.00%	102.00%	102.00%	102.00%	102.00%	101.00%	76.00%	99.00%	99.00%	92.00%	N/A	N/A	
QS-17	Quality & Safety	Outstanding Actions Relating to SIs, Outside of Timescales	111	126	112	117	141	114	112	116	117	117	112	129	130	N/A	N/A	
QS-19	Quality & Safety	Deep Clean Compliance %	82.50%	72.80%	64.00%	94.90%	95.00%	85.00%	82.00%	73.00%	41.50%	94.90%	64.00%	70.00%	74.00%	95.00%	-	
QS-20	Quality & Safety	Health & Safety Incidents	22	35	33	31	29	59	47	39	30	31	33	36	31	N/A	N/A	
WF-24	Workforce HR	Current licence details held for Operational Staff %	86.40%	89.50%	90.40%	92.40%	96.10%	96.10%	96.00%	93.80%	92.60%	91.10%	91.50%	91.18%	91.08%	100.00%	-	
QS-22	Quality & Safety	Manual Handling Incidents	24	29	32	22	17	43	28	35	33	22	32	29	26	N/A	N/A	
QS-25	Quality & Safety	Flu Vaccine Compliance	78.80%		79.80%	80.10%						80.10%	79.80%		58.00%	90.00%	-	
FL-2	Fleet	Number of RTCs per 10k miles travelled												0.63	0.69	N/A	N/A	
FL-3	Fleet	% of planned vehicle services completed												71.00%	76.00%	N/A	N/A	
SE-1	Strategic Estates	% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)												94.00%	94.00%	100.00%	-	

\+ Outperformed target
\- Underperformed target
= On target

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-11	Operations 999	JCT Allocation to Clear at Scene Mean	01:20:16	01:22:00	01:19:51	01:19:00	01:18:57	01:14:38	01:17:12	01:16:00	01:16:34	01:16:44	01:17:56	01:17:45	01:18:35	N/A	N/A	
999-11	Operations 999	JCT Allocation to Clear at Hospital Mean	01:57:53	01:57:24	01:51:48	01:49:29	01:49:30	01:50:58	01:49:19	01:52:57	01:53:43	01:54:04	01:55:44	01:55:40	01:57:04	N/A	N/A	
M-1	Medical	**Cardiac ROSC Utstein %	40.90%	40.00%	48.50%	40.00%	41.00%	40.50%	48.70%	54.20%	48.70%	57.10%				45.10%	+	
M-2	Medical	Cardiac ROSC ALL %	15.70%	16.30%	23.70%	22.00%	23.00%	24.00%	28.30%	31.00%	24.80%	34.00%				23.80%	+	
M-12	Medical	**Sepsis Care Bundle %	87.00%	84.20%	86.30%	85.00%	85.00%	83.50%	84.00%	81.30%	86.20%	84.50%	85.40%			85.00%	+	
M-3	Medical	Cardiac Survival Utstein %	15.90%	25.70%	33.30%	18.00%	28.00%	27.30%		31.30%	30.60%	23.50%				25.60%	-	
M-4	Medical	Cardiac Survival ALL %	4.20%	5.10%	9.10%	8.00%	13.70%	12.30%		14.00%	10.00%	10.80%				9.60%	+	
M-11	Medical	Cardiac Arrest - Post ROSC %	85.50%	75.30%	61.60%	78.00%	81.00%	78.50%	90.30%	75.80%	68.00%	75.30%				76.80%	-	
M-5	Medical	**Acute STEMI Care Bundle Outcome %	65.60%	64.10%	63.90%	74.00%	69.00%	60.30%	57.30%	60.60%	62.70%	54.00%	55.40%			64.70%	-	
M-6	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	02:22:00	02:33:00	02:14:00	02:20:00	02:20:00	02:36:00	02:21:00	02:19:00	02:20:00	02:20:00	02:14:00			02:22:00	+	
M-7	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	03:14:00	03:26:00	03:02:00	03:15:00	03:02:00	03:50:00	03:17:00	03:17:00	03:02:00	03:15:00	03:02:00			03:14:00	+	
M-8	Medical	Stroke - Call to Hospital Arrival Mean	01:28:59	01:46:00	01:24:00	01:27:00	01:28:00	01:35:00	01:31:00	01:26:00	01:28:00	01:27:00	01:24:00			01:29:00	+	
M-9	Medical	Stroke - Call to Hospital Arrival 90th Centile	02:20:00	02:57:00	02:15:00	02:22:00	02:07:00	02:21:00	02:15:00	02:14:00	02:07:00	02:22:00	02:15:00			02:20:00	+	
M-10	Medical	**Stroke - Assessed F2F Diagnostic Bundle %	96.60%	96.90%	95.80%	95.00%	96.00%	95.70%	96.80%	94.10%	97.10%	97.10%	97.90%			96.30%	+	
M-13	Medical	Sensitivity of Cardiac Arrest Detection During Telephone Triage %	93.30%	87.00%	93.40%	82.00%	82.00%	82.20%	84.10%	91.20%	95.50%	95.20%				93.80%	-	

NB:
M-1 to M-16 are reported up to 4-months in arrears

\+ Outperformed target
\- Underperformed target
= On target

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
M-14	Medical	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	73.80%	74.30%	79.30%	79.00%	78.00%	77.30%	80.00%	79.40%	80.30%	85.00%				77.90%	+	
M-16	Medical	Proportion of Non-EMS Witnessed Cardiac Arrests with PAD Applied to Patient %	6.30%	5.70%	4.90%			5.80%		12.10%	6.40%	8.40%				7.30%	+	
999-13	Operations 999	ECAL Mean Response Time	00:24:03	00:23:07	00:24:22	00:24:03	00:24:18	00:22:57	00:22:56	00:23:31	00:23:43	00:24:20	00:23:36	00:23:07	00:24:03	N/A	N/A	
999-12	Operations 999	999 Operational Abstraction Rate %	35.30%	36.00%	32.50%	33.30%	25.20%	25.80%	31.00%	33.10%	27.10%	34.70%	32.90%	30.82%	32.95%	28.00%	-	
WF-20	Workforce L&OD	Statutory & Mandatory Training % Year to Date	71.50%	72.70%	74.70%	84.50%	12.20%	24.90%	36.80%	40.90%	42.80%	43.90%	47.80%	52.18%	56.71%	95.00%	-	
WF-6	Workforce HR	Statutory & Mandatory Training Rolling Year %	76.10%	75.60%	76.20%	78.70%	67.10%	60.70%	63.30%	67.00%	66.60%	65.90%	66.30%	68.64%	65.44%	95.00%	-	
999-17	Operations 999	Responses Per Incident	1.08	1.08	1.09	1.00	1.01	0.99	1.01	1.09	1.09	1.08	1.09	1.09	1.09	1.09	=	
999-18	Operations 999	Section 136 Mean Response Time	00:31:21	00:32:10	00:29:58	00:33:17	00:23:37	00:33:15		00:18:10	00:23:22	00:17:36	00:16:07	00:32:10	00:31:21	N/A	N/A	
999-19	Operations 999	Section 135 Mean Response Time			00:06:04	00:35:04	03:48:17	00:22:29	00:23:57	00:22:29	03:48:17	01:43:52	00:06:04			N/A	N/A	
999-20	Operations 999	ePCR Usage	96.40%	96.20%	96.10%	96.70%	97.00%	91.00%	95.70%	93.10%	96.20%	96.70%	96.70%	93.88%	97.04%	95.00%	+	
999-24	Operations 999	Number of Hours Lost at Hospital Handover	5426	4583	2296	2237	2271	3249	2614	3898	3568	3838	4547	4404	4233	N/A	N/A	
999-25	Operations 999	Hours Lost at Handover as a Proportion of Provided Hours %	1.90%	1.60%	0.80%	0.80%	0.80%	1.00%	0.90%	1.40%	1.40%	1.50%	1.60%	1.64%	1.54%	N/A	N/A	
M-24	Medical	ClinEd: Course Capacity Utilisation Associate Ambulance Practitioner %	96.00%	93.00%	93.00%	93.00%	93.00%	93.00%	92.00%	92.00%	92.00%	92.00%	91.00%	90.00%	90.00%	100.00%	-	
M-24	Medical	ClinEd: Course Capacity Utilisation Transition to Practice %	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	75.00%	74.00%	75.00%	73.00%	73.00%	73.00%	100.00%	-	
M-25	Medical	ClinEd: Students at Risk of Not Obtaining Qualification %	40.00%		39.00%	44.00%	46.00%	45.00%	39.00%	29.00%	25.00%	23.00%	19.00%	25.00%	24.00%	N/A	N/A	

Notes:
M-1 to M-16 are reported up to 4-months in arrears
999-19 where there is no data e.g. Dec-21, this indicates there was zero activity during the month

\+ Outperformed target
\- Underperformed target
= On target

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

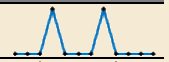
IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
WF-34	Workforce HR	Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	31.40%	31.20%	31.60%	31.40%	31.40%	31.30%	31.60%	32.50%	31.60%	30.30%	29.40%	29.40%		27.20%	+	
WF-35	Workforce HR	Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	18.60%	18.90%	18.80%	19.00%	19.00%	19.00%	18.80%	18.40%	18.00%	17.80%	17.50%	17.50%		22.00%	-	
WF-36	Workforce HR	Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	50.00%	49.90%	49.60%	49.60%	49.60%	49.60%	49.50%	49.30%	50.40%	51.90%	53.10%	53.10%		50.80%	+	
OS-1	Operational Support Desk	% of OSD vehicle movements achieved		98.00%	98.50%	99.00%	98.00%	97.00%	98.00%	96.00%	97.00%	99.50%	99.00%	99.00%	99.00%	100.00%	-	
999-30	Operations 999	% 999 frontline hours compliance (profile compliance by hour)												84.86%	81.50%	100.00%	-	

NB:
WF-34 – WF-36 are reported 2-months in arrears

+ Outperformed target
- Underperformed target
= On target

Performance by Domain
Caring: Performance Dashboard

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
QS-12	Quality & Safety	Complaints relating to privacy and respect %		0.00%	0.00%	0.00%	0.20%	0.00%	0.00%	0.00%	0.20%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	
QS-10	Quality & Safety	Proportion of Complaints Relating to Crew Attitude %	37.00%	38.00%	50.00%	56.00%	31.00%	33.00%	31.00%	18.00%	25.00%	56.00%	50.00%	24.00%	28.00%	N/A	N/A	

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Responsive: Performance Dashboard

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
111-1	Operations 111	111 Calls Offered	115809	93018	87249	110294	119979	135942	126452	138484	127167	123604	139429	121449	135035	N/A	N/A	
111-2	Operations 111	111 Calls Answered in 60 Seconds %	55.40%	62.90%	74.00%	73.10%	53.40%	36.50%	33.90%	29.10%	33.70%	27.10%	16.30%	23.19%	24.57%	95.00%	-	
111-3	Operations 111	111 Calls Abandoned - (Offered) %	8.20%	6.10%	3.00%	3.50%	7.70%	14.80%	15.90%	19.70%	15.50%	19.00%	30.20%	25.65%	25.48%	5.00%	-	
111-4	Operations 111	111 to 999 Referrals (Answered Calls) %	13.90%	14.90%	15.00%	13.40%	8.70%	9.10%	9.70%	9.30%	9.30%	9.10%	8.90%	8.95%	8.51%	13.00%	+	
111-4	Operations 111	999 Referrals	12384	11903	11064	12058	8188	8901	8805	8675	8585	7961	7648	7162	7628	N/A	N/A	
111-5	Operations 111	A&E Dispositions %	14.60%	14.70%	15.40%	15.60%	15.20%	14.90%	16.00%	9.10%	8.10%	8.90%	8.30%	8.70%	8.25%	9.00%	+	
111-5	Operations 111	A&E Dispositions	12925	11683	11349	14047	14261	14571	14472	8501	7534	7790	7153	6962	7395	N/A	N/A	
111-7	Operations 111	Clinical Contact %				48.10%	48.20%	45.20%	44.90%	46.00%	46.00%	46.20%	48.00%	49.35%	52.17%	50.00%	+	
111-8	Operations 111	Ambulance Validation %				95.40%	95.30%	95.10%	90.60%	95.20%	93.60%	95.90%	95.60%	94.90%	96.86%	85.00%	+	
999-10	Operations 999	999 Calls Answered	76806	70262	50316	60200	61386	77074	71529	85769	77173	81649	86089	76122	78778	N/A	N/A	
999-10	Operations 999	Incidents	66615	65239	56470	62648	62845	65474	67474	65161	62343	60808	64510	62534	63924	N/A	N/A	
999-1	Operations 999	999 Call Answer Mean	00:00:24	00:00:25	00:00:44	00:00:58	00:00:42	00:00:48	00:00:08	00:00:22	00:00:05	00:00:04	00:00:02	00:00:26	00:00:24	00:00:05	-	
999-1	Operations 999	999 Call Answer 90th Centile	00:01:29	00:01:28	00:02:29	00:03:03	00:02:22	00:02:34	00:00:22	00:01:19	00:00:02	00:00:02	00:00:01	00:01:28	00:01:30	00:00:10	-	

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Responsive: Performance Dashboard

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-2	Operations 999	Cat 1 Mean	00:09:09	00:08:42	00:09:08	00:09:00	00:08:45	00:08:49	00:07:57	00:08:18	00:07:32	00:07:37	00:07:33	00:08:42	00:09:10	00:07:00	-	
999-2	Operations 999	Cat 1 90th Centile	00:16:24	00:16:03	00:16:19	00:16:25	00:16:03	00:16:19	00:14:54	00:15:08	00:13:56	00:14:14	00:13:53	00:16:03	00:16:24	00:15:00	-	
999-3	Operations 999	Cat 1T Mean	00:11:06	00:10:43	00:11:15	00:11:07	00:10:51	00:10:54	00:09:36	00:10:24	00:09:20	00:09:02	00:09:01	00:10:43	00:11:06	00:19:00	+	
999-3	Operations 999	Cat 1T 90th Centile	00:19:58	00:20:00	00:20:21	00:20:19	00:20:03	00:20:14	00:17:38	00:19:13	00:17:13	00:16:46	00:16:36	00:20:01	00:19:58	00:30:00	+	
999-4	Operations 999	Cat 2 Mean	00:33:34	00:34:17	00:34:55	00:30:58	00:29:42	00:30:37	00:21:28	00:26:11	00:18:54	00:18:37	00:16:48	00:34:17	00:33:34	00:18:00	-	
999-4	Operations 999	Cat 2 90th Centile	01:08:19	01:10:41	01:10:47	01:00:37	00:58:53	01:00:47	00:40:51	00:50:55	00:34:58	00:34:46	00:31:09	01:10:42	01:08:19	00:40:00	-	
999-5	Operations 999	Cat 3 90th Centile	06:14:03	06:21:14	08:06:05	07:12:42	06:17:02	07:21:23	03:51:24	05:40:07	02:58:41	02:49:03	02:01:52	06:21:14	06:14:03	02:00:00	-	
999-6	Operations 999	Cat 4 90th Centile	08:57:09	08:30:25	09:53:30	08:43:12	05:29:55	06:51:57	04:39:46	07:21:59	04:28:40	03:29:30	02:44:51	08:30:25	08:57:09	03:00:00	-	
999-7	Operations 999	HCP 3 Mean	03:12:01	03:08:40	04:18:12	03:46:37	03:32:39	04:06:19	02:32:00	03:25:11	02:02:40	01:39:18	01:25:11	03:08:40	03:12:01	N/A	N/A	
999-7	Operations 999	HCP 3 90th Centile	07:01:05	07:28:23	10:01:35	08:37:59	08:28:04	08:36:33	05:08:05	06:56:27	04:00:25	03:23:05	02:55:47	07:28:24	07:01:05	N/A	N/A	
999-7	Operations 999	HCP 4 Mean	03:59:08	03:45:42	05:23:02	04:47:22	04:46:11	04:56:09	03:20:43	04:22:49	02:44:10	02:01:07	01:49:46	03:45:42	03:59:08	N/A	N/A	
999-7	Operations 999	HCP 4 90th Centile	09:05:50	08:38:29	12:48:15	10:28:52	10:41:54	09:20:02	06:21:05	08:01:14	05:11:59	04:28:16	04:10:26	08:38:29	09:05:50	N/A	N/A	
999-9	Operations 999	Hear & Treat %	8.60%	8.00%	6.00%	6.90%	6.90%	9.30%	7.90%	9.60%	9.00%	8.80%	10.30%	9.97%	9.39%	10.00%	-	
999-9	Operations 999	See & Treat %	36.30%	37.40%	35.20%	32.60%	32.10%	31.20%	31.60%	32.00%	32.10%	31.30%	30.50%	31.17%	32.48%	35.00%	-	
999-9	Operations 999	See & Convey %	55.10%	54.60%	58.80%	60.50%	61.00%	59.40%	60.50%	58.40%	59.00%	59.80%	59.10%	58.90%	58.15%	55.00%	-	

\+ Outperformed target
\- Underperformed target
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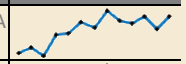
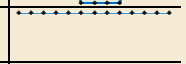
Performance by Domain
Responsive: Performance Dashboard

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-10	Operations 999	CFR Attendances	648	749	580	1034	1089	1337	1219	1592	1354	1290	1467	1166	1474	N/A	N/A	
999-10	Operations 999	FFR Attendances	175	205	142	316	260	364	241	425	383	339	353	293	343	N/A	N/A	
QS-4	Quality & Safety	Complaints Reporting Timeliness %	69.00%	95.00%	64.50%	88.00%	81.00%	98.00%	96.00%	87.00%	81.00%	88.00%	64.50%	84.00%	77.00%	95.00%	-	
QS-5	Quality & Safety	Number of Complaints	61	69	48	64	68	72	116	106	114	64	48	93	72	N/A	N/A	
QS-6	Quality & Safety	Number of Compliments	140	173	191	187	208	159	162	171	177	187	191	150	148	N/A	N/A	
QS-15	Quality & Safety	Complaints per 1000 999 Calls Answered	0.79	0.98	0.95	1.06	1.11	0.09	0.16	0.13	0.14	1.06	0.95	0.01	0.01	N/A	N/A	
QS-16	Quality & Safety	Compliments per 1000 999 Calls Answered	1.82	2.46	3.80	3.91	3.69	0.21	0.23	0.21	0.22	3.91	3.80	0.02	0.02	N/A	N/A	
QS-14	Quality & Safety	Learning from deaths: Number of Structured Judgment Reviews	20	20	20	20	20	20	20	20	20	20	20			20		
QS-26	Quality & Safety	Learning from deaths: Number of SJRs showing harm	0	0	0	0	0	0	0	0	0	0	0			0		
999-14	Operations 999	Time Spent in SMP 3 or Higher %	75.00%	60.70%	1.30%	12.10%	15.40%	36.00%	68.90%	83.00%	70.70%	82.50%	86.20%	72.88%	72.57%	N/A	N/A	
C-2	Corporate	Number of BCIs	7	3	2	0	0	1	2	1	1	1	1	2	1	0	-	
BI-1	Business Intelligence	Number of Marval Requests Completed	43	50	57	69	44	62	73	47	48	68	52	46	26	N/A	N/A	

NB:
QS-14 and QS-26 are reported 3-months in arrears

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Well-Led: Performance Dashboard

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
WF-5	Workforce HR	Appraisals YTD	41.60%	43.20%	45.70%	52.20%	3.40%	7.00%	9.10%	10.70%	11.30%	12.50%	13.90%	15.51%	17.55%	85.00%	-	
WF-40	Workforce HR	Appraisals Rolling Year %				52.20%	48.90%	40.80%	36.80%	34.10%	31.60%	30.30%	28.70%	26.99%	27.36%	85.00%	-	
WF-7	Workforce HR	Annual Rolling Turnover Rate	11.20%	10.90%	10.50%	10.30%	10.80%	11.40%	12.10%	12.90%	13.60%	13.90%	14.50%	15.18%	15.43%	N/A	N/A	
WF-8	Workforce HR	Annual Rolling Sickness Absence	7.40%	7.10%	7.30%	7.10%	7.10%	7.30%	7.50%	7.70%	7.90%	8.10%	8.30%	8.58%	8.57%	5.00%	-	
WF-9	Workforce HR	Disciplinary Cases	2	1	1	4	9	8	2	6	1	4	1	4	1	N/A	N/A	
WF-10	Workforce HR	Individual Grievances	9	8	5	8	10	8	8	5	9	8	10	2	2	N/A	N/A	
WF-11	Workforce HR	Collective Grievances	0	0	1	0	1	1	1	1	0	2	0	1	1	N/A	N/A	
WF-12	Workforce HR	Bullying & Harrassment Internal	1	1	1	6	5	4	1	0	4	3	3	0	1	0	-	
WF-13	Workforce HR	Whistleblowing	0	0	0	0	0	0	0	3	0	0	0	0	0	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak Up: Total Open Cases	25		28	7	31	33	36	45	20	7	28	18	25	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak up: Open cases re possible patient safety issues	1	4	4		2	3	3	2	2	0	4	4	1	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak up: Cases Closed in Month With Resolution	0		1	4	0	0	1	0	0	4	1	7	0	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak up: Cases Closed in Month Without Resolution	0		1	12	2	2	1	25	0	12	1	0	0	N/A	N/A	
WF-29	Workforce HR	Staff Acting Up/Secondments %		2.70%	2.60%	3.10%	2.90%	2.90%	2.70%	2.30%	2.20%	2.50%	2.50%	2.51%	2.57%	N/A	N/A	

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Well-Led: Performance Dashboard

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

IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
WF-37	Workforce HR	Diversity: Disability - declared %	4.00%	4.00%	4.00%	4.20%	4.20%	4.20%	4.30%	4.30%	4.30%	4.80%	4.80%	4.60%	5.60%	N/A	N/A	
WF-38	Workforce HR	Diversity: Disability - declined to declare %	10.00%	10.00%	10.00%	7.80%	7.80%	7.80%	7.50%	7.50%	7.50%	7.00%	7.00%	7.00%	2.88%	0.00%	-	
WF-39	Workforce HR	Diversity: Ethnicity - BAME %	5.50%	5.50%	5.50%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.81%	6.70%	-	
WF-27	Workforce L&OD	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	Workforce Wellbeing	Absence Relating to Mental Health %	5.30%	4.70%	8.10%	6.70%	6.70%	8.40%	8.90%	11.50%	8.20%	9.80%	5.90%	7.06%	4.52%	N/A	N/A	
WF-19	Workforce Wellbeing	Absence Relating to MSK %	3.10%	2.80%	8.10%	4.50%	8.30%	6.20%	5.70%	5.60%	6.10%	5.60%	5.70%	2.40%	2.81%	N/A	N/A	
WF-25	Workforce Wellbeing	Number of Wellbeing Hub Referrals	112	95	96	115	111	138	125	111	93	142	79	127	72	0	-	
WF-30	Workforce Wellbeing	Time from referral to offered wellbeing appointment (days)	14	14	14	14	14	14	14	14	14	21	28	14	14	14	=	
999-27	Operations 999	% of Meal Breaks Taken				99.20%	91.00%	98.40%	98.60%	98.30%	98.40%	98.40%	98.00%	96.78%	98.15%	N/A	N/A	
999-28	Operations 999	% of Meal Breaks Outside of Window				49.90%	51.10%	54.80%	59.30%	59.10%	58.70%	58.80%	60.70%	60.29%	59.56%	N/A	N/A	
999-15	Operations 999	999 Frontline Late Finishes/Over-Runs %	61.10%	59.50%	51.00%	52.40%	51.90%	60.20%	53.40%	50.60%	49.20%	51.90%	53.30%	50.78%	50.35%	N/A	N/A	
999-15	Operations 999	Average Late Finish/Over-Run Time	00:39:59	00:46:00	00:41:59	00:41:00	00:41:00	00:41:00	00:43:27	00:47:33	00:44:03	00:40:17	00:40:19	00:46:00	00:40:00	N/A	N/A	
999-21	Operations 999	Provided Bank Hours %	5.60%	2.30%	0.30%	0.30%	0.40%	0.60%	0.60%	0.70%	1.70%	0.00%	0.90%	0.80%	0.88%	N/A	N/A	
999-21	Operations 999	Provided Overtime Hours %	9.10%	11.50%	15.40%	14.60%	9.10%	8.60%	10.40%	10.50%	9.30%	11.40%	12.00%	10.45%	8.92%	N/A	N/A	
999-21	Operations 999	Provided PAP Hours %	5.80%	5.90%	6.10%	6.30%	4.30%	4.80%	4.50%	4.60%	5.30%	6.80%	6.90%	5.28%	5.06%	N/A	N/A	

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Performance by Domain
Well-Led: Performance Dashboard

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IPRID	Department	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Target	Vs Target	Sparkline
999-22	Operations 999	999 Remaining Annual Leave FY	45.00%	33.00%	27.00%	20.00%	53.00%		84.00%		34.60%	62.50%	55.70%	51.60%	45.90%	25.00%	-	
FL-1	Fleet	Vehicles Older Than Target Age %	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	36.00%	36.00%	36.00%	36.00%	41.00%	41.00%	0.00%	-	
C-1	Corporate	Policies & Procedures Outstanding Review %	11.80%	11.80%	11.00%	11.30%	15.80%	17.40%	29.00%	32.00%	37.00%	36.50%	37.20%	40.78%	43.13%	0.00%	-	
QS-24	Quality & Safety	Organisational Risks Outstanding Review %	14.00%	59.00%	57.00%	52.00%	59.00%	81.00%	73.00%	81.00%	40.40%	52.00%	57.00%	42.25%	38.65%	30.00%	-	
IT-1	IT	CAD System Uptime %						98.900%	85.960%	100.000%	99.900%	100.000%	100.000%	96.710%	99.990%	99.90%	+	
IT-2	IT	Telephony System Uptime %						85.690%	100.000%	100.000%	100.000%	100.000%	100.000%	96.710%	99.860%	99.90%	-	
IT-3	IT	ePCR System Uptime %						84.390%	100.000%	97.900%	100.000%	100.000%	100.000%	99.250%	99.420%	99.90%	-	
IT-4	IT	Number of Calls to IT Service Desk	916	1297	1436	1924	1324	1442	1214	1214	1187	1372	1090	1084	856	N/A	N/A	
IT-5	IT	Marval IT Requests Raised - IT Service Desk	1359	1561	1559	1847	1638	1705	1503	1288	1168	1477	1414	1520	1262	N/A	N/A	
IT-5	IT	Marval IT Requests Raised - Critical Systems Team	480	539	694	724	728	757	765	775	664	611	592	654	510	N/A	N/A	
IT-6	IT	Missed Calls to IT Service Desk	201	369	460	624	586	456	378	382	447	441	377	286	238	245	+	
FL-4	Fleet	% of DCA vehicles off road (VOR)												12.00%	10.00%	N/A	N/A	
FL-5	Fleet	% of SRV vehicles off road (VOR)												7.00%	7.00%	N/A	N/A	
FL-10	Fleet	Average miles between vehicle failures												49485.00	44022.00	N/A	N/A	
999-29	Operations 999	% PAP shift fulfilment vs. contract					96.00%	107.00%	106.00%	103.00%	107.00%	108.00%	111.00%	96.00%	88.00%	95.00%	-	
SE-2	Strategic Estates	Risk assessed building and asset condition survey compliance %												100.00%	100.00%	100.00%	=	
SE-3	Strategic Estates	FM performance against SLA												97.00%	98.00%	100.00%	-	

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Performance by Domain
Well-Led: Finance Dashboard (October 2021)

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

ID	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£23376.60	£23858.00	£26134.50	£35076.00	£23241.00	£23340.80	£23325.10	£23415.40	£23521.20	£29157.60	£23450.50	£24049.10	£25088.10	£24358.10	£730.00		
F-9	Income (£000s) YTD	£201994.00	£225852.00	£251986.50	£287063.00	£23241.00	£46582.10	£69907.20	£93332.60	£116853.80	£146011.40	£169461.90	£193511.00	£218599.10	£217444.40	£1154.70	£294258.00	£76813.60
F-2	Operating Expenditure (£000s) Month	£24451.80	£25312.10	£24952.70	£38485.00	£23947.00	£24554.20	£24345.40	£24929.90	£25040.50	£27981.60	£24300.60		£26396.10	£26020.10	£376.00		
F-10	Operating Expenditure (£000s) YTD	£204633.90	£230346.00	£255298.70	£293784.00	£23947.00	£48503.60	£72849.00	£97787.90	£122828.40	£150810.00	£175110.60	£199895.70	£226291.80	£225830.00	£461.80	£303269.10	£77439.10
F-3	Capital Expenditure (£000s) Month	£1080.59	£4378.10	£1223.15	£4138.00	£1618.00	£987.96	£983.67	£1252.68	£412.32	£655.48	£395.11		£2476.90	£3063.00	£-586.10		
F-14	Capital Expenditure (£000s) YTD	£9755.85	£14138.03	£15361.18	£19499.00	£1618.00	£2605.91	£3589.58	£4842.26	£5254.58	£5910.07	£6305.18	£9210.27	£11687.18	£15218.00	£-3530.82	£24794.93	£9576.93
F-4	Cost Improvement Plan (CIP) (£000s) Month	£8.00	£522.00	£478.00	£709.00	£0.00	£0.00	£150.00	£430.00	£250.00	£238.00	£161.00		£181.32	£506.00	£-324.68		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£2855.00	£3790.00	£4268.00	£4977.00	£0.00	£0.00	£150.00	£580.00	£830.00	£1068.00	£1229.00	£1479.84	£1661.16	£4366.00	£-2704.84	£5872.00	£1506.00
F-6	Surplus/Deficit (£000s) Month	£-1075.20	£-1454.10	£1181.80	£-3409.00	£-706.00	£-1213.40	£-1020.30	£-1514.50	£-1519.30	£1176.00	£-850.10	£-736.00	£-1308.00	£-1662.00	£354.00		
F-7	Cash Position (£000s) Month	£46819.00	£41747.00	£51441.00	£40152.00	£36526.00	£36448.00	£35923.00	£36684.00	£38289.00	£40507.00	£46592.00	£45791.00	£43638.00	£18372.52	£25265.48	£18372.52	£0.00
F-8	Agency Spend (£000s) Month	£205.95	£106.34	£-80.27	£155.00	£169.00	£250.04	£107.24	£347.61	£234.08	£168.06	£154.98		£255.95	£264.00	£-8.05		
F-16	Agency Spend (£000s) YTD	£1603.68	£1710.00	£1630.00	£1784.00	£169.00	£418.90	£526.14	£873.76	£1107.84	£1275.89	£1430.87	£1623.06	£1879.01	£2536.00	£-656.99	£2638.40	£102.40

Performance by Domain
Well-Led: Performance Dashboard

Summary of Financial Performance
December 2021

Key Performance Indicators

Month							Year To Date						Full Year					
% 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	£000 Prior Year	% PY Var
7.3%	23,377	24,358	25,088	730	3.0%	**INCOME**	217,444	218,599	1,155	0.5%	201,994	8.2%	290,605	294,258	3,653	1.3%	287,063	2.5%
(7.4)%	18,109	19,479	19,448	31	0.2%	PAY	165,061	167,419	(2,358)	(1.4)%	152,541	(9.8)%	219,751	223,252	(3,501)	(1.6)%	203,049	(10.0)%
85.1%	45,556	6,396	6,803	(408)	(6.4%)	NON PAY	59,460	57,869	1,591	2.7%	51,571	(12.2)%	78,775	78,574	201	0.3%	90,533	13.2%
58.8%	63,665	25,874	26,251	(377)	(1.5)%	**OPERATING EXPENDITURE**	224,521	225,288	(767)	(0.3)%	204,112	(10.4)%	298,526	301,826	(3,300)	(1.1)%	293,581	(2.8)%
(97.1)%	(40,288)	(1,516)	(1,163)	353	(23.3)%	**OPERATING SURPLUS/(DEFICIT)**	(7,077)	(6,689)	387	(5.5)%	(2,118)	215.8%	(7,921)	(7,568)	353	(4.5)%	(6,519)	16.1%
(9.3)%	133	146	145	1	0.7%	FINANCING COSTS	1,310	1,004	306	23.4%	922	(8.9)%	1,745	1,444	302	17.3%	203	(611.1)%
96.8%	(40,421)	(1,662)	(1,308)	354	21.3%	**SURPLUS/(DEFICIT)**	(8,386)	(7,693)	693	8.3%	(3,040)	(153.1)%	(9,666)	(9,011)	655	6.8%	(6,722)	(34.1)%
0.0%	3	1	(292)	(293)	(29300.0)%	ADJUSTMENTS TO SURPLUS/(DEFICIT)	28	(579)	(607)	(22)	(9)	(6200.3)%	31	(576)	(607)	(1958.1)%	57	1110.5%
96.0%	(40,431)	(1,661)	(1,600)	61	3.7%	**ADJUSTED SURPLUS/***(DEFICIT) : CONTROL TOTAL*	(8,358)	(8,272)	86	1.0%	(3,049)	(171.3)%	(9,635)	(9,587)	48	0.5%	(77)	(12415.8)%
% 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	Incidents Prior Year	% PY Var
(4.3%)	66,690	71,469	63,855	(7,614)	(10.7%)	A&E ACTIVITY per Plan	603,019	574,803	(28,216)	(4.7%)	557,253	3.1%	806,987	761,194	(45,793)	(5.7%)	741,767	2.6%
✓	3	3	3		✓	**USE OF RESOURCES RATING**	3	3		✓	3	✓	3	3		✓	1	✓
	Prior Year	Plan	Actual	Variance			Plan	Actual	Variance		Prior Year		Plan	Forecast	Variance		Prior Year	
✗	421	506	181	(325)	✗	**CIPS**	4,366	1,661	(2,705)	✗	3,268	✗	5,872	5,872	0	✓	4,977	✓
✓	1,085	3,063	2,477	586	✓	**CAPITAL**	15,218	11,687	3,531	✓	9,760	✓	25,491	24,795	696	✓	19,499	✓
✓	46,819	18,373	43,638	25,265	✓	**CASH POSITION**	18,373	43,638	25,265	✓	46,819	✓	24,360	47,032	22,672	✓	40,152	✓
✗	4,498	4,615	4,401	214	✗	**WTE**	4,391	4,386	5	✗	4,430	✓	4,350	4,346	3	✗	4,452	✗
✗	2,421	1,410	1,554	(144)	✓	**COVID-19 SPEND**	10,808	9,134	1,674	✓	13,508	✗	15,019	14,229	790	✓	19,556	✗
% 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	£000 Prior Year	% PY Var
(24.3)%	206	264	256	8	3.0%	**AGENCY STAFF**	2,536	1,879	657	25.9%	1,604	(17.2)%	3,298	2,638	660	20.0%	1,784	(47.9)%
						PRIVATE AMBULANCE PROVIDERS (PAP)												
(266.5)%	313	0	1,147	(1,147)	0.0%	Covid-19	1,020	1,462	(442)	(43.3)%	1,804	19.0%	1,020	1,972	(952)	(93.3)%	2,451	19.5%
(724.9)%	272	691	2,241	(1,551)	(224.5)%	Non Covid-19 (BAU)	4,863	3,519	1,344	27.6%	5,188	32.2%	4,172	4,794	(622)	(14.9)%	6,281	23.7%
(479.5)%	585	691	3,389	(2,698)	(390.6)%	**TOTAL**	5,883	4,980	902	15.3%	6,992	28.8%	5,192	6,766	(1,574)	(30.3)%	8,732	22.5%

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

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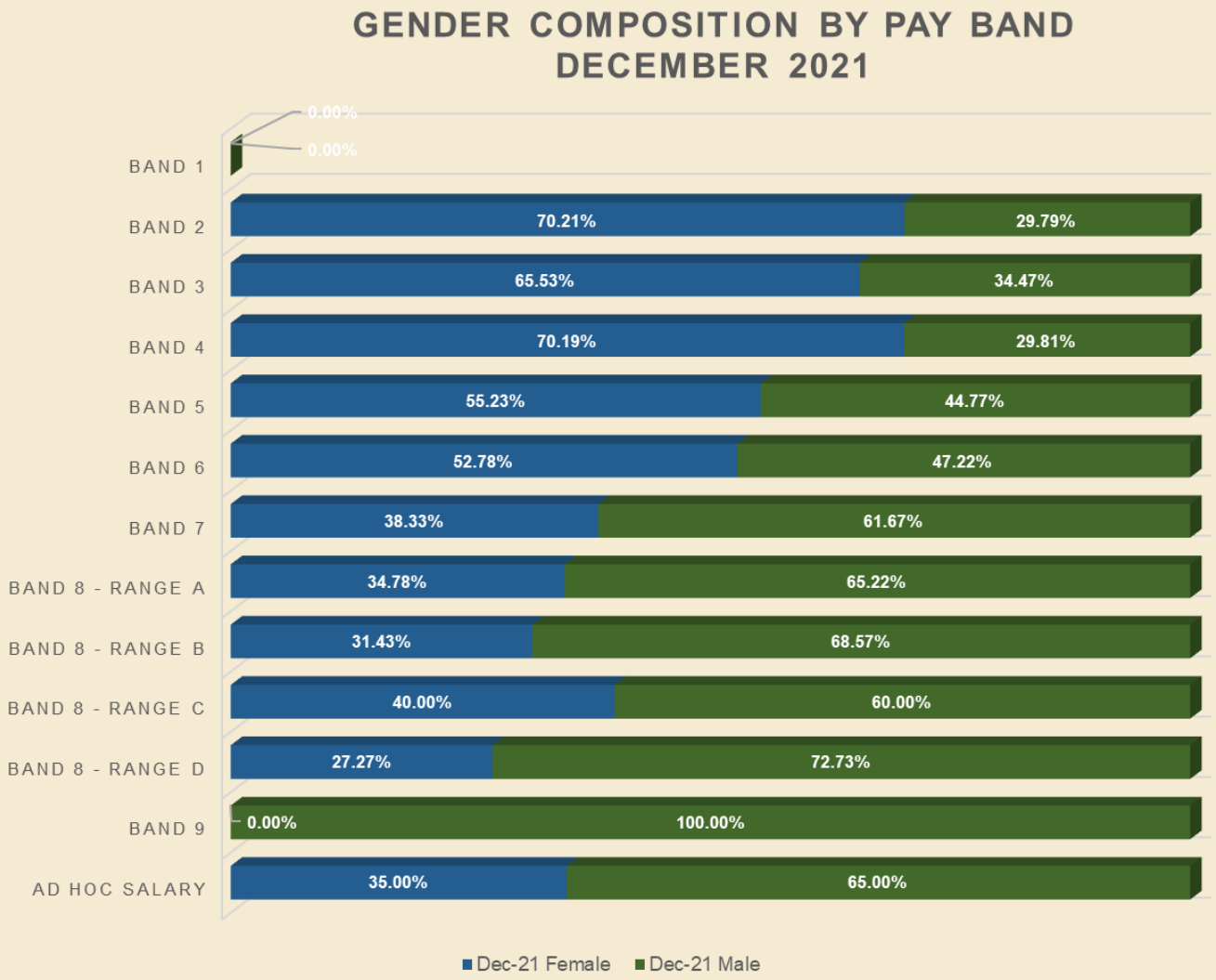


National Benchmarking
999 Emergency Ambulance Service (December 2021)

Key indicators at a glance for December 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	00:02:18	00:01:26	00:04:56	00:00:37	00:00:26	00:02:22	00:01:56	00:01:30	00:02:50	00:05:27	00:00:32	00:02:12
Calls Answered	925116	81274	87249	88254	1702	153307	43798	131728	53721	91692	114530	77861
Mean Call Answer Time	00:00:45	00:00:25	00:01:34	00:00:13	00:00:11	00:00:40	00:00:41	00:00:28	00:00:47	00:02:08	00:00:11	00:00:36

Incident Proportions (Over All Incidents)	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	732007	63855	72264	67235	2515	111273	36185	92153	54209	70295	92466	69557
C1 Incidents %	11.25%	7.95%	13.18%	12.47%	5.96%	9.86%	8.95%	16.09%	7.17%	11.67%	10.82%	11.65%
C2 Incidents %	56.00%	55.21%	59.98%	59.11%	41.75%	55.66%	57.23%	54.13%	49.12%	60.28%	53.75%	56.56%
C3 Incidents %	14.91%	23.31%	12.32%	11.88%	34.31%	12.98%	13.75%	10.44%	25.62%	15.48%	14.90%	12.85%
C4 Incidents %	0.58%	0.44%	0.41%	0.15%	2.39%	1.00%	1.15%	0.25%	1.52%	0.19%	0.67%	0.21%

Incident Outcomes	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	12.33%	9.40%	9.40%	11.88%	8.27%	17.06%	12.67%	10.91%	12.53%	9.48%	15.95%	10.73%
See & Convey %	50.77%	56.66%	54.61%	49.82%	58.05%	48.01%	51.89%	51.73%	48.78%	48.03%	47.00%	53.92%
See & Treat %	32.23%	32.51%	32.89%	33.01%	32.88%	31.79%	26.61%	30.86%	34.53%	39.11%	31.43%	28.28%

Response Performance	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:16:12	00:16:03	00:20:40	00:16:14	00:17:23	00:11:59	00:12:38	00:15:17	00:16:30	00:20:51	00:14:27	00:17:10
90th Centile Response Time: C2	01:59:12	01:10:43	02:12:29	02:03:32	00:44:34	01:55:53	01:43:59	02:33:58	01:08:07	02:49:19	01:53:39	01:42:23
90th Centile Response Time: C3	07:11:44	06:21:13	08:01:59	07:27:01	02:09:36	05:26:14	07:24:57	10:57:11	04:59:49	08:22:08	08:55:41	06:00:47
90th Centile Response Time: C4	08:05:16	09:42:15	07:49:25	07:01:10	02:38:29	07:58:45	04:05:01	19:10:59	06:03:32	07:42:55	09:32:55	09:00:21
Mean Response Time: C1	00:09:13	00:08:42	00:11:33	00:08:57	00:09:12	00:07:09	00:07:14	00:09:05	00:08:46	00:11:38	00:08:19	00:09:49
Mean Response Time: C2	00:53:21	00:34:17	01:01:00	00:55:28	00:23:25	00:52:29	00:47:38	01:06:43	00:32:49	01:13:16	00:48:19	00:46:56

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

Key indicators at a glance for August 2021

Cardiac Arrest	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Proportion who had ROSC on arrival at hospital %	25.83%	27.01%	23.91%	28.15%	33.33%	32.00%	31.82%	24.05%	20.24%	25.26%	23.90%	20.82%
Proportion who had ROSC on arrival at hospital utstein %	46.77%	50.00%	54.72%	48.39%		53.85%	77.27%	38.10%	50.00%	43.14%	31.25%	40.00%

NB: NHSE's most recent publication of national clinical outcomes provides is for August 2021.
Please note the report no longer includes 'proportion of cardiac arrests discharged live'.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Performance Charts (by domain)

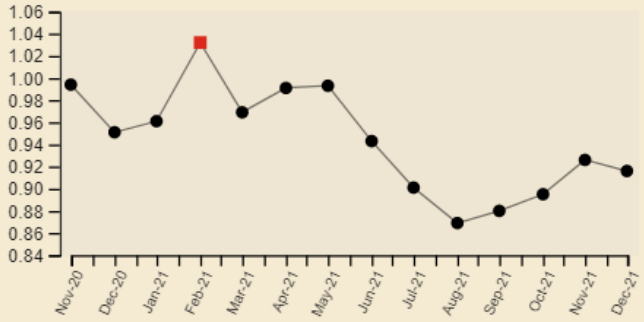
Best placed to care, the best place to work

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

999-12

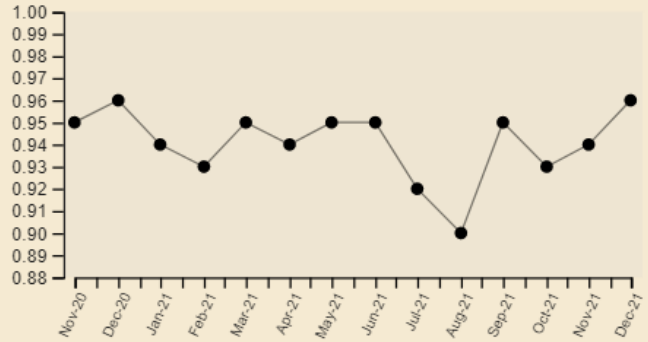
999 Frontline Hours Provided %



December 2021	91.60%
Target	100.00%

QS-7

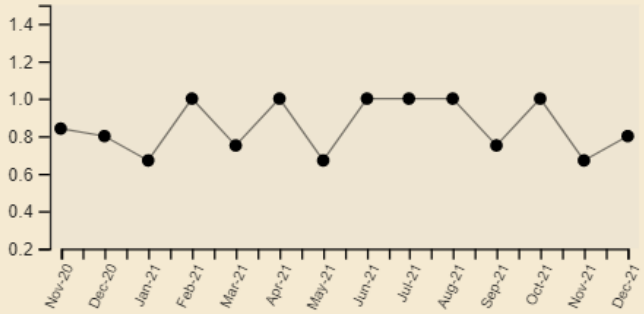
Hand Hygiene Compliance %



December 2021	96.00%
Target	90.00%

QS-3

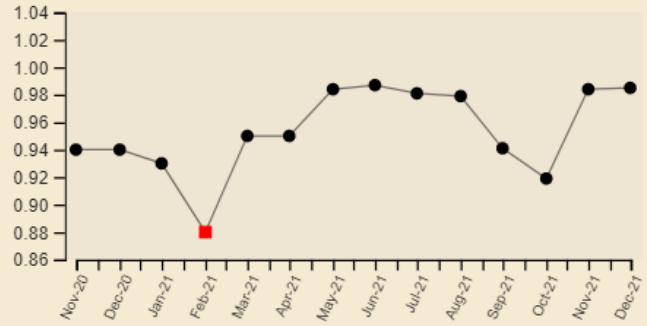
Duty of Candour Compliance %



December 2021	80.00%
Target	100.00%

MM-7

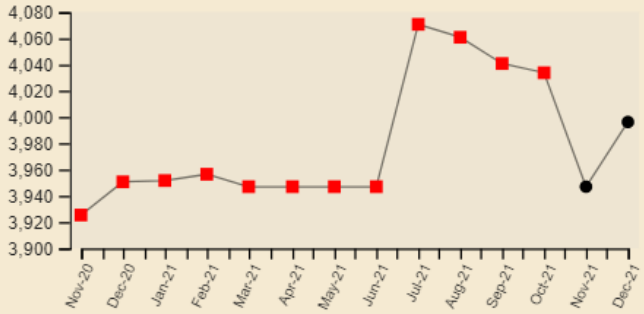
Medicines Management % of Audits Completed



December 2021	98.50%
Target	100.00%

WF-3

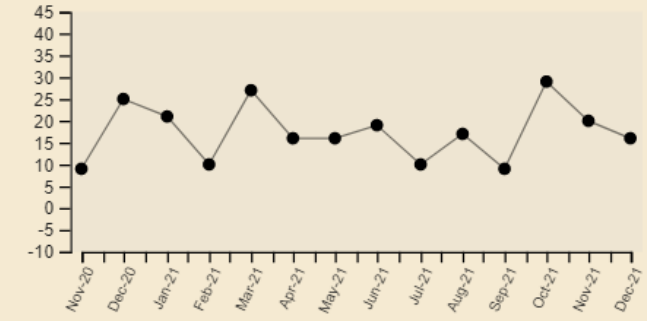
Finance Establishment (WTE)



December 2021	3996
Target	N/A

MM-5

Number of CD Breakages



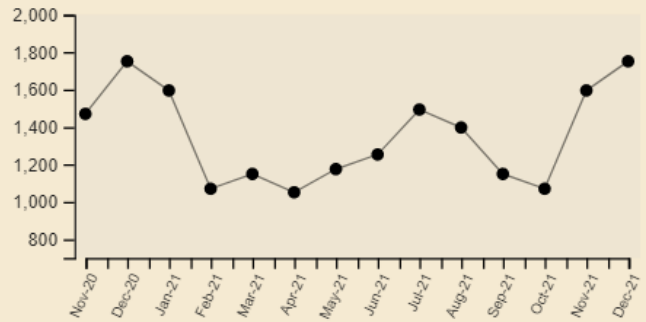
December 2021	16
Target	N/A

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

QS-1

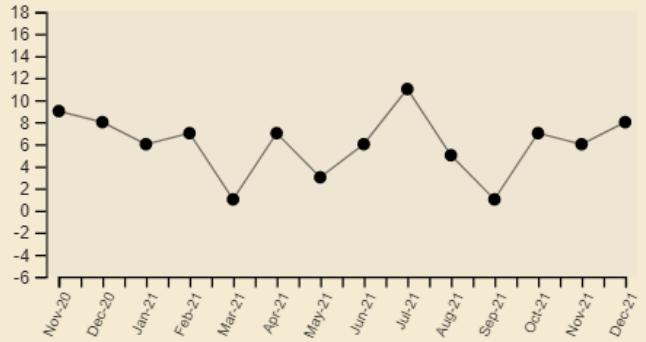
Number of Datix Incidents



December 2021
1751
Target
N/A

QS-2

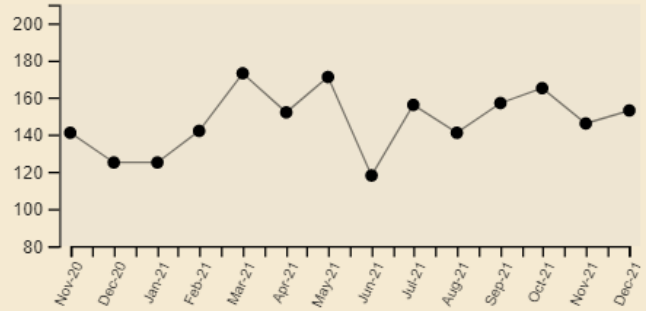
Number of Incidents Reported as SIs



December 2021
8
Target
N/A

MM-1

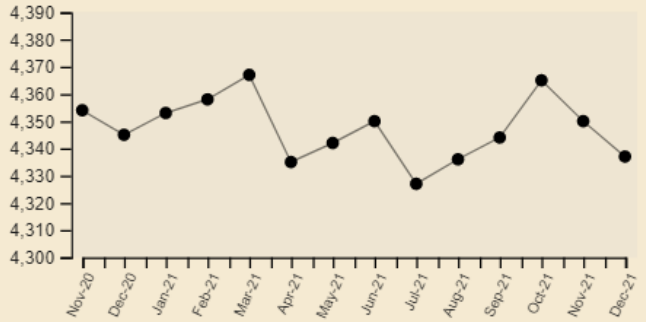
Number of Medicines Incidents



December 2021
153
Target
N/A

WF-2

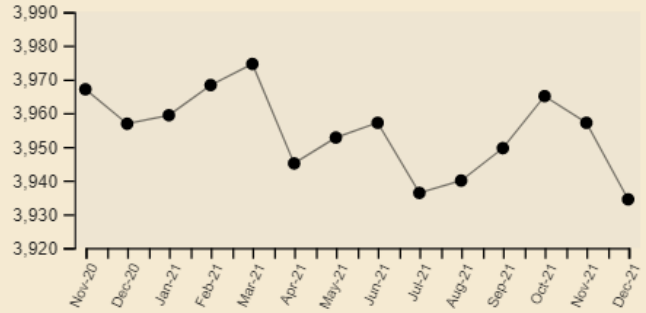
Number of Staff Headcount (Excl bank and agency)



December 2021
4337
Target
N/A

WF-1

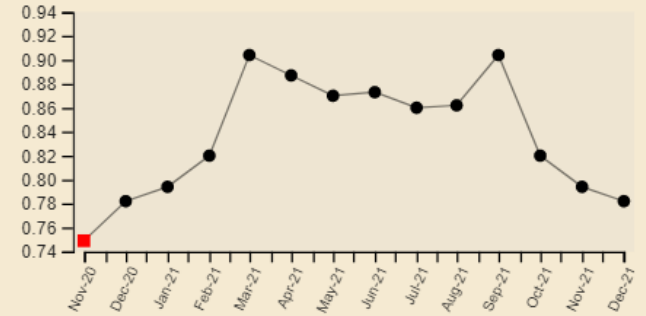
Number of Staff WTE (Excl bank and agency)



December 2021
3934
Target
3996

QS-8

Safeguarding Training Completed (Children) Level 2 %



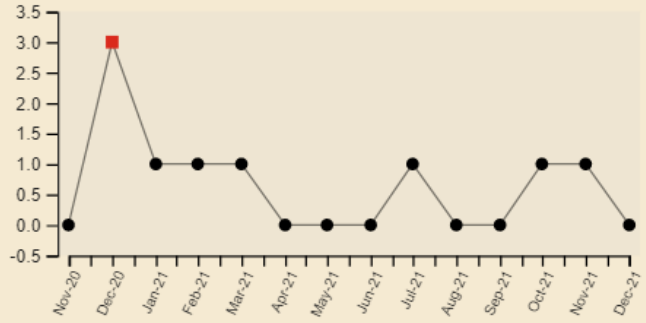
December 2021
78.20%
Target
95.00%

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

MM-4

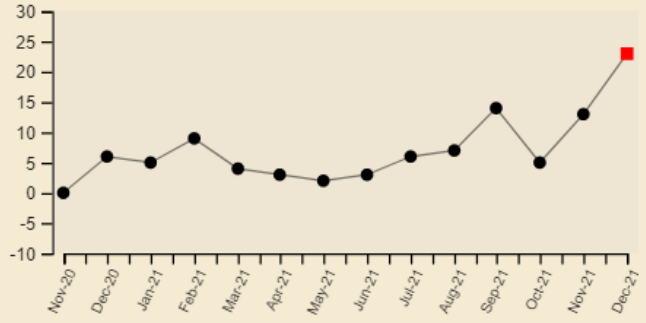
Single Witness Signature Use CDs Non-Omnicell



December 2021
0
Target
0

MM-3

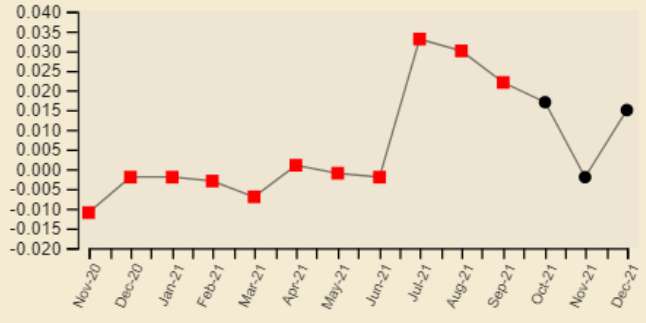
Single Witness Signature Use CDs Omnicell



December 2021
23
Target
0

WF-4

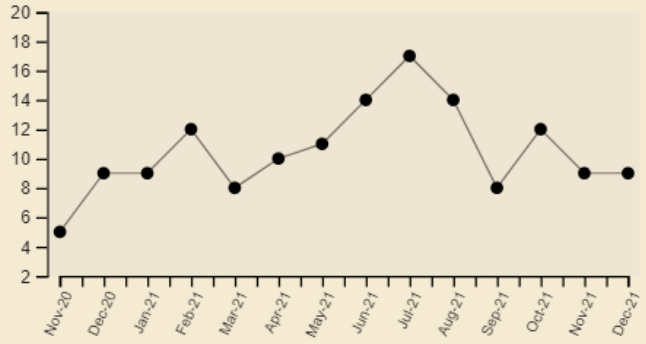
Vacancy Rate %



December 2021
1.50%
Target
N/A

QS-9

Number of RIDDOR Reports



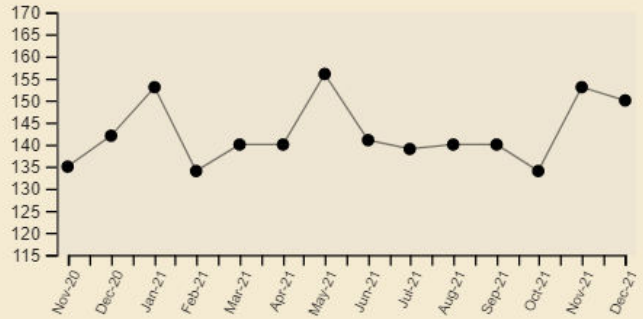
December 2021
9
Target
N/A

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-6

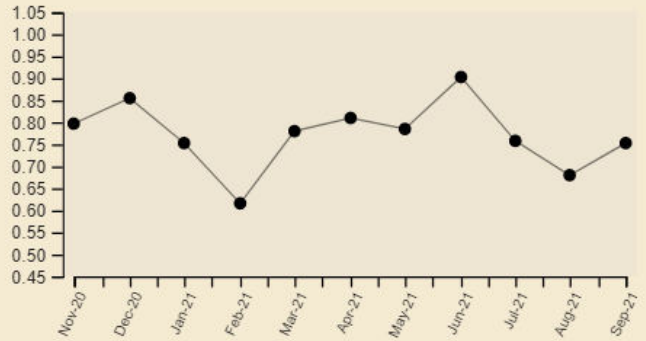
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean



December 2021
02:30:00
Target
02:22:00

M-11

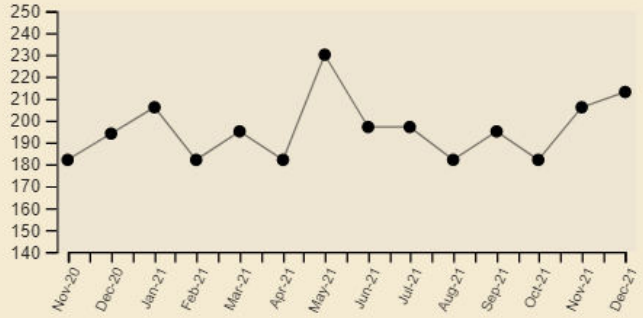
Cardiac Arrest - Post ROSC %



September 2021
75.30%
Target
76.80%

M-7

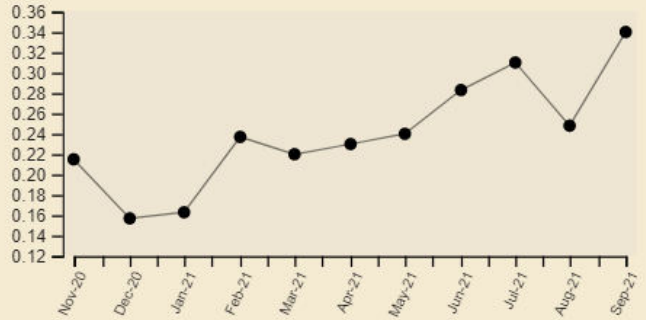
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile



December 2021
03:33:00
Target
03:14:00

M-2

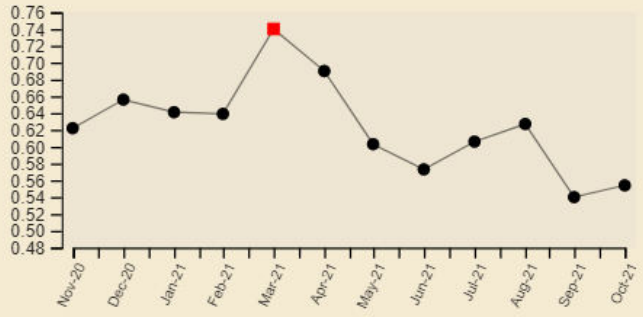
Cardiac ROSC ALL %



September 2021
34.00%
Target
23.80%

M-5

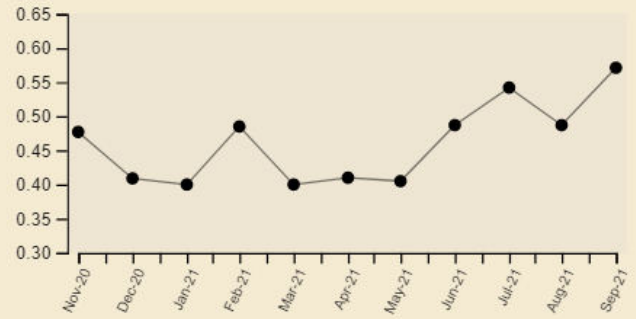
**Acute STEMI Care Bundle Outcome %



October 2021
55.40%
Target
64.70%

M-1

**Cardiac ROSC Utstein %



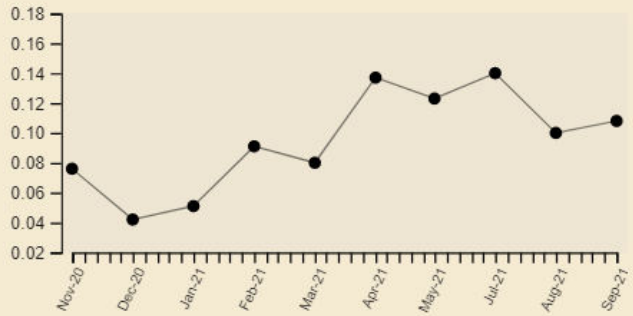
September 2021
57.10%
Target
45.10%

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-4

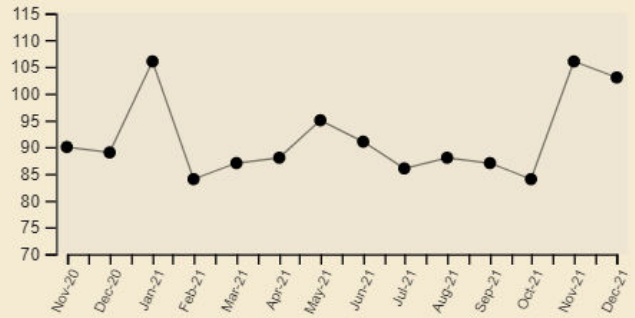
Cardiac Survival ALL %



September 2021
10.80%
Target
9.60%

M-8

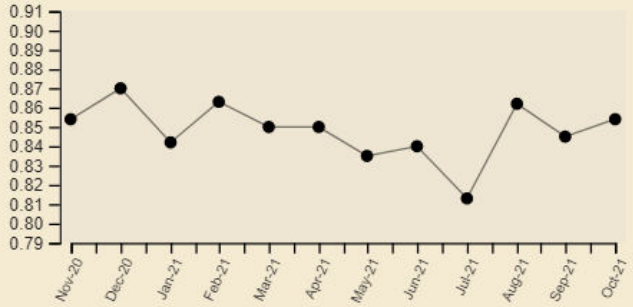
Stroke - Call to Hospital Arrival Mean



December 2021
01:43:00
Target
01:29:00

M-12

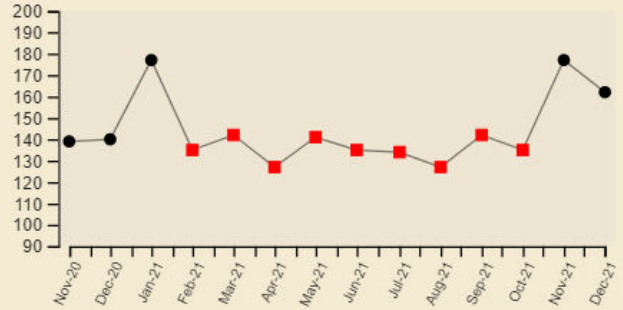
**Sepsis Care Bundle %



October 2021
85.40%
Target
85.00%

M-9

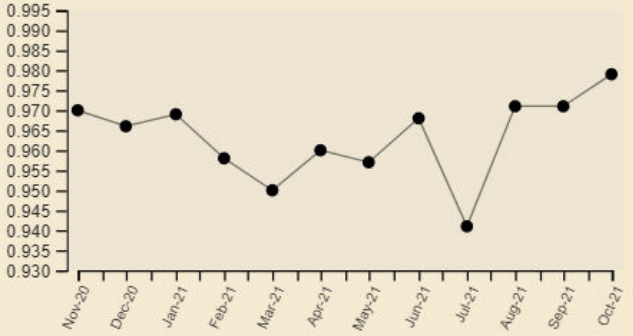
Stroke - Call to Hospital Arrival 90th Centile



December 2021
02:42:00
Target
02:20:00

M-10

**Stroke - Assessed F2F Diagnostic Bundle %



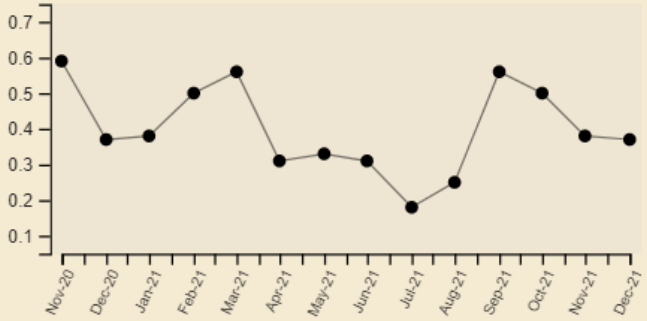
October 2021
97.90%
Target
96.30%

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 %



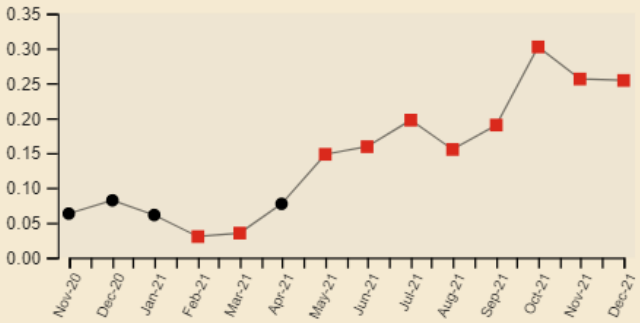
December 2021
37.00%
Target
N/A

Performance by Domain
Responsive: Performance Charts

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

111-3

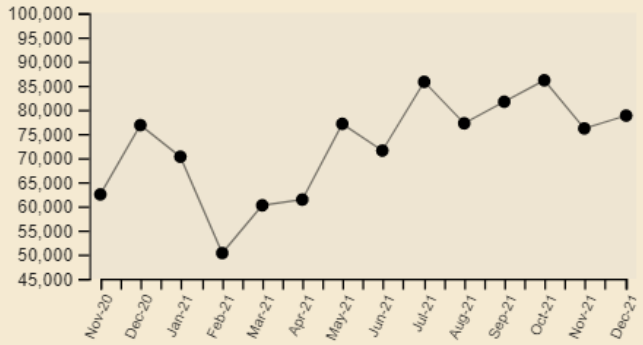
111 Calls Abandoned - (Offered) After 30 Seconds %



December 2021
25.40%
Target
5.00%

999-10

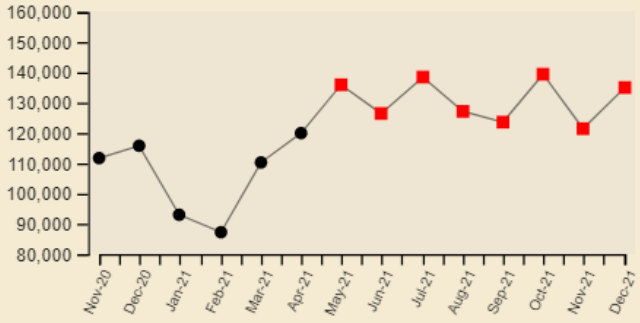
999 Calls Answered



December 2021
78778
Target
N/A

111-1

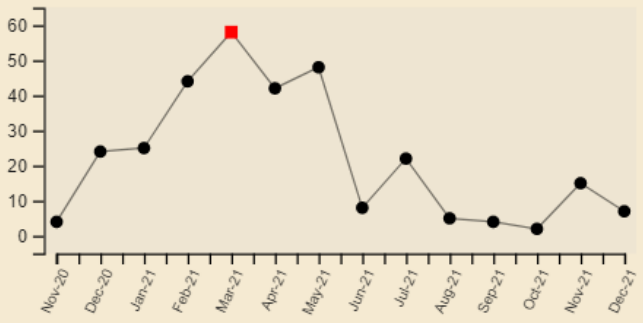
111 Calls Offered Actual



December 2021
135035
Target
N/A

999-1

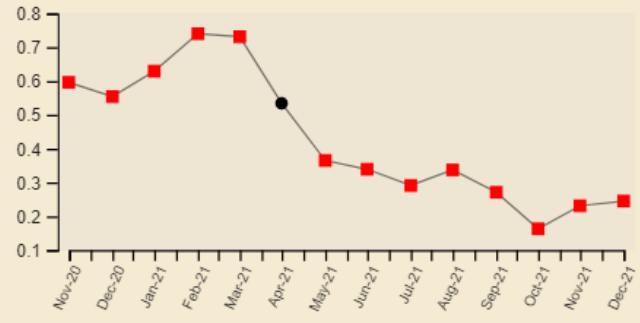
999 Call Answer Mean



December 2021
00:00:07
Target
00:00:05

111-1

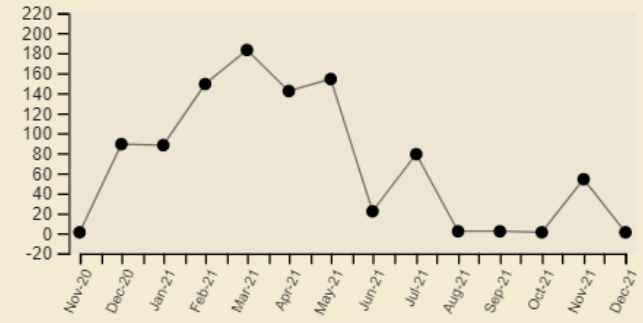
111 Calls Answered in 60 Seconds %



December 2021
24.50%
Target
95.00%

999-1

999 Call Answer 90th Centile



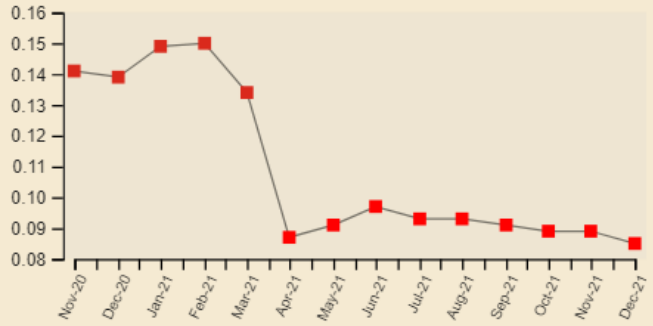
December 2021
00:00:01
Target
00:00:10

Performance by Domain
Responsive: Performance Charts

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

111-4

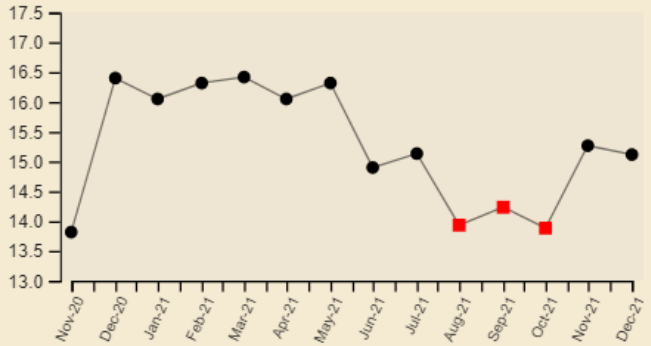
999 Referrals (Answered Calls) %



December 2021
8.50%
Target
13.00%

999-2

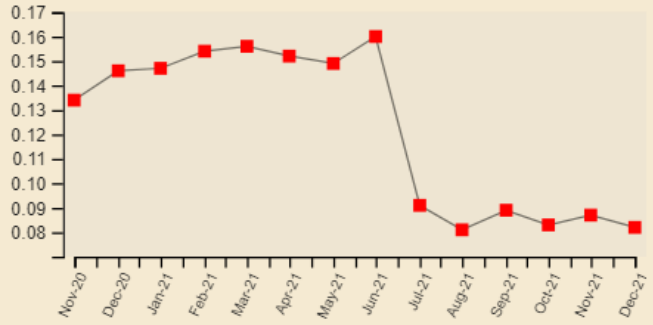
Cat 1 90th Centile



December 2021
00:15:07
Target
00:15:00

111-5

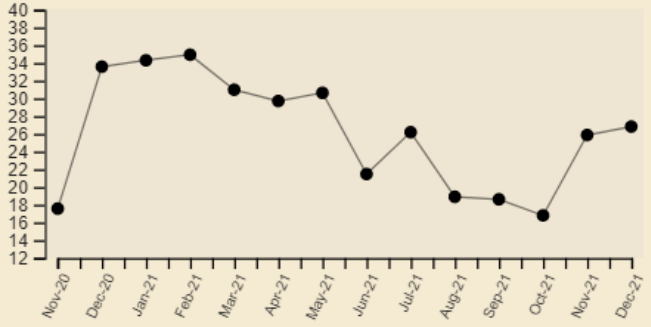
A&E Dispositions %



December 2021
8.20%
Target
9.00%

999-4

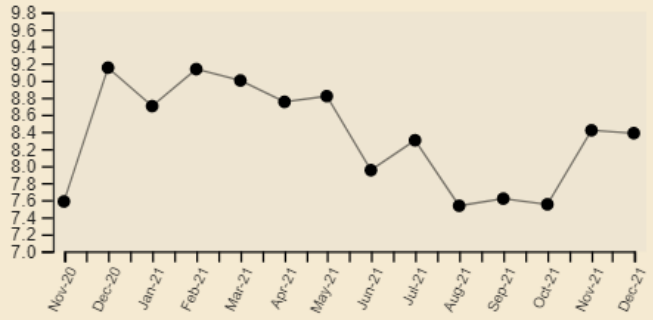
Cat 2 Mean



December 2021
00:26:49
Target
00:18:00

999-2

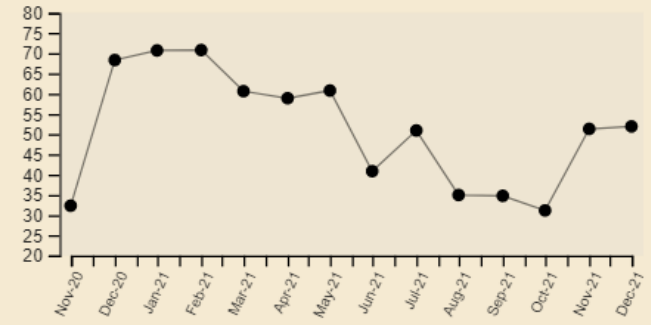
Cat 1 Mean



December 2021
00:08:23
Target
00:07:00

999-4

Cat 2 90th Centile



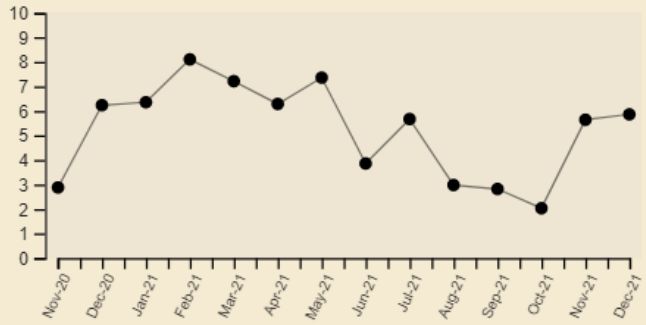
December 2021
00:51:55
Target
00:40:00

Performance by Domain
Responsive: Performance Charts

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

999-5

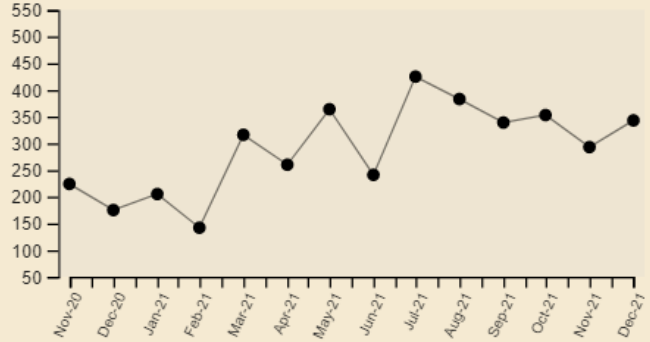
Cat 3 90th Centile



December 2021
05:51:35
Target
02:00:00

999-10

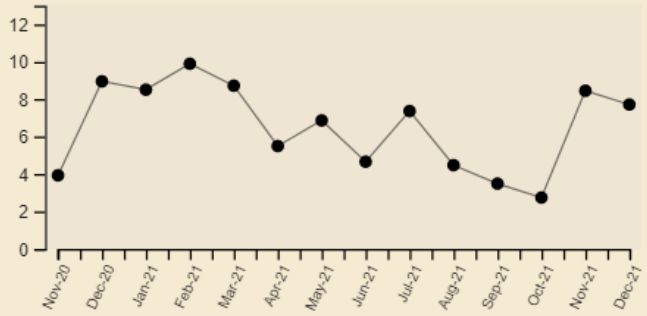
Fire First Responder Attendances



December 2021
343
Target
N/A

999-6

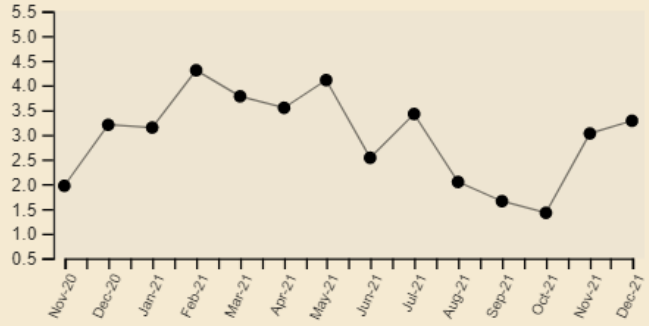
Cat 4 90th Centile



December 2021
07:42:55
Target
02:44:51

999-7

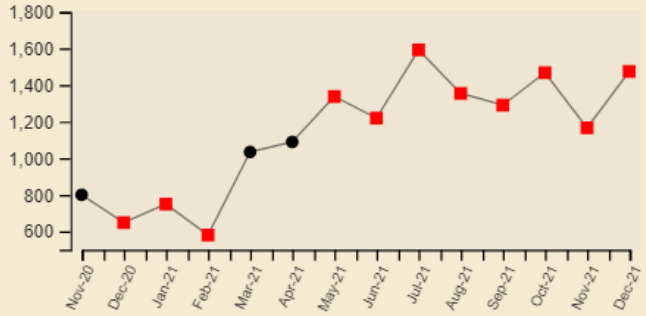
HCP 3 Mean



December 2021
03:16:55
Target
N/A

999-10

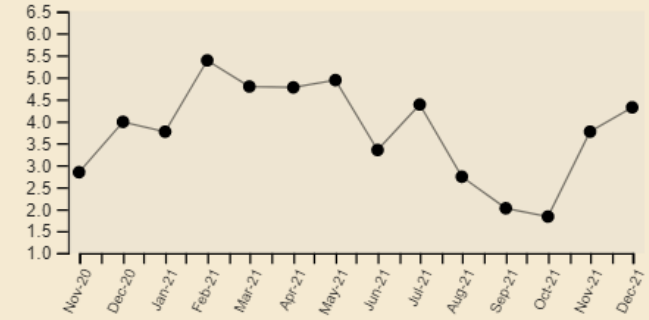
Community First Responder Attendances



December 2021
1474
Target
N/A

999-7

HCP 4 Mean



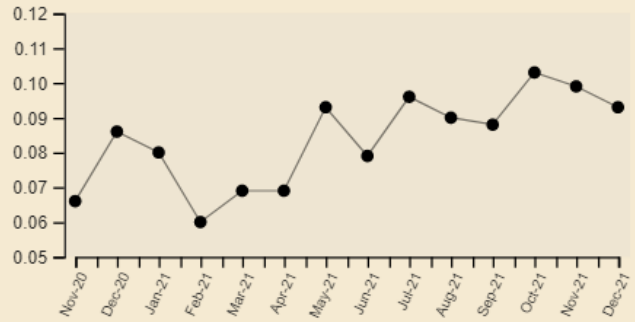
December 2021
04:18:54
Target
N/A

Performance by Domain
Responsive: Performance Charts

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

999-9

Incident Outcome Hear & Treat %

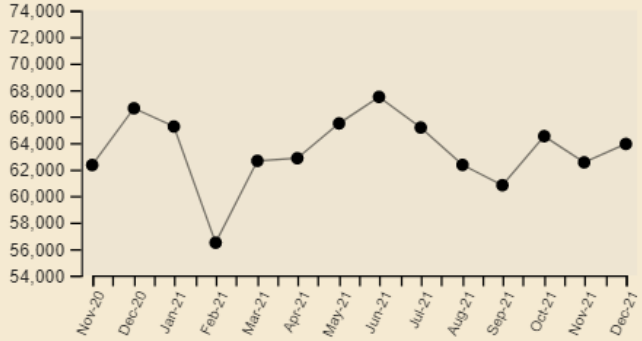


December 2021: 9.30%

Target: 10.00%

999-10

Incidents A7

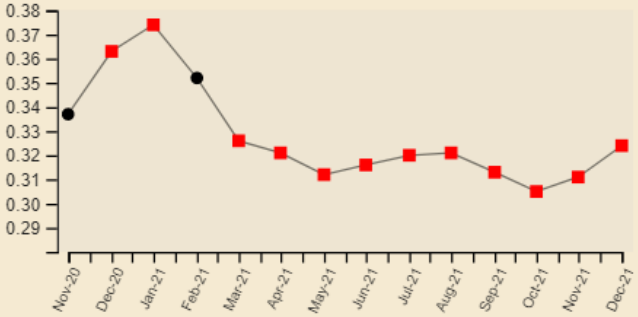


December 2021: 63924

Target: N/A

999-9

Incident Outcome See & Treat %

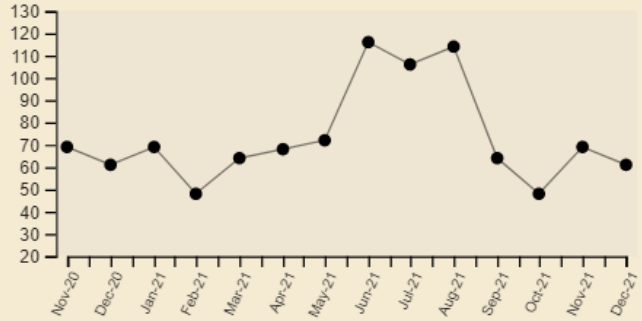


December 2021: 32.40%

Target: 35.00%

QS-5

Number of Complaints

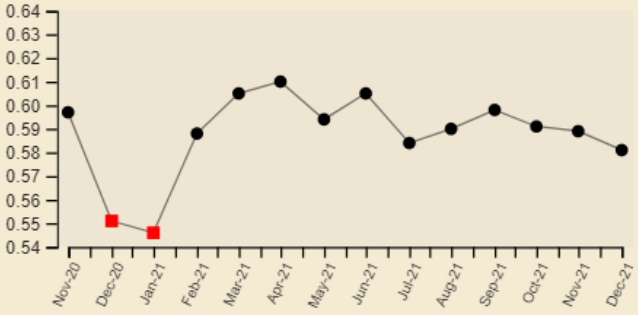


December 2021: 61

Target: N/A

999-9

Incident Outcome See & Convey %

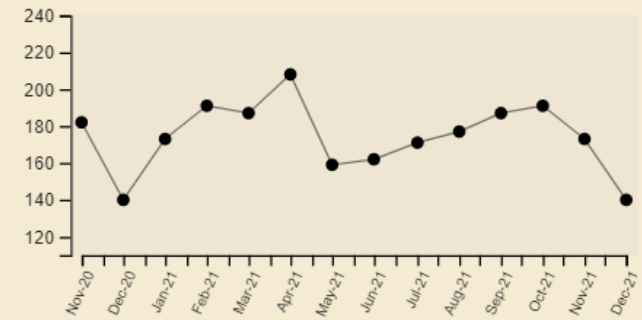


December 2021: 58.10%

Target: 55.00%

QS-6

Number of Compliments



December 2021: 140

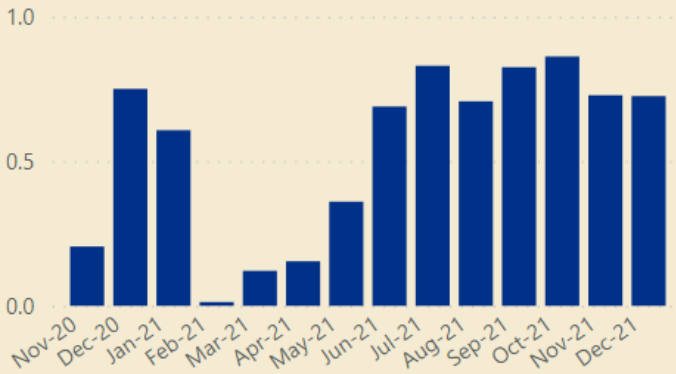
Target: N/A

Performance by Domain
Responsive: Performance Charts

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

999-14

Surge Managemnt Plan Level 3 or Higher %



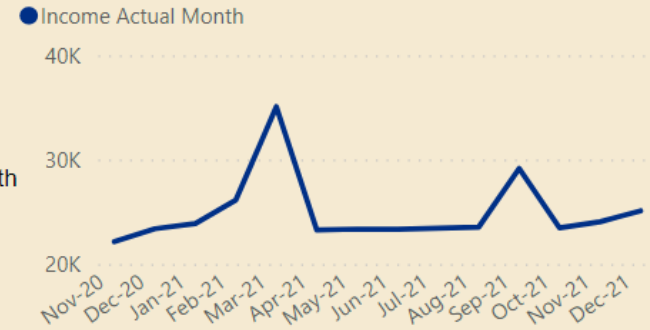
December 2021
72.50%
Target
N/A

Performance by Domain
Well-Led: Performance Charts

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

F-1

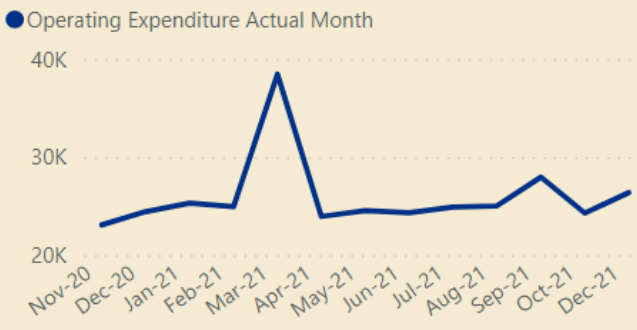
Income Actual Month



December 2021
£25088.10
Plan
£24358.10

F-2

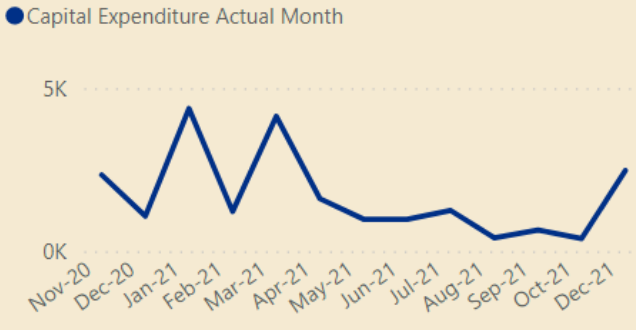
Operating Expenditure Actual Month



December 2021
£26396.10
Plan
£26020.10

F-3

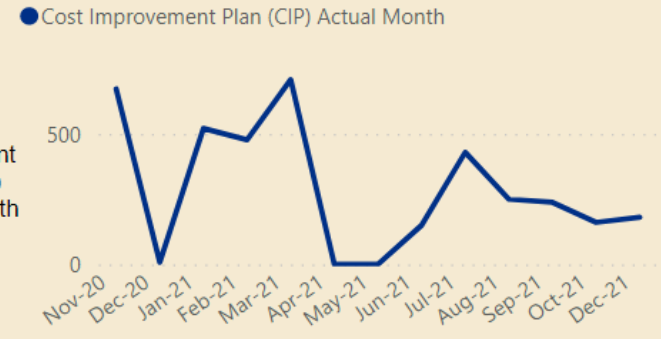
Capital Expenditure Actual Month



December 2021
£2476.90
Plan
£3063.00

F-4

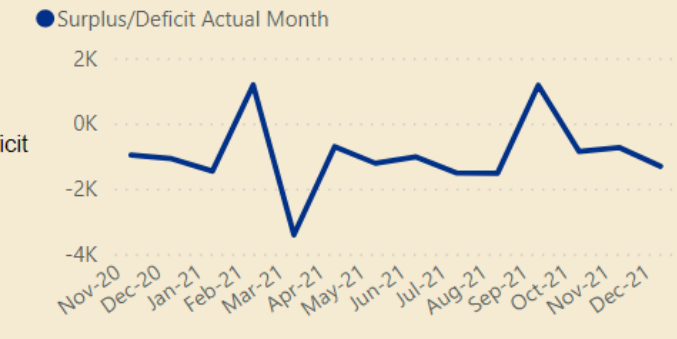
Cost Improvement Plan (CIP) Actual Month



December 2021
£181.32
Plan
£506.00

F-6

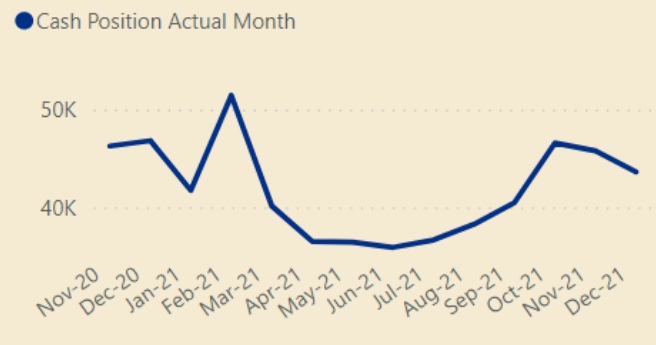
Surplus/Deficit Actual Month



December 2021
£-1308.00
Plan
£-1662.00

F-7

Cash Position Actual Month



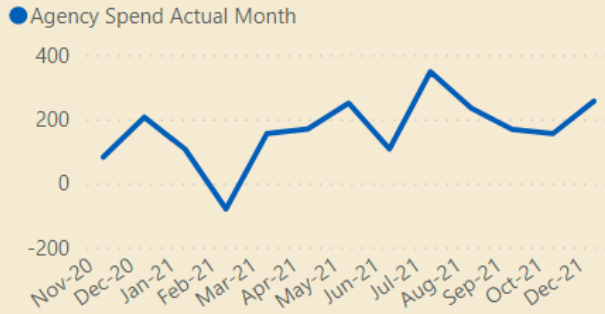
December 2021
£43638.00
Plan
£18372.52

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

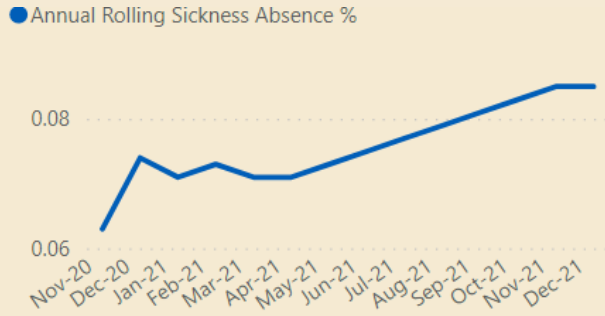
Agency Spend (£000s) Month



December 2021
£255.95
Plan
£264.00

WF-8

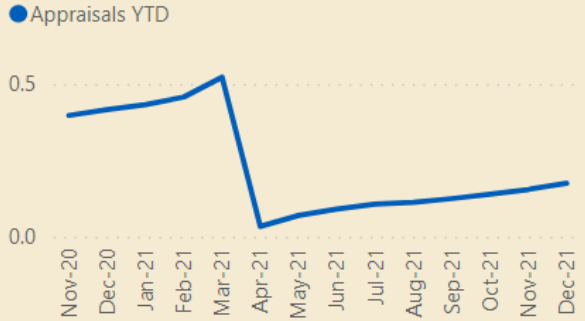
Annual Rolling Sickness Absence %



December 2021
8.50%
Target
5.00%

WF-5

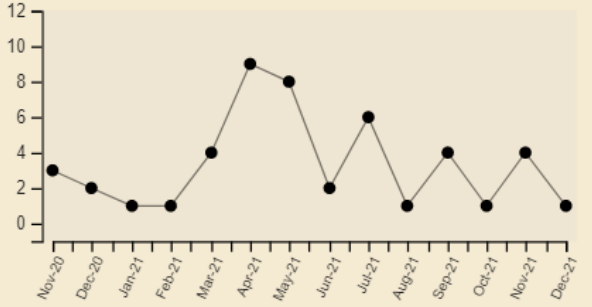
Appraisals YTD



December 2021
17.50%
Target
85.00%

WF-9

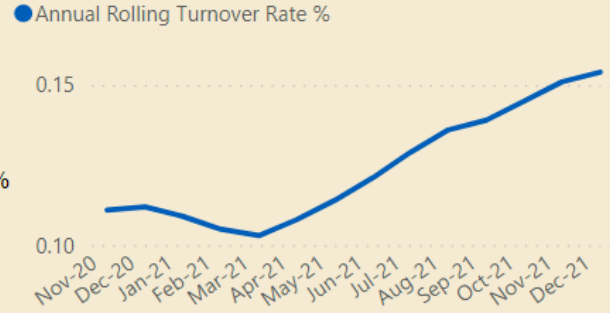
Disciplinary Cases



December 2021
1
Target
N/A

WF-7

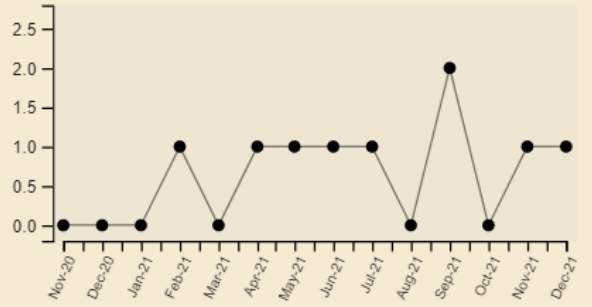
Annual Rolling Turnover Rate %



December 2021
15.40%
Target
N/A

WF-11

Collective Grievances



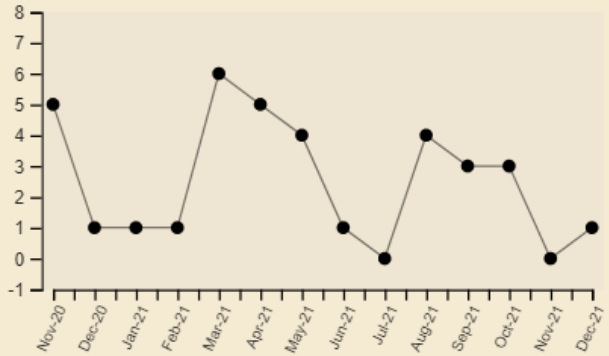
December 2021
1
Target
N/A

Performance by Domain
Well-Led: Performance Charts

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

WF-12

Bullying & Harrassment Internal



December 2021

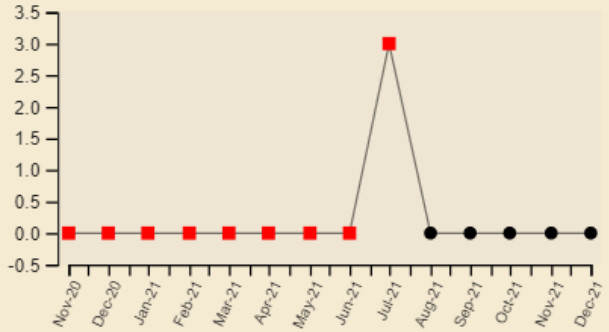
1

Target

0

WF-13

Whistleblowing



December 2021

0

Target

N/A

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Glossary & Metrics Library

Best placed to care, the best place to work

Appendix 2
Glossary & Metrics Library

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
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
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations

F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

Appendix 2
Glossary & Metrics Library

RAG	Red – Amber – Green
REAP	Resource Escalatory Plan
RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations
ROSC	Return of spontaneous circulation
SCAS	South Central Ambulance Service
SI	Serious Incident
SIG	Serous Incident Group
STEMI	ST-Elevation Myocardial Infarction
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
TIA	Transient Ischaemic Attack (mini-stroke)
Transports	See AQI A53 + A54
UCL	Upper Control Limit
WTE	Whole Time Equivalent (staff members)
YTD	Year to Date

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Symbol & Chart Keys

Best placed to care, the best place to work

Appendix 3
Symbols & Chart Keys

Symbol Key

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

Ambulance Call Categories (Ambulance Response Programme)

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

Chart Key

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

SECAMB Board

Performance Committee Escalation Report to the Board

Date of meeting	06 January 2022
Overview of key issues/areas covered at the meeting:	The committee acknowledged the recent incident where one member of staff sadly died and another was seriously injured and our thoughts are with all those affected. **Assurance Process and Escalation Assured** An update was provided on the evolution of the revised executive performance assurance process, where the weekly meetings alternate between performance improvement and forward planning. Recent focus had been on preparation for the Christmas and New Year period and in particular the impacts of sickness / self-isolation and other abstractions. There was also focus on workforce planning for 2022/23 and the expected impacts of Omicron over the next 5-6 weeks. Acknowledging the uncertainty, the executive were planning for the peak to be around mid-January with then a slower decline than we had with the Delta variant. In light of this, January was expected to result in a continued rise in sickness and isolation. The committee is assured by the approach being taken by the executive, which over the past couple of months has really helped to focus on the right areas using increasingly better intelligence / data. The committee noted that the more structural and therefore longer-term solutions are being considered as part of the review of the care delivery model which is one aspect of Better by Design. **Integrated Plan: 2022 – 2023 Partial Assurance** This is a really positive step forward. At its meeting in November the committee was presented with a framework for Integrated Planning going forward. This is based on demand projections overlaid with realistic operational assumptions to help establish the most optimal solution that balances resource requirements, budget and performance. This is initially for the 2022/23 and is a precursor exercise to the 2-5-year horizon which will be the basis of the new Care Delivery Model design, due to commence in the coming weeks. The committee reviewed the baseline assumptions and requirements with the focus initially on the WTE in field operations based on our current operating model. Further resource areas are being developed through January to include Call-handling, Fleet, Make Ready and 111 CAS, in preparation for discussions with commissioners as part of budget-setting for next year. The committee explored some of the detailed analysis of the underlying assumptions / improvements. It also clarified that commissioners and other stakeholders are supportive of our approach. The committee also explored the ambition (it is quite ambitious) and the need to ensure the right balance between the ambition and being deliverable. In summary, the committee felt that the limiting factor for next year will be the ability to recruit and train additional NQPs and ECSWs, with plans already at full capacity. However, the plans provide a realistic and affordable workforce target. To then get to a reasonable trajectory to meet ARP will require (in addition to achieving the

	workforce plan) significant operational improvements, such as in hear and treat and reduction in job cycle time. This will require a resource improvement methodology, which is currently a gap. **12-week look ahead Assured** The committee considered the projections to the w/c 4 February that set out the best and worst-case scenarios. Despite managing relatively well over Christmas, due to a combination of better hours and public behaviour / lower demand, the worst is expected given the profile of COVID. The committee was reassured by the good level of understanding and challenged the executive on its mitigation plans. It concluded that the executive is doing all it reasonably can; this includes a submission of a MACA request (via the ICS) and using the COVID management team to ensure staff awaiting PCR tests can return as quickly as possible. **Performance Management Overview Partial Assurance** This section of the meeting was focussed on the immediate actions being taken. It was positive to learn that the staff welfare trucks were being used and 'Halo' was being used to support staff at hospitals. Also that there was continued effort despite the challenges in performance to ensure a high level of compliance with meal breaks. Although the committee acknowledged the importance of focussing on our own performance (and impact on patients) nonetheless some comfort was received by the national AQI Performance Report (for November) that shows that SECamb compares relatively well with other ambulance trusts. The Performance Improvement Plan remains focussed on fewer areas of the wider plan to ensure greatest impact over the winter period. Wrap-up times have seen localised improvements however this is not consistent across the board. There has been an increased overall of at-scene times, but this is likely to have contributed to a reduction in overall conveyance. The committee explored the impact of hospital handover delays in the context of many acute trusts declaring critical incidents. It acknowledged the challenge of patient flow and staffing levels at hospitals. We do implement our handover policy but can only do this when there is space and some emergency departments are at full capacity and so there is nowhere to hand patients over to. The regular regional meetings focus on this, but there are no easy solutions. In terms of the good provision of hours over the Christmas period, the committee asked the executive about how they will be undertaking a benefit realisation assessment. This will come back as a management response in due course. Lastly, there was a discussion about the recent emergence of a national push for a 111 virtual call centre. There appears to be come clinical risk to be worked through and there is an issue about timing too that we and other providers have escalated. **Additional Funding - progress against delivery** A verbal update was provided on EMA and clinical recruitment in the EOC, linked to the non-recurrent funding provided late last year. There is good progress and we are meeting the related performance improvement trajectories, in particular call answer

	performance.
Any other matters the Committee wishes to escalate to the Board	The committee noted the implications of the mandated COVID vaccinations. As currently know (work still to do) there is a potential issue for 293 (of 3009) staff that fall within scope. An update on this will be provided at the Board meeting in January. It was a good meeting with excellent discussion. The committee congratulated the executive for the level of performance over the past few weeks, which was in the face of such adversity. The improvements in forecasting helps us understand the challenges ahead which will put us on the front foot.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Operational Performance Committee

The aim of the observation is for Governors to see and understand the assurance NEDs seek in action. The Trust is keen for NEDs to undertake their business as they would if Governors were or were not at the meeting.

Part A should be used for general observations about the functioning of the Committee. Please keep your observations brief and do not detail any confidential information leading to redaction.

If Governors have any individual concerns on NEDs performance or style, they can speak to the Chair directly (David Astley) or the Senior Independent Advisor and Deputy Chair (Michael Whitehouse).

Date of meeting: 6 January 2022

Governors present: Harvey Nash, Alison Fisher

The following report is from the Governor/s, noting their observations.

1. Prior to the meeting:

Contact from the Chair (Howard Goodbourn) re any issues from Governors for the meeting, which were passed on. He offered both pre-and post-meeting sessions. HN had a helpfulbrief phone discussion beforehand.

2. Introductions:
Governors introduced. CEO asked for brief silence in respect of the death of Alice Clark, wished the two injured paramedics well and praised the actions of all the duty team last night. NB. David Ruis-Celeda was the duty Director (his first time).

3. Attendance:
Full NED and Executive/substitute attendance with others brought in for specific items. CEO present throughout. SECAmb Chair was on leave.

4. Agenda:
Full and comprehensive coverage of performance items both current and future, with extensive supporting documents and statistics. Some papers were late, mitigated by the holiday period and staff absences, but all were available prior to meeting.

5. Discussion during meeting:
All participants engaged well and interactions were insightful but sometimes strayed off point. The CEO and others gave informed views on current and imminent COVID issues (hospital delays, staff absence and vaccination rates) based on both internal

data and extensive work with top level NHS and Government and frequent collaborative contacts with emergency partners, providers and suppliers. Examples given of SECAmb initiatives to address delays. Good use of presentation slides to pick out pertinent points.

6. Chair:
Howard Goodbourn chaired well and while the timing of individual items was flexed, all items were covered and the meeting kept to time. He picked up on a number of the Governor points raised prior to the meeting not otherwise addressed (e.g. quoted recruitment numbers did not include replacement of attrition, training for managers key) and persisted when responses were incomplete

7. De-brief:
We had a useful 20 minute discussion with Howard G after the meeting in which he sought and welcomed our feedback and thoughts.
Discussion was wide-ranged including:

- use of First Responders
- compulsory vaccinations for front-line
- support of staff morale
- Better by Design progress
- increasing consultations and Union involvement at local and national level

NB. As a new Governor, Alison said she took ages to read the papers because of acronyms the number of which seem to grow daily!

8. Conclusion:
The agenda was tight, but it did not feel that discussion was curtailed, though some points were laboured. It was chaired well so the meeting finished on time. Everyone was well-prepared so no clarifications required. Challenges were balanced and responses were, on the whole, full, clear and honest (eventually in some cases). The OPC is effective and focussed with NEDs actively involved and engaged.

Southeast Coast Ambulance Service NHS Foundation Trust

SECAmb Board

WWC Escalation Report to the Board

Date of meeting	**09 December 2021**
Overview of issues/areas covered at the meeting:	**Executive Escalation** At each Board committee meeting is a standing agenda item for the executive to escalate or raise any specific 'live' issues the committee ought to be aware of. There were three issues raised by the Executive Director of HR & OD: 1. Firstly, and for awareness, the national ballot for potential industrial action, related to the 3% pay award. 2. The consultation for the Medway and Banstead MRCs, affecting just under 1000 staff. This is ongoing and external resource has been secured to ensure the right level of capacity is in place to manage this process. 3. The mandatory vaccination policy for patient facing staff. Management is working through the potential impact on the Trust and how to support the affected staff. The committee explored the steps that may be taken such as having one to ones with individuals who choose not to be vaccinated, and the potential consequences. In review of the **committee dashboard**, taken from the IPR, the committee challenged the low completion rates for appraisals - 28% year to date, which is much lower than last year. While it supported the introduction of a new appraisal system aimed at improving the quality of appraisals, it felt that we needed to ensure more immediate improvement. It learnt that there is a recording issue that the executive is aware of and in the process of fixing, and the committee will review this is greater detail at its next meeting in February. Management Responses: **HR Performance Update Assured** In the past few months the committee has been focussed on the implementation of new HR systems. Going forward, this focus will shift to performance, and how these systems support processes, such as recruitment (time to hire), payroll etc. There is now better data on time to hire and the feedback from the new payroll provider / system has been positive, to-date. The supervisor self-service is a positive step forward as this empower managers with a better level of management information.

Workforce Planning and Recruitment Internal Audit Partial Assurance
The committee received some assurance from the progress against the actions taken in response to the 'Partial Assurance' Internal Audit review. There is a review of the workforce plan schedule for the WWC meeting in February.

Health & Wellbeing Partial Assurance
A Health and Wellbeing Programme Board has been established by EMB to develop the Occupational Health tender; undertake a value for money review of the H&W service; and draft the H&W strategy. The team are consulting with stakeholders and using feedback from surveys etc. to help inform this work.

The committee noted that the Trust invests over £1m each year on this service, which is positive. It also reinforced that the wellbeing hub is just one aspect of staff health, welfare and wellbeing. As importantly, is good line management, appropriate and timely training and development, as well as ensuring the right capacity, support and equipment.

There were then a number of scrutiny items:

Sickness Action Plan Partial Assurance
There is a specific plan to help better manage staff sickness. The committee received an overview and progress to-date and noted that some aspects of the plan were still incomplete (e.g. gaps in leads / timeframes). The committee has added this as a standing agenda item until the plan is complete.

Learning and Development Plan – Operational Focus for 2022 - 2025 Partial Assurance
A really helpful presentation was received on the developing learning and development plan. This is a joint effort between operations, learning and OD, and clinical education. Priorities have been established for training, learning and development and the committee explored these and tested how management intends to deliver in the context of the sustained operational pressures (abstraction).

The committee is assured by the fact that we are now looking at this much more holistically and tackling the really tricky issues. It noted that not everyone needs the same level of training and that there is better clarity on overall cost. The multidisciplinary approach is positive and helps to start to address the tension between performance, development, and abstraction. Balancing these tensions is not easy but doing so is central to this and so must be (and is) the first step. The executive is clear that we need to develop something that is sustainable within reasonable tolerance, such as 'normal' sickness.

The committee supported this approach acknowledging that despite a robust plan there will be times when operational pressures are such that some training and development will need to be paused. However, the challenge to the executive is to ensure this is more of an exception than it has been in recent times with clarity about what cannot be delayed, such as some stat/man training.

Overall, the committee believes this is a really good step forward and it will oversee delivery of the plan from April 2022.

FTSU Partial Assurance

Following on from the Freedom to Speak Up Guardian (FTSUG) report to the Trust Board in September, the committee invited the FTSUG to this meeting to give more detail on the types of issues related specifically to management / HR. This included where there are hotpots and how we demonstrate learning.

There was a helpful discussion about the gaps in being able to always demonstrate learning and the committee noted the work ongoing with the HR team to make improvements to this. Despite this, there is evidence of good learning outcomes, for example at Guildford OU a concern was raised about the lack of training, and the member of staff wasn't getting anywhere with their line manager. After using FTSU a model response was made working in partnership with the person to ensure a positive outcome. This helped rebuild their confidence in the local management team.

The committee reinforced the need to shift the balance of emphasis of what comes through FTSU, so that the general management issues can be dealt with promptly as part of the line management structure.

A second paper was received by the committee setting out all the various initiatives to ensure SECAmb is the best place to work. The committee will add this as a standing agenda item to monitor progress.

Incidents of Violence & Aggression Partial Assurance

The committee received an update on the body worn camera trial, the work ongoing with Police (related to prosecutions), and the de-escalation training. The paper did not include specific assurances on the effectiveness of the measures we have in place to support staff and keep them safe. It therefore asked for a further paper to come to its February meeting.

With regards the body worn camera trial we are part of a national trial and will feed into the national evaluation. Together with the benefits we establish, this will then inform any decision for future investment.

Clinical Education Strategy

The committee received a good draft of the strategy at its meeting in October and received a verbal update on the developments since then, which include greater emphasis on digital technology and also equity and access; how we intend to break down silos / ensure more integration; and clarity on the approach to delivering education for those who are actively working.

The committee explored the links with clinical supervision and reinforced the need for

	this strategy to be responsive to changes. In terms of how this fits within a broader education and training strategy the committee sought assurance that there is good integration between the HR, medical and operations directors. The final section of the meeting was the Forward Look / Horizon Scan. Here the executive updated the committee on the steps to improve the working environment within EOC/111. This includes action to better support managers and to increase leadership capacity. Two external people have been brought in and their fresh eyes will help both senior-level capacity and ensure learning. An update will be received at the next meeting.
Any other matters the Committee wishes to escalate to the Board	The quality of the presentations and discussion was very good and there is a more future view being taken across the issues. However, some papers were late and feedback was provided about the range of presentation styles and how these might be adapted to better inform the committee.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Workforce and Wellbeing Committee

The aim of the observation is for Governors to see and understand the assurance NEDs seek in action. The Trust is keen for NEDs to undertake their business as they would if Governors were or were not at the meeting.

Part A should be used for general observations about the functioning of the Committee. Please keep your observations brief and do not detail any confidential information leading to redaction.

If Governors have any individual concerns on NEDs performance or style, they can speak to the Chair directly (David Astley) or the Senior Independent Advisor and Deputy Chair (Michael Whitehouse).

Date of meeting: 9 December 2021

Governors present: Colin Hall, Alison Fisher, Nigel Robinson

The following report is from the Governor/s, noting their observations.

1. Prior to the meeting:
The pre-meet with the Chair started late because of connection issues.
There was a set of papers missing from the pack.

2. Introductions:
Not really done because of a very full agenda and time constraints.

3. Attendance:
Full NED and Executive attendance with others brought in for specific items.

4. Agenda:
Full and wide-ranging, re-arranged at times to suit participants.

5. Discussion during meeting:
All participants engaged well, and interactions were insightful. Discussion between key participants for each agenda item was very detailed, frank and probing.

6. Chair:
Laurie McMahon

7. De-brief:
Colin and Alison took part to give feedback for the Observation. Nigel could not stay on for this due to time constraints

8. Conclusion:
The agenda was huge, so it felt that discussion was curtailed at some points, but it was chaired well so the meeting finished close to time.

Everyone was well-prepared so no clarifications required, but some items appeared rushed.

Challenges around appraisals, training, absence and immunisations were balanced and responses were clear and honest as was recognition that tough times do not appear to be ending.

Because there were no introductions, an organisation chart would have been useful.

The meeting was very well chaired. There was a sense of frustration throughout the meeting that time was so short and there were so many important items to properly discuss. Lots of enthusiasm was evident from all attendees and an obvious willingness to do well and get somewhere.

Ali Mohammed, Giles Adams and Emma Williams were particularly articulate and knowledgeable about their key subject matters.

Time management was a clear and distracting pressure. So much discussion and debate, but frankly even if a whole day were available, I'm not sure it would have covered all the issues.

The emerging issues which were discussed around COVID immunisation and CPD are massive and a great imposition looming toward the trust.

Overall a great meeting.

This report is a tri - party compilation by all Governors observing the meeting.

SECAmb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 13 January 2022
Overview of key issues/areas covered at the meeting:	In review of the **committee (IPR) dashboard**, the committee noted the work on developing targets. At its previous meetings two areas from the dashboard were identified for further scrutiny, both were covered at this meeting. Under **executive escalation**, nothing specific required escalation, but in relation to the recent RTC where a member of staff very sadly died, the committee noted the ongoing SI investigation and the separate review of RTCs to establish any themes / learning. There were two *Management Responses* (related to gaps in assurance from previous meetings): **Duty of Candour Compliance** **Assured** At its meeting on 18 November 2021 the committee highlighted from the Dashboard a concerning trend in compliance with the Duty of Candour. It asked for information about the work to ensure this is prioritised, and assurance that despite missing the time-based targets Duty of Candour is always completed. Firstly, the committee was pleased to see that in November there was 100% compliance. It learned that the main reason for the previous dip related to capacity in SI the team, due to the number of SI investigations and, in particular, harm reviews. However, duty of candour was always implemented, even when it was outside of the time-based target. The committee noted that the numbers (requiring duty of candour) are small and so using percentages in the IPR rather than numbers can be a little misleading. It also acknowledged how difficult these conversations can be and so training is really critical. It therefore asked for information in due course about how we are preparing managers for these conversations and also investigating incidents. In the meantime, noting the competing priorities, the committee is assured that there is the right level of focus in ensuring this requirement is always met. **111 Electronic Prescribing Service (EPS)** **Assured** At its meeting on 21 May 2021 the committee received a paper on the introduction of the EPS in 111. The committee asked for an update to include themes and trends. This was provided, setting out the quality assurance framework in place to facilitate EPS. The committee noted there is as expected for the type of service, a high prevalence of antibiotics. There is currently just one non-medical prescriber (NMP) and work is ongoing to phase pharmacists, closely overseen by the Chief Pharmacist. The committee explored the approach between what a GP prescribes and what comes to an NMP. Overall the committee is assured by this service, and how it is being implemented. It forms a strong part of our offer to the communities we serve. Going forward there is work to ensure less variability in prescribing and to keep a close review of the number of out of hours' prescriptions. The committee has asked for a management response in 6 months' time on these two issues. The main *scrutiny items* were as follows:

Infection Prevention and Control (IPC) - Hand Hygiene Partial Assurance

This paper was requested in December, following review of the IPR dashboard that showed variable compliance. It explained that the answer isn't necessarily messaging as there has been somewhat of a message overload in recent months. Instead, management is doing some targeted and sustained improvement work. The recent low compliance in the main are issues related to bare below elbows and wearing watches, and these are for local management to manage, as set out in the IPC improvement plan.

The paper gave some data showing a link between sub optimal hand hygiene and staff hours lost due to sickness, such as respiratory / gastro illnesses. The committee is clear that we must keep reinforcing the importance of hand hygiene, and it explored how we do this in a way that get across the cultural point.

The executive confirmed that there is a well-established outbreak management framework in place, and this helps to educate local managers about how to restrict cross infection. In addition there is some targeted improvement for specific Operating Units.

The committee found the paper really helpful. It clarified the different contributing factors, such as working in full PPE, and the committee acknowledge that there is some IPC fatigue not just here but across the NHS.

The outcomes of the IPC improvement plan will be reviewed by the committee later in the year.

GoodSam update Assured

The committee asked for this paper to seek assurance on the approach and implementation of GoodSam. It was assured by the approach, noting that there is scope to expand further, subject to our appetite for risk, and that there have been no adverse incidents since its introduction.

We started using just our own staff then moved on to other agencies (health professionals) who are required to provide evidence of qualification / registration.

In terms of issues, the executive explained that there is some improvement needed in how we stand down people effectively (when the patient is found not to be in cardiac arrest), which is ongoing.

The committee acknowledged how incredibly public spirited it is for people to give their time to this. It reinforced the need to thank and recognise these volunteers, and to publicise good outcomes, perhaps linked to the volunteer and cardiac arrest strategies.

EOC Safety - Mental Health Partial Assurance

On 26 October 2021, the Trust implemented the Suicide / Overdose validation process to provide greater clinical oversight to patients who present as suicidal or who have taken an overdose. Following the Cleric change, a couple of issues were identified that are being addressed. One of these relates to functionality (where some calls aren't automatically being upgraded) that Cleric has been asked to fix. In the meantime, there is reliance on manual intervention from the EOC clinical team, which requires one-to-one training and shared learning.

Despite this, and from the data available, we can ascertain that overall the Trust now has much greater oversight of calls for patients experiencing a mental health crisis, with intervention for some cases resulting in appropriate categorisation of the call through upgrading or signposting to alternative dispositions.

The committee noted some gaps in reporting that need resolving to be able to more accurately establish how well this new process is working. However, while it is assured that safety is improved, due to more robust clinical visibility and awareness of this

vulnerable group, further improvement is to follow, especially with regards the automated process via the CAD. A progress report will be considered in six months' time.

Research and Development – Outcomes **Assured**
A good paper was considered that set out the key studies in progress. The committee acknowledged that these studies are long term in duration and, for some of them, it will be several years before the results are reported. In turn, this means it is unlikely to be possible to evidence the impact of these studies for a while yet. The Research and Development Department are working with various areas/departments within the Trust to ensure that the Trust develops robust mechanisms of evaluation of research impact.

This paper summarised the ten studies in progress, which excludes the grant applications in areas such as end of life care, organisational change, and interprofessional working within care homes.

The CFR study is closest to being reported, but this is still only halfway through. Funded by NIHR and led by the University of Lincoln, this study is looking at CFR provision by investigating current activity, costs of provision, and views of patients, public, CFR schemes and rural care providers. The purpose is to investigate patients' experiences of having community first responders attend to them for a medical emergency before or around the time that ambulance staff arrive. The study will enable recommendations to be made that will lead to improvements in patient care.

The committee heard also about the softer impacts of research, such as the increasing number of paramedics being published and getting involved in research. It is really assured by the research that is ongoing.

The committee also recognised the impact of the R&D team on our response to COVID, e.g. the rapid literature searches to evidence some of our decisions / procedures.

The committee then considered a number of *Annual Reports*:

Complaints / Patient Experience Annual Report 2020/21
The committee reviewed this report, noting the areas for development / improvement, including the revamping of the Patient Experience Group to help ensure better balance with patients and carers. It heard that this is now established and working better. The relations with Health Watch have also been strengthened, and we now attend their regional meetings and work with them to triangulate data. Other improvements of note include the better collation of protected characteristics from complainants.

In terms of complaints responsiveness, in the year reported the Trust responded to 87% within 25 working days, which the committee commended especially considering the context of the pandemic.

Learning from Deaths Q4 2020/21
This report covering Q4 of last year coincided with the peak of the Delta variant, which explains the higher number of deaths in January 2021. It affected all age groups above 40 years. The structured judgmental reviews found that overall the standard of care was good / excellent in 75% of cases; others (poor / very poor) related to delays in C1, although few impacted on the eventual outcome for the patients.

In terms of learning, these reviews helped to identify that while we are effective at when to stop resus, improvement is needed on the processes that guide when to start resus. Other areas for development relate to documentation and how to explain the rationale for specific treatments.

There was also a review of all 14 child deaths. The initial care was good or excellent in nine cases and the other five were linked to delays, neither impacted the eventual outcome.

	Incidents & Serious Incidents Annual report The committee noted that the number of SIs is decreasing, although we are still a high reporter, which is positive as shows openness. One reason for this decrease is the work to ensure we more consistently hold to the definition of what an SI is. It also noted the improvement needed to better embed recommendations / actions. The executive is working to ensure more focussed actions. The final section of the meeting was the *Forward Look/Horizon Scan* section. There were two issues discussed here. Firstly, related to the **triage destination for paediatric cardiac arrests in mid-Sussex.** This relates to the Princess Royal Hospital and a request for all such transfers to go instead to Brighton. Our medical director expressed some concerns about this and escalated to NHSE who via their medical director confirmed the position. We have alerted commissioners. There was also an update on the **falls pilot**. This was a proof of concept and the executive is now looking to roll this out in March 2022. Lastly, there was a discussion about COVID management, and the committee sought assurance on the arrangements since Bethan left. The COVID management group continues as before and in due course this will move to BAU.
Any other matters the Committee wishes to escalate to the Board	None.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Quality & Patient Safety Committee

The aim of the observation is for Governors to see and understand the assurance NEDs seek in action. The Trust is keen for NEDs to undertake their business as they would if Governors were or were not at the meeting.

Part A should be used for general observations about the functioning of the Committee. Please keep your observations brief and do not detail any confidential information leading to redaction.

If Governors have any individual concerns on NEDs performance or style, they can speak to the Chair directly (David Astley) or the Senior Independent Advisor and Deputy Chair (Michael Whitehouse).

Date of meeting: 13 January 2022

Governors present: Harvey Nash

The following report is from the Governor, noting their observations.

1. Prior to the meeting: Received all papers in advance, including a most helpful pdf version from Elaine Taylor.

2. Introductions: Tom Quinn (QPS Chair) welcomed me to the meeting and we agreed to stay on the link for a short debrief at the end. Tom also welcomed each guest speaker by name throughout the meeting,

3. Attendance: NEDs - Tom Quinn, Subo Shanmuganathan, Liz Sharp, David Astley
Exec Dirs – David Hammond (for CEO, Dir HR and Dir Ops), Judith Ward, Fionna Moore, Peter Lee

4. Agenda:
Full Agenda with approx. timings, covering both regular and specific report items. The latter included Duty of Candour, 111 Electronic Prescribing, Hand Hygiene, GoodSan App, EOC Safety-Mental Health, Research projects, 2020/21 Complaint/Patient Experience Report, Learning from Deaths Q4 2020/21 etc

5. Discussion during meeting:
The full agenda was covered, with full engagement from all attendees, including some very good inputs and responses from invited speakers on specific items. The tragic RTC resulting in the death of one and serious injuries to two other paramedics was remarked and condolences expressed to all affected.

The NEDs had clearly read and were familiar with the documents and subject areas, asking pertinent constructive questions throughout and, on occasion, pressing for additional detail or commitment effectively. At different points all the NEDs gave praise to good quality reporting and activities. Discussions covered both current and future activities taking account of Covid / Flu and other impacts

6. Chair:
The Chair managed the meeting well, flexing the agenda timings to make best use of time, provide a short break and still cover all items fully and finish the meeting to schedule. Tom Quinn ensured all questions were put and answered, that specific topic speakers were welcomed, able to respond fully and thanked for their work, and actions captured.
In the meeting review he commented on the good quality of all the reports received, but suggested that some could be more succinct and that more use of a common format would be useful (which I would endorse).

7. De-brief:
Tom Quinn and I talked for about 10 minutes after the meeting. Aside from some points already mentioned I fed back -

(a) the criticality of adequate effective training (especially for managers) had come up in many of the topics (e.g. Difficult conversations, Leadership, Hand Hygiene, Complaint handling etc) reinforcing the need to ensure this is delivered.
(b) while there had been some progress on aspects of patient experience (patient friendly version of strategy, getting some new PEG members) the level of progress indicated in the meeting was more than that seen by the two Governors (myself and a colleague) on the PEG since 11/2020. Too often PEG meetings were cancelled, shifted or poorly attended, actions delayed and deadlines missed. We readily accept the impact of operational pressures but if real progress has been made it is well behind the scenes and yet to be seen by us.
(c) The issue of what to communicate to the public on paediatric cardiac arrest destinations for mid-Sussex echoes discussions the CoG has had around overall comms on pandemic response performance. I had previously been reassured by discussion with David Astley and this was reinforced by his comments in the meeting on the need to provide clear lines and support for the crews etc directly involved.

8. Conclusion:
This was a constructive well-managed meeting in which the NEDs showed insight and engagement with issues across QPS and actively questioned and sought assurance on areas of concern, both current and future.

SECAMB Board

Finance and Investment Committee (FIC) Escalation report to the Board

Date of meeting	20 January 2022
Overview of key issues/areas covered at the meeting:	**Month 9 - Financial Performance Assured** There was a very detailed review of financial performance in the context of the position at month 9. We are reporting a deficit of £1.6m in month 9, which is slightly better than plan; this takes the reported cumulative deficit to £8.3m, which is also broadly in line with plan. The productive hourly rate for frontline workforce remains high due mainly to an increase in abstraction, and the overtime incentives for December totalling £1m (£0.8m for Christmas period). The committee explored how we measure productivity as a unified metric and this led to a helpful discussion about how we ensure internal productivity, but also productivity that helps the wider system. The way management is thinking about this is reassuring and it links directly to the Trust strategy. Cost improvements to date are £1.7m against a target of £4.4m. While this adverse position can be partly explained by operational pressures, the committee heard about the significant changes that are needed in the Trust's approach to efficiency savings. A number of initiatives are being taken forward to improve the operational delivery model, to help ensure we make better use of available resources, improve efficiency and optimise performance. Against this background, the Cost Improvement Programme will be relaunched as the Efficiency Programme during the planning for 2022/23. The committee noted that there still need to be some cash releasing from this but supported the view that it is principally about efficiency and improving service provision. In time this must be engrained in the way we operate. There is a good level of assurance that the executive is taking a more mature and forward-thinking approach via Better by Design, which will lead to better clarity about where we identify efficiencies as part of integrated planning. There are no significant remaining risks to delivering the financial plan in the current year, but there does remain significant uncertainties for next year and beyond. The committee has asked for a view later in the year on the longer-term financial projections to align with what Better by Design can reasonably achieve. **Update on Financial Planning Partially Assured** The Planning and Contracting Guidance was published on 24 December 2021 and the finance team is working through the detail, which includes a tariff at 1.7% (Inflation growth of 2.8% less 1.1% efficiency). This year there is specific reference to a requirement for ambulance trusts to meet Category 1 and 2 ARP targets and for acute trusts to meet handover targets (100% <60 mins; 95% <30mins; 65% <15 mins). The draft plans are due by 17 March 2022, with final plans by 28 April 2022. This will require Board approval.

The committee reviewed some of the risks and opportunities such as:

- ICS allocations may not provide funds to support the required workforce requirements
- Impact of Flowers and other costs not covered by Tariff (e.g. local pay agreements)
- Continued impact of pandemic combined with reduced funding
- Continued deficits will adversely affect cash for investment
- Guidance supporting the need to meet Category 1 and 2 standards and 111 capacity

The legislation for the ICS structures has been pushed out to June 2022 and in the meantime, work is needed to better understand the implications of accountability v responsibility between providers and the ICS.

Commissioning Contracts **Partially Assured**
A report was received giving an update on the Trust's NHS commissioned contracts and services, and potential new business across the region, related to mental health and end of life services.

Noting that contract management is currently different while the block contract is in place (due to the pandemic), the committee challenged the executive on the extent to which we are adequately set up to provide robust commercial contract management. It suggested that we seek an external view on how we are currently configured to see where there might be gaps.

Business Case Tracker **Partially Assured**
The committee noted the tracker and explored how management prioritises one investment / project over another and whether more could be done at budget setting. It concluded that while some things will not be known at the start of year, other aspects could be better planned. Until then there is a gap in assurance on the appropriateness of prioritisation and related management control. It challenged the executive to make improvements in this over the next 12 months, so that when we agree annual budgets there is better clarity about where during the year, we will support additional investments that align with the strategy. Until we get to this point the business case process will continue to be too reactive.

Fleet Update (including Internal Audit Report) **Partially Assured**
A helpful paper was received updating on some recent fleet issues. Firstly, related to the Fiat seatbelts, the issue is now better understood and there is a risk assessment being designed for the relevant staff (that struggle with the positioning of the seatbelt). Fiat has been engaged as have the national procurement team as this is a national specification linked to the Carter Review. The outputs of this will help inform any revision to the fleet strategy.

In exploring this issue, it has helped management to highlight other issues linked to the familiarisation with fleet and equipment, and so a fleet user group has been established to help ensure these are resolved.

The paper also outlined some of the immediate actions from the recent fatal RTC on 5

	January 2022. We report all RTCs (including chipped windshields, broken mirrors, scratches when manoeuvring in tight locations, etc), via the MyCRA app, which links with our insurer. In addition, all RTCs involving injuries are reported on Datix. The analysis of this data shows that in the context of driving in excess of 15,000,000 miles per year, in the past two years we have reported a total of 1018 incidents, 1.39 per day. From this, 59 injuries have been reported; three have resulted in moderate harm, and three in a fatality. The paper also included national benchmarking data from our insurer, who insure all English ambulance trusts and, despite some variances within individual policies, and different geographies having different overall mileage requirements, we are not an outlier for overall claims, sitting just above the first quartile. A Driver Safety Forum which will include our insurers is being established to conduct monthly reviews so that we identify issues earlier and take more proactive actions. With regard to the RTC on 5 January the committee is assured that we are working closely with Kent Police who are leading on the investigation, and a full internal SI investigation will follow in line with our standard procedures. Lastly, the committee reviewed the recently concluded fleet internal audit review, which was Partial Assurance. A number of recommendations were made but the key conclusion was that, in broad terms, we have a fleet system but aren't using the data. Some of the actions mentioned above arise from this review and in the January IPR (on the Board agenda) there is new fleet data to increase visibility. While overall the committee can only be partially assured with fleet management, it is confident that we now have a robust plan to make the necessary improvements. **Strategic Estates Progress Report Assured** Statutory Compliance across the estate remains at a satisfactory high level, with an average throughout the last reporting period (up to Nov 2021) at 94% of the statutory planned maintenance requirements being fully completed on, or prior to, their required due date. The slight drop from the previous 98.4% was due to a small number of outstanding Water Risk Assessment caused by a change in specialist contractor, which have all now been completed. We continue to maintain the build fabric and environmental quality of our properties at Category B: *sound, operationally safe and exhibits only minor deterioration* as stipulated in our Estates Strategy. Going forward, the executive is in the process of reviewing the strategic estates governance structure to widen the remit to include all BAU activity, in addition to creating oversight over the infrastructure development plans linking the Estates Strategy with the Performance Cell and other enabling strategies, such as Logistics and Medicines. It will also incorporate oversight over the relevant aspects of the SECAmb Green Plan as it develops, and feed into Better by Design. The committee is assured by the management of the estate and the steps being made to further strengthen the governance.

	SECAmb 'Green' Strategy The committee welcomed the development of this strategy, as a direction of travel. It noted that a detailed delivery plan is to be developed with the aim of having this in place by April 2022. The committee recommends that the Board approves this strategy which will be a golden thread through Better by Design and all we do going forward. The challenge to the executive and to the Trust Board is that if we are really going to get behind this and ensure it informs all our future investment decisions then it needs to be properly resourced. The committee suggests that when the delivery plan is developed, the Board receives this to test that we have the right resources to achieve the stated goals. The committee then considered a number of **business cases**. Firstly, related to the Medway MRC, a paper was received explaining why the costs have increased. Some of this relates to things unforeseen, such as increases to materials due to Brexit/Pandemic, but the committee felt that for some other issues we might have better predicted these in the planning stage. There will be a post project review where any lessons will be identified. The risk of not receiving the full wave 4 funding for this MRC remains – this is in the region of £2.8m. The executive continues to explore whether this can be moved into next year. The other business cases that the committee recommend to the Board for approval are: ▪ COVID – EOC ▪ COVID - 111 ▪ 111 First – Activity ▪ Microsoft Licensing
Any other matters the Committee wishes to escalate to the Board	This was another good meeting with constructive debate and exploration of important issues.

SECamb Board

Summary Report on the Audit & Risk Committee

Date of meeting	**02 December 2021**
Overview of issues/areas covered at the meeting:	
External Audit: Annual Report and Accounts	The committee agreed the **external audit plan** for 2021/22. No significant issues have been identified as part of the pre-audit work and KPMG appeared assured by the management planning for IFRS16. As with last year, the deadline for submission of the accounts is mid-June and so the committee and Board schedule has been slightly revised to take account of this. The committee also sought assurance that management has a robust plan for the production of the **annual report**.
Internal Audit	The committee confirmed the internal audit plan was progressing well and RSM gave it assurance that the reviews would be concluded in time for year-end. One review was considered at this meeting related to **Better by Design.** This was an early review of the governance arrangements, as they are being established. The finding was that this is being well thought through and there are adequate controls to mitigate any conflicts of interests. The programme of Better by Design continues to evolve and is becoming more encompassing that initially planned. As such some of the governance arrangements are yet to be finalised. The committee will continue to assure itself the arrangements are robust and working effectively.
Counter Fraud	The committee received a helpful progress report against the annual plan. The committee continues to be assured that we have a healthy counter fraud culture with strong controls. It noted the work on the fraud prevention impact assessment which is on track to be delivered within the agreed timeframe.
EPRR Annual Assurance	The annual assurance review of our EPRR arrangements concluded partial assurance; last year was substantial assurance. The executive felt this is a fair outcome based on the evidence it was able to demonstrate. Some of this relates to the impact of COVD, in particular in relation to the ability to complete all training and live exercising. In addition, there is a full review of the standards due, as it is acknowledged that some are poorly drafted and so not reasonably achievable. This is work ongoing. There is a robust action plan that the committee will review at its next meeting.
IPR review	The committee received a good overview of the work ongoing to further develop the IPR. Initially the focus is on the structure to ensure the exception reporting is more central and therefore user friendly. There is also work on the metrics and inclusion of more targets.
Risk Management Policy	A review of the revised risk management policy was undertaken. The committee challenged the executive to ensure this provides for a more horizontal approach to help

	identify and mitigate the systemic risks.
Other matters	The committee received an early update on the recent **Critical Incident** related to the CAD. The well-established review processes are in place which will have some independent oversight, and the committee will get a full update at its meeting in March. The committee also followed up its earlier review of the internal controls arising from '**Operation CARP'** and, specifically the eight workstreams. By the time of the Board meeting this will now be in the public domain. Once the review is complete the committee will be seeking assurances that to the best of our reasonable ability, we have mitigated any recurrence. Lastly, the committee sought assurance that we are preparing adequately for the **National COVID Inquiry**. We seem to be well-prepared and are linked in with the lead ICS where preparation is managed through the EPRR route.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Quality & Patient Safety (QPS) Committee

Council of Governors

March 2022

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

Membership & Participation

South East Coast Ambulance Service NHS Foundation Trust

Membership

- Tom Quinn, Non-Executive Director (Chair)
- Subo Shanmuganathan, Non-Executive Director
- Liz Sharp, Non-Executive Director
- David Astley, Chairman
- Executive Director of Quality & Nursing (Executive Lead)
- Executive Medical Director
- Executive Director of Operations
- Executive Director of HR & OD

Regular Attendees

- Chief Executive
- Company Secretary

2021/2022 Meeting Overview

- Membership attendance – Good
- 6 Scheduled meetings
- 2 Extraordinary meetings
- All meetings quorate

2021/2022 Meeting Overview

- Review of attendees
- Refresh of Cycle of Business
- Review of Terms of Reference

Content - Scheduled Meetings

- Annual Cycle of Business paused, refresh planned for March 2022
- Agenda organised by
  - ➢ Escalation

    E.G. Committee Dashboard, Executive Escalations to the Committee
  - ➢ Management Responses (response/information to previous items)

    E.G. Medicines Pouch Tagging, Impact of Clinical Audit Actions, Public Access Defibrillators
  - ➢ Scrutiny items (design & effectiveness of Trust's systems and processes)

    E.G. Serious Incidents themes and analysis, IPC Board Assurance Framework, Patient Experience, Bariatric Care, Harm Reviews, Mental Health, 111 Electronic Prescribing, Fleet RTCs
  - ➢ Annual Reports

    E.G. Clinical Audit Plan, Cardiac Arrest plan, Controlled Drugs Accountable Officer Report
- Forward Look/ Horizon Scanning
- AOB

Content -Extraordinary Meetings

- There was one planned extra meeting (October 2021) that could be stood down if not required. This was not required at the time and stood down.
- 3 Extraordinary meetings were arranged during the year:
  - 19/08/2021 Assurance on how the Trust is keeping patients safe during the continuing period of major operational pressures
  - 16/09/2021 Medicines Governance/Controlled Drugs (joint meeting with AuC)
  - 22/11/2021 Sexualised Behaviours

Outcomes & Assurance

Covid-19 Management	Assured
Serious Incidents	Continued focus on this throughout the year -
Clinical Outcomes – AQIs	Continued focus on this throughout the year
Patient Safety in REAP 4	Continued focus on this throughout the year
Medicines Governance	Assured
EOC/111 Clinical Safety	Partial Assurance
Harm Reviews	Assured
Birthing Centre Transfers	Assured
Public Access Defibrillators	Assured for phase 1, further work ongoing with the BHF Circuit
EOC Patient Safety – Mental Health	Partial Assurance
Duty of Candour	Assured
111 Prescribing	Assured
IPC Hand Hygiene	Partial Assurance
GoodSam	Assured
Research & Development	Assured

QPSC 2021 - 2022

South East Coast Ambulance Service NHS Foundation Trust

‘Scrutiny’ Items Mapped to CQC Key Lines of Enquiry

- Covid-19 Management
- Operational Patient Safety
- Patient Safety during REAP 4
- EOC /111 Clinical safety
- IPC Hand Hygiene
- Research & Development
- Fleet Update including RTC
- 111/CAS Patient Safety
- Serious Incidents Report
- Bariatric Care
- 111 Electronic Prescribing
- GoodSam
- IPC Board Assurance Framework
- EOC Patient Safety
- Harm Reviews
- Medicines Governance
- Review of Clinical Services & Outcomes by clinical grade
- EOC Safety – Mental Health
- Delivery against Patient Experience Strategy

Monitoring Governance including Annual reports

- Safeguarding
- Learning from Deaths
- Research & Development
- National Guidance
- Complaints/Patient Experience
- Clinical Audit
- Incidents & Serious Incidents
- Regulatory & Licensing
- Controlled Drugs Accountable Officer
- Quality Account
- Quality Assurance

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Close

Tom Quinn, Non-Executive Director and Chair of QPS

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Quality and Patient Safety Committee ('QPS') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to quality governance (encompassing patient safety, clinical effectiveness and patient experience) are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three Independent Non-Executive Directors and at least three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Tricia McGregor, Independent Non-Executive Director (Chair)
Lucy Bloem, Independent Non-Executive Director
Terry Parkin, Independent Non-Executive Director
David Astley, Chairman
Executive Director of Nursing & Quality (Executive Lead)
Executive Medical Director
Executive Director of Operations
Executive Director of HR & OD

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Company Secretary
- Deputy Medical Director
- Chief Pharmacist
- Consultant Nurse / Paramedic
- Head of IT
- Senior 999 Operations Manager
- Senior 111 Operations Manager

5.2. Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least six times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of governance and internal control in relation to the areas with its purview are designed well and operating effectively to:

- Promote safety and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care
- Ensure the effective and efficient use of resources through evidenced-based clinical practice
- Protect the heath and safety of trust employee and
- Ensure compliance with legal, regulatory and other obligations

8. Purview

The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference. The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support

The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next

meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	5 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. RMCGC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1		23 October 2017	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Updated membership
2.1		23 May 2019	Updated membership Clarified that frequency of meetings is to be agreed at the start of each year
2.2			Section 7 – Addition of bullet points confirming overall role of the committee Minor revision to section 9 – to remove the specificity of who will provide administrative support.

QPS CoB Review				20.5.21	22.7.21	19.8.21	16.9.21	22.10.21	18.11.21	13.1.22	17.3.22
Subject Area	**Notes for Inclusion**	**Exec Lead**	**Category**			SCRUTINY MTG		SCRUTINY MTG			
Admin											
Introduction & Apologies		Chairperson		✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interests Document		Chairperson		✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting		Chairperson		✓	✓	✓	✓	✓	✓	✓	✓
Action Log		Chairperson		✓	✓	✓	✓	✓	✓	✓	✓
Management Responses											
Adhoc, as per matters arising		ALL		✓	✓		✓		✓	✓	✓
Administration of Salbutamol	Deferred from May 2022	Medical Director									
Medicines Tagging Trial (Formerly Changes to the Medicines Coding System)	Deferred from November 2020 / Deferred from Mar 2021	Medical Director		✓							
PAP Governance (Due in May as Scrutiny item)		Director of Operations		See below	-		-		-	-	-
Data and Impact of Delayed Attendance on Patient Safety: Welfare Calls, No Send, Hospital Handover Delays	Deferred by Ops from Mar 2021	Director of Operations		✓							
Vehicle Strategy: Decision-Making Process Update (Incl. Datix Incident Analysis, and Vehicle Adjustments)	Deferred from xx	Director of Operations		✓							
Impact of Clinical Audit Actions on Patient Outcomes		Medical Director		✓							
Public Access Defibrillators (PAD) – Management Plan		Company Secretary		✓							
Review of the command structure	Requested via LB (Chair) in March 2021 To include all aspects of governance and assurance including competencies, training, and decision making	Director of Operations					✓				
QPS committee to seek assurance on the workforce/recruitment pipeline for specialist paramedics (PPs and CCPs).	Action from Trust Board (rcvd 22/03/21) Take with scheduled agenda item in July	Director of Operations			✓						
Scrutiny: Key metrics to highlight key risks and successes / Exception reporting											
Covid-19 Management	Inc. Vaccinations, PPE, Track & Trace, Staff Safety	Director of Nursing & Quality	A	✓	✓	✓	✓	✓	✓	✓	✓
111/CAS Patient Safety	Key metrics, Pathways licence compliance updates, Risks and Issues	Director of Operations	A	✓	✓	✓	✓	✓	✓	✓	✓
EOC Patient Safety	Key metrics, Pathways licence compliance updates, Risks and Issues	Director of Operations	A	✓	✓	✓	✓	✓	✓	✓	✓
Operational Patient Safety	Key metrics. Inc. Delayed Response, Handover, Staffing, Updates, Risks and Issues	Director of Operations	A	✓	✓	✓	✓	✓	✓	✓	✓
Serious Incidents	SI Actions Position Statement; actions raised, closed and progress (inc. themes and trends)	Director of Nursing & Quality	A	✓	✓	✓	✓	✓	✓	✓	✓
Safeguarding	Inc. Managing Allegations (PLUS deep-dive TBC)	Director of Nursing & Quality	B	Annual report			✓				
Infection Prevention Control	Internal Controls & effectiveness, adherence ro regualtions and progress against objectives. Including the Effectiveness of MRC/VPP Model and Vehicle Cleanliness	Director of Nursing & Quality	B		Annual report					✓	
Fleet & Logistics Services and Outcomes	Inc. RTC Report / IPC & MRC Compliance etc.	Director of Operations	A		✓			✓			✓
Patient Records	Inc. PCR/ePCR Compliance, IBIS	Medical Director	B			✓				✓	

Medical Diagnostic Equipment Quarterly Review	Inc. Medical Gases	Director of Operations	A		✓			✓			✓
PAP Governance and Patient Safety	Inc. Quality Assurance Outcomes (Highlights)	Director of Operations	A	✓				✓			✓
Lessons Learned & Quality Improvement	Identification and Application (e.g Incidents, Litigaton, Claims, SI's, etc.)	Director of Nursing & Quality	A		✓			✓			✓
Paediatric Services and Outcomes	Dashboard/ Tracker (SIs, Complaints, Incidents and any variation - U5s)	Medical Director	C				✓				
Clinical Outcomes: Cardiac Arrest	Holistic approach / plan to cover all-Trust identified issues e.g. SIs, clincal audit, PAD sites, medical devices	Medical Director	A		✓		Ann.Report		✓		
Mental Health Services and Outcomes	Inc. S136 Transfers	Director of Nursing & Quality	C				✓				
Clinical Outcomes: AQIs	Deep Dive into STEMI (May 2021)	Medical Director	A	✓			✓			✓	
Obstetric Services and Outcomes	Focus on Birthing Units and transfer requests Use of Midwives in EOC (Linked to Ockenden, and legal cases)	Medical Director	A		✓			✓			✓
Review of Clinical Services and Outcomes by Clinical Grade	To include NQPs / Safety of Discharge / Conveyance / Back-up times	Director of Operations	A		✓			✓			✓
HART/EPRR & NARU (RESILIENCE) Services and Outcomes	(NB: NARU audit date under review) Integrate EPRR with HART as overall 'NARU Update'	Director of Operations	B				✓ (Audit)			✓	
CFR and Volunteer Services and Outcomes	Scope of Practice and Strategy Inc. PAD sites/GoodSam/Ntl Defib Register	Director of Operations	A	✓	✓		✓			✓	
Consent to Treatment	Review incident numbers - hold TBC (LS to contact Datix team)	Medical Director	A	✓			✓			✓	
Bariatric Care	Vehicle equipment, Location of services, Policy, Performance analysis, Tasking, Training and Outcomes	Medical Director	B		✓				✓		
Frequent Caller Services and Outcomes		Medical Director	B			✓			✓		
Dementia Care Services and Outcomes	Inc. Patients with Learning Disabilities / Progress against strategy	Director of Nursing & Quality	A	✓			✓			✓	
End of Life Care Services and Outcomes		Medical Director	B			✓			✓		

Patient Experience Services and Outcomes	Complaints, Compliments and Engagement	Director of Nursing & Quality	B			✓			✓		Ann.Report
Freedom to Speak Up	Focus on Patient Safety Issues	Director of Nursing & Quality	A		Annual report			✓			✓
Research & Development		Medical Director	B			✓				✓	
Legal Aspects of Patient Safety	Claims, Litigation, Coroners and Reporting etc.	Company Secretary	B		✓			✓			
			No. Items	11	16	10	14	13	10	13	13
Monitoring: Governance arrangements / Quarterly progress against (action/project) plans and/or targets											
Medicines Management Review	EPS update - May Full Meds Mgmt Review - July	Medical Director	A	✓	✓				✓		Ann.Report (Below)
National Guidance (JRCALC, NICE)	JRCALC+ App - access and compliance	Medical Director	A		✓				✓		✓
Progress against CDAO Plan		Medical Director									
Progress against Clinical Audit Plan	*Inc. clinical audit outcomes re: Bariatric and Dementia Services (timings TBC once substantial Head of CA / QI in post) *Include timings / deadlines to the recommendations in the Safety of Discharge audit plan and to include the grade / role of crew members making the discharge in all future audits	Medical Director	A		✓				✓		Ann.Report (Below)
Regulatory Licensing and Compliance	(CQC, MHRA, NHSP, HSE, ICO) Inc. CQC Priorities and improvement journey	Director of Nursing & Quality	A		✓				✓		✓
Annual Research Plan		Medical Director	C	✓							
Learning from Deaths	Inc. Mortality and Morbidity Quarterly Review (Consider including paediatric deaths - U12)	Medical Director	A	✓			✓		✓		Ann.Report (Below)
Governance & Risk Management: Progress against Trust-level Priorities											
Annual Training	Assurance in the delivery of role specific key annual CPD (compliance and planning)	Director of Operations	A		✓					✓	✓

Quality Account	Development*/Mid-Year Review**/Sign-off*** Inc. Progress against Quality Improvement Priorities 2020-21: Clinical Supervision, MHFA, Fallers (update on one priority per mtg)	Director of Nursing & Quality	A	✓♦			✓♦♦				✓♦♦♦
Quality Assurance Visits		Director of Nursing & Quality	A		✓				✓		Ann.Report (Below)
Review of BAF/QPS Risks		Director of Nursing & Quality	A	✓	✓		✓		✓	✓	✓
QIA Review (Inc. CIP)		Director of Nursing & Quality	A		✓		✓		✓		✓
Annual Reports / Strategies										
Cardiac Arrest		Medical Director					✓				
Clinical Audit	TBC	Medical Director			✓						
Controlled Drugs Accountable Officer (CDAO)		Medical Director					✓				
Learning from Deaths (Inc. CA & Conveyance)	TBC	Medical Director		TBC							
Complaints (Patient Experience)		Director of Nursing & Quality		TBC							
Freedom to Speak Up		Director of Nursing & Quality			✓						
IPC		Director of Nursing & Quality			✓						
Quality Assurance		Director of Nursing & Quality									✓
Safeguarding		Director of Nursing & Quality		✓							
Review										
Cycle of Business		Chairperson					✓				✓
Terms of Reference		Chairperson			✓					✓	
Horizon Scanning		ALL		✓	✓		✓		✓	✓	✓
Next Meeting Agenda		Chairperson		✓	✓		✓		✓	✓	✓
Meeting Effectiveness		Chairperson		✓	✓		✓		✓	✓	✓
Annual Self-Assessment		Company Secretary									✓

Category A	Every meeting
Category B	Every other meeting
Category C	Once a year