South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

31 March 2022
10.00-13.30

Via Video Conference

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Administration					
75/21	10.00	Welcome and Apologies for absence	-	-	Chair
76/21	10.01	Declarations of interest	-	-	Chair
77/21	10.02	Minutes of the previous meeting: 27 January 2022	**Y**	Decision	Chair
78/21	10.03	Matters arising (Action log)	**Y**	Decision	PL
Context					
79/21	10.05	Chairs Report	**Y**	Information	Chair
80/21	10.15	Board Assurance Framework Risk Report	**Y**	Assurance	PL
81/21	10.25	Chief Executive's report	**Y**	Information	PA
Quality & Performance					
82/21	10.40	Integrated Performance Report Incl. Committee Reports	**Y**	Information	PA
83/21	12.00	Learning from Deaths – Q1 2021/22	**Y**	Information	FM
84/21	12.10	Infection Prevention & Control Board Assurance Framework	**Y**	Assurance	RN
85/21	12.20	Gender Pay Gap Report	**Y**	Information	AM
Strategy					
Trust Strategy:					
86/21	12.30	Better by Design	**Y**	Information	PA
Investments					
87/21	12.55	a) DCA Replacement b) OTL Establishment Business Case c) Frontline Ops – COVID Costs Business Case	**Y** **Y** **Y**	Decision Decision Decision	DR EW EW
Closing					
88/21	13.15	Any other business	-	Discussion	Chair
89/21	-	Review of meeting effectiveness	-	Discussion	Chair
After the meeting is closed questions will be invited from members of the public					

Date of next Board meeting: 26 May 2022

South East Coast Ambulance Service NHS FT Trust Board Act

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)
25.11.2021	48 21a	WWC to seek assurance on the steps being taken to improve completion of appraisals and escalate to the Trust Board, as required.	LM	Q1 2022/23	WWC	C
25.11.2021	48 21b	WWC to explore whether we are doing all we can do make SECamb an attractive place for students to want to come and work (and then stay).	LM	Q1 2022/23	WWC	IP

Key

	Not yet due
	Due
	Overdue
	Closed

ion Log

Comments / Update
Considered the committee - see the releated escalation report to the Board
Will be added to the cycle of business for 2022/23 - and reported back to Board via the escalation report.

NHS
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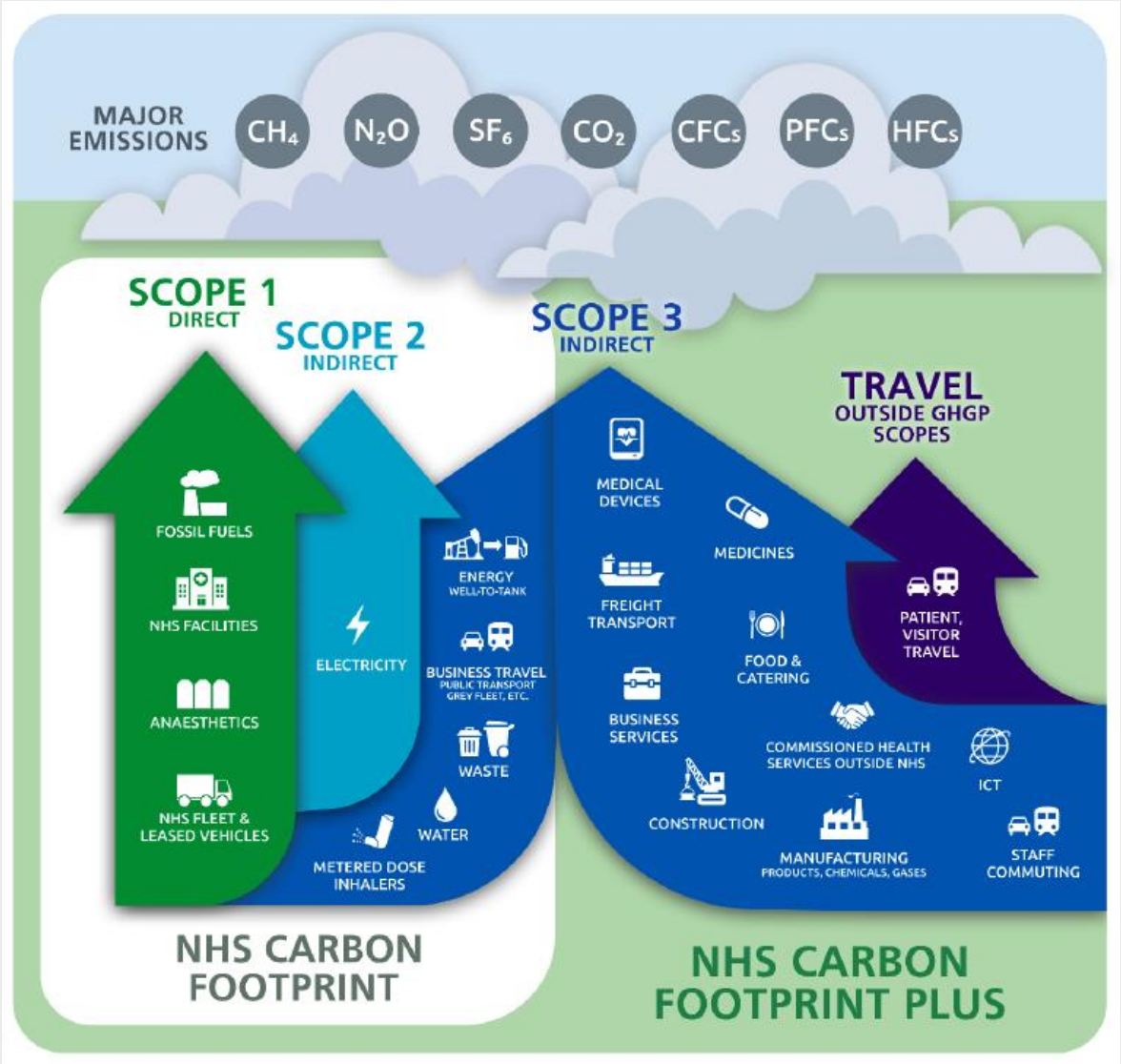
Green Plan Development

David Ruiz-Celada
Executive Director for Planning & Business Development

31 March 2022

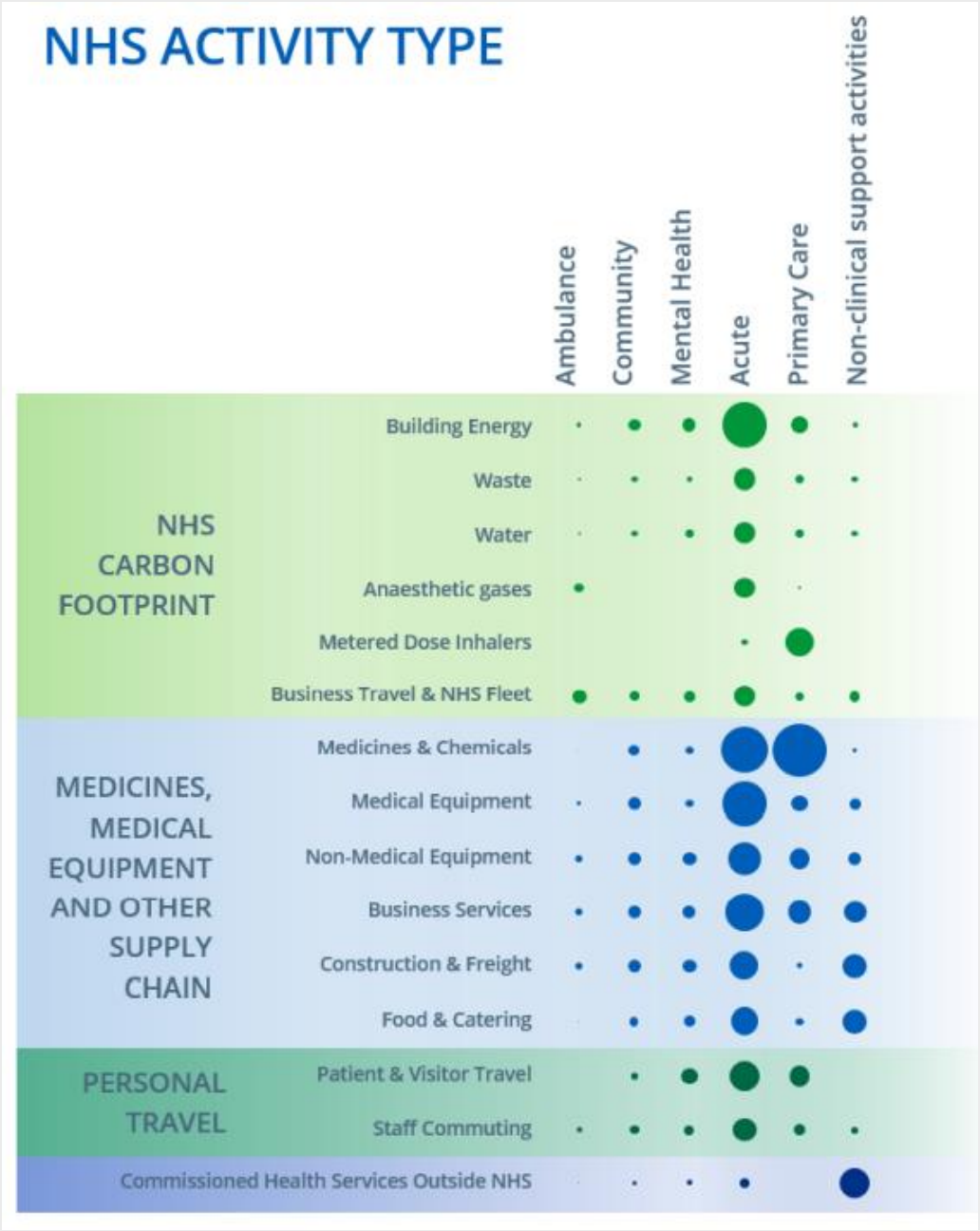
Our ambition

1. Ensure the Trust is supporting the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions:
   - Emissions the Trust controls directly – 80% reduction by 2028-2032; net zero by 2040
   - Emissions the Trust can influence – 80% reduction by 2036-2039; net zero by 2040
2. Prioritise interventions which improve patient care and community wellbeing whilst tackling climate change and broader sustainability issues
3. Enable the Trust to plan and make capital investments whilst increasing efficiencies



Key areas of focus

- Sustainable models of care
- Travel and transport
- Facilities, estates, energy and waste management
- Digital enablement
- Supply chain
- Education and learning



Sources of carbon emission by activity type and setting of care

Our approach

Phase 1		Phase 2		Phase 3
Objective 1 **Establish the Baseline**	**Objective 2** **Develop a Roadmap**	**Objective 3** **Monitoring & Reporting**	**Objective 4** **Resourcing & Governance**	**Not in scope (yet)** **Delivery**
▪ Establish a baseline "as-is" and breakdown by source for all of SECAmb's direct carbon footprint	▪ Develop a roadmap, inclusive of sensible and evidence-based interim reduction targets up to 2045 ▪ Detailed deliverables scoped for the next 3-years (inclusive of quick wins and existing programmes already in place) ▪ Detailed 10-year plan in line with direct scope targets ▪ High level plan to 2045 and achieving full net-zero	▪ Identify a clear methodology for annual monitoring and reporting against evidence-based targets ▪ Board assurance framework for emissions monitoring to be embedded	▪ Identify the resources, investment profiles and internal governance arrangements required to ensure delivery against the plan ▪ Review of capital and revenue plans ▪ Review of associated enabling strategies (i.e. estates and fleet)	▪ Delivery expected from Q4 22/23 ▪ Alignment of resources and investment from 23/24
Development of Green Plan		Implementation of Green Plan		Ongoing Delivery

Approximate Timeline

Phase 1		Phase 2		Phase 3
Objective 1 Establish the Baseline	Objective 2 Develop a Roadmap	Objective 3 Monitoring & Reporting	Objective 4 Resourcing & Governance	Not in scope (yet) Delivery
▪ Establish a baseline "as-is" and breakdown by source for	▪ Develop a roadmap, inclusive of sensible and evidence- ▪ with direct scope targets ▪ High level plan to 2045 and achieving full net-zero	▪ Identify a clear methodology for annual monitoring and	▪ Identify the resources, investment profiles and strategies (i.e. estates and fleet)	▪ Delivery expected from Q4 22/23
Development of Green Plan		Implementation of Green Plan		Ongoing Delivery

Q1 22/23
Commission de-carbonisation advisory specialists (currently undergoing market competition) –
Business Case

Q2 22/23
Phase 1
Establish Baseline
Develop Roadmap

Q3 22/23
Phase 2
Monitoring and Reporting
Resourcing and Governance

Q4 and on-going
Phase 3
Start delivery
On-going monitoring

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Item No	79-21

Name of meeting	Trust Board
Date	31.03.2022
Name of paper	Chair's Report
Report Author	David Astley, Chairman

The last couple of months have been very challenging and, despite all our efforts, we continue to struggle to respond in a timely way to those needing our services. This is set out in the Integrated Performance Report (IPR) and summarised by the Chief Executive.

At the last Board meeting in January there was reference to Better by Design. There is more detail provided about this on today's agenda. This is effectively the programme of work that will help to deliver the Trust's strategic objectives. The Board used some time in February to work through the priorities within Better by Design and, while I know it is difficult to be too optimistic about the future given the current pressures, the Board is convinced that this programme will enable the Trust to sustainably achieve safe, quality and effective services.

In other words, the first part of this Board meeting sets out the current operational challenges, and the latter part is our longer-term strategic response.

As usual, we include as part of the review of the IPR, the work of our Board Committees. These are integral to our board assurance framework and confirm the levels of assurance across the range of functions that aim to deliver quality services.

The Board met earlier this month to build on some of the work it started toward the end of last year in relation to how we can make SECAmb the best place to work. There continues to be issues with 'culture' and using the feedback from the most recent staff survey, which is due to be published on 30 March, we need to continue to drive forward the work on improving staff experience. The Board has a central role in this and, as part of its ongoing development, will be scoping an external well-led governance review in the coming weeks, building on the recent CQC well-led inspection, to ensure the Trust is well-placed to lead the improvements needed over the next period.

Lastly, a farewell. This will be Laurie McMahon's last Board meeting having taken the decision to step down from his role as NED. Laurie has been a very effective Board member over the past four years using his expertise in helping the Board develop its strategy and in chairing the workforce and wellbeing committee. On behalf of the Board, I thank Laurie for his contributions and wish him the very best for the future.

South East Coast Ambulance Service NHS
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Agenda No	80-21

Name of meeting	Trust Board
Date	31 March 2022
Name of paper	Board Assurance Framework Risk Report
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic priorities and sets out the controls, assurances, and actions. It is used by the Board and its committees to inform the areas it needs to focus, when setting agendas.
Recommendations, decisions or actions sought	The Board is asked to review the report and seek assurance on how the risks are being managed and considered by the relevant committee.

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

Board Assurance Framework (BAF) Risk Report

1. Introduction

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

Should the Executive consider it necessary to add or remove a risk, it will make a recommendation to the Trust Board, directly or via the relevant Board committee, for decision. Changes recommended in this version are set out in section 4.

2. Structure of the BAF Risk Report

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

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

Board / Committee	Agenda Item	BAF Risk
Finance and Investment – March	Financial Planning / Month 11 Position	5
Performance – March	Integrated Plan / Improvement Plan / Performance Cell	1 & 2
Quality & Patient Safety – March	SI Report / Clinical Outcomes	2
Workforce and Wellbeing – February	Workforce Planning / Training & Development Plan / Clinical Education Strategy	3 & 2
Board – February	Better by Design	2, 3 & 5

4. Management Review & Recommendation

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

Since the last Board meeting risk 7 (VCOD) has been removed. This followed the Government's public consultation, leading to the revocation of the regulation.

5. Conclusion

The Executive believes that the BAF risk report is sufficiently focussed on the right high-risk areas that affect the Trust's ability to meet its strategic goals. The committees continue to focus its agendas on these risks and the levels of assurance are set out in the related escalation reports to the Board.

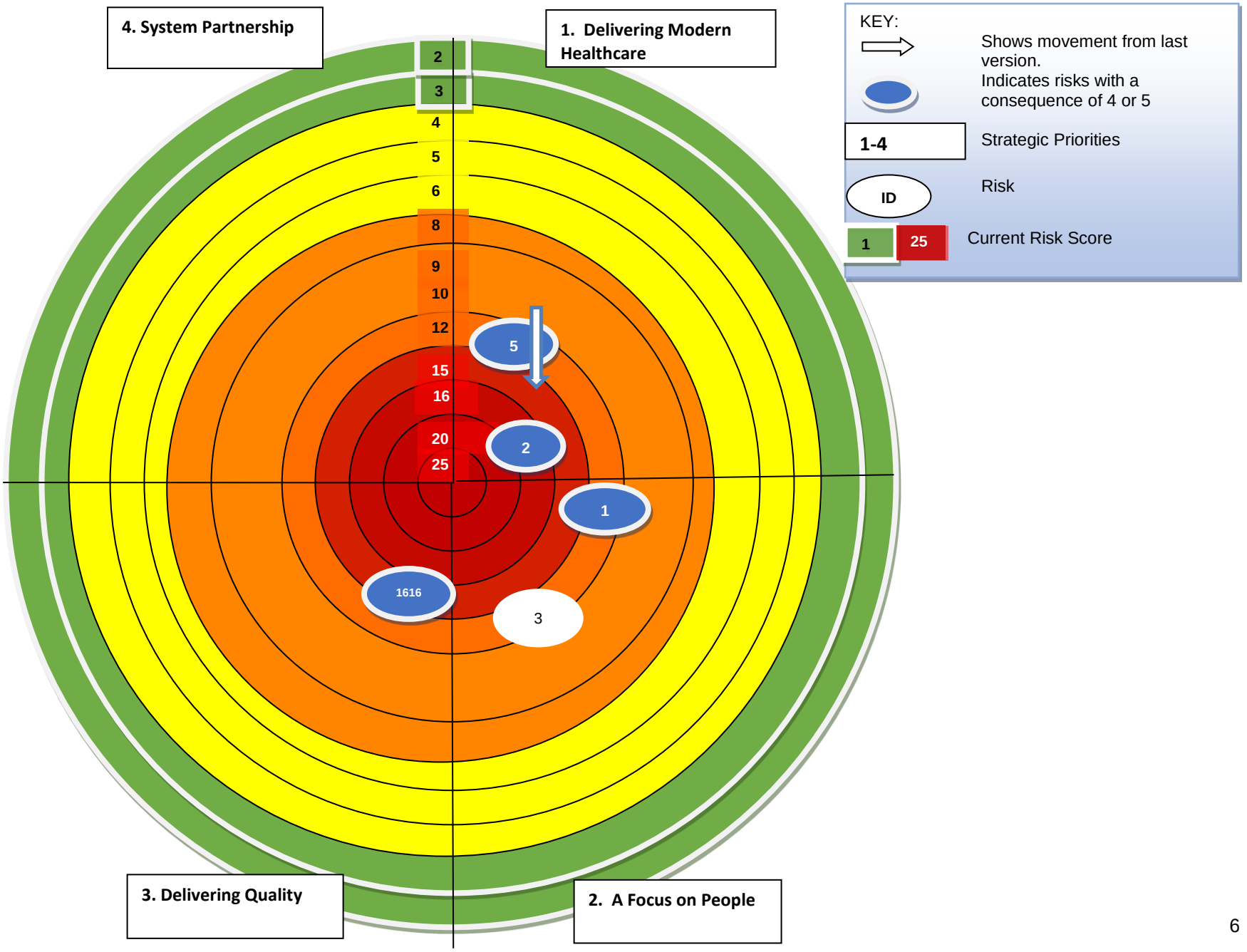
On the Board agenda this month is Better by Design. This is the programme that aims to directly mitigate each of the BAF risks, highlighting their strategic nature and how the risks are interconnected.

The BAF risk report will continue to be used by the Board and its committees to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

Dashboard

Link to Priorities	Risk ID / Theme	BAF Dashboard	Initial Score	Current Score	Target Score	Target Date	Board Oversight
1 & 3	Risk ID 2 111 & 999 Performance	Risk that our operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need.	20	16	08	March 2023	Performance /QPS
	Risk ID 1616 NHS 111 and Single Virtual Contact Centre	There is a risk that the current and future plans for the 111 and EOC operational models will be affected as a result of Single Virtual Contact Centre plans which are in progress following a mandate from NHS England. This may lead to negative impacts on performance, patient safety, provider agency and strategic direction.	16	16	08	TBC	Performance Committee
1 & 3	Risk ID 5 Financial Sustainability	Risk that we are unable to develop a robust long term financial plan to deliver safe and effective services, due to uncertainty over the future with national/regional plans.	16	12	04	Q2 2022/23	FIC
2	Risk ID 1 Workforce Sustainability	Risk that we will lose a significant number of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce.	16	12	08	March 2023	WWC / Performance
2 & 3	Risk ID 3 Education Training & Development	Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development	15	12	06	March 2023	WWC

	Risk ID 7	Vaccination a Condition of Deployment		20	16	08	April 2022	WWC


4. System Partnership
1. Delivering Modern Healthcare
3. Delivering Quality
2. A Focus on People
2
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12
15
16
20
25
5
2
1
1616
3
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Priorities
ID
Risk
1
25
Current Risk Score

Appendix A

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

Underlying Cause / Source of Risk:	**Accountable Director**	Medical Director
Risk that we will lose a significant number of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce.	**Scrutinising Forum**	EMB
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**12** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Work in partnership with six higher education institutions (HEIs) for pre-registration paramedic education programmes Clinical Education Strategy established – to be approved at Board in January. Recruitment of 108 ECSWs and 175 NQPs (Initial recruitment day for ECSW started) Continue with the increased PAP provision secured over the winter period (150 WTE equivalent) Plan to achieve an overtime rate of 7.6% over the year, inclusive of bank staff. Clinical Education Strategy Delivery Plan established Workforce Plan established – engaging with commissioners on the different scenarios

Gaps in Control
Implementation of the clinical education strategy

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Working with the Regional Leads and PCN's to limit the recruitment from the Ambulance service whilst the issue is collectively addressed. Working with HEE to ensure an effective pipeline. Agree with commissioners the Workforce Plan Clinical Education Strategy Delivery Plan	

Last management review	Executive Management Board	**Last committee review**	17.02.2022 Workforce and Wellbeing Committee 01.03.2022 Performance Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Chief Operating Officer
Risk that our operating model is not suitably designed to ensure efficient and effective management of demand and patient need.	**Scrutinising Forum**	Organisation Change Group
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Operational Performance and Sustainability Plan – focus on key actions to improve processes / use of resources Better by Design – a programme to establish the most effective delivery model. Use of REAP Board established a new performance committee

Gaps in Control
Establishing the right care delivery model.

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Operational Performance (-) High sickness rates / low provision of hours (-) REAP 4 & recent BCIs	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Operational Performance and Sustainability Plan Development of the new Performance Cell BBD Programme to review the care delivery model	The plan is in place and being monitored weekly by EMB Demand led planning (performance and predictive analytics) introduced in June and informing the integrated plan from 2022. BBD agreed by the Board – engagement planned with key stakeholders during Q1-2 to develop the solutions

Last management review	Executive Management Board	**Last committee review**	01.03.2022 Performance Committee 17.03.2022 Quality and Patient Safety Committee

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

Underlying Cause / Source of Risk: Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development. .	**Accountable Director**	Director of Operations
	Scrutinising Forum	Senior Management Group
	Initial Risk Score	**15** (Consequence 3 x Likelihood 5)
	Current Risk Score	**12** (Consequence 3 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**06** (Consequence 3 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Key Skills delivery programme Management development programme Clinical Education Strategy Workforce / Integrated Planning & Training gap analysis

Gaps in Control
Education, Training and Development (ETD) Strategy Insufficient funding for the actual level of activity and abstractions Training Plan 2022/23

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Operational pressures / REAP 4 (-) Additional abstraction (carry over of leave due to the pandemic) (+) Some Key Skills Prioritised in Q1 2021/22 and delivery to staff not had training in past 18 months.	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
ETD strategy being developed Integrated Planning scenarios established – engagement with commissioners. Training plan to be developed using the gap analysis	

Last management review	Executive Management Board	**Last committee review**	17.02.2022 Workforce & Wellbeing Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Chief Operating Officer / Director of Finance
Risk that we are unable to develop a robust long term financial plan to deliver safe and effective services, due to uncertainty over the future with national/regional plans.	**Scrutinising Forum**	Executive Management Board
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)
Block contract in place Interim financial arrangements to March 2022 Financial plan developed using the integrated planning modelling

Gaps in Control
Funding clarity for 2022/23 to align with BBD Potential ongoing deficit could result in a cash shortfall that may affect future capital plans ICS capital limits

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) financial management: achieving plan (- +) 111 First funding received but only up to March 2022	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
To agree the financial plan with commissioners based on the scenarios arising from the integrated planning modelling.	

Last management review	Executive Management Board	**Last committee review**	22.03.2022 Finance and Investment Committee

Priority 1 & 3	**BAF Risk ID 1616** NHS 111 and Single Virtual Contact Centre	**Date risk opened: 07.01.2022**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
There is a risk that the current and future plans for the 111 and EOC operational models will be affected as a result of Single Virtual Contact Centre plans which are in progress following a mandate from NHS England. This may lead to negative impacts on performance, patient safety, provider agency and strategic direction.	**Scrutinising Forum**	EMB
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

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

Gaps in Control

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
CCG liaison and have identified Risk Continual engagement with NHSE Directly Current Operating solution has framework to support regional clinical solution (CAS DoS Profiles / DAB etc) Working with AACE and national heads of 111 forum	

Last management review	Executive Management Board	**Last committee review**	Review scheduled for 21.04.2022 Performance Committee

Priority	BAF Risk ID 7 – TO BE CLOSED Vaccination a Condition of Deployment	Date risk opened:

Underlying Cause / Source of Risk:	Accountable Director	Director of HR
There is a risk that a number of staff will be lost as a consequence of vaccination being a condition of deployment. This may lead to workforce gaps, inability to meet demand and therefore negative impacts on performance and patient safety.	**Scrutinising Forum**	EMB
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)
Task & Finish Group established Roles in Scope agreed in conjunction with Unions. Staff identified and 1:1s being arranged Webinar held

Gaps in Control
A number of 'unknown' vaccination status

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Number of potential staff affected decreasing. Down to circa 180 as at 18.01.2022.	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
See detail in the paper on the Board agenda 27.01.2022	

Last management review	Executive Management Board	Last committee review	

Appendix B
Strategic Priorities

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

Appendix C

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Negligible	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service	Service loss in a number of non-critical areas <6 hours	Service loss of any critical area	Extended loss of essential service in more than one critical area	Loss of multiple essential services in critical areas

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

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	81-21

Name of meeting	Trust Board
Date	31.03.2022
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 February and March 2022 to date. Section 4 identifies management issues I would like to specifically highlight to the Board.

A. Local Issues

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

3 As part of its weekly meeting, the EMB regularly considers quality, 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.

4 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:

- Improving staff experience, including publication of staff survey results
- Training and Development planning
- Review of Wellbeing Provision
- Better By Design development
- Agile Working
- Preparation for CQC inspections

5 EMB have also agreed a number of investment decisions including:

- Increase in number of Operational Team Leaders to match establishment increase
- Developments to IT infrastructure utilising central funding
- Purchase of additional Double-Crewed Ambulances (DCAs) through a five-year replacement programme
- Investment in new Primary Response Bags
- Ventilator replacement programme

6	**Engagement with key stakeholders** On 10th February 2022 I attended a regional session covering the Elective Recovery Plan led by the Chief Executive of the NHS, Amanda Pritchard together with colleagues from across the South East and South West. I also took part in an NHS workshop on reducing ambulance handover delays with all the Chief Executives and Accountable Officers in the South East.
7	During the period, I have also attended regular sessions involving the emerging Integrated Care Boards (ICBs) in our region, including, Kent, Surrey Heartlands and Sussex. These are valuable opportunities to ensure SECAmb are properly embedded in these new systems from the beginning.
8	**New Director of Quality & Nursing** Further to my previous updates, I am pleased to confirm that Robert (Rob) Nicholls started with SECAmb on 14th February 2022 as our new Executive Director of Quality & Nursing.
9	A nurse since 1993, Rob has held several senior roles in the NHS, most recently in his previous position as Director of Nursing Division of Medicine and Integrated Care at Imperial College Healthcare NHS Trust.
10	Rob has had a busy few weeks since starting with us but brings a great deal of experience with him which I know will only help us to continue to move forwards our quality agenda.
11	**Funeral of Alice Clark** On 24th February 2022, I was proud . along with150 colleagues from SECAmb, London Ambulance Service (LAS), the Air Ambulance and Kent Fire & Rescue Service (KFRS) as we joined family and friends to bid farewell to Paramedic Alice Clark, who tragically died following a road traffic collision on the A21 on 5th January 2022.
12	Staff formed a guard of honour along the drive to the chapel and the cortege included an ambulance as well as two LAS motorbikes. Standard bearers from SECAmb, LAS and KFRS led those attending into the chapel and during the extremely moving service, Dr Fionna Moore reflected on Alice's ambulance career with both LAS and SECAmb.
13	It was a very touching and emotional service and I was very proud to see so many staff from across the emergency services come together to show their love and respect for Alice.
14	Thank you to the team at Paddock Wood for ensuring that the family's wishes were carried out throughout the planning of Alice's funeral.
15	**Dr Fionna Moore receives her Queen's Ambulance Service Medal (QAM)** On 15th February 2022 we were extremely proud when Medical Director, Dr Fionna Moore was presented with her QAM by HRH The Princess Royal at an investiture at Windsor Castle, having been named as a recipient in last summer's Queen's Birthday Honours.
16	Fionna is one of the UK's longest-serving Emergency Medicine Consultants and has contributed to significant changes in UK pre-hospital practice over the last three decades. She has enjoyed a distinguished and lengthy career in the ambulance service spanning more

	than 20 years and was one of just six recipients to receive the medal in last year's announcement.
17	I know that many across SECAmb were delighted to see Fionna receive this recognition - she is held in the very highest regard among our staff and the wider ambulance service, both nationally and internationally.
	B. Regional Issues
18	**Care Quality Commission (CQC) Inspection** During March 2022, the CQC have undertaken inspections of our A&E and 111 services, as well as a 'Well Led' inspection, focussing on governance and leadership within the Trust.
19	Although we will not receive their report for a number of weeks, the CQC have asked us to pass on their thanks for the extremely open and positive way in which they were received by all SECAmb colleagues they met during their visit. We will not wait for the final report before we take action and have begun planning to take action about those areas highlighted in the initial feedback that we have received so far.
	C. National Issues
20	**COVID-19 outbreak** As the pandemic progresses, we are continuing to monitor the situation closely although we recognise that nationally, the NHS is moving towards the recovery phase of the pandemic.
21	Governance**:** The COVID Management Group (CMG) continues to meet regularly and will remain in place for the next three months to allow a safe transition of any remaining COVID requirements into 'business as usual' within the relevant departments.
22	In particular, our Emergency Planning & Resilience Team will take responsibility for ensuring that SECAmb is able to respond to any requirements and requests for information to support the national COVID-19 Public Inquiry, announced by the Prime Minister in December 2021.
23	As we move into a recovery phase and having undertaken a full review of the additional COVID-19 resources introduced during the pandemic, we will be standing down our COVID Management Team and Test & Trace Cell on 31st March 2022.
24	I'd like to thank all those who've been part of the team during the past two years, playing an important role in supporting colleagues during the challenges of the pandemic.
25	Impact on staff numbers: During this period and reflecting the number of cases in the community, we continue to see an increased impact on our staffing levels due to the growing numbers of staff away from work with confirmed COVID and the on-going impact on staff with long COVID. We continue to work hard to support staff to return to work safely when possible.
26	Mandatory vaccines for patient-facing NHS staff: During March 2022, we were informed that the Government had concluded its consultation on the revocation of vaccination as a condition of deployment (VCOD) for healthcare workers and confirmed that it was revoking the previous legislation; the regulations enforcing this decision came into effect on 15th March 2022.

27	This formally removed the requirements that were due to come into force in health and wider social care settings on 1st April 2022 meaning that COVID vaccination was no longer a condition of deployment or employment in the NHS.
28	In line with the change of law, we have also removed the requirement for COVID-19 vaccination as a condition of employment for all new staff starting after 1st April 2022.
29	National Day of Reflection: 23rd March 2022 marked the second National Day of Reflection and two years since the announcement of the first national lockdown.
30	We took the opportunity to pay tribute to the five colleagues lost during the past year and marked a minute's silence at HQ at midday, remembering all those lost during the pandemic.
31	Although the pandemic is in a very different phase now, things do remain tough but I remain extremely proud of the continuing commitment and stoicism shown by every single member of staff.
	NHS Staff Survey
32	The NHS Staff Survey launched this year on 22nd September and closed on 26th November 2021. Our final return rate was 61%.
33	The results of the survey will be published nationally on 30th March 2022; as well as identifying key themes and trends, we will also look to work with local teams to develop their own plan to address issues highlighted by their teams.
	Launch of 'Work Without Fear' campaign
34	On 28th February 2022, the Association of Ambulance Chief Executive (AACE) launched 'Work Without Fear' - a national campaign which aims to address the growing aggression and violence aimed at ambulance staff.
35	The 'Work Without Fear' campaign has been instigated because of a growing number of staff reporting being abused or attacked. Nationally, nearly 12,000 staff – an increase of 35 per cent in the last five years – were targeted but the most significant rise happened during the first year of the pandemic when assaults jumped by 23 per cent compared with the year before.
36	Locally, SECAmb has also seen an increase in reported violence and aggression in the last three years. Numbers have jumped from 584 reported cases in 2019 to 921 last year – an increase of more than 50 per cent – including 287 reported physical assaults.

37	It is deeply saddening that while, as a nation we came together during the height of the pandemic to praise frontline NHS colleagues for their efforts, there were still a small minority of people intent on abusing and attacking our staff.
38	We are supporting the campaign and, in line with our colleagues across England, will be raising awareness of the issue via our social media channels and via local media outlets. I am pleased that two SECAmb colleagues will feature in the national campaign.
	D. Escalation to the Board
	Operational Performance
39	It remains a challenging time operationally. We continue to see spikes of high demand at times, which causes operational pressure for us, due to the resources we have available to respond to patients, both on the road and in our control centres; these are significantly impacted by staff absence due to a range of COVID-related issues and high sickness levels.
40	As is evident from the national ambulance response time data published recently for February 2022, all ambulance services nationally remain under considerable pressure as does the wider NHS system.
41	The impact of staff shortages on many NHS and social care organisations remains a key issue and we know this is impacting on patient flow through hospitals and the ability to discharge patients with social care needs. In turn, this leads to periods when our crews experience significant delays when handing over patients at hospital.
42	We are continuing to work hard to ensure that we provide as responsive a service as possible to our patients, despite the resource constraints we have been experiencing. Our 999 performance remains stable overall, although we remain concerned about longer response times to patients in Categories 2 and 3, as well as longer call answer times than we would like.
43	As a result of the on-going challenging situation, we remain at REAP Level 4. Our REAP Level is regularly reviewed to enable us to respond to changing operational pressures and take all possible steps to maximise our operational performance.
44	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.
45	However, we recognise that there are no easy solutions to the current challenges and longer terms actions are required to make a significant difference including more targeted recruitment, better alignment of rotas with demand and improved system working to tackle wider issues around access to GPs and hospital capacity.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
March 2022

Data up to and including February 2022

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

The aim of this report is to provide the Board with the key performance indicators and trends that the Executive is focused on, and highlight areas of particular strong performance, as well as reporting on the exception areas where concerns have been identified. On slides 5 and 6 you will find the operational scorecards for Field Operations, EOC, and 111. From slide 7 you will find the performance highlights, and from slide 11 you will find our exception reports.

Philip Astle
Chief Executive

Our operational performance continues to be challenged. After a period in January and February where a combination of lower demand, acuity, and stronger overall resource provision led to de-escalating to REAP 3 for the first time in months, we have had to re-escalate to REAP 4 in March. This has been mainly due to high call volumes and acuity for C1 and C2 peaking at almost 80% of our overall activity. In addition, we are experiencing high levels of sickness impacting staff abstraction, which has peaked at around 40%. Finally, we have seen a steady increase in pressure within our systems, with hours lost at hospital trending upwards and now matching similar levels than those experienced in December 2021. This is causing significant issues in our ability to respond to patients, despite targeted incentives driving overtime over 13%. Similar trends are present in EOC where call-handling performance has seen a decline in performance as a result in March. We continue to focus on our escalation actions to dynamically manage the risk to patients in our outstanding stack, via clinical supervision within EOC and welfare call-backs and texting, and we have introduced taxi deployment to take patients to hospital where clinically appropriate to do so. By contrast, in March 2022 we have been >70% of the time at high levels of surge, where this was 1.5% in February 2021. Due to the ongoing high levels of sickness, broader system pressures, and increase in overall activity as the weather gets warmer, we expect to remain in REAP 4 for several weeks.

In our 111 service, we continue receiving volumes of calls over the contracted volumes, leading to poor response times. Despite this, our clinical validation rates remain strong at well over 90%, meaning we do not have inappropriate referrals to our 999 service, helping us protect our emergency operation.

The high levels of sickness of up to 15% against a target of 6% across all services remains our biggest concern, both due to the impact it has on the safety of our patients, and the overall resiliency of our workforce. The combination of on-going high-demand, and our challenges in meeting it, means that everybody who is on duty is working extraordinarily hard to keep our patients safe. I would like to take this opportunity to thank everybody for the work you do every day despite these challenges.

Finally, as the financial year comes to an end, we expect to come in on-plan for 21/22. Despite this, we have a planned deficit of £9.6m which is balanced out at an ICS level, and the Board should note that this is likely to make our planning for 22/23 very difficult, as we aspire to balance our activity, resources, and performance, to ensure we can safely meet patient demand.

Current Operational Performance
999 Emergency Ambulance Service – 13-week trend for the period of (13/12/21 – 14/03/22)

CAT 1

	28/02	07/03	14/03	Last 13 Weeks
Mean	00:09:02	00:10:10	00:09:07	
90th Centile	00:16:07	00:16:20	00:16:26	
RPI	1.55	1.53	1.53	
Count of Incidents	1033	1161	1073	

CAT 1T

	28/02	07/03	14/03	Last 13 Weeks
Mean	00:11:04	00:12:37	00:11:04	
90th Centile	00:19:59	00:20:35	00:20:17	
RPI	1.56	1.54	1.51	
Count of Incidents	671	739	670	

999 Call Handling

	28/02	07/03	14/03	Last 13 Weeks
Mean Call Pickup Time (Seconds)	29	43	29	
Call Pickup Time 90th Percentile (Seconds)	102	141	106	
Call Pickup Time 95th Percentile (Seconds)	141	184	142	
Call Pickup Time 99th Percentile (Seconds)	223	272	217	
Average Call Length (seconds)	370	372	373	
Abandon Rate	1.40%	1.94%	1.12%	
Staff Hours Provided Vs 5926.133333 target	90.4%	87.6%	86.3%	

CAT 2

	28/02	07/03	14/03	Last 13 Weeks
Mean	00:34:15	00:42:08	00:41:48	
90th Centile	01:10:16	01:30:41	01:28:44	
RPI	1.06	1.06	1.06	
Count of Incidents	7587	7890	7696	

CAT 3

	28/02	07/03	14/03	Last 13 Weeks
Mean	02:47:43	03:19:45	03:41:14	
90th Centile	06:18:13	07:47:29	08:57:58	
RPI	1.07	1.07	1.07	
Count of Incidents	3472	3350	3235	

Call Cycle Time

	28/02	07/03	14/03	Last 13 Weeks
Clear at Scene	01:19:56	01:19:39	01:19:14	
Clear at Hospital	01:55:43	01:55:29	01:58:23	
Hours Lost at Hospital	1400	1491	1737	

CAT 4

	28/02	07/03	14/03	Last 13 Weeks
Mean	04:01:32	03:50:39	04:53:45	
90th Centile	08:11:42	08:36:53	11:58:26	
RPI	1.08	1.05	1.03	
Count of Incidents	87	62	80	

Demand/Supply

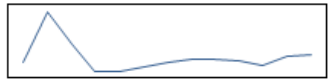
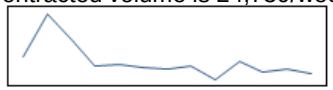
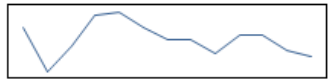
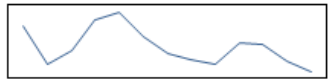
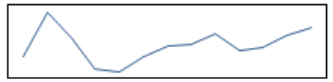
	28/02	07/03	14/03	Last 13 Weeks
999 Call Volume	18367	20027	20492	
Incidents	13945	14336	14223	
Transports	8361	8404	8135	
Staff Hours Provided Vs 67635 target	89.6%	88.6%	87.7%	

Incident Outcome

	28/02	07/03	14/03	Last 13 Weeks
See and Convey	60.0%	58.6%	57.2%	
See and Treat	31.3%	32.0%	31.7%	
Hear and Treat	8.8%	9.4%	11.1%	

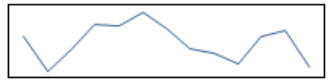
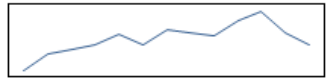
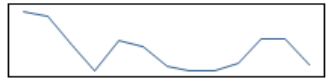
Current Operational Performance
NHS 111 Clinical Assessment Service – 13-week trend for the period of (13/12/21 – 14/03/22)

111 Demand/Supply

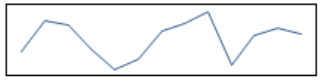
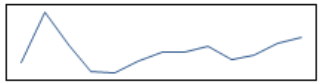
	28/02	07/03	14/03	Last 13 Weeks
111 Call Volume	23750	26356	26720	
Calls Answered	18703	19051	18552	
Calls Answered % of Volume	78.7%	72.3%	69.4%	
% Calls Answered in 60 seconds (> 95%)	37.1%	24.0%	15.3%	
% Calls abandoned after 30 seconds(< 5%)	15.9%	21.7%	24.6%	

Note – Contracted volume is 24,730/week

111 Referal rates

	28/02	07/03	14/03	Last 13 Weeks
AMB referral rate % (<13%)	9.1%	9.2%	8.4%	
A&E referral rate % (<9%)	10.2%	9.3%	8.7%	
Clinical referral rate % (>50%)	52.8%	52.8%	50.9%	

111 Call Handling

	28/02	07/03	14/03	Last 13 Weeks
Triage Rate (% Calls Answered triaged)	97.0%	97.5%	97.1%	
Cat3/4 Validation Rate	96.0%	96.2%	93.8%	
Average Speed to Answer	00:05:49	00:08:37	00:09:51	

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Performance Highlights

Best placed to care, the best place to work

Trust Overview:
Summary of Performance Highlights

Domain	ID	Highlights
Safe	Number of Datix Incidents (QS-1)	The Trust saw an increase of 10% of incidents reported for January 2022 v/s January 2021 and there was similar uplift for February with a 14.3% increase. This shows the Trust commitment to logging and learning from incidents. There are 1595 incidents on datix that are awaiting a managers' review. Moderate and above harm incidents are reviewed weekly at the Serious Incident Group. Every incident reported on datix are reviewed by the datix team within a 48 hours window and there is an escalation process for incidents deemed to be above the low harm rating. The trajectory is to close above 75% of the backlog in Q1 – this would be monitor monthly at the Clinical Governance Group
Safe	Violence and Aggression Incidents (QS-13)	Staff reported 108 violence and aggression incidents in January 2022. During February 2022 staff reported 88 incidents. Body worn cameras are being trialled at 6 sites which are Gatwick, Thanet, Medway, Brighton, Sheppey and Tongham. During January, Body worn cameras were deployed 699 times within the trial locations. During February, Body worn cameras were deployed 619 times within the trial locations.
Safe	Outstanding Actions Relating to SI's, Outside of Timescales (QS-17)	The number of overdue SI actions has decreased from 123 open actions in Jan 22 to 106 in Feb 22. The SI Team continues to work closely with action owners to identify evidence of completion. However, there are longstanding actions that could be reviewed and closed with supportive evidence. To achieve this; a weekly check and challenge review meeting will be initiated in Aril 22 with action owners. The Director of Quality and Nursing would oversee the review process and report progress to the Clinical Governance Group. The SI process would be part of the Trust's quality governance review and aligned to the new National SI framework when published.

Trust Overview:
Summary of Performance Highlights

Domain	ID	Highlights
Safe	Deep Clean Compliance % (QS-19)	The deep clean figures have been monitored at monthly contract meetings between Churchill and SECAmb since the new contract in August. There have been some staffing issues in some areas which has meant that deep cleans were not been achieved in some areas. These have improved over the last few months due to Churchills concentrating their hours to catch up with the deep cleans that they were behind on. This was achieved by drafting staff from other areas, sometimes on overtime, to catch up the deficit. Some areas are still short-staffed but it is hoped that the deep cleans will remain constant.
Safe	Health & Safety Incidents (QS-20)	There were 24 Health and Safety incidents reported in January 2022. During February 2022, staff reported 18 Health and Safety incidents.

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-1	Quality & Safety	Number of Datix Incidents	1070	1149	1051	1175	1253	1493	1397	1149	1070	1398	1652	1706	1532	N/A	N/A	
QS-13	Quality & Safety	Violence and Aggression Incidents (Number of Victims - Staff)	60	60	65	73	87	91	99	60	60	76	117	108	88	N/A	N/A	
MM-1	Medicines Management	Number of Medicines Incidents	142	173	152	171	118	156	141	157	165	146	153	107	89	N/A	N/A	
MM-5	Medicines Management	Number of CD Breakages	10	27	16	16	19	10	17	9	29	20	16	22	16	N/A	N/A	
QS-17	Quality & Safety	Outstanding Actions Relating to SIs, Outside of Timescales	112	117	141	114	112	116	117	117	112	129	130	123	106	N/A	N/A	
QS-19	Quality & Safety	Deep Clean Compliance %	64.00%	94.90%	95.00%	85.00%	82.00%	73.00%	41.50%	94.90%	64.00%	70.00%	74.00%	88.00%	92.00%	95.00%	-	
QS-20	Quality & Safety	Health & Safety Incidents	33	31	29	59	47	39	30	31	33	36	31	24	18	N/A	N/A	

Trust Overview:
Summary of Performance Highlights

Domain	ID	Highlights
Effective	Cardiac Survival Utstein % (M-3) Cardiac Survival ALL % (M-4)	In November 2021, there was a 1.43% increase (above the mean) of patients in cardiac arrest when in SECAmb care and who go on to survive for at least 30 days (M-4). Currently this is positive progress but due to the small number of incidents involved, this could be normal variation. We will continue to monitor over the next two months to see if this becomes an upwards trend. The same can be attributed to the Cardiac Survival Utstein % (M-3), which is currently sitting 11% above the mean.
Well-Led	Organisational Risks Outstanding Review % (QS-24)	We continue to see a month-on-month improvement with our risk reviews and key to this has been the support of our BSM's in following up with risk owners. Going forward, we will be moving away from a blanket monthly review of all risks to a review frequency determined by the current risks score. Metric Definition - *Risk review compliance provides an assurance that risk are being reviewed within the frequency set out based on the current risk rating. Reviews provide for updating mitigations, assurances and gaps within identified risks, to support the movement of risk to a proportionate level with due consideration to the Trust Risk Appetite and Tolerances.*

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
M-3	Medical	Cardiac Survival Utstein %	33.30%	18.00%	28.00%	27.30%	No Data	31.30%	30.60%	23.50%	20.00%	36.80%	No Data	No Data	No Data	25.60%		
M-4	Medical	Cardiac Survival ALL %	9.10%	8.00%	13.70%	12.30%	No Data	14.00%	10.00%	10.80%	8.00%	11.00%	No Data	No Data	No Data	9.60%		

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-24	Quality & Safety	Organisational Risks Outstanding Review %	57.00%	52.00%	59.00%	81.00%	73.00%	81.00%	40.40%	52.00%	57.00%	42.20%	38.60%	32.00%	31.00%	30.00%	-	

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Exception Reports

Best placed to care, the best place to work

Trust Overview:
Summary of Exceptions - Safe

Domain	ID	Exceptions
Safe	999 Frontline Hours Provided % (999-12)	Front-line resource hrs provision continues to be a significant challenge, primarily due to the high levels of abstractions as a result of a range of issues, particularly sickness (Covid and non-Covid related) and annual leave.
Safe	Hand Hygiene Compliance %	There has been a downward trend in the Trust hand hygiene audits in Q3 and Q4. The review of this KPI and associated action plan was received by QPS in Jan 2022. The main reason for non-compliance are compliance to Clinically Ready (Bare Below the Elbows) and staff not carrying hand gel at all times.
Safe	Single Witness Signature Use CDs Omnicell (MM-3) Single Witness Signature Use CDs Non-Omnicell (MM-4)	CD single witness for Omnicell sites is 38, that is 38 times this activity has occurred. 16 of these are confirmed as authorised as the OTL's have confirmed there was no witness available, the remaining 22 are under review by the OTL's. CD single witness for non-Omnicell sites is 170, This is the total number of times this activity occurred. 169 of these occasions have been confirmed as authorised by the OTL's, only one reported as not authorised
Safe	Compliant NHS Pathways (EMA) % (M-22) Required NHS Pathways Audit Completed (Clinical) % (M-23)	M-22: Compliant NHS Pathways (EMA) % : Monthly performance dropped from 83% in Jan 22 to 82% in Feb 22 M-23: Required NHS Pathways Audit Completed (Clinical) % : Monthly performance dropped from 101% in Jan 22 to 90% in Feb 22.

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
999-12	Standards: 999 Frontline Hours Provided % Definition: % of operational hours provided against target hours per day, as set out in Demand and Capacity review from 2017	Front-line resource hours provision continues to be a significant challenge, primarily due to the high levels of abstractions as a result of a range of issues, particularly sickness (Covid and non-Covid related) and annual leave. ○ Sickness absence levels, both short and long term, were significantly higher (approximately double) in the second half of January and throughout February compared to the same period last year. ○ Annual leave has been running at above the maximum planned level due to the high level of new starters, school half-term holidays and additional carry over of annual leave from 2020-21. .

Action Plan

Actions being taken to mitigate issues:

<u>Optimising resource levels</u>

- Targeted overtime incentives ran throughout January and February – particularly focused on specific shifts across each day. This has contributed to the proportion of overtime hours being 10.6% and 12.2% for January & February respectively.
- NHSE additional winter monies used to secure additional Private Ambulance Providers (PAP) hours from November 2021 through to end of March 2022. In January and February, PAPs supplied 5.8% for each month.
- Robust management of abstractions, particularly annual leave and sickness, recognising that the latter area has been more complex due to the current NHSE guidance regarding Covid-related sickness management.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing monitoring

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
999-12	Operations 999	999 Frontline Hours Provided %	103.20%	96.90%	99.10%	99.30%	94.30%	90.10%	86.90%	88.00%	89.50%	92.60%	91.60%	92.74%	88.96%	100.00%	-	

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 % Definition: As above	There has been a downward trend in the Trust hand hygiene audits in Q3 and Q4. The review of this KPI and associated action plan was received by QPS in Jan 2022. The main reason for non-compliance are compliance to Clinically Ready (Bare Below the Elbows) and staff not carrying hand gel at all times.

Action Plan

Actions being taken to mitigate issues:
The IPC Team have already raised the issues with local management teams across the Trust, but a more in depth action is being developed to help support staff understanding of the need to compliance with all aspects of the hand hygiene procedure. Further Quality Assurance visits to every OU are scheduled for Quarter 1 and this will provide the local teams with data from all of the IPC audits along with sickness absence figures for infection related illness.

Accountable Executive

Named person:
Executive Director for Quality and Nursing

Complete by date:
Ongoing

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-7	Quality & Safety	Hand Hygiene Compliance %	93.00%	95.00%	94.00%	95.00%	95.00%	92.00%	90.00%	95.00%	93.00%	84.00%	81.00%	87.00%	78.00%	90.00%	-	

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
MM-3 MM-4	Standards: Single Witness Signature Use CDs Omnicell Single Witness Signature Use CDs Non-Omnicell Definition: As above	CD single witness for Omnicell sites is 38, that is 38 times this activity has occurred. 16 of these are confirmed as authorised as the OTL's have confirmed there was no witness available, the remaining 22 are under review by the OTL's. CD single witness for non-Omnicell sites is 170, This is the total number of times this activity occurred. 169 of these occasions have been confirmed as authorised by the OTL's, only one reported as not authorised.

Action Plan

Actions being taken to mitigate issues:
Team leaders are reviewing outstanding occurrences to confirm if authorised.

Accountable Executive

Named person:
Executive Medical Director

Complete by date:
Ongoing

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
MM-3	Medicines Management	Single Witness Signature Use CDs Omnicell	9	4	3	2	3	6	7	14	5	13	23	38	*No Data*	0		
MM-4	Medicines Management	Single Witness Signature Use CDs Non-Omnicell	1	1	0	0	0	1	0	0	1	1	0	170	*No Data*	0		

NB: Please note MM-3 & MM-4 is reported 2-months in arrears

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
M-22 M-23	Standards: Compliant NHS Pathways (EMA) % Required NHS Pathways Audit Completed (Clinical) % Definition: As above	NHS Pathways (NHSP) EMA Audits: These are either completed retrospectively after the call has been taken by either the EMA, or as Live audits undertaken in real time (via silent monitoring). Live auditing for EMA's commenced December 2021. NHSP audits follow the National NHSP auditing framework. NHS Pathways Clinical Audits: These have all been completed retrospectively after the call has been taken by the Clinician in EOC. Live auditing has been introduced for clinicians on 1st March 2022. Marval Requests: These additional audits are undertaken for incident/serious incident, safeguarding, coroners' reviews etc., and also contribute to the monthly figures, however due to investigation timelines these are received/conducted some weeks later. Impacts: • Live Audit is suspended during times of high demand in EOC, and available auditors move to undertaking retrospective auditing. In REAP the auditors cease auditing and support call taking, thereby reducing capacity to undertake monthly audits • Mid/end February saw a significant increase in Marval requests resulting in auditors being redirected from the monthly audits. These high-volume requests are currently ongoing. • Audit team capacity adversely impacted due to long- and short-term sickness/annual leave during February 22.

Action Plan

Actions being taken to mitigate issues:

- Audit feedback is provided by email for compliant audits. Non-compliant audits are now fed back by the auditor unless there are major safety concerns where it is passed to an EOC Team Leader to feedback to their staff member.
- Live audit feedback is undertaken following the audits to enhance reflection and learning. Initial feedback has been very positive.
- EOC Training Department supporting high numbers of new starters in EOC through induction and mentoring.
- EOC Practice Development (audit) Leads working closely with EOC Management and EOC Training to identify and target non-compliance gaps through staff development, 1:1's, coaching and mentoring.
- Review of triggers, and timeliness of Marval requests now underway with the risk management leads.

Accountable Executive

Named person:
Executive Medical Director

Complete by date:
16/03/2022

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
M-22	Medical	Compliant NHS Pathways Audits (EMA) %	83.00%	85.00%	83.00%	84.00%	84.00%	90.00%	82.00%	84.00%	84.00%	78.00%	96.00%	83.00%	82.00%	100.00%	-	
M-23	Medical	Required NHS Pathways Audits Completed (Clinical) %	97.00%	100.00%	102.00%	102.00%	102.00%	102.00%	101.00%	76.00%	99.00%	99.00%	92.00%	101.00%	90.00%	N/A	N/A	

Trust Overview:
Summary of Exceptions - Effective

Domain	ID	Exceptions
Effective	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean (M-6) Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile (M-7)	Most STEMI calls are triaged as C2. Response times for C2 calls have been adversely affected by recent periods of REAP 4.
Effective	Stroke – Call to Hospital Mean (M-8) Stroke – Call to Hospital 90th Centile (M-9)	Response times for Stroke care are affected by difficulties in identification via NHS Pathways. This means that some calls are triaged as C1, some as C2 and some as C3. C2 and C3 calls have been adversely affected by REAP 4 pressures resulting in delayed attendance.
Effective	Section 136 Mean Response Time (999-18)	Although performance has improved from November to December, time remains outside of Cat 2 mean by approximately 13 minutes.

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-6 M-7	Standards: Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile Definition: As above	Most STEMI calls are triaged as C2. Response times for C2 calls have been adversely affected by recent periods of REAP 4. Latest Trust audit data is in line with the national benchmarking data which reflects similar pressures. However, there are some internal factors contributing to lengthy times to angiography such as non-registrants waiting on scene for back-up and doing the entire care bundle before leaving scene.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: • Ongoing education for all TTP staff, and CPD for existing staff on the importance of reducing time on scene. • Local follow-up for non-registrants who have waited on scene for paramedic back-up. • Improved local OU audit feedback so that local managers can feedback and give support to staff on reducing delays	Named person: Executive Medical Director Complete by date: Ongoing

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
M-6	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	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	02:33:00	02:30:00	No Data	No Data	02:22:00	-	
M-7	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	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	03:26:00	03:33:00	No Data	No Data	03:14:00	-	

NB: Please note M-6 & M-7 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
M-8 M-9	Standards: Stroke – Call to Hospital Mean Stroke – Call to Hospital 90th Centile Definition: As above	Response times for Stroke care are affected by difficulties in identification via NHS Pathways. This means that some calls are triaged as C1, some as C2 and some as C3. C2 and C3 calls have been adversely affected by REAP 4 pressures resulting in delayed attendance. Some Stroke calls are triaged as C3 when onset is outside 4 hours. Where telemedicine is used (Kent), on scene times may be extended to make the call. However, this is more than compensated for by reduced times from door to scanner, once at the receiving Stroke hospital (so overall times from call to scanner is reduced). Overall times on scene are reasonable given frequent difficulties with extrication for Stroke patients (approximately 30 minutes).

Action Plan

Actions being taken to mitigate issues:

- NHSE call to door metric may not be a reasonable indicator as telemedicine is used more, and the Trust may be adversely affected by the use of telemedicine in terms of audit metrics of call to door.
- Call to scanner may be a more meaningful metric, This will be highlighted to the National Stroke Leads for consideration.
- Onset time of <4 hours is going to be changed nationally to 11 hours in April 2022.

Accountable Executive

Named person:
Executive Medical Director

Complete by date:
May 2022

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
M-8	Medical	Stroke - Call to Hospital Arrival Mean	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	01:46:00	01:43:00	No Data	No Data	01:29:00	-	
M-9	Medical	Stroke - Call to Hospital Arrival 90th Centile	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	02:57:00	02:42:00	No Data	No Data	02:20:00	-	

NB: Please note M-8 & M-9 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
999-18	Standards: Section 136 Mean Response Time Definition: Section 136 is part of the Mental health Act that gives the police emergency powers to take a patient to a place of safety (and to keep them there). It is preferable for patients under this section to be conveyed in an ambulance rather than a police van, and these calls are categorised as C2 under the ARP standards.	Although performance has improved from November to December, time remains outside of C2 mean by approximately 13 minutes. Note: This exception report should be considered in conjunction with that of the ARP performance targets as the section 136 response time measure is in line with C2 performance targets.

Action Plan

Actions being taken to mitigate issues:

- Optimising resource levels within field EOC & field operations to enable maximum staffing within all areas to support prioritisation and responsiveness of the Trust to all calls.
- There is ongoing engagement work with commissioners across the SECAmb footprint in relation to an additional focus to support patients with mental health presentations who make contact with ambulance services. Whilst this is for the full range of conditions, the response to S136 incidents will be reviewed.

Accountable Executive

Named person:
Executive Director of Operations

Complete by date:
Ongoing monitoring

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
999-18	Operations 999	Section 136 Mean Response Time	00:29:58	00:33:17	00:23:37	00:33:15	*No Data*	00:18:10	00:23:22	00:17:36	00:16:07	00:32:10	00:31:21	00:22:44	00:25:56	N/A	N/A	

Trust Overview:
Summary of Exceptions - Responsive

Domain	ID	Exceptions
Responsive	% 111 calls answered in 60 seconds (111-2) % 111 calls abandoned (111-3)	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. In addition, with abstractions at an exceptionally high level, particularly via sickness & annual leave.
Responsive	999 Calls Answered (mean and 90th centile) (999-1) Cat 1 (mean and 90th centile) (999-2,) 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)	There are a range of contributory factors which contribute to the poor performance across all metrics. In particular reduced resource provision as a result in of vacancy rates and high levels of abstraction.
Responsive	Number of BI Marvel Requests Closed in Month (BI-1)	The number of BI Marval tickets closed gives an indication of the delivery of ad-hoc requests by the BI team. The BI team available to provide the capacity to deliver the ad-hoc requests is currently limited to 5 team members and consequently any absence has a significant impact.

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
111-2 111-3	Standards: % 111 calls answered in 60 seconds % 111 calls abandoned	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. In addition, with abstractions at an exceptionally high level, particularly via sickness & annual leave, this is also resulting in resulting in very challenging resource levels across all areas of the 111 service. 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:

Optimising resource levels

- The service has embarked on a major recruitment drive and training plan for Health Advisor (HA) call handlers in Q4 and into Q1, with the Trust engaged in ongoing dialogue with commissioners and NHS E to secure the requisite funding to support this recruitment.
- Continued close monitoring of abstractions continues in line with Trust policy, and national guidance for Covid-19 related absences.

Accountable Executive

Named person

Executive Director for Operations

Complete by date:

Ongoing monitoring

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
111-2	Operations 111	111 Calls Answered in 60 Seconds %	74.00%	73.10%	53.40%	36.50%	33.90%	29.10%	33.70%	27.10%	16.30%	23.10%	24.50%	45.76%	28.58%	95.00%	-	
111-3	Operations 111	111 Calls Abandoned - (Offered) %	3.00%	3.50%	7.70%	14.80%	15.90%	19.70%	15.50%	19.00%	30.20%	25.60%	25.40%	14.06%	17.92%	5.00%	-	

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999-1 999-2 999-4 999-5 999-6 999-7	Standards: 999 Calls Answered (mean and 90th centile) (999-1) Cat 1 (mean and 90th centile) (999-2,) 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)	There are a range of contributory factors which contribute to the poor performance across all metrics. In particular reduced resource provision as a result in of vacancy rates and high levels of abstraction (particularly due to sickness & leave), as well as a reduction in efficiencies such as job cycle time and hospital handover challenges. The ARP performance framework is evidence-based in terms of both the target set, and the clinical implications of each target. • 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 February 2022 SECAmb overall performance fell in call answering, C2-C4 with improvements seen in C1 call metrics.

Action Plan

Actions being taken to mitigate issues:

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

- The continued robust management of abstractions such as sickness and annual leave
- Continued implementation of a programme of incentives to optimise additional hours
- Additional resource hours are being sourced via clinical managers and clinicians within other areas of the Trust – particularly as the Trust is now at REAP level 4

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
- 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 for Operations

Complete by date:

Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

NB: Metrics continued on next slide.

Performance by Domain
Responsive: Exception Report

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

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
999-1	Operations 999	999 Call Answer Mean	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	00:00:25	00:00:24	00:00:12	00:00:16	00:00:05	-	
999-1	Operations 999	999 Call Answer 90th Centile	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	00:01:29	00:00:38	00:00:59	00:00:10	-	
999-2	Operations 999	Cat 1 Mean	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	00:09:09	00:08:36	00:08:44	00:07:00	-	
999-2	Operations 999	Cat 1 90th Centile	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	00:15:49	00:15:47	00:15:00	-	
999-4	Operations 999	Cat 2 Mean	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	00:28:22	00:32:17	00:18:00	-	
999-4	Operations 999	Cat 2 90th Centile	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	01:10:41	01:08:19	00:56:57	01:06:25	00:40:00	-	
999-5	Operations 999	Cat 3 90th Centile	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	04:34:42	05:34:50	02:00:00	-	
999-6	Operations 999	Cat 4 90th Centile	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	05:34:24	06:55:58	03:00:00	-	
999-7	Operations 999	HCP 3 Mean	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	02:23:50	02:46:40	N/A	N/A	
999-7	Operations 999	HCP 3 90th Centile	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	07:28:23	07:01:05	05:27:14	05:49:50	N/A	N/A	
999-7	Operations 999	HCP 4 Mean	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	03:04:42	03:38:42	N/A	N/A	
999-7	Operations 999	HCP 4 90th Centile	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	06:53:33	07:59:11	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
BI-1	Standards: Number of BI Marvel Requests Closed in Month (BI-1)	The number of BI Marval tickets closed gives an indication of the delivery of ad-hoc requests by the BI team. The BI team available to provide the capacity to deliver the ad-hoc requests is currently limited to 5 team members and consequently any absence has a significant impact. A combination of fewer working days in February, annual leave and sickness has meant that capacity within the team has been reduced and consequently fewer tickets closed in February than previous months. Additionally, team members are going through a consultation process as part of the Performance Cell Transformation, time has been given to focus on the consultation to ensure team and individual wellbeing during this stressful time. It's important to have a responsive BI function – enabling us to make the right data-driven decisions.

Action Plan

Actions being taken to mitigate issues:

The Performance Cell Transformation proposes to bring together a mix of existing teams such as: BI, IUC Informatics and EOC Information. The additional capacity this provides may not have an immediate affect while team members adjust, the medium- and longer-term benefits would mitigate this issue.

The consultation outcome is expected 17 March 2022.

Accountable Executive

Named person

Executive Director of Planning and Business Development

Complete by date:

Ongoing

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
BI-1	Business Intelligence	Number of Marval Requests Completed	57	69	44	62	73	47	48	68	52	46	26	44	26	N/A	N/A	

Trust Overview:
Summary of Exceptions – Well-led

Domain	ID	Exceptions
Well-led	% Annual rolling sickness rate (WF-8)	The Trust remains to have high levels of absence. We have seen a 0.49% increase in absence since January 2022, our current absence % is 16.13%.
Well-led	% First Line Managers Who Have Had Leadership Training (Fundamentals) (WF-27)	First line managers have been under-developed over several years. Line managers are critical to the success of the organisation.
Well-led	Appraisals YTD (WF-5) % Appraisals Rolling Year (WF-40)	Low appraisal completion across the Trust. Line managers should have regular appraisals and one to ones with their staff.
Well-led	Diversity: Disability – Declared % (WF-37) Diversity: Ethnicity – BAME % (WF-39)	This data is only reported at end of quarter and therefore data from end of quarter three has been pulled across for this month. The next data run for workforce diversity will be undertaken at the end of April 2022.
Well-led	% Vehicles Older Than Target Age	Our fleet strategy sets out target ages for each of our fleet vehicle types. This is based on the recommendations from the Carter report, and indicates that we should not have vehicles of the national specification older than 5 years. We are reviewing these recommendations with our own information now that we have been running a mix of fleet for some time.
Well-led	% Policies and Procedures Outstanding Review (C-1)	Due to COVID and REAP levels, the chasing and updating of policies and procedures had reduced at the end of 2020, when the number of policies and procedures outstanding for review was steady at approximately 11%. We have started to refocus on those that are in more urgent need for review and so in the coming 6-9 months we expect the percentage to reduce.

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: As above	The Trust remains to have high levels of absence. We have seen a 0.49% increase in absence since January 2022, our current absence % is 16.13%. Covid is having a serious impact on the absence % with 167 colleagues in alternative duties across the trust. This should obviously be celebrated that we are able to offer this to our colleagues, however the 167 colleagues who are not in their substantive roles within operations is 5.5K hours a week off our front line.

Action Plan

Actions being taken to mitigate issues:

The HR and Operations team continue to work on the Operation Action Plan to support our colleagues back into the workplace. HR have amended the Managing Sickness and Absence Policy with regard to Alternative Duties tracking and this will be taken to JPF on the 21st March for sign off. NHS guidelines have been released in January with guidance of how to manage colleagues with Long Term Covid and, if stakeholders have engaged in time, this paper will be taken to JPF on the 21st March. We will review in April if these changes in policy will also help reduce our absence % across the trust.

Accountable Executive

Named person:

Executive Director of HR and Operations

Complete by date:

Ongoing monitoring

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
WF-8	Workforce HR	Annual Rolling Sickness Absence	7.30%	7.10%	7.10%	7.30%	7.50%	7.70%	7.90%	8.10%	8.30%	8.50%	8.50%	8.50%	8.79%	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
WF-27	Standards: % First Line Managers Who Have Had Leadership Training (Fundamentals) Definition: Percentage of staff turnover on an annual rolling rate	First line managers have been under-developed over several years. Line managers are critical to the success of the organisation. They should be supported to undertake training to develop their skills and capabilities to enable them to manage staff, improve employee engagement and experience.

Action Plan

Actions being taken to mitigate issues:

The Made@secamb management development outline was developed into a full strategy by the end of Q2 21/22. A task & finish group focussed on developing the Fundamentals programme for first line managers was paused during REAP 4. The T&F group has reconvened to develop the implementation plan for the Fundamentals programme to commence in Q1 22/23. Currently, first line managers have access to a range of development opportunities provided via the Trust's corporate membership with NHS Elect. The L&D team is working with external providers to commission additional development opportunities to augment the offer for managers.

Accountable Executive

Named person:

Executive Director of HR & Organisational Development

Complete by date:

Ongoing monitoring

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
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%	-	

Performance by Domain
Well-led: Exception Report

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

ID	Standard	Background
WF-5 WF-40	Standards: Appraisals YTD % Appraisals Rolling Year Definition: As above	Low appraisal completion across the Trust. Line managers should have regular appraisals and one to ones with their staff. The appraisal is an important part of employee engagement and is an opportunity for staff to receive feedback, discuss their career aspirations and development needs. Providing feedback to staff and supporting their development improves staff experience and will improve patient outcomes.

Action Plan

Actions being taken to mitigate issues:

Appraisal completion rates remain low although there has been a slight improvement. A new Appraisal Policy was agreed during Q3. The policy changes the appraisal year from April to March to anniversary of start date. The L&OD team are leading the rollout of the implementation of the new ESR Appraisal. Phase 1 (HR) is complete. Phase 2 (Corporate Services) commences in March 2022. L&OD will work with OUs/Directorates to develop appraisal action/recovery plans to bring them closer to 100% compliance during 2022/2023.

Accountable Executive

Named person:

Executive Director of HR & Organisational Development

Complete by date:

Ongoing monitoring

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
WF-5	Workforce HR	Appraisals YTD	45.70%	52.20%	3.40%	7.00%	9.10%	10.70%	11.30%	12.50%	13.90%	15.50%	17.50%	25.52%	33.83%	85.00%	-	
WF-40	Workforce HR	Appraisals Rolling Year %	*No Data*	52.20%	48.90%	40.80%	36.80%	34.10%	31.60%	30.30%	28.70%	26.90%	27.30%	33.28%	38.74%	80.00%	-	

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
WF-37 WF-39	Standards: Diversity: Disability – Declared % Diversity: Ethnicity – BAME % Definition:	This data is only reported at end of quarter and therefore data from end of quarter three has been pulled across for this month. The next data run for workforce diversity will be undertaken at the end of April 2022.

Action Plan

Actions being taken to mitigate issues:

No further action is required in relation to reporting but organisational support to continue progress against actions identified in the integrated equality action plan is required to increase the diversity of the workforce.

Accountable Executive

Named person:

Executive Director of HR & Organisational Development

Complete by date:

Not required

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
WF-37	Workforce HR	Diversity: Disability - declared %	4.00%	4.20%	4.20%	4.20%	4.30%	4.30%	4.30%	4.80%	4.80%	4.60%	5.60%	5.60%	5.60%	N/A	N/A	
WF-39	Workforce HR	Diversity: Ethnicity - BAME %	5.50%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.80%	5.80%	5.80%	6.70%	-	

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	Our fleet strategy sets out target ages for each of our fleet vehicle types. This is based on the recommendations from the Carter report, and indicates that we should not have vehicles of the national specification older than 5 years. We are reviewing these recommendations with our own information now that we have been running a mix of fleet for some time.

Action Plan

Actions being taken to mitigate issues:

A business case has been approved through to FIC and is due to be presented at the Board in March 2022. This business case sets out the plan to put us on a 5-year cycle of fleet replacement meaning that we consistently have a fleet under target age. Whilst we are reviewing this in line with our own data from our vehicles, this initial investment for 22/23 enable us to de-commission some of the older fleet, reducing the % over H2 of 22/23 when the new fleet will be commissioned.

Accountable Executive

Named person:
Executive Director of Planning and Business Development

Complete by date:

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
FL-1	Fleet	Vehicles Older Than Target Age %	35.00%	35.00%	35.00%	35.00%	35.00%	36.00%	36.00%	36.00%	36.00%	41.00%	41.00%	41.00%	41.00%	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
C-1	Standards: % Policies and procedures outstanding review	Due to COVID and REAP levels, the chasing and updating of policies and procedures had reduced at the end of 2020, when the number of policies and procedures outstanding for review was steady at approximately 11%.

Action Plan

Actions being taken to mitigate issues:

We have started to refocus on those that are in more urgent need for review and so in the coming months we expect the percentage to reduce. This assumes REAP levels ease as a proportion of our policies require significant operational engagement which is difficult to secure during sustained high levels of escalation.

Accountable Executive

Named person:
Chief Executive

Complete by date:
Ongoing – target 10% by the end of Q3.

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%	-	

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Appendices

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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-1	Quality & Safety	Number of Datix Incidents	1070	1149	1051	1175	1253	1493	1397	1149	1070	1398	1652	1706	1532	N/A	N/A	
QS-2	Quality & Safety	Number of Incidents Reported as SIs	7	1	7	3	6	11	5	1	7	6	5	5	5	N/A	N/A	
999-12	Operations 999	999 Frontline Hours Provided %	103.20%	96.90%	99.10%	99.30%	94.30%	90.10%	86.90%	88.00%	89.50%	92.60%	91.60%	92.74%	88.96%	100.00%	-	
QS-3	Quality & Safety	Duty of Candour Compliance %	100.00%	75.00%	100.00%	67.00%	100.00%	100.00%	100.00%	75.00%	100.00%	80.00%	100.00%	100.00%	100.00%	100.00%	=	
QS-7	Quality & Safety	Hand Hygiene Compliance %	93.00%	95.00%	94.00%	95.00%	95.00%	92.00%	90.00%	95.00%	93.00%	84.00%	81.00%	87.00%	78.00%	90.00%	-	
QS-8	Quality & Safety	Safeguarding Training Completed (Children) Level 2 %	82.00%	90.40%	88.70%	87.00%	87.30%	86.00%	86.20%	90.40%	82.00%	84.00%	84.20%	83.30%	83.61%	85.00%	-	
QS-13	Quality & Safety	Violence and Aggression Incidents (Number of Victims - Staff)	60	60	65	73	87	91	99	60	60	76	117	108	88	N/A	N/A	
MM-1	Medicines Management	Number of Medicines Incidents	142	173	152	171	118	156	141	157	165	146	153	107	89	N/A	N/A	
MM-3	Medicines Management	Single Witness Signature Use CDs Omnicell	9	4	3	2	3	6	7	14	5	13	23	38	*No Data*	0		
MM-4	Medicines Management	Single Witness Signature Use CDs Non-Omnicell	1	1	0	0	0	1	0	0	1	1	0	170	*No Data*	0		
MM-5	Medicines Management	Number of CD Breakages	10	27	16	16	19	10	17	9	29	20	16	22	16	N/A	N/A	
MM-7	Medicines Management	Medicines Management % of Audits Completed	88.00%	95.00%	95.00%	98.40%	98.70%	98.10%	97.90%	94.10%	91.90%	98.40%	98.50%	87.30%	93.90%	100.00%	-	
WF-1	Workforce HR	Number of Staff WTE (Excl bank and agency)	3968	3974	3945	3952	3957	3936	3939	3949	3965	3957	3934	3944	3940	3962	-	
WF-2	Workforce HR	Number of Staff Headcount (Exc bank and agency)	4358	4367	4335	4342	4350	4327	4336	4344	4365	4350	4337	4351	4351	N/A	N/A	
WF-3	Workforce HR	Finance Establishment (WTE)	3956	3946	3946	3946	3946	4070	4060	4040	4033	3946	3996	3976	3962	N/A	N/A	
WF-4	Workforce HR	Vacancy Rate %	-0.30%	-0.70%	0.10%	-0.10%	-0.20%	3.30%	3.00%	2.20%	1.70%	-0.20%	1.50%	0.80%	0.56%	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-9	Quality & Safety	Number of RIDDOR Reports	12	8	10	11	14	17	14	8	12	15	11	7	11	N/A	N/A	
WF-16	Workforce HR	DBS Compliance %	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) %	90.00%	93.00%	92.00%	92.00%	87.00%	97.00%	94.00%	95.00%	96.00%	96.00%	93.00%	87.00%	93.00%	N/A	N/A	
M-21	Medical	Required NHS Pathways Audits Completed (EMA) %	49.00%	96.00%	103.00%	105.00%	83.00%	53.00%	70.00%	78.00%	102.00%	99.00%	92.00%	112.00%	100.00%	N/A	N/A	
M-22	Medical	Compliant NHS Pathways Audits (EMA) %	83.00%	85.00%	83.00%	84.00%	84.00%	90.00%	82.00%	84.00%	84.00%	78.00%	96.00%	83.00%	82.00%	100.00%	-	
M-23	Medical	Required NHS Pathways Audits Completed (Clinical) %	97.00%	100.00%	102.00%	102.00%	102.00%	102.00%	101.00%	76.00%	99.00%	99.00%	92.00%	101.00%	90.00%	N/A	N/A	
QS-17	Quality & Safety	Outstanding Actions Relating to SIs, Outside of Timescales	112	117	141	114	112	116	117	117	112	129	130	123	106	N/A	N/A	
QS-19	Quality & Safety	Deep Clean Compliance %	64.00%	94.90%	95.00%	85.00%	82.00%	73.00%	41.50%	94.90%	64.00%	70.00%	74.00%	88.00%	92.00%	95.00%	-	
QS-20	Quality & Safety	Health & Safety Incidents	33	31	29	59	47	39	30	31	33	36	31	24	18	N/A	N/A	
WF-24	Workforce HR	Current licence details held for Operational Staff %	90.40%	92.40%	96.10%	96.10%	96.00%	93.80%	92.60%	91.10%	91.50%	91.10%	91.00%	93.62%	97.94%	100.00%	-	
QS-22	Quality & Safety	Manual Handling Incidents	32	22	17	43	28	35	33	22	32	29	26	22	26	N/A	N/A	
QS-25	Quality & Safety	Flu Vaccine Compliance	79.80%	80.10%	No Data	No Data	No Data	No Data	No Data	80.10%	79.80%	No Data	58.00%	60.00%	64.00%	90.00%	-	
FL-2	Fleet	Number of RTCs per 10k miles travelled	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	0	0	0.65	0.69	TBC		
FL-3	Fleet	% of planned vehicle services completed	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	71.00%	76.00%	76.00%	83.00%	TBC		
SE-1	Strategic Estates	% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	94.00%	94.00%	94.00%	96.00%	95.00%	-	

\+ 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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
999-11	Operations 999	JCT Allocation to Clear at Scene Mean	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	01:17:44	01:18:34	01:18:56	01:18:31	N/A	N/A	
999-11	Operations 999	JCT Allocation to Clear at Hospital Mean	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	01:57:03	01:54:39	01:55:15	N/A	N/A	
M-1	Medical	**Cardiac ROSC Utstein %	48.50%	40.00%	41.00%	40.50%	48.70%	54.20%	48.70%	57.10%	48.70%	51.30%	No Data	No Data	No Data	45.10%		
M-2	Medical	Cardiac ROSC ALL %	23.70%	22.00%	23.00%	24.00%	28.30%	31.00%	24.80%	34.00%	24.80%	23.10%	No Data	No Data	No Data	23.80%		
M-12	Medical	**Sepsis Care Bundle %	86.30%	85.00%	85.00%	83.50%	84.00%	81.30%	86.20%	84.50%	85.40%	84.70%	No Data	No Data	No Data	85.00%		
M-3	Medical	Cardiac Survival Utstein %	33.30%	18.00%	28.00%	27.30%	No Data	31.30%	30.60%	23.50%	20.00%	36.80%	No Data	No Data	No Data	25.60%		
M-4	Medical	Cardiac Survival ALL %	9.10%	8.00%	13.70%	12.30%	No Data	14.00%	10.00%	10.80%	8.00%	11.00%	No Data	No Data	No Data	9.60%		
M-11	Medical	Cardiac Arrest - Post ROSC %	61.60%	78.00%	81.00%	78.50%	90.30%	75.80%	68.00%	75.30%	68.00%	75.50%	No Data	No Data	No Data	76.80%		
M-5	Medical	**Acute STEMI Care Bundle Outcome %	63.90%	74.00%	69.00%	60.30%	57.30%	60.60%	62.70%	54.00%	55.40%	54.30%	No Data	No Data	No Data	64.70%		
M-6	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	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	02:33:00	02:30:00	No Data	No Data	02:22:00	-	
M-7	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	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	03:26:00	03:33:00	No Data	No Data	03:14:00	-	
M-8	Medical	Stroke - Call to Hospital Arrival Mean	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	01:46:00	01:43:00	No Data	No Data	01:29:00	-	
M-9	Medical	Stroke - Call to Hospital Arrival 90th Centile	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	02:57:00	02:42:00	No Data	No Data	02:20:00	-	
M-10	Medical	**Stroke - Assessed F2F Diagnostic Bundle %	95.80%	95.00%	96.00%	95.70%	96.80%	94.10%	97.10%	97.10%	97.90%	97.60%	No Data	No Data	No Data	96.30%		

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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
M-13	Medical	Sensitivity of Cardiac Arrest Detection During Telephone Triage %	93.40%	82.00%	82.00%	82.20%	84.10%	91.20%	95.50%	95.20%	95.50%	93.80%	No Data	No Data	No Data	93.80%		
M-14	Medical	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	79.30%	79.00%	78.00%	77.30%	80.00%	79.40%	80.30%	85.00%	80.30%	74.10%	No Data	No Data	No Data	77.90%		
M-16	Medical	Proportion of Non-EMS Witnessed Cardiac Arrests with PAD Applied to Patient %	4.90%	No Data	No Data	5.80%	No Data	12.10%	6.40%	8.40%	6.40%	6.90%	No Data	No Data	No Data	7.30%		
999-13	Operations 999	ECAL Mean Response Time	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	00:22:35	00:23:13	N/A	N/A	
999-12	Operations 999	999 Operational Abstraction Rate %	32.50%	33.30%	25.20%	25.80%	31.00%	33.10%	27.10%	34.70%	32.90%	30.80%	32.90%	33.70%	36.26%	28.00%	-	
WF-20	Workforce L&OD	Statutory & Mandatory Training % Year to Date	74.70%	84.50%	12.20%	24.90%	36.80%	40.90%	42.80%	43.90%	47.80%	52.10%	56.70%	62.73%	72.66%	95.00%	-	
WF-6	Workforce HR	Statutory & Mandatory Training Rolling Year %	76.20%	78.70%	67.10%	60.70%	63.30%	67.00%	66.60%	65.90%	66.30%	68.60%	65.40%	72.07%	76.59%	95.00%	-	
999-17	Operations 999	Responses Per Incident	1.09	1.00	1.01	0.99	1.01	1.09	1.09	1.09	1.09	1.09	1.09	1.09	1.09	1.09	=	
999-18	Operations 999	Section 136 Mean Response Time	00:29:58	00:33:17	00:23:37	00:33:15	No Data	00:18:10	00:23:22	00:17:36	00:16:07	00:32:10	00:31:21	00:22:44	00:25:56	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	No Data	No Data	No Data	No Data	N/A	N/A	
999-20	Operations 999	ePCR Usage	96.10%	96.70%	97.00%	91.00%	95.70%	93.10%	96.20%	96.70%	96.70%	93.80%	97.00%	96.12%	97.41%	95.00%	+	

NB: M-1 to M-16 are reported up to 4-months in arrears
999-19 where No Data is shown 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

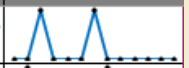
IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
M-24	Medical	ClinEd: Course Capacity Utilisation Associate Ambulance Practitioner %	93.00%	93.00%	93.00%	93.00%	92.00%	92.00%	92.00%	92.00%	91.00%	90.00%	90.00%	92.00%	85.00%	100.00%	-	
M-27	Medical	ClinEd: Course Capacity Utilisation Transition to Practice %	65.00%	65.00%	65.00%	65.00%	65.00%	75.00%	74.00%	75.00%	73.00%	73.00%	73.00%	73.00%	73.00%	100.00%	-	
M-25	Medical	ClinEd: Students at Risk of Not Obtaining Qualification %	39.00%	44.00%	46.00%	45.00%	39.00%	29.00%	25.00%	23.00%	19.00%	25.00%	24.00%	26.00%	29.00%	N/A	N/A	
WF-34	Workforce HR	Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	31.60%	31.40%	31.40%	31.30%	31.60%	32.50%	31.60%	30.30%	29.40%	29.40%	29.70%	30.20%	*No Data*	29.00%		
WF-35	Workforce HR	Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	49.60%	49.60%	49.60%	49.60%	49.50%	49.30%	50.40%	51.90%	53.10%	53.10%	51.00%	17.90%	*No Data*	23.00%		
WF-36	Workforce HR	Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	18.80%	19.00%	19.00%	19.00%	18.80%	18.40%	18.00%	17.80%	17.50%	17.50%	19.30%	51.80%	*No Data*	47.90%		
OS-1	Operational Support Desk	% of OSD vehicle movements achieved	98.50%	99.00%	98.00%	97.00%	98.00%	96.00%	97.00%	99.50%	99.00%	99.00%	99.00%	96.00%	96.00%	100.00%	-	
999-30	Operations 999	% 999 frontline hours compliance (profile compliance by hour)	*No Data*	*No Data*	*No Data*	*No Data*	*No Data*	*No Data*	*No Data*	*No Data*	*No Data*	84.80%	81.50%	82.90%	81.66%	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

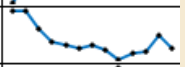
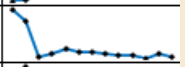
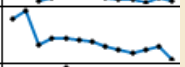
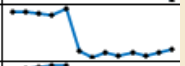
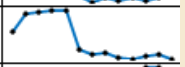
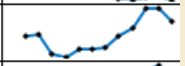
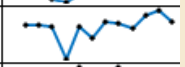
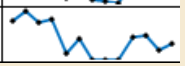
Our staff involve and treat our patients with compassion, kindness, dignity and respect

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-12	Quality & Safety	Complaints relating to privacy and respect %	0.00%	0.00%	0.20%	0.00%	0.00%	0.00%	0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	
QS-10	Quality & Safety	Proportion of Complaints Relating to Crew Attitude %	50.00%	56.00%	31.00%	33.00%	31.00%	18.00%	25.00%	56.00%	50.00%	24.00%	28.00%	28.00%	28.00%	N/A	N/A	

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Responsive: Performance Dashboard

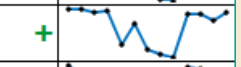
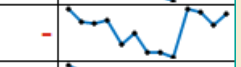
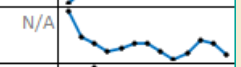
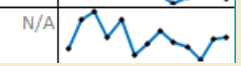
Our services are organised so that they meet our patient's needs

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
111-1	Operations 111	111 Calls Offered	87249	110294	119979	135942	126452	138484	127167	123604	139429	121449	135035	111471	100617	N/A	N/A	
111-2	Operations 111	111 Calls Answered in 60 Seconds %	74.00%	73.10%	53.40%	36.50%	33.90%	29.10%	33.70%	27.10%	16.30%	23.10%	24.50%	45.76%	28.58%	95.00%	-	
111-3	Operations 111	111 Calls Abandoned - (Offered) %	3.00%	3.50%	7.70%	14.80%	15.90%	19.70%	15.50%	19.00%	30.20%	25.60%	25.40%	14.06%	17.92%	5.00%	-	
111-4	Operations 111	111 to 999 Referrals (Answered Calls) %	15.00%	13.40%	8.70%	9.10%	9.70%	9.30%	9.30%	9.10%	8.90%	8.90%	8.50%	9.14%	8.78%	13.00%	+	
111-4	Operations 111	999 Referrals	11064	12058	8188	8901	8805	8675	8585	7961	7648	7162	7628	7882	6495	N/A	N/A	
111-5	Operations 111	A&E Dispositions %	15.40%	15.60%	15.20%	14.90%	16.00%	9.10%	8.10%	8.90%	8.30%	8.70%	8.20%	8.72%	9.39%	9.00%	-	
111-5	Operations 111	A&E Dispositions	11349	14047	14261	14571	14472	8501	7534	7790	7153	6962	7395	7515	6943	N/A	N/A	
111-7	Operations 111	Clinical Contact %	*No Data*	48.10%	48.20%	45.20%	44.90%	46.00%	46.00%	46.20%	48.00%	49.30%	52.10%	52.26%	50.28%	50.00%	+	
111-8	Operations 111	Ambulance Validation %	*No Data*	95.40%	95.30%	95.10%	90.60%	95.20%	93.60%	95.90%	95.60%	94.90%	96.80%	97.49%	95.90%	85.00%	+	
999-10	Operations 999	999 Calls Answered	50316	60200	61386	77074	71529	85769	77173	81649	86089	76122	78778	71054	67386	N/A	N/A	
999-10	Operations 999	Incidents	56470	62648	62845	65474	67474	65161	62343	60808	64510	62534	63924	62514	56127	N/A	N/A	
999-1	Operations 999	999 Call Answer Mean	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	00:00:25	00:00:24	00:00:12	00:00:16	00:00:05	-	
999-1	Operations 999	999 Call Answer 90th Centile	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	00:01:29	00:00:38	00:00:59	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
999-2	Operations 999	Cat 1 Mean	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	00:09:09	00:08:36	00:08:44	00:07:00	-	
999-2	Operations 999	Cat 1 90th Centile	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	00:15:49	00:15:47	00:15:00	-	
999-3	Operations 999	Cat 1T Mean	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	00:10:26	00:10:43	00:19:00	+	
999-3	Operations 999	Cat 1T 90th Centile	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	00:20:00	00:19:58	00:19:28	00:20:07	00:30:00	+	
999-4	Operations 999	Cat 2 Mean	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	00:28:22	00:32:17	00:18:00	-	
999-4	Operations 999	Cat 2 90th Centile	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	01:10:41	01:08:19	00:56:57	01:06:25	00:40:00	-	
999-5	Operations 999	Cat 3 90th Centile	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	04:34:42	05:34:50	02:00:00	-	
999-6	Operations 999	Cat 4 90th Centile	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	05:34:24	06:55:58	03:00:00	-	
999-7	Operations 999	HCP 3 Mean	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	02:23:50	02:46:40	N/A	N/A	
999-7	Operations 999	HCP 3 90th Centile	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	07:28:23	07:01:05	05:27:14	05:49:50	N/A	N/A	
999-7	Operations 999	HCP 4 Mean	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	03:04:42	03:38:42	N/A	N/A	
999-7	Operations 999	HCP 4 90th Centile	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	06:53:33	07:59:11	N/A	N/A	
999-9	Operations 999	Hear & Treat %	6.00%	6.90%	6.90%	9.30%	7.90%	9.60%	9.00%	8.80%	10.30%	9.90%	9.30%	8.65%	9.48%	N/A	N/A	
999-9	Operations 999	See & Treat %	35.20%	32.60%	32.10%	31.20%	31.60%	32.00%	32.10%	31.30%	30.50%	31.10%	32.40%	32.05%	31.08%	N/A	N/A	
999-9	Operations 999	See & Convey %	58.80%	60.50%	61.00%	59.40%	60.50%	58.40%	59.00%	59.80%	59.10%	58.90%	58.10%	59.34%	59.48%	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
999-10	Operations 999	CFR Attendances	580	1034	1089	1337	1219	1592	1354	1290	1467	1166	1474	1309	1398	N/A	N/A	
999-10	Operations 999	FFR Attendances	142	316	260	364	241	425	383	339	353	293	343	309	298	N/A	N/A	
QS-4	Quality & Safety	Complaints Reporting Timeliness %	64.50%	88.00%	81.00%	98.00%	96.00%	87.00%	81.00%	88.00%	64.50%	84.00%	77.00%	85.40%	90.00%	95.00%	-	
QS-5	Quality & Safety	Number of Complaints	48	64	68	72	116	106	114	64	48	93	72	105	93	N/A	N/A	
QS-6	Quality & Safety	Number of Compliments	191	187	208	159	162	171	177	187	191	150	148	213	179	N/A	N/A	
QS-15	Quality & Safety	Complaints per 1000 999 Calls Answered	0.95	1.06	1.11	0.09	0.16	0.13	0.14	1.06	0.95	0.01	0.01	0.00	0.00	N/A	N/A	
QS-16	Quality & Safety	Compliments per 1000 999 Calls Answered	3.80	3.91	3.69	0.21	0.23	0.21	0.22	3.91	3.80	0.02	0.02	0.00	0.00	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	*No Data*	*No Data*	20		
QS-26	Quality & Safety	Learning from deaths: Number of SJRs showing harm	0	0	0	0	0	0	0	0	0	0	0	*No Data*	*No Data*	0		
999-14	Operations 999	Time Spent in SMP 3 or Higher %	1.30%	12.10%	15.40%	36.00%	68.90%	83.00%	70.70%	82.50%	86.20%	72.80%	72.50%	45.68%	65.26%	N/A	N/A	
C-2	Corporate	Number of BCIs	2	0	0	1	2	1	1	1	1	2	1	1	0	0	=	
BI-1	Business Intelligence	Number of Marval Requests Completed	57	69	44	62	73	47	48	68	52	46	26	44	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
WF-5	Workforce HR	Appraisals YTD	45.70%	52.20%	3.40%	7.00%	9.10%	10.70%	11.30%	12.50%	13.90%	15.50%	17.50%	25.52%	33.83%	85.00%	-	
WF-40	Workforce HR	Appraisals Rolling Year %	*No Data*	52.20%	48.90%	40.80%	36.80%	34.10%	31.60%	30.30%	28.70%	26.90%	27.30%	33.28%	38.74%	80.00%	-	
WF-7	Workforce HR	Annual Rolling Turnover Rate	10.50%	10.30%	10.80%	11.40%	12.10%	12.90%	13.60%	13.90%	14.50%	15.10%	15.40%	15.64%	16.13%	N/A	N/A	
WF-8	Workforce HR	Annual Rolling Sickness Absence	7.30%	7.10%	7.10%	7.30%	7.50%	7.70%	7.90%	8.10%	8.30%	8.50%	8.50%	8.50%	8.79%	5.00%	-	
WF-9	Workforce HR	Disciplinary Cases	1	4	9	8	2	6	1	4	1	4	1	3	2	N/A	N/A	
WF-10	Workforce HR	Individual Grievances	5	8	10	8	8	5	9	8	10	2	2	12	11	N/A	N/A	
WF-11	Workforce HR	Collective Grievances	1	0	1	1	1	1	0	2	0	1	1	0	1	N/A	N/A	
WF-12	Workforce HR	Bullying & Harrassment Internal	1	6	5	4	1	0	4	3	3	0	1	3	2	0	-	
WF-13	Workforce HR	Whistleblowing	0	0	0	0	0	3	0	0	0	0	0	0	0	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak Up: Total Open Cases	28	7	31	33	36	45	20	7	28	18	25	30	22	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak up: Cases Opened in Month	4	*No Data*	2	3	3	2	2	0	4	4	1	12	18	N/A	N/A	
QS-27	Quality & Safety	Freedom to Speak up: Cases Closed in Month	1	4	0	0	1	0	0	4	1	7	0	7	8	N/A	N/A	
WF-29	Workforce HR	Staff Acting Up/Secondments %	2.60%	3.10%	2.90%	2.90%	2.70%	2.30%	2.20%	2.50%	2.50%	2.50%	2.50%	2.30%	2.23%	N/A	N/A	
WF-37	Workforce HR	Diversity: Disability - declared %	4.00%	4.20%	4.20%	4.20%	4.30%	4.30%	4.30%	4.80%	4.80%	4.60%	5.60%	5.60%	5.60%	N/A	N/A	
WF-38	Workforce HR	Diversity: Disability - declined to declare %	10.00%	7.80%	7.80%	7.80%	7.50%	7.50%	7.50%	7.00%	7.00%	7.00%	2.80%	2.80%	2.80%	0.00%	-	
WF-39	Workforce HR	Diversity: Ethnicity - BAME %	5.50%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.80%	5.80%	5.80%	6.70%	-	

\+ Outperformed target
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Performance by Domain
Well-Led: Performance Dashboard

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IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
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 %	8.10%	6.70%	6.70%	8.40%	8.90%	11.50%	8.20%	9.80%	5.90%	7.00%	4.50%	6.44%	6.68%	N/A	N/A	
WF-19	Workforce Wellbeing	Absence Relating to MSK %	8.10%	4.50%	8.30%	6.20%	5.70%	5.60%	6.10%	5.60%	5.70%	2.40%	2.80%	2.15%	5.11%	N/A	N/A	
WF-25	Workforce Wellbeing	Number of Wellbeing Hub Referrals	96	115	111	138	125	111	93	142	79	127	72	105	73	0	-	
WF-30	Workforce Wellbeing	Time from referral to offered wellbeing appointment (days)	14	14	14	14	14	14	14	21	28	14	14	14	14	14	=	
999-27	Operations 999	% of Meal Breaks Taken	*No Data*	99.20%	91.00%	98.40%	98.60%	98.30%	98.40%	98.40%	98.00%	96.70%	98.10%	98.31%	98.10%	N/A	N/A	
999-28	Operations 999	% of Meal Breaks Outside of Window	*No Data*	49.90%	51.10%	54.80%	59.30%	59.10%	58.70%	58.80%	60.70%	60.20%	59.50%	54.06%	58.53%	N/A	N/A	
999-15	Operations 999	999 Frontline Late Finishes/Over-Runs %	51.00%	52.40%	51.90%	60.20%	53.40%	50.60%	49.20%	51.90%	53.30%	50.70%	50.30%	47.35%	47.99%	N/A	N/A	
999-15	Operations 999	Average Late Finish/Over-Run Time	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	00:39:59	00:39:00	00:40:00	N/A	N/A	
999-21	Operations 999	Provided Bank Hours %	0.30%	0.30%	0.40%	0.60%	0.60%	0.70%	1.70%	0.00%	0.90%	0.80%	0.80%	0.88%	1.01%	N/A	N/A	
999-21	Operations 999	Provided Overtime Hours %	15.40%	14.60%	9.10%	8.60%	10.40%	10.50%	9.30%	11.40%	12.00%	10.40%	8.90%	10.58%	12.19%	N/A	N/A	
999-21	Operations 999	Provided PAP Hours %	6.10%	6.30%	4.30%	4.80%	4.50%	4.60%	5.30%	6.80%	6.90%	5.20%	5.00%	5.82%	5.75%	N/A	N/A	
999-22	Operations 999	999 Remaining Annual Leave FY	27.00%	20.00%	53.00%	*No Data*	84.00%	*No Data*	34.60%	62.50%	55.70%	51.60%	45.90%	37.00%	31.00%	N/A	N/A	
FL-1	Fleet	Vehicles Older Than Target Age %	35.00%	35.00%	35.00%	35.00%	35.00%	36.00%	36.00%	36.00%	36.00%	41.00%	41.00%	41.00%	41.00%	0.00%	-	
C-1	Corporate	Policies & Procedures Outstanding Review %	11.00%	11.30%	15.80%	17.40%	29.00%	32.00%	37.00%	36.50%	37.20%	40.70%	43.10%	44.10%	44.80%	0.00%	-	
QS-24	Quality & Safety	Organisational Risks Outstanding Review %	57.00%	52.00%	59.00%	81.00%	73.00%	81.00%	40.40%	52.00%	57.00%	42.20%	38.60%	32.00%	31.00%	30.00%	-	

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Performance by Domain
Well-Led: Performance Dashboard

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IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
IT-1	IT	CAD System Uptime %	No Data	No Data	No Data	98.900%	85.960%	100.000%	99.900%	100.000%	100.000%	96.700%	99.900%	99.183%	100.000%	99.90%	+	
IT-2	IT	Telephony System Uptime %	No Data	No Data	No Data	85.690%	100.000%	100.000%	100.000%	100.000%	100.000%	96.700%	99.800%	98.971%	100.000%	99.90%	+	
IT-3	IT	ePCR System Uptime %	No Data	No Data	No Data	84.390%	100.000%	97.900%	100.000%	100.000%	100.000%	99.200%	99.400%	99.385%	100.000%	99.90%	+	
IT-4	IT	Number of Calls to IT Service Desk	1436	1924	1324	1442	1214	1214	1187	1372	1090	1084	856	1128	1180	N/A	N/A	
IT-5	IT	Marval IT Requests Raised - IT Service Desk	1559	1847	1638	1705	1503	1288	1168	1477	1414	1520	1262	1581	1325	N/A	N/A	
IT-5	IT	Marval IT Requests Raised - Critical Systems Team	694	724	728	757	765	775	664	611	592	654	510	696	634	N/A	N/A	
IT-6	IT	Missed Calls to IT Service Desk	460	624	586	456	378	382	447	441	377	286	238	263	160	245	+	
FL-4	Fleet	% of DCA vehicles off road (VOR)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	12.00%	10.00%	11.00%	11.00%	TBC		
FL-5	Fleet	% of SRV vehicles off road (VOR)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	7.00%	7.00%	5.00%	4.00%	TBC		
FL-6	Fleet	% of OTL vehicles off road (VOR)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	7.00%	20.00%	TBC		
FL-7	Fleet	% of PP vehicles off road (VOR)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	7.00%	7.00%	TBC		
FL-8	Fleet	% of CCP vehicles off road (VOR)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	0.00%	0.00%	TBC		
FL-9	Fleet	% of SORT vehicles off road (VOR)	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	4.00%	5.00%	TBC		
FL-10	Fleet	Average miles between vehicle failures	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	38911	44128.7	TBC		
999-29	Operations 999	% PAP shift fulfilment vs. contract	No Data	No Data	96.00%	107.00%	106.00%	103.00%	107.00%	108.00%	111.00%	96.00%	88.00%	104.00%	95.00%	95.00%	=	
SE-2	Strategic Estates	Risk assessed building and asset condition survey compliance %	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	100.00%	100.00%	100.00%	100.00%	95.00%	=	
SE-3	Strategic Estates	FM performance against SLA	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	97.00%	98.00%	97.00%	98.00%			

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Performance by Domain –
Well-Led: Finance Dashboard (February 2022)

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ID	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£26134.50	£35076.00	£23241.00	£23340.80	£23325.10	£23415.40	£23521.20	£29157.60	£23450.50	£24049.10	£25088.10	£24865.50	£24640.50	£24358.10	£282.40		
F-9	Income (£000s) YTD	£251986.50	£287063.00	£23241.00	£46582.10	£69907.20	£93332.60	£116853.80	£146011.40	£169461.90	£193511.00	£218599.10	£243464.60	£268105.10	£266160.60	£1944.50	£295289.70	£29129.10
F-2	Operating Expenditure (£000s) Month	£24952.70	£38485.00	£23947.00	£24554.20	£24345.40	£24929.90	£25040.50	£27981.60	£24300.60	£24785.10	£26396.10	£25269.10	£24949.00	£25243.20	£-294.20		
F-10	Operating Expenditure (£000s) YTD	£255298.70	£293784.00	£23947.00	£48503.60	£72849.00	£97787.90	£122828.40	£150810.00	£175110.60	£199895.70	£226291.80	£251560.90	£276509.90	£276948.30	£-438.40	£303334.80	£26386.50
F-3	Capital Expenditure (£000s) Month	£1223.15	£4138.00	£1618.00	£987.96	£983.67	£1252.68	£412.32	£655.48	£395.11	£2905.10	£2476.90	£2428.81	£0.00	£3594.00	£-3594.00		
F-14	Capital Expenditure (£000s) YTD	£15361.18	£19499.00	£1618.00	£2605.91	£3589.58	£4842.26	£5254.58	£5910.07	£6305.18	£9210.27	£11687.18	£14115.98	£14115.98	£22126.00	£-8010.02	£25431.31	£3305.31
F-4	Cost Improvement Plan (CIP) (£000s) Month	£478.00	£709.00	£0.00	£0.00	£150.00	£430.00	£250.00	£238.00	£161.00	£250.84	£181.32	£963.31	£392.69	£489.00	£-96.31		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£4268.00	£4977.00	£0.00	£0.00	£150.00	£580.00	£830.00	£1068.00	£1229.00	£1479.84	£1661.16	£2624.31	£3017.00	£5356.00	£-2339.00	£5872.00	£516.00
F-6	Surplus/Deficit (£000s) Month	£1181.80	£-3409.00	£-706.00	£-1213.40	£-1020.30	£-1514.50	£-1519.30	£1176.00	£-850.10	£-736.00	£-1308.00	£-403.60	£-308.50	£-885.10	£576.60		
F-7	Cash Position (£000s) Month	£51441.00	£40152.00	£36526.00	£36448.00	£35923.00	£36684.00	£38289.00	£40507.00	£46592.00	£45791.00	£43638.00	£47832.00	£53937.00	£22217.52	£31719.48	£22217.52	£0.00
F-8	Agency Spend (£000s) Month	£-80.27	£155.00	£169.00	£250.04	£107.24	£347.61	£234.08	£168.06	£154.98	£192.19	£255.95	£284.74	£170.08	£255.00	£-84.92		
F-16	Agency Spend (£000s) YTD	£1630.00	£1784.00	£169.00	£418.90	£526.14	£873.76	£1107.84	£1275.89	£1430.87	£1623.06	£1879.01	£2265.41	£2435.49	£3050.00	£-614.51	£2638.40	£-411.60

Performance by Domain
Well-Led: Performance Dashboard

Summary of Financial Performance
February 2022

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
(5.7)%	26,135	24,358	24,641	282	1.2%	**INCOME**	266,161	268,105	1,945	0.7%	251,987	6.4%	290,605	295,290	4,685	1.6%	287,063	2.9%
(10.7)%	16,650	18,644	18,430	214	1.1%	PAY	202,887	203,954	(1,067)	(0.5)%	187,809	(8.6)%	219,751	221,237	(1,486)	(0.7)%	203,049	(9.0)%
12.0%	7,360	6,453	6,480	(27)	(0.4%)	NON PAY	72,461	72,362	99	0.1%	66,282	(9.2)%	78,775	81,753	(2,979)	(3.8)%	90,533	9.7%
(3.7)%	24,010	25,097	24,910	187	0.7%	**OPERATING EXPENDITURE**	275,348	276,316	(967)	(0.4)%	254,091	(8.7)%	298,526	302,991	(4,465)	(1.5)%	293,581	(3.2)%
(112.7)%	2,124	(739)	(269)	470	(63.6)%	**OPERATING SURPLUS/(DEFICIT)**	(9,188)	(8,211)	977	(10.6)%	(2,105)	290.1%	(7,921)	(7,701)	220	(2.8)%	(6,519)	18.1%
73.1%	145	146	39	107	73.2%	FINANCING COSTS	1,600	194	1,406	87.9%	1,207	83.9%	1,745	344	1,401	80.3%	203	(69.5)%
(115.6)%	1,979	(885)	(309)	577	65.2%	**SURPLUS/(DEFICIT)**	(10,788)	(8,405)	2,383	22.1%	(3,312)	(153.8)%	(9,666)	(8,045)	1,621	16.8%	(6,722)	(19.7)%
0.0%	3	1	(99)	(100)	(10000.0)%	ADJUSTMENTS TO SURPLUS/(DEFICIT)	30	(1,469)	(1,499)	(50)	(10)	(15184.6)%	31	(1,468)	(1,499)	(4835.5)%	57	2675.4%
(120.6)%	1,982	(884)	(408)	477	54.0%	**ADJUSTED SURPLUS/***(DEFICIT) : CONTROL TOTAL*	(10,758)	(9,874)	884	8.2%	(3,322)	(197.2)%	(9,635)	(9,513)	122	1.3%	(77)	(12319.2)%
% 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
(0.6%)	56,469	63,566	56,141	(7,425)	(11.7%)	A&E ACTIVITY per Plan	738,694	693,433	(45,261)	(6.1%)	679,061	2.1%	806,987	761,194	(45,793)	(5.7%)	741,767	2.6%
✓	1	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	
✗	478	489	393	(96)	✗	**CIPS**	5,356	3,017	(2,339)	✗	4,268	✗	5,872	3,965	(1,907)	✗	4,977	✗
✗	1,223	3,594	0	3,594	✓	**CAPITAL**	22,126	14,116	8,010	✓	15,361	✓	25,491	25,431	60	✓	19,499	✓
✓	51,441	22,218	53,937	31,719	✓	**CASH POSITION**	22,218	53,937	31,719	✓	51,441	✓	24,360	56,093	31,733	✓	40,152	✓
✗	4,580	4,586	4,400	185	✗	**WTE**	4,365	4,387	(22)	✗	4,451	✓	4,350	4,370	(21)	✗	4,452	✗
✗	2,782	1,390	1,156	234	✗	**COVID-19 SPEND**	13,630	11,557	2,073	✓	18,312	✗	15,019	13,400	1,619	✗	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
311.9%	(80)	255	170	85	33.3%	**AGENCY STAFF**	3,050	2,435	615	20.1%	1,630	(49.4)%	3,298	2,638	660	20.0%	1,784	(47.9)%
						PRIVATE AMBULANCE PROVIDERS (PAP)												
(700.1)%	228	184	1,824	(1,640)	(891.5)%	Covid-19	1,939	2,139	(200)	(10.3)%	2,282	6.3%	2,123	2,309	(186)	(8.8)%	2,451	5.8%
(616.6)%	388	691	2,784	(2,093)	(302.9)%	Non Covid-19 (BAU)	6,245	4,061	2,184	35.0%	5,983	32.1%	6,936	4,018	2,918	42.1%	6,281	36.0%
(647.5)%	616	875	4,608	(3,733)	(426.6)%	**TOTAL**	8,184	6,200	1,984	24.2%	8,265	25.0%	9,059	6,327	2,732	30.2%	8,732	27.5%

Performance by Domain
Well-Led: Performance Charts

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F-1 Income Actual Month

February 2022	Plan
£24640.50	£24358.10

F-2 Operating Expenditure Actual Month

February 2022	Plan
£24949.00	£25243.20

F-3 Capital Expenditure Actual Month

February 2022	Plan
£0.00	£3594.00

F-4 Cost Improvement Plan (CIP) Actual Month

February 2022	Plan
£392.69	£489.00

F-6 Surplus/Deficit Actual Month

February 2022	Plan
£-308.50	£-885.10

F-7 Cash Position Actual Month

February 2022	Plan
£53937.00	£22217.52

*Values in '000

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

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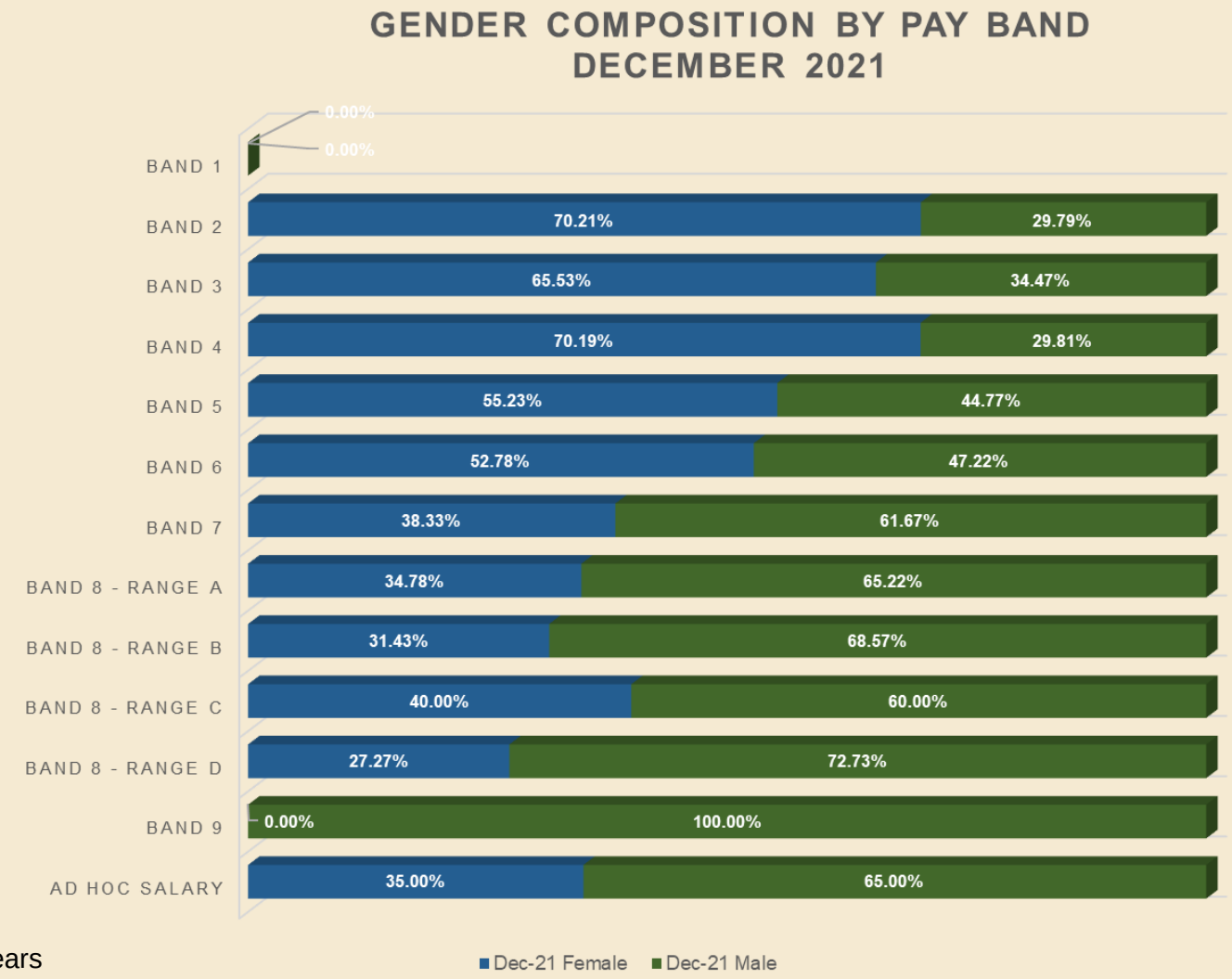

NB: Data is pulled quarterly in arrears

National Benchmarking
999 Emergency Ambulance Service (February 2022)

Key indicators at a glance for February 2022

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	00:01:08	00:01:01	00:02:38	00:00:03	00:00:04	00:00:52	00:00:22	00:00:00	00:02:47	00:03:40	00:00:02	00:00:12
Calls Answered	764252	70221	76105	73569	1578	126749	32564	101101	44720	88359	87084	62202
Mean Call Answer Time	00:00:22	00:00:16	00:00:52	00:00:05	00:00:05	00:00:13	00:00:09	00:00:03	00:00:46	00:01:14	00:00:03	00:00:05

Incident Proportions (Over All Incidents)	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	644006	56141	62683	57917	2165	93099	33144	84645	46828	61055	82701	63628
C1 Incidents %	10.49%	7.30%	12.64%	12.38%	5.40%	9.65%	7.91%	13.33%	7.25%	12.24%	9.96%	9.80%
C2 Incidents %	54.24%	53.46%	59.82%	58.03%	44.06%	54.80%	54.08%	50.54%	49.28%	56.79%	52.86%	53.48%
C3 Incidents %	17.97%	25.36%	14.28%	13.64%	32.47%	18.68%	20.03%	15.78%	26.09%	16.71%	16.52%	16.47%
C4 Incidents %	0.64%	0.49%	0.47%	0.18%	1.66%	1.04%	1.23%	0.37%	1.53%	0.19%	0.82%	0.33%

Incident Outcomes	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	11.21%	9.47%	8.57%	11.02%	8.96%	12.27%	9.59%	10.05%	11.38%	11.08%	15.37%	11.00%
See & Convey %	52.65%	56.62%	56.21%	51.62%	58.24%	52.89%	54.21%	53.54%	52.74%	46.77%	48.78%	54.65%
See & Treat %	31.15%	31.19%	32.09%	31.58%	32.24%	31.24%	26.85%	29.29%	33.75%	38.41%	29.88%	27.07%

Response Performance	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:15:43	00:15:47	00:19:42	00:16:18	00:16:31	00:11:28	00:11:54	00:14:29	00:16:03	00:21:04	00:14:17	00:15:13
90th Centile Response Time: C2	01:31:54	01:06:24	01:57:05	01:41:47	00:51:03	01:22:05	00:55:19	01:18:50	01:02:49	03:20:06	01:11:51	01:03:41
90th Centile Response Time: C3	05:30:21	05:34:59	07:29:54	06:26:43	02:54:12	04:23:58	02:58:23	04:26:48	04:50:46	10:32:57	05:55:34	03:15:59
90th Centile Response Time: C4	06:52:23	07:49:44	07:32:45	06:04:37	03:45:57	07:31:04	02:58:38	09:45:19	06:03:48	09:10:53	07:52:50	04:11:47
Mean Response Time: C1	00:08:51	00:08:43	00:10:43	00:08:56	00:08:32	00:06:47	00:06:37	00:08:23	00:08:51	00:11:39	00:08:11	00:08:45
Mean Response Time: C2	00:42:07	00:32:16	00:53:44	00:48:19	00:25:45	00:37:31	00:27:20	00:35:34	00:30:42	01:25:25	00:33:36	00:29:45

National Benchmarking
999 Emergency Ambulance Service Clinical Outcomes (February 2022)

Key indicators at a glance for February 2022

Cardiac Arrest	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Proportion who had ROSC on arrival at hospital %	24.78%	25.09%	21.30%	24.03%	16.67%	25.36%	34.25%	31.03%	15.00%	24.68%	24.29%	22.54%
Proportion who had ROSC on arrival at hospital utstein %	45.27%	47.73%	41.30%	47.92%	0.00%	44.19%	77.78%	50.00%	47.83%	37.25%	43.10%	34.04%

NB: NHSE's most recent publication of national clinical outcomes provides is for February 2022.
Please note the report no longer includes 'proportion of cardiac arrests discharged live'.

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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

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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

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 17 March 2022
Overview of key issues/areas covered at the meeting:	Under **executive escalation**, nothing specific required escalation, but the committee noted the extreme pressure internally and within the wider system. Subject to how this progresses and the information provided from the harm reviews, the committee agreed to call extraordinary meetings to seek assurance that we are doing all we can to keep patients safe. The Medical Director also highlighted the continuing COVID sickness and the confusion / mixed messaging about when there will be a change to PPE guidance, which relates to inconsistencies with what is in place for the NHS compared with the general public. There was one *Management Responses* (related to gaps in assurance from previous meetings): **IPR – NHS Pathways audits** **Partial Assurance** The practice development team undertake audits in line with NHS Pathways and also do tail audits to align with harm reviews. The committee explored the data and levels of compliance and how we triangulate outcomes of audits to ensure they help to make a difference. There is a process to use trends and the relationship with the training department is very good. The committee also challenged the process for how we record actions to test how this had led to improvement against re-audit. Some assurance was provided about this; there is an action tracker in line with what we have for clinical audit actions. A 'management response' was requested to give further assurance on how audit leads to specific actions / improved compliance, including how we identify thematic issues and use the action tracker. The committee noted the positive approach to live audits, which few other ambulance services are doing, and the flexibility shown by the audit team to provide call handling at times of extreme pressure. The committee concluded that there has been good progress made. It takes assurance that audits are being undertaken, but partially assured overall as we haven't seen the detail on actions, learning and outcomes. This is what will come back in May, as a management response. The main *scrutiny items* were as follows: **Impact of Clinical Audit Actions [action 008/21]** **Assured** Firstly, an overall update was provided on the clinical audit plan. The committee is assured with the completion of actions and the overall audit plan. The second part of the paper confirmed the impact of Clinical Audit Actions on Patient Outcomes. The committee noted that the data shows improvement, but some of this was marginal and so it challenged whether greater improvement could be made, for example it wondered if greater improvement could have been made with the audit of management of patients with a suspected fractured neck of femur, as this was over a five-year period since the last audit.

	A new system is being procured to improve how we provide data to local teams where there may be hotspots; at present it is more generalised data. The committee is encouraged by this and noted that this is expected in the latter part of Q1. The committee concluded that it is assured with the effectiveness of clinical audit and the link with clinical education is commended to ensure learning. **IPC Board Assurance Framework Partial Assurance** Committee reviewed the IPC BAF noting there are two principal gaps in assurance; 1. *Monitoring of IPC practice to ensure it is implemented effectively*. The committee noted that the IPR highlights issues such as hand hygiene and deep clean compliance. And at its previous meeting received an assurance paper on this and will review the related IPC improvement plan to ensure we achieve the stated outcomes. 2. *Fit testing.* Some assurance was received on this in the discussion as currently there is no guidance requiring fit testing and so our use of powered hoods ensures we are compliant. A PPE uniform group has been established to ensure effective ongoing controls and assurance. The committee asked the executive to ensure the BAF includes mitigating actions and this will be included in time for the version that comes to the Board. The committee also asked whether the elements of the framework relating to antimicrobial stewardship now applied to the Trust given the introduction of prescribing in 111 and the volume of antibiotics prescribed. The Medical Director confirmed that the Chief Pharmacist was providing oversight and would report back at a future meeting In conclusion, the committee takes partial assurance and has asked for a management response on PPE more broadly. **Serious Incidents Report Partial Assurance** This paper provided an overview of the serious incidents (SI) the Trust has declared during January and February 2022 and an overview of SIs agreed for closure in the period. There were three themed/cluster SIs, two relating to delayed dispatch/attendances and one relating to call answer delay incidents. Going forward, the committee has asked for more detail on learning and outcomes. In the committee IPR dashboard there is a KPI for outstanding SI actions outside of timescale, and the trend is that this is consistently over 100. The reasons for this were explored, which included some actions being unclear and a lack of awareness due to the way some are allocated. As part of the revised report to the committee (to include learning and outcomes) it has asked that more assurance is provided on closing the actions. **Clinical Outcomes – Stroke Services update Assured** This paper provided a summary update on the following: ▪ Stroke transformation within the SECAmb region ▪ Telemedicine (including current research) ▪ Thrombectomy The committee agreed that our work in collaboration with systems is an exemplar. It demonstrates how best to interact to improve services for patients. The committee explored the extent to which patients with suspected stroke get seen quickly when there are queues at emergency departments (EDs), and assurance was

	received that we do a pre alert to those EDs not implementing telemedicine so that patients go direct to the resus department. In conclusion, the committee commended this great work. It recognises the geographic disparity in provision and issues this causes us and noted the shared decision making across the system. It is assured we are doing all we reasonably can for this patient group. **Fleet update – including RTC Assured** A paper was requested to set out the fleet patient safety-related issues, in particular the seatbelt issues and vehicle familiarisation, and the trend analysis on our RTC's following the recent incident in which a member of staff lost their life. With regards seatbelts, minimal operational issues have arisen as a consequence and no patient or staff harm has been reported. A Vehicle User Group forum has been established comprised of Union colleagues, operational managers, fleet, driver training, and driver standards, to ensure we have a clearly governed visibility of risks and control measures, as well as action plans to resolve any gaps we may identify. This will also ensure the Fleet team are focussing on the priority areas. The data related to RTCs confirms we are not an outlier when compared with other Trusts. A Driver Safety Forum with attendees drawn from all Trust stakeholders and our insurers is being established by the Driving Standards Manager to conduct a monthly review of trends by OU and by individuals, ensuring any early signs of driver safety concern are identified and immediately addressed. This will include a regular review of outstanding driver licence validations following the move to the Driver Check automated system that is now live. The committee relayed a concern from some Governors about the space within the Fiats and if this impacted the ability to do CPR in back of the ambulance. It asked for a management response on this specific issue (related to all our fleet) noting that CPR in the back of ambulances is ineffective and so infrequent and that the specification of ambulances is developed through the Carter Review in collaboration with all ambulance services and in consultation with other stakeholders. The executive reinforced this point, explaining that we do still feedback and challenge the national team, with the current seatbelt issue being a live example. The management response will include how we identify issues and feed into the national specifications. In conclusion, this was a really helpful paper and the committee is assured by the process in place to identify and address issues with fleet safety. The committee then considered the **Learning from Deaths Report** from Q1, noting that the number are not significantly different from previous months. We are seeing an increase in advanced care plans. The structured reviews demonstrate good or excellent care in 88% of the cases. The reason for other 12% is generally in initial management e.g. delay in arriving. It is reassuring that no significant harm has been found as a consequence of these delays, but the committee acknowledges the poor patient experience. In terms of learning, the committee noted that this is becoming increasingly challenging; to identify new learning. However, work in underway to try and pick out more patients with learning disabilities and severe mental illness, and target reviews for these groups. The committee is assured by the robust process for the structured reviews and the low incidence of poor care. The learning points are recurring and some there are no easy fixes, such as delays that are outside of our reasonable control. Under the horizon scan part of the meeting the committee received a verbal update on the work to develop the **Clinical Safety Plan;** this will replace the surge management plan. It is a nationally mandated revision to ensure greater clinical focus. The Committee

	requested consideration of a threshold to escalate safety concerns to trigger extraordinary committee meetings (as mentioned above). The Director of Operations agreed to take this away and would report back. Lastly, the committee considered the approach to the **Quality Account**. It noted the timeline and there are no issues to escalate.
Any other matters the Committee wishes to escalate to the Board	**Delivery against Patient Experience Strategy** was deferred and this will come to the May meeting instead. A meeting is being held in late March to review the committee's approach and plan for the coming year.

Southeast Coast Ambulance Service NHS Foundation Trust

SECAmb Board

WWC Escalation Report to the Board

Date of meeting	**17 February 2022**
Overview of issues/areas covered at the meeting:	In review of the **committee dashboard**, taken from the IPR, the committee was satisfied that the key issues are within its current sphere of focus. There was a discussion about how the IPR could be used to identify any hotpots which will be picked up as part of the development work ongoing. **Executive Escalation** At each meeting there is a standing agenda item for the executive to escalate or raise any specific 'live' issues the committee ought to be aware of. There was one issue raised by the Executive Director of HR & OD related to VCOD. At the time of this meeting the outcome of the Government's consultation was awaited and the committee noted that until then the right approach was to keep work on hold and meetings and comms to the essential minimum. There was a good discussion about the support in place for staff who were struggling with this legislation with welfare being provided locally via the OUMs. There was one *Management Responses* (related to gaps in assurance from previous meetings): **EOC/111 Culture – Action being taken Partial Assurance** Following the deep dive in October a paper was received setting out the themes and actions taken in response. Work is ongoing and so the committee is currently not able to quantify the impact fully. However, in relation to the correlation between levels of resource and staff experience, this seems to have improved as a result of the significant number of new call handers recruited in recent months. However, the theme around behaviours and its link to management development is not much different as it is more systemic and will take longer to resolve. A further update will be considered in May. In the meantime, while it was helpful to see the feedback collated and actions being taken, the committee asked the executive to ensure timescales against each action. It also asked for assurance on how the actions will ensure the impact needed to prevent recurrence. **Management of Incidents of Violence and Aggression Partial Assurance** The Head of Health & Safety set out the steps being taken to address violence and aggression, using the NHS Violence Prevention and Reduction Standards. It was helpful to see where we are and to get better clarity on the key gaps. The committee asked the

executive to ensure that we link actions against the gaps and include clear timescales to understand better what is being prioritised. The committee will monitor the action plan and asked that the executive shares progress with staff to reassure them that we are taken action to keep them safe.

Concern was expressed about conflict resolution/de-escalation training and this is critical but yet hasn't been provided in recent years. The executive assured the committee that this is now part of core skills going forward. It also clarified that despite the gap in training, clinicians understand dynamic risk assessment and so can and do use these skills to manage their own safety.

Lastly, the committee noted the progress with the body worn cameras trial and will look forward to the assessment of this when the trial concludes.

There were then a number of *scrutiny* items:

Improving Staff Experience **Partial Assurance**
An update was provided on the approach being taken to improve staff experience, which is informed by a number of sources including staff surveys. The results of the most recent staff survey will be used to ensure there are no gaps in the improvement plan.

The staff survey was again this year a very good marker of engagement with 2594 (out of 4251 eligible) employees completing the survey. This is 61%, slightly below the 63% response rate of 2020, although the total number of respondents in 2021 was the largest in the history of the survey at SECAmb surpassing the 2020 total by 21 responses. The results are due in March.

A staff engagement toolkit has been developed to help local teams understand, communicate, and engage on the improvements they need to prioritise, in their specific areas. This toolkit will also help managers engage better on an ongoing basis.

The committee wasn't sure how well engaged managers will be with the toolkit and so has asked for some information on this in due course. But overall, the steps in place to improve staff experience is really encouraging. It challenged the executive to provide appropriate assurances that the actions will lead to better outcomes as this is all crucial to our success and therefore our 'performance'. This will continue to be a standing agenda item.

Appraisals **Partial Assurance**
The committee asked for assurance on the steps being taken to ensure every member of staff receives an appraisal, given the concerning trend identified in the IPR. The new process looks promising, but the paper lacked assurance on the implementation plan which is due to be reviewed by the Executive Management Board. The implementation started with the HR directorate first to learn early lessons and identify issues with the system before wider roll out.

There is little that can be done to improve appraisal rates for this year (about to end), which are very low, but the Committee did note the apparent disparity with the staff survey results that tend to demonstrate a higher number completed. Management believes this is about recording and steps are being taken to ensure this is corrected.

The committee reinforced that while completion of appraisals is important, quality is paramount and is pleased to note therefore that the new process focusses on improving quality.

The committee particularly noted the risk of operational pressures and the ongoing discussion about abstraction; how do we ensure the time needed to undertake appraisals is prioritised? Therefore, while it supports the new approach which looks effective on paper, there is a gap in assurance in how this will be translated into practice. The committee will closely monitor this to test the effective implementation.

Clinical Education Strategy – Delivery Plan **Assured**
The committee received the structure of the delivery plan and will receive regular progress updates. There is confidence in some elements of the plan but there is much work needed such as operational engagement related to capacity, if for example we were to bring the ECSW plan in house. Some concern was expressed about the bridging course and risk that there will not be enough take up. And a risk about the perception of clinical education within trust, so getting clinical educators of high calibre will be a challenge.

The committee explored how clinical education sits within the wider Education Training and Development and the executive are working this through as part of Better by Design.

Overall, the committee is assured by this comprehensive plan and will seek ongoing assurance on its implementation.

The committee received an update on the "**Until It Stops Campaign**" which includes the steps to prevent sexual harassment at SECAmb. There is a soft launch which acknowledges this will be a long-term approach that needs to be sustained to ensure real change in behaviours. The key element is about education and training both in terms of how to behave and how to speak up. The approach acknowledges the problem, sets out the method for change and how this is intended to achieve the goal to eliminate sexual misconduct and harassment in the workplace.

The committee really welcomes this campaign. It noted that one measure of effectiveness will be an increase in reporting. The new appraisal system mentioned earlier focusses equally on behaviours than performance, so there will be consequences.

The final section of the meeting was the *Forward Look / Horizon Scan*. Here the executive updated the committee on **Staff Health & Wellbeing**. It noted the following:

	• Review of the current strategy/structure • Following approval of the Business Case progress initiatives funded by the £155k NHSEI Volunteer Funds. • To review and complete the updated NHS Framework exercise and to implement a 10-step action plan provided by ACCE for all ambulance Trusts. • To launch the Wellbeing microsite Q4. • To publicise and promote the wellbeing conversation templates • To embed a robust suicide postvention process. The committee supported all of this work. There is much going on and lots of effort and focus on the wellbeing of our people. The committee also discussed **organisational development and change**, specifically the role of the committee in overseeing the integrated OD project via Better by Design.
Any other matters the Committee wishes to escalate to the Board	At this meeting Maisy, **HR Graduate Management trainee at SECAmb,** joined to talk about her experience of the programme at SECAmb, which started in September. She provided a really helpful overview of what has been to-date a positive experience. This is really good for Trust to host graduate trainees. The committee felt we needed to do more to encourage trainees to experience the Trust and to make sure our 'people with potential' are able to gain experience of other organisations.

Southeast Coast Ambulance Service NHS Foundation Trust

SECAmb Board

WWC Escalation Report to the Board

Date of meeting	**25 February 2022**
Overview of issues/areas covered at the meeting:	This was an extraordinary meeting to focus primarily on workforce planning (to help balance supply with demand) and training and development. The Board is aware of the tension between abstraction and training and development, which is one of the BAF risks, and this meeting explored how we are considering and managing this. Given the link with performance, members of the Performance Committee were invited to attend. **Training & Development Partial Assurance** A paper was received baselining the training and development requirements for operations, in the context of the tension there is with abstraction, which has been running higher than what we are budgeted for. The key drivers are sickness and other (non-planned) leave, along with self-isolation. The approach taken by the executive is to focus on the specific components of abstraction as each requires different management approaches. This links directly to the resource we can provide to meet the demand on our services and so each component is being assessed as a 'cost pressure' (not financial but in relation to hours) so that it can be better quantified and inform decisions, accordingly. The committee welcomed this approach, noting that in the recent past when there are significant operational pressures training is the first thing we stop. While it is always a difficult balance, this has consequences in a number of areas. The committee challenged the data underpinning this analysis and received assurances that the executive is now much more confident in the data. The next step is to map each component against the relevant policies / operating procedures and some of this will take as much as 12-24 months. This is why the executive are developing different strategies for the different areas. The two areas of assurance the committee will continue to seek are: ▪ how we protect training and development from being the first thing to stop when we have operational pressures, given the historic training and development gap that has been identified as a root cause of a number of key issues linked to 'culture'. ▪ Notwithstanding the longer-term approach needed to ensure sustainable changes, we have clarity on how we will ensure a deliverable training and development plan this year. The committee supported the approach to develop a plan over a multi-year cycle, and to really maximise the various modes of delivery. The executive has established a new Education Training and Delivery Group that will oversee all of this.

The committee acknowledged that the next 12 months will be a transition period; the analysis provided took four months to pull together, which highlights the complexity, and this is just the scoping. However, it does provide a much better understanding and the next step will be to consider the implications and development of a sustainable plan.

Overall the committee is assured we are moving in the right direction, but there are gaps in assurance related to having a robust plan and the current and likely ongoing operational pressures.

Operations Sickness Absence Plan Not Assured
The committee reflected that sickness management is a key driver for managing abstraction and therefore the ability to ensure training and development. There is a plan in place and while the committee accepts some of the outcomes will take longer to be achieved, the evidence suggests that the actions, to date, have had minimal impact.

Linked to previous discussion about management training the committee explored the extent to which managers are equipped to effectively manage sickness and is there appropriate HR support. There was some positive evidence provided such as an increase in referrals to OH.

The committee is currently not assured that the sickness management plan is effective. It has asked for regular updates in the coming year so it can track progress and test what can reasonably be expected, e.g. what the measures of success will be.

Workforce Plan Assured
A good paper was received outlining the approach to workforce planning from 2022/23, starting with a review of the baseline, so that we establish what will be a realistic recruitable and trainable workforce that balances performance and challenges related to training etc. This has informed how the plan can be delivered, noting the assumptions and risks. It will also inform the commissioning discussions. With regards the need for rota development to better match the demand profile, the committee sought assurance that we will engage staff and unions.

The committee concluded that we have a good integrated process and approach to workforce planning, which includes - core forecast scenarios; planning assumptions; methodology modelling; workforce requirements; and a financial impact assessment.

Gender Pay Gap
Overall, this is a mixed picture, some improvement, some worsening. We are seeing a larger variance at the lower end of the pay scales, where males are under-represented. We need more females at the upper end of pay scales and so need to look at recruitment processes and any unconscious biases.

	The committee supported the recommendation to start reporting on ethnicity pay gap and will consider a paper on this in due course, setting out a suggested approach. The committee is realistic on how quickly we can start to make changes in some of these areas, such as the gender imbalance in operations in senior roles. This will require a long-term approach. There was support for talent management targeted at females and going to some female-only shortlists, in the higher pay bands.
Any other matters the Committee wishes to escalate to the Board	There was a good set of papers, with good data informing intelligent analysis. The issues are being seen as integrated and we are getting better at anticipating where they link to other parts of the business. The approach to this meeting worked well and so it may be worth considering using joint committee meetings more, so as to reduce the load on executives and to ensure all aspects of complex issues are adequately scrutinised and commented upon.

SECAMB Board

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

Date of meeting	22 March 2022
Overview of key issues/areas covered at the meeting:	**Month 11 - Financial Performance Assured** We are reporting a deficit of £0.4m in month 11, £0.5m better than plan; this takes the reported cumulative deficit to £9.9m, which is £0.9m better than plan. There are no significant remaining risks to delivering the financial plan in the current year, but there remain significant uncertainties for next year. Cost improvements to date are £3.0m against a target of £5.4m; the adverse position can be partly explained by operational pressures, but significant changes are needed in the Trust's approach to efficiency savings. FIC noted circa 40% are non-recurrent CIPs which reinforces that we are currently too transactional. The committee challenged the executive to approach efficiencies more systemically. The cash balance at the end of February increased to £53.9m; this remains significantly above plan due to a combination of favourable factors, including proceeds from property sales. The committee is satisfied that this is a simple consequence of a range of factors that weren't reasonably foreseeable. Despite the risks from 2022, the committee is assured with the way the finances are planned and managed. **Financial Planning Partially Assured** The committee has an integrated discussion about planning scenarios and financial planning. The paper summarised the current annual planning scenarios and associated enabling plans and key risks. There are four scenarios that are being discussed with commissioners. Our preferred and most realistic option is where we recruit and maximise our resources as much as possible through current HR and Clinical Education capacity, whilst also delivering operational efficiencies with the system of up to 8% by the end of the year. Modelling shows this would improve performance. However, we would still not consistently hit our performance targets in 22/23 and financial sustainability would be compromised. In fact, each of the scenarios results in a deficit, based on the latest indicative funding levels from the ICS. This is after assuming between £7-8.8m of cash-releasing efficiency savings. There may be some funding flexibility within the system, but it is highly unlikely that this would eliminate the circa £31m projected deficit under the 'most likely' scenario. It is also unrealistic to assume this could be mitigated through additional efficiency savings. The committee is assured by the clarity of the analysis and the approach which is about having a financial plan to deliver quality. Some of issue is in how far we and the ICS can plan ahead, which links to the BAF risk on having a robust long term financial plan. While the committee accepted the analysis, it noted the need to be open about the challenges, and if we are not able to agree a plan that achieves ARP then we need to

	show an improvement trajectory that takes account of peaks in demand such as winter. In other words, the committee agreed the plan is realistic but is not where we would ideally want it to be. The Board should note also that the likely scenarios include very stretched targets which place much reliance on people / recruitment. The executive acknowledges there are risks throughout and it has been very clear about this; the plan clarifies where we need to focus our efforts to give us best chance of delivery. A management response was requested to give assurance that we can report clearly against the enabling programmes that are underpinning the planning scenarios. The committee also asked about the engagement plan and the extent to which the executive is clear who the key stakeholders are to make this work. It suggested that a draft engagement plan is presented to the Board in April. In the meantime: ▪ Contract negotiations with commissioners are ongoing – we note the genuine funding constraints ▪ Baseline planning assumptions have been developed ▪ A range of planning scenarios has been modelled; the key variables are availability of funding, level of operational performance, efficiency improvements and the Trust's appetite for another year of financial deficit ▪ The underlying position and implications for contract discussions and longer-term planning will be assessed in due course ▪ Good progress has been made in building budgets from 'bottom up' When the budget is presented to the Board, we need to acknowledge we are responsible for financial management and delivery of safe and effective patient care. Therefore, we will need to be clear what we are funded to deliver so the Board can agree what it is acceptable. In conclusion the committee is assured with the approach and process of planning in so far as what is within our control, however, it can only be partially assured until we are clearer about outcomes. The committee supported the proposed five-year **capital plan** for 2022/23 to 2026/27, subject to funding. Separate business cases will come through in the usual way. A paper was also considered giving the progress on all our current property **disposals** with a total sales value of c£14m. The committee explored the issues and mitigations in place re Banstead OU; where it is proving particularly difficult to secure new ACRPs due to the lack of suitable properties in the right locations to replace the existing Ambulance Stations. The **business cases** that the committee recommend to the Board for approval are: ▪ <u>SORT Enhancements</u> This is a requirement and is fully funded.

	▪ DCA Replacement This gives us an over-arching direction for fleet replacement and separate business cases will follow. The aim is to replace 80 DCAs per year, subject to available funding, and get to a 5-year replacement cycle. ▪ OTL Establishment This increases the establishment in line with what has previously been agreed - 18 staff per OTL. There was a separate discussion about how the Board obtains ongoing assurance that middle managers are equipped and supported to deliver change needed over time, noting the work of the workforce committee in this regard. ▪ Frontline Ops – COVID Costs This if fully funded and the business case sets out how we have used the funding.
Any other matters the Committee wishes to escalate to the Board	This was another good meeting with constructive debate and exploration of important issues. The papers were of a good quality.

SECamb Board

Summary Report on the Audit & Risk Committee

Date of meeting	**10 March 2022**
Overview of issues/areas covered at the meeting:	
External Audit	The committee received an update on the **external audit plan** for 2021/22. There continue to be no significant issues to flag.
Internal Audit	The committee confirmed the internal audit plan would be concluded in time for year-end. Three **Internal Audit Reviews** were considered at this meeting. Reasonable Assurance was provided for 'financial forecasting and management', and for 'recruitment and visa's'. There was however a Partial Assurance outcome for 'fleet management', primarily as a result of the Trust not using the information from the fleet system as effectively as it could to drive productivity. The management actions to rectify this have been agreed and some have already been completed; for example there is now new fleet data included in the IPR. Although the outcome of this review was below the line, it is an example of good governance as management had identified an issue and asked Internal Audit to help shape the improvement plan. The committee supported the **2022/23 audit plan** and noted the positive **draft 2021/22 Head of Internal Audit Opinion** for governance and risk management.
Counter Fraud	The committee received a helpful progress report against the annual plan. The committee continues to be assured we are in a strong position and the annual assessment does not identify any significant gaps.
Annual Governance Statement (AGS)	A review of the headline issues to be included in the years AGS was undertaken, with feedback given the Chief Executive, including the need to ensure there is a look forward, in addition to looking back.
Self-Rostering Controls	This was a management response, requested by the committee earlier in the year to obtain assurances that we are taking effective measures to improve the management of self-rostering of Operational Team Leaders (OTLs) within Field Operations. This was following a negative audit review in early 2021. The committee was content with what has happened in recent months and asked for ongoing assurance to be obtained via the workforce and wellbeing committee.
Whistleblowing	Overall, the committee is assured with the controls in place to ensure there are adequate mechanisms to support staff to speak up when they have a concern. There was a good discussion about how we use freedom to speak up (FTSU) and in particular, the FTSU Guardian. We are able to demonstrate that people do speak up but work is needed to ensure the right channels are always used, for example, using the line management structure for management-related issues. The committee noted the review by the workforce and wellbeing committee on this specific issue, as reported to the Board in

	January.
Risk Management / BAF	The committee supports the revised risk management process that is due to be implemented from April 2022, noting the importance of the training element to ensure it is effective. The committee also reviewed the BAF risks, and how they are aligned to the work of Better by Design.
Other matters	There was an update on the new **payroll system** that appears to have been implemented effectively. A detailed paper will come to the next meeting in May.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Learning from Deaths Report – Quarter 1 – 2021/22

1.0 Introduction

1.1 When deaths occur, it is important that we review the care to understand if there is anything that we could have done differently before the death, during the death or following the death. This review of care should then improve future care. If carers, relatives, staff or other organisations raise concerns to SECAmb, about the care of a patient at the time of their death, they will be fully involved in any review of the death.

1.2 SECAmb Trust Board approved the Learning from Deaths Policy in November 2019. This policy sets out the national standards of randomly reviewing the care of 20 patients per month (from across the 10 Operating Units) and must include deaths during a C1/C2 delayed response, deaths during a C3/4 delayed response, deaths following hand over of the patient to another provider and deaths where the initial decision was to leave the patient at home and then they subsequently died.

1.3 There are additional statutory requirements to provide information to the Child Death Overview Panel for all children who die, a requirement to report deaths of people with Learning Disabilities to LeDeR (Learning Disabilities Mortality Reviews), a requirement to report all deaths of people with serious mental health conditions to their mental health trust and a requirement to report all obstetric incidents (which meet their criteria) must be reported to the Healthcare Safety Investigations Branch (HSIB).

2.0 Overview of Quarter 1 (21/22) mortality data

2.1 Table 1 shows the total number of deaths per month broken down into sex. Where the sex of the patient has not been recorded or staff have been unable to identify the sex, this is categorised as 'unknown sex'.

Table 1

Month (2020)	Female	Male	Unknown	Total Deaths	Month (2021)	Female	Male	Unknown	Total Deaths
Jan	277	377	7	661	Jan	406	543	0	949
Feb	265	369	4	638	Feb	286	378	1	665
March	285	413	9	707	Mar	248	383	0	631
April	341	466	11	818	Apr	254	366	0	620
May	265	347	5	617	May	207	335	1	543
June	214	325	13	552	June	204	323	1	528
July	223	367	2	592	July				
Aug	266	370	3	639	Aug				
Sept	204	333	3	540	Sept				
Oct	240	354	0	594	Oct				

Nov	225	380	1	606	Nov				
Dec	334	464	0	798	Dec				

2.2 Table 2 shows the breakdown of the number of people who died in each age bracket:-

Table 2

Age Range (Yrs)	**No. of patients who died – April 2021**	**No. of patients who died – May 2021**	**No. of patients who died – June 2021**
Under 1 year	2	2	
1-2			
2-3			1
3-4	1		
4-5			
5-6			
6-7			
7-8			
8-9			1
9-10			
10-11			
11-12			
12-13			
13-14		1	
14-15		1	1
15-16			
16-17	1	1	
17-18		2	1
18 – 29	14	12	7
30 – 39	16	17	16
40 – 49	38	28	33
50 – 59	71	74	53
60 – 69	97	86	73
70 – 79	132	109	118
80 – 89	167	130	145
90 – 99	72	72	66
100+	6	2	0
Age unknown	3	6	11

2.3 Table 3 shows the numbers of patients who had an Advance Care Plan (ACP)/Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, those who were 'dead on arrival' and those on whom we attempted resuscitation:-

Table 3

	No. of patients who died – Apr 21	**No. of patients who died – May 21**	**No. of patients who died – Jun 21**
Dead on arrival	263	228	202
Resuscitation attempted	197	182	171
Advance Care Plan/Do not attempt resus (DNACPR)	143	116	125
Professional Decision not to Resuscitate	16	15	26
End of Life	1	2	2

3.0 Review process

3.1 In accordance with the Trust's Learning from Deaths policy, 20 random cases have been selected to be reviewed per month (60 reviews per quarter). The 20 cases were from across the 10 Operating Units. The Structured Judgemental Review (SJR) is the nationally approved review process and SJRs were carried out on the 60 cases.

3.2 The Executive Medical Director, Deputy Medical Director, Assistant Medical Director (Critical Care), Assistant Medical Director (Urgent Care), both Consultant Paramedics (Urgent Care), Associate Director of Quality and Compliance and the End of Life Care Lead undertook the reviews.

3.3 Table 4 shows the outcomes of the Structured Judgemental Reviews of the 60 randomly selected deaths in Quarter 4 20/21.

Table 4

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	41 (68%)	9 (15%)	3 (5%)	6 (10%)	1 (2%)	0 (0%)
On scene handling (Care)	57 (95%)	2 (3%)	1 (2%)	0	0	0
Transfer and Handover (Including discharge and worsening care advice)	18 (30%)	0	0	0	0	42 (70%)
Other Aspects of Care (quality and legibility of records)	48 (80%)	7 (12%)	4 (7%)	1 (2%)	0	0
Overall Assessment of Care	44 (73%)	9 (15%)	3 (5%)	4 (7%)	0	0

3.4 Trends of poor care over previous quarters

3.4.1 The Trust's Quality and Patient Safety Committee of the Trust Board requested further detail of trends of 'poor' or 'very poor' care over previous quarters.

3.4.2 Table 5 shows the number of times that care was found to be 'poor' or 'very poor' in each phase of care provided (initial, on scene, transfer, other and overall).

Table 5

	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Poor Care	16 (5%)	6 (2%)	11 (3.7%)	11 (3.7%)
Very Poor Care	1 (0.3%)	0	2 (0.7%)	1 (0.3%)

3.5 Learning from each phase of care

Most judgemental reviews undertaken identified good or excellent care. Of particular note is the level of compassionate care provided to families and carers. There is some identified learning from each phase of the care as detailed below:-

3.5.1 Initial Management

In the 10 cases where care was seen to be 'adequate', 'poor', or 'very poor' there was a delay in reaching the scene. The majority of calls are classed as Category 1 and should receive a response within 7 minutes. This corresponds with the wider NHS system pressures at that time. For most of those incidents where the Trust has taken longer than 7 minutes to arrive on scene, the reviewers have not identified any significant harm caused to those patients as they were either already dead or were receiving adequate bystander CPR/defibrillation. The 'very poor' care related to a 45 minute response time to a Category 1 call to a 77 year old gentleman with cancer who was having difficulty breathing and had sadly died when the crew arrived on the scene. The reviewers also assessed the likelihood of success of resuscitation if the crews had arrived any earlier and felt that in the majority of cases, the outcome is unlikely to have been any different.

3.5.2 On Scene Handling

1 case was reviewed as being adequate care. This was related to the dates being incorrect within the electronic Patient Care Record (ePCR) indicating that the wrong patient details had been recorded in the Emergency Operations Centre (EOC) and subsequently the details were not checked by the attending crew.

3.5.3 Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying. There were no cases of adequate or poor care during hand over this quarter.

3.5.4 Other aspects of care (including documentation)

There were five patients where the care was described as 'adequate' or 'poor'.

The patient identified as receiving poor care was related to an 80 year old gentleman who has received a 54 minute response to a Category 1 call. The care was judged as poor because the ePCR was not completed thoroughly enough and no rationale described for why resuscitation was not started on arrival.

3.5.5 Overall Care

The seven cases identified as overall 'adequate' or 'poor care' were directly related to the cases already discussed in the sections above.

3.6 Avoidability

For each Structured Judgemental Review a decision is made on whether the death could have been avoidable. If the death could have been avoided, a Serious Incident is declared and then investigated.

3.6.1. Table 6 shows the outcome for the avoidability of death reviews undertaken.

Table 6

	No of reviews
Definitely Avoidable	0
Strong possibility of avoidability	0
Probably avoidable (more than 50:50)	0
Probably avoidable but not very likely (less than 50:50)	1
Slight evidence of avoidability	8
Definitely not avoidable	50

4.0 Referrals to the Learning from Deaths panel

4.1During this reporting period, there were two incidents referred to the Learning from Deaths panel for review.

4.2 The first case was from April 2021. A 73 year old lady had called 999 for dizziness and weakness which had resulted in a fall when out shopping. The crew had fully assessed her and she had recovered fully by the time the crew arrived. She was advised to contact her GP to discuss the symptoms she had suffered. We received another call to 999 less than 24 hours later as the lady was now in cardiac arrest. Following a review of all the records it was felt that the first crew had made the correct decisions and that it would have been difficult to predict that this patient would deteriorate within 24 hours.

4.3 The second case was from June 2021. A 94 year old man had contacted his care line and as he had picked a scab from his leg and it was bleeding. The call was categorised as a Category 2 call and the Trust took 53 minutes to arrive to the scene. Sadly when the crew had arrived, the patient was already dead and had lost 1,500mls of blood from the wound site. The patient was on ‘blood-thinners’ which is not taken into consideration during an NHS Pathways triage when categorising a call. Following thorough assessment, it was concluded that if the Trust had arrived on scene within 17 minutes there is a chance that the crew may have been present when the patient went into cardiac arrest, however, due to the age of the patient and the co-morbidities he was suffering, it is unlikely that resuscitation would have been successful.

5.0 Learning from the random review of 60 deaths

6.1 In the majority of the 60 reviews undertaken, the care of the patient good or better. In most cases, our policies were correctly followed, thorough history taking was completed,

examinations were robustly recorded and the outcomes for the patient were clearly documented.

6.2 In a small number of reviews there was a delay in attending the patient. The reviewers have not found evidence that these delays significantly impacted on the outcome for most of the patients, however two cases were identified where a delay to a Category 1 and a Category 2 call may have impacted on the outcome for the patient.

6.3 Crew members are making sensible and compassionate judgements when talking to relatives and carers about resuscitation attempts and are clearly documenting these conversations.

6.4 Support from Operational Team Leaders (OTLs) and Critical Care Paramedics (CCPs) in the management of complex arrests is clearly documented and it is evident that everything that could be done to save life is being attempted.

6.5 As in the previous quarterly report, from the way that we collect the data on deaths, we need a clearer process to identify those patients who have a mental health condition or learning disability. All these patients who have died should be referred to the LeDeR programme for review or those with mental health conditions we should notify their mental health Trust, but we currently don't have an automatic recognition system in the software to advise us of these deaths. A review of our electronic Patient Care Record (ePCR) is currently being performed and this issue is included in the review.

6.6 Consistent with other ambulance trusts, we do not have a system to identify patients who have died within 24-48 hours of admission to hospital to be able to review their pre-hospital care. NHS Improvement are looking into ways of identifying these patients.

6.0 Conclusion

The panel have identified many examples of very good compassionate care. Delays in getting to the patient continues to be the leading cause of concern related to care of people at the end of their life or care of relatives when the patient

7.0 Actions resulting from the review of deaths from Quarter 4 20/21

Action	**Who?**	**Update/Date**
Raise issue of Primary Care planning for end of life care for patients at the EOLC regional groups	Trust End of Life Care Lead	April 2022 - **COMPLETE**
Learning from Deaths Group to issue advice on 'when not to start resuscitation' to provide greater clarity for crews.	Learning from Deaths Group	April 2022 – **COMPLETE**

Learning from Deaths Group to provide guidance on the use of photos of the deceased within the patient records.	Learning from Deaths Group	April 2022
Learning from Deaths Group to review the use of the Cardiac Arrest Form due to a number of incidents reviewed having no form completed.	Learning from Deaths Group	April 2022 - **COMPLETE**
Raise the issue of patients on 'blood-thinners' currently not being taken into consideration during triage.	Issue to be escalated to NHS Pathways.	**COMPLETE** – NHS Pathways have agreed to review their triage process for patients on 'blood-thinners'.

Dr Richard Quirk
Deputy Medical Director
February 2022

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	84-21

Name of meeting	Trust Board
Date	31.03.2022
Name of paper	IPC Board Assurance Framework Version 1.8
Executive Lead	Executive Director of Quality & Nursing
Synopsis	The Infection Prevention and Control Board Assurance Framework was introduced last year by NHS England, to support providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The framework helps to assess the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards. Using this framework is not compulsory, however, SECAmb has been using it for the past 18 months. Some changes have been made since the version last seen by the Board and these are highlighted in yellow.
Recommendations, decisions or actions sought	For assurance.

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

Infection Prevention and Control board assurance framework

1. **Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on the pathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation	**N/A** **N/A** **N/A** **N/A**		

rooms/units as part of the Trusts winter plan.			
• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Working Safely Guidance in place and always adhered to. Any breeches are managed by the COVID Management and IPC Teams.	None	
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are:			
○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area.	Ambulance specific hierarchy of controls are in place to match the ambulance setting.	None	
○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE.			
○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Regular updates are provided to staff via the 16-00 calls and email.	None	
• if the organisation has adopted practices that differ from those recommended/stated	**N/A**		

in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.			
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	Reports provided via the COVID Management Group (CMG).	None	
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Yes, during any site visits.	None	

• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Local Managers are responsible for monitoring compliance to PPE guidelines and report any breaches via the Trusts DATIX incident reporting system.	Need to hold local leadership meetings to discuss any issues with IPC Practices.	The IPC Team are planning bi-monthly visits to each area across the Trust to ensure adherence to IPC Practices are in place locally.
• the application of IPC practices within this guidance is monitored, eg: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination.	The IPC Team along with local IPC Champions visit local hospital sites to undertake spot checks for IPC compliance.	Limited time for IPC Champions to carry out these tasks	The IPC Team will incorporate IPC Champions into their planned visits as described above. Any gaps will be reported back to the local management teams.
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	The Head of IPC updates the framework as required and in line with national timeframes.	None	
• the Trust Board has oversight of ongoing outbreaks and action plans.	Via CMG	None	
• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	The Trust has supplied Powered Hoods to all patient facing staff.	There is still a need to provide staff with an alternative FFP3 option. This will also require further fit testing for staff and is being discussed for a solution.	The newly formed Uniform / PPE Working Group will review the current situation and put in place any required future workstreams to ensure this is fully compliant. The first meeting is scheduled for the 29th April 2022.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Managed by the Estates Team with input from IPC	None	
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Change proposal process in place with Estates Team	None	
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Audit plan in place and reports into the IPC Team for any compliance issues.	None	
• increased frequency of cleaning should be incorporated into the environmental	All three call centers have increased the frequency for environmental cleaning.	None	

decontamination schedules for patient isolation rooms and cohort areas.			
• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Decontamination procedure in place for all clinical areas of the Trust.	None	
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Standard cleaning products are in place and used in line with the decontamination procedure.	None	
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Yes, and information forms part of the decontamination procedure.	None	
• a minimum of twice daily cleaning of: ○ patient isolation rooms. ○ cohort areas. ○ Donning & doffing areas ○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. ○ where there may be higher environmental contamination rates, including:	Only in the call centers as not required on other Trust sites. Staff are instructed to follow decontamination procedures as described in the Trusts IPC Manual for Procedures. This includes repair and servicing decontamination processes	None None	

▪ toilets/commodes particularly if patients have diarrhoea.			
• A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ○ following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	**N/A**		
• reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	As per the decontamination for re-useable equipment procedure.	None	
• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Local management and the Make Ready Teams hi-light any		

	non-compliance issues via DATIX		
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	All patient transport vehicles meet the recommendations.	None	
• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	**N/A**		
• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**N/A**		
• where possible air is diluted by natural ventilation by opening windows and doors where appropriate	**N/A**		
• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	**N/A**		

• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	**N/A**		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing. ○ to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements is adhered to, and boards continue to maintain oversight • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	The Trust doesn't have a mandatory reporting requirement for antibiotics. However, we do review all antibiotic use via our internal Medicines Team and PGD Group meetings.	None	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			

• Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• visits from patient's relatives and/or careers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	**N/A**		
• national guidance on visiting patients in a care setting is implemented;	**N/A**		
• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	**N/A**		
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	**N/A**		
• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. 8 |	**N/A**		

Infection prevention and control board assurance framework			
• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	**N/A**		
• visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	**N/A**		
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Signage and posters are in place in all areas of the Trust.	None	
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-	Reviewed and adapted for ambulance service use by the IPC Team	None	

behaviours-imp-toolkit.pdf (england.nhs.uk)			
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people - Not Applicable to Ambulance Services			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for triage questions to ask; • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any			

patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. • patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.			

• patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all			

patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.			
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	The IPC Team provide training to all levels of staff via face to face or workbooks. All staff have access to the latest guidance and continue to complete level 1 and 2 IPC annual training via a workbook.	None Possible gap with FFP3 fit testing due to the use of Powered Hoods None	As described in section 1.

• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Managed via the IPC Team and CMG	None	
• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Level 2 PPE advised for all patient contacts in the ambulance service.	None	
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	**N/A**		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	As per Working Safely Guidance.	None	
• staff understand the requirements for uniform laundering where this is not provided for onsite.	Uniform Procedure provides staff with the latest guidance.	None	
• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Action Cards available to all staff that provide guidance on all COVID-19 latest guidance.	None	
• to monitor compliance and reporting for asymptomatic staff testing	Test and Trace Team in place and lead on all staff cases / concerns.	None	

• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC Team attend regional calls on a weekly basis and update the Trust as required. **N/A**	None	

7. Provide or secure adequate isolation facilities – Not Applicable to Ambulance Services			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.			

• patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased			
8. Secure adequate access to laboratory support as appropriate – Not Applicable to Ambulance Services			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals; • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance; • regular monitoring and reporting of the testing turnaround times with focus on			

the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); • screening for other potential infections takes place; • that all emergency patients are tested for COVID-19 on admission; • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission; • that sites with high nosocomial rates should consider testing COVID negative patients daily; • that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge;		

• that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission. • there is an assessment of the need for a negative PCR and 3 days selfisolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all	IPC audit tools available via the BI platform.	No time allocated to IPC Champions to carry out tasks. OTL's have limited	As described in section 1.

staff (permanent, agency and external contractors). •		time to support due to operational pressures.	
• staff are supported in adhering to all IPC policies, including those for other alert organisms.	Yes, via regular updates and training sessions.	None	
• safe spaces for staff break areas/changing facilities are provided. staff are supported in adhering to all IPC policies, including those for other alert organisms;	As per Working Safely Guidance	None	
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak management Framework in place and the IPC Team oversee this process.	None	
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	All compliant with latest guidance.	None	
• PPE stock is appropriately stored and accessible to staff who require it.	Push pallet system still in place across the NHS and no issues at this time.	None	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			

• staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Fully compliant.	None	
• bank, agency, and locum staff follow the same deployment advice as permanent staff.	All latest procedures and guidance are shared with private providers and bank staff.	None	
• staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Latest guidance for self-isolation fully adhered to.	None	
• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Yes	None	
• a fit testing programme is in place for those who may need to wear respiratory protection.	Pending discussions as the Trust use a Powered Hood currently for FFP3 compliance.	Possible gap with FFP3 fit testing due to the use of Powered Hoods	As described in section 1.
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness and absence. o facilitate access of staff to antiviral treatment where necessary and implement a vaccination	This is managed by the IPC Team as not part of the Occupational Health contract.	None	

programme for the healthcare workforce o lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 o encourage staff vaccine uptake.			
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance	Fully compliant	None	
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; o that advice is available to all health and social care staff, including specific advice to those at risk from complications. o Bank, agency, and locum staff who fall into these categories should follow the	Completed	None	

same deployment advice as permanent staff. o A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as advised by occupational health/public health. • staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods. • that where fit testing fails, suitable alternative equipment is provided.	Fully compliant As described previously, Powered Hoods used within the Trust at this time. Previous fit testing was carried out but will need updating and will form a future plan to ensure full compliance to the national guidance.	None Need to discuss future plans for FFP3 compliance within the Trust.	As described in section 1.

Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	**N/A**		

• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work	Working Safely Guidance in place across all parts of the Trust. Test and Trace along with HR ensure this area is being managed. As above	None None None	

	Item No	85/21
Name of meeting	Trust Board	
Date	31.03.2022	
Name of paper	Gender Pay Audit as at 31st March 2021	
Executive sponsor	Ali Mohammed, Director of Human Resources and Organisation Development	
Author name and role	Asmina Islam Chowdhury, Programme Lead, ED&I	

This paper provides assurance that the Trust is meeting its legislative duties in publishing its annual Gender Pay Audit.

The paper also provides detail and analysis of the audit as well as details of actions to be undertaken to help address the disparity.

Gender Pay Gap Report

1. Introduction

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

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

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

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

2. What does the audit cover?

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

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

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

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

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

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

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

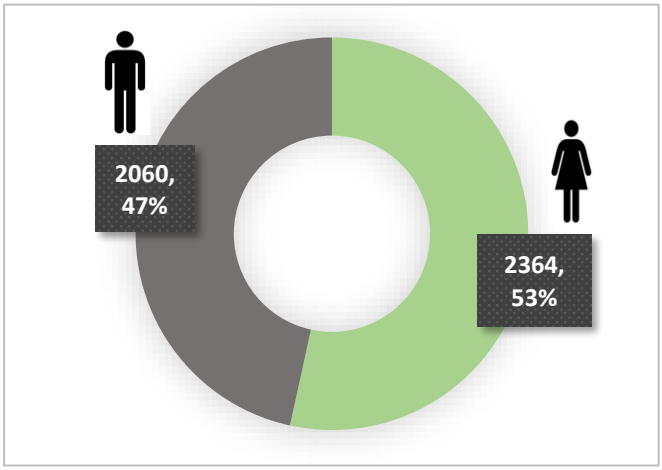
- **Proportion of males and females receiving a bonus payment** – total males and females receiving a bonus payment divided by the number of relevant employees.

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

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

3. Our Gender Pay Gap data

3.1. Our data for this submission is **as at 31st March 2021**, when the Trust workforce consisted of 2,364 females (53%) and 2060 males (47%), totalling 4,424 employees.



There was a 10% increase in our workforce between 31st March 2020 and 31st March 2021. In the same period, the Trust had 12% increase in the number of women in the organisation overall compared to 7% increase for men. However, females made up 62% (286) of leavers for this period with the most common reason given being work life balance.

Our workforce gender profile continues to see a growth in the number of females year on year.

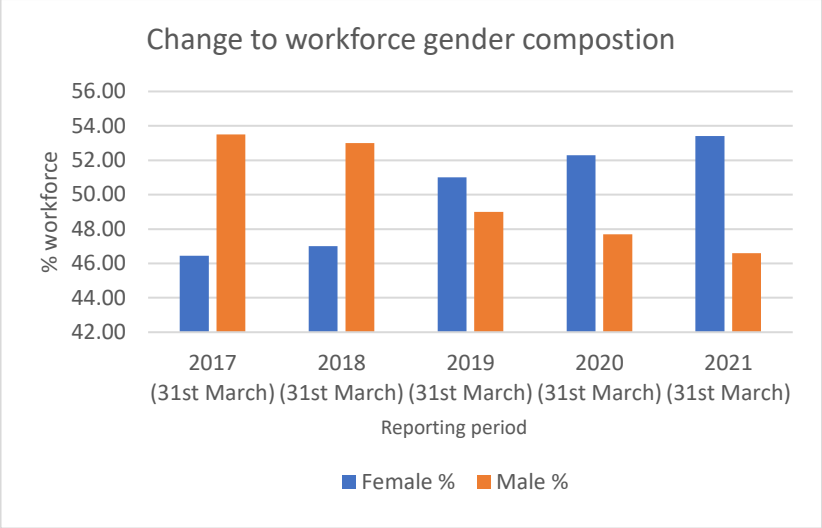


Chart 2: Changes to workforce Gender composition 2017 to 2021

3.2. Mean and median gender pay gap in hourly pay

The table below shows the difference in the mean and median hourly rates, and the pay gap as a percentage for 2019 to 2021.

Table 1 shows an annual increase in the mean hourly rate between males and females, with the difference continuing to grow year on year. However, we should be mindful that the mean figure can be impacted by those with very high or very low salaries.

There is a further decrease in the median (average) hourly rate of pay. The median helps us to measure what level of roles are typically being undertaken by men in comparison to women in the organisation, and the data indicates a small but positive increase for a second consecutive year.

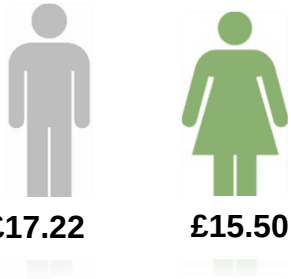
Both sets of figures indicate that we continue to have a gender pay gap, with some small increase to gender diversity at the upper quartiles of the Trust.

	31st March 2019		31st March 2020		31st March 2021	
Gender	Mean Hourly Rate	Median Hourly Rate	Mean Hourly Rate	Median Hourly Rate	Mean Hourly Rate	Median Hourly Rate
Male	£14.52	£13.71	£15.78	£14.85	£17.22	£16.04
Female	£13.22	£11.96	£14.37	£13.17	£15.50	£14.27
Difference	£1.30	£1.75	£1.42	£1.68	£1.71	£1.78
Pay Gap %	8.95%	12.77%	8.99%	11.30%	9.94%	11.09%

Table 1: Gender Pay Gap for 2019 to 2021

All Trust Staff - Overall Mean vs. Median average hourly rate - 31/03/2021

Mean average hourly rate

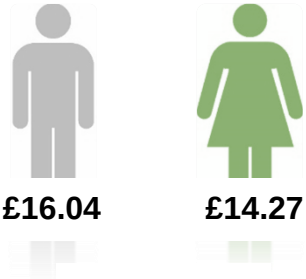


£17.22 **£15.50**

9.9% difference

This means **women earned 90p** for every **£1** that men earnt when comparing mean hourly wages.

Median average hourly rate



£16.04 **£14.27**

11.1% difference

This means **women earned 89p** for every **£1** that men earnt when comparing median hourly wages.

Proportion of males and females in each pay quartile

3.3. The figures in table 2 (below) show a ranking of our employees from highest to lowest paid, dividing this into equal quartiles and providing a percentage breakdown of the number of males and females in each of these. Whilst organisational growth has been evenly spread across the four quartiles at 9.95% each this is not evenly represented in the changes to the gender profile of the workforce by quartile.

3.4. For the first time, since we commenced Gender Pay reporting the highest variances are not in the upper pay quartile where females are underrepresented but at the lower quartiles where females are significantly overrepresented in the lowest paid roles within the organisation.

In the lowest quartile there are 26% more females than male colleagues, and 21% more female than male colleagues in the second quartile (lower middle). This trend has been increasing over the last three years and is believed to be driven by increases in the number of Health Advisors and EMA's (AFC pay band three). The call centres provide more opportunity for part time and flexible working, which continue to primarily be utilised by female colleagues. The male headcount at the lowest quartile remained stagnant between 2020 and 2021, and there was a 6% growth in the number of males in quartile 2 in comparison to a 13% growth in females.

3.5. The number of females in quartile three has dropped slightly below the 50:50 equity that had been achieved in the previous 12 months. Whilst this may seem like a small change, the number of males in this quartile has grown at more than double the rate of females at 14% and is likely to have an impact when considering future succession planning.

3.6. The percentage of males in the upper quartile continues to represent 31% of all males in the overall workforce, in comparison to 19% of all females in the organisation.

	31st March 2019				31st March 2020				31st March 2021			
	Female		Male		Female		Male		Female		Male	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%	Headcount	%
1- Lower pay quartile	512	57.8	374	42.2	595	59.2	410	40.8	695	62.9	410	37.1
2- Lower middle pay quartile	551	57.9	400	42.1	594	59.0	412	41.0	670	60.6	436	39.4
3 - Upper middle pay	443	47.3	493	52.7	510	50.7	496	49.3	541	48.9	565	51.1
4 - Upper pay	386	40.2	574	59.8	405	40.2	602	59.8	458	41.4	649	58.6

Table 2: Gender pay Gap by quartile, 2019 to 2021

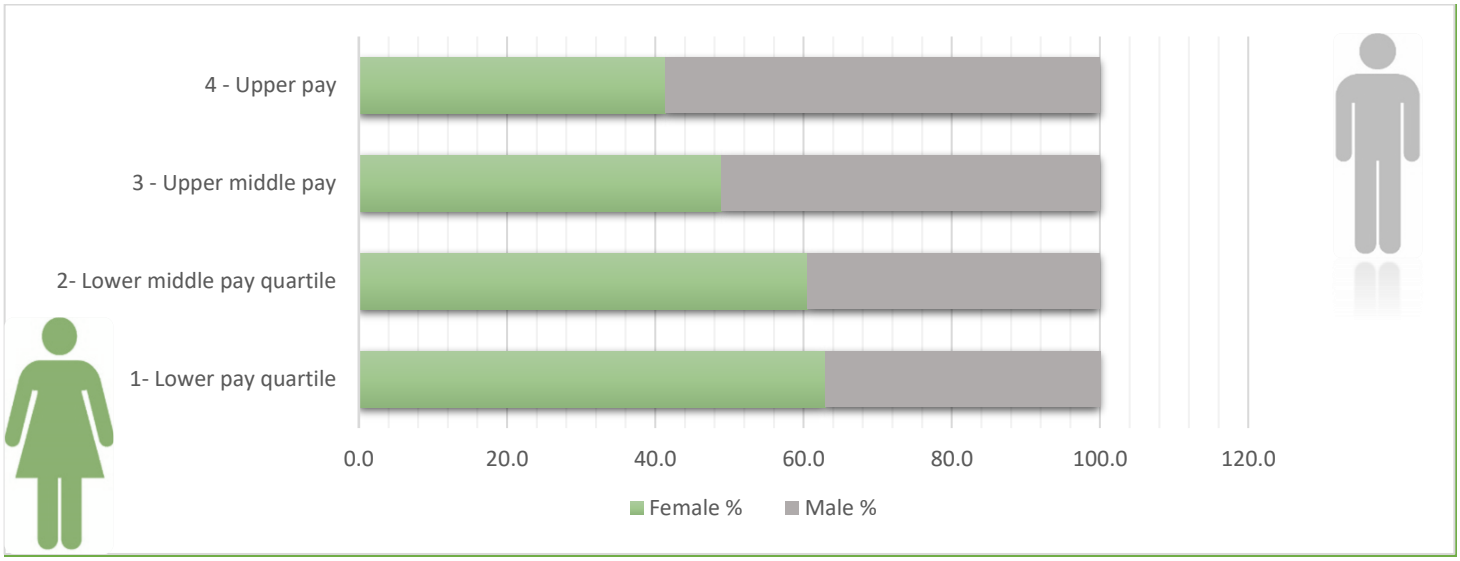


Chart 3: All Trust Staff - Proportion of males and females in each pay quartile - 31/03/2021

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

To provide further context around composition of the quartiles, our workforce data for 31st March 2020 shows that approximately 99.8% of our employees were within pay bands two and seven. The GPA quartiles do not align with specific bands. As such, due to the GPA methodology and our workforce make up, the upper quartile will also contain a proportion of employees at band six, and therefore in planning actions to make improvements, it is

important that we consider the GPA results alongside workforce breakdown by pay band and gender.

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

3.9. The gender pay calculations are based on hourly rate after a number of factors have been added or deducted to the employee's basic pay. The hourly rate can also be significantly impacted by location (addition of high cost area allowance), team (addition of recruit and retain premia), and person's individual circumstances (minus Tusker and childcare schemes) so two colleagues of the same gender, pay band and pay point could potentially be at a different hourly rate due to their individual enhancements or deductions.

Mean and median bonus gender pay gap.

3.10. The only bonus payments made by the Trust are to eligible staff who apply for the Clinical Excellence Awards (CEAs), which can be awarded nationally or locally. Due to the small numbers of bonus payments made in 2021 potentially rendering recipients identifiable if published, the Trust will not be publishing any data for this part of the Gender Pay Gap report. Bonus payments are awarded in recognition of excellent practice over and above contractual requirements.

Gender by pay band

3.11. Although Agenda for Change (AFC) ensures that we are proving equal pay for equal work, we can see discrepancies in the ratio of males to females within pay bands. It is this discrepancy which is largely responsible for our gender pay gap.

The charts below show a greater number of males than females in posts at pay band 7 and above. Chart 5 shows that whilst the number of females in Band 7 posts has increased by less than 1%, there have been reductions in the number of female postholders at every band from 8A – 9, with the exception of 8B.

The overrepresentation of females in the lowest pay bands also negatively impacts the pay gap. However, our recruitment data shows that when males apply to these roles, they are more likely to be appointed than a female shortlisted applicant. There is a significant difference in the number of males to females who are applying for and therefore being shortlisted into our entry level roles.

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

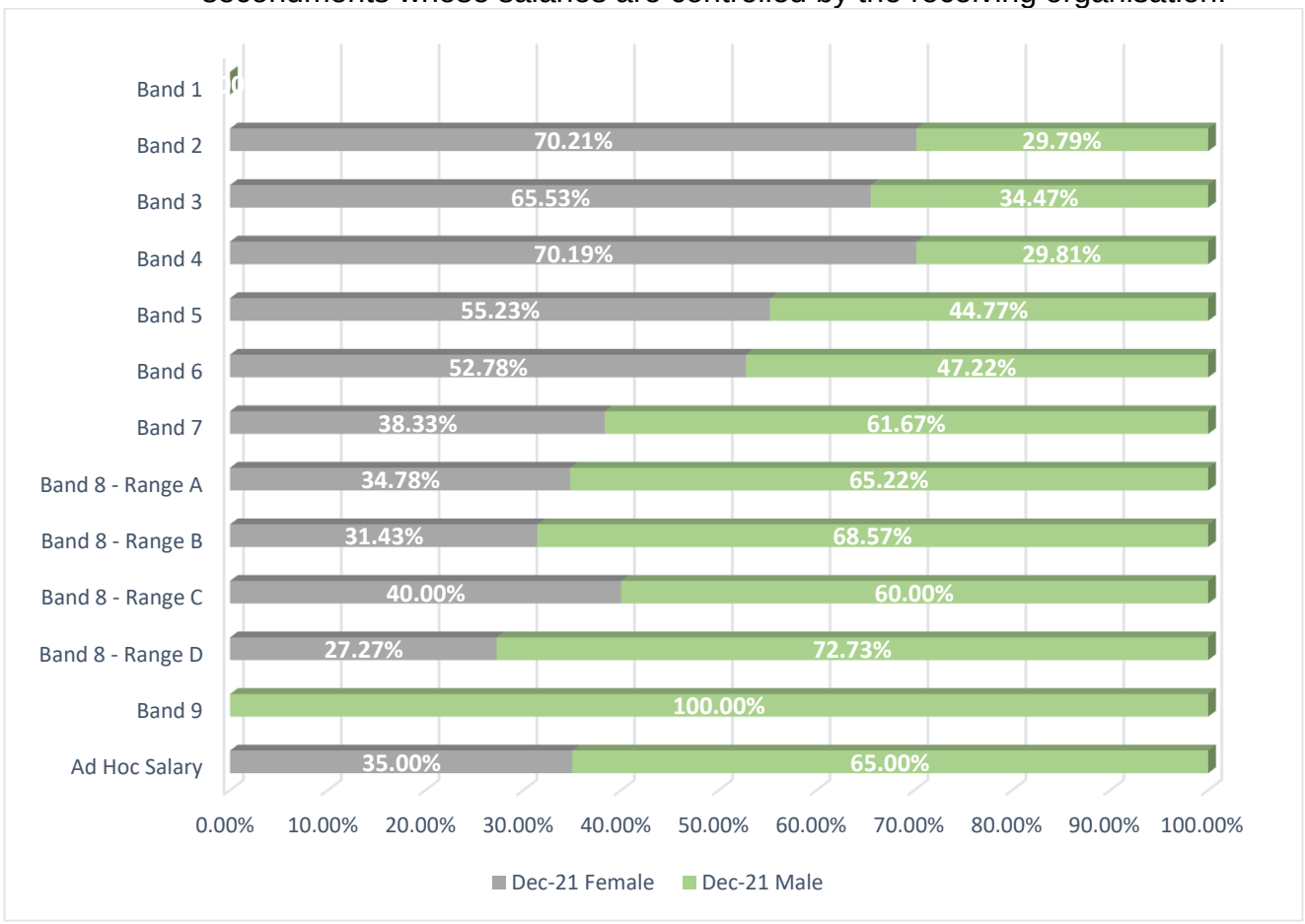


Chart 4: Workforce by Pay band and Gender, December 2021

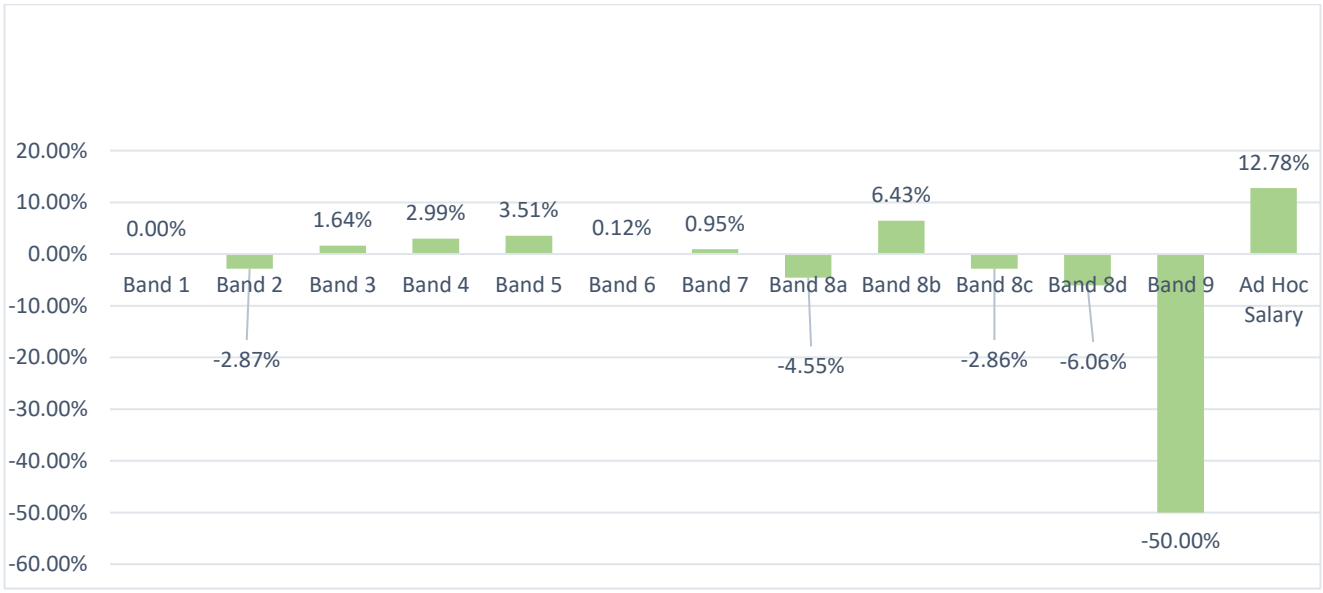


Chart 5: Difference in % Females from between March 20 and December 21

3.13. The workforce gender profile below, also identifies the largest areas of discrepancy to be bands 8 and above in Operations, both Field and 111 and EOC in favour of males. However, it should be noted that Field operations saw a 5% worsening in the representation of females at band 8 and above. The 0% females in 111 at band 8 and above that we saw in this report last year has been addressed with the combining of the EOC and 111 leadership teams.

	2019		2020		2021	
All Staff	Female %	Male %	Female %	Male %	Female %	Male %
Bands 1-4	59.86%	40.14%	61.76%	38.24%	63.23%	36.77%
Bands 5-7	45.72%	54.28%	44.87%	55.13%	46.72%	53.28%
Bands 8+	33.82%	66.18%	35.83%	64.17%	36.75%	63.25%
Ad hoc	31.25%	68.75%	27.43%	72.57%	30.03%	69.97%

	2019		2020		2021	
Operations - Field	Female %	Male %	Female %	Male %	Female %	Male %
Bands 1-4	50.69%	49.31%	53.22%	46.78%	54.61%	45.39%
Bands 5-7	43.41%	56.59%	44.57%	55.43%	46.37%	53.63%
Bands 8+	20.45%	79.55%	26.24%	73.76%	21.63%	78.37%
Ad hoc	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

	2021		
Operations - 111 & EOC*	Female %	Male %	*Previously reported separately therefore comparable data is not provided for 2019 and 2020
Bands 1-4	73.48%	26.52%	
Bands 5-7	69.66%	30.34%	
Bands 8+	37.50%	62.50%	
Ad hoc	0.00%	0.00%	

	2019		2020		2021	
Support Staff	Female %	Male %	Female %	Male %	Female %	Male %
Bands 1-4	53.85%	46.15%	72.29%	27.71%	75.11%	24.89%
Bands 5-7	39.52%	60.48%	33.60%	66.40%	33.54%	66.46%
Bands 8+	46.75%	53.25%	39.30%	60.70%	40.07%	59.93%
Ad hoc	31.25%	68.75%	27.43%	72.57%	30.03%	69.97%

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

3.14. Comparative data against the other ambulance Trusts for the 2022 GPA publication is not yet fully available. However, the published data for the

2021 submission (based on 31st March 2020) shows SECAmb was above both the sector average for both mean and median pay gaps.

4.

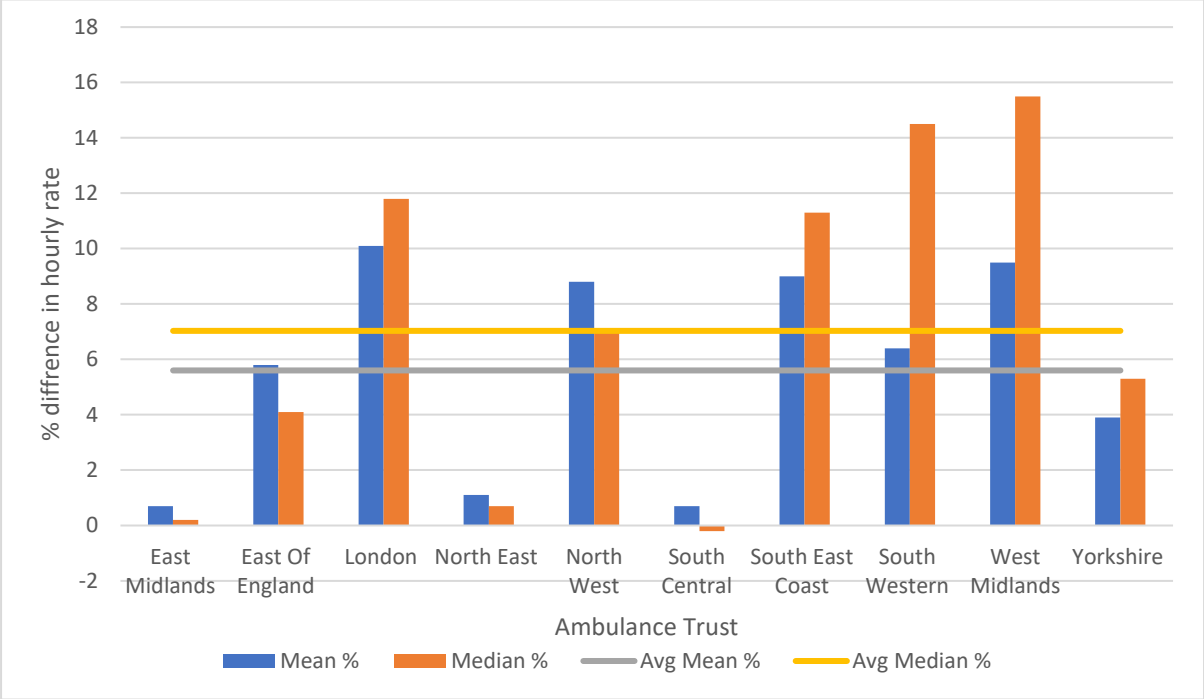


Table 6: Ambulance sector comparison of mean and median pay gap as at 31st March 2020

Ambulance Trust	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in top pay quartile
East Midlands	54%	48%	53%	42%
East Of England	39%	47%	53%	51%
London	58%	47%	48%	40%
North East	46%	45%	49%	38%
North West	55%	54%	47%	37%
South Central	46%	56%	52%	50%
South East Coast	**59%**	**59%**	**51%**	**40%**
South Western	48%	54%	42%	40%
West Midlands	55%	49%	48%	38%
Yorkshire	58%	53%	48%	43%

Table 6: Ambulance sector comparison of by quartile as at 31st March 2020

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

5. Conclusion

5.1. There was a 0.9% increase in our mean Gender pay gap and 0.4% improvement in the median pay gap. The latest workforce data shows previous positive improvements at the higher pay bands has been lost in the past 18 months. There continues to be an over representation of women on lower pay bands.

5.2. Whilst we do not have an equal pay issue, pay gender pay gap in SECAmb does remain and work to reduce this must be ongoing and include exploring best practice across the sector and beyond.

5.3. Data analysed both as part of this report, and for the Diversity and inclusion annual report indicate that positive action in talent management and the creation of a workplace that supports a healthier work life balance is required to support female colleagues to progress. This work needs to happen alongside existing work to debias our recruitment processes and has received Board commitment as part of our existing Integrated Equality Action Plan, published September 2021.

5.4. The Trust will work with the Gender Equality Network (GEN) to maximise opportunities to advance gender equality across the organisation and gender diversity in leadership.

5.5. It does not follow that achieving 50:50 at every pay band will result in a zero gender pay gap due to the impact of individual circumstances on hourly rate of pay. However, a greater pay gap indicates underlying issues in a workplace's support for gender diversity which need to be addressed, including opportunities for progression, equitable talent management, and access to flexible working. Inequity at the higher and lower ends of the organisation can be damaging to organisational reputation and brand. Improving equity in gender representation will support the reduction of a gender pay gap.

6. Governance

6.1. On 10 January, Inclusion Working Group approved the approach given in 5.3, and agreed the actions within the Integrated Equality Action Plan, which includes actions to improve gender diversity, must be delivered to enable progress in this area.

6.2. They also approved the submission of the Trust GPA results to the government portal ahead of 31st March 2022 and publishing of the data to our public facing website as per the requirements of the Equality Act 2010, subject to Trust governance processes.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

SECAmb
Better by Design

March 2022

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

What is important for our patients – why we are here

Our Purpose

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

Our Values

'In all the work that we do, the Trust's values of Demonstrating Compassion and Respect, Acting with Integrity, Assuming Responsibility, Striving for Continuous Improvement and Taking Pride will underpin what we do today and in the future'.

Our Priorities

*Delivering Modern Healthcare for **our patients** by continuing our focus on our core services of 999 & 111 Clinical Assessment Service*

A focus on People meaning everyone is listened to, respected and well supported

Delivering Quality by listening, learning and improving

System Partnership by contributing to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care

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Our strategy

NHS
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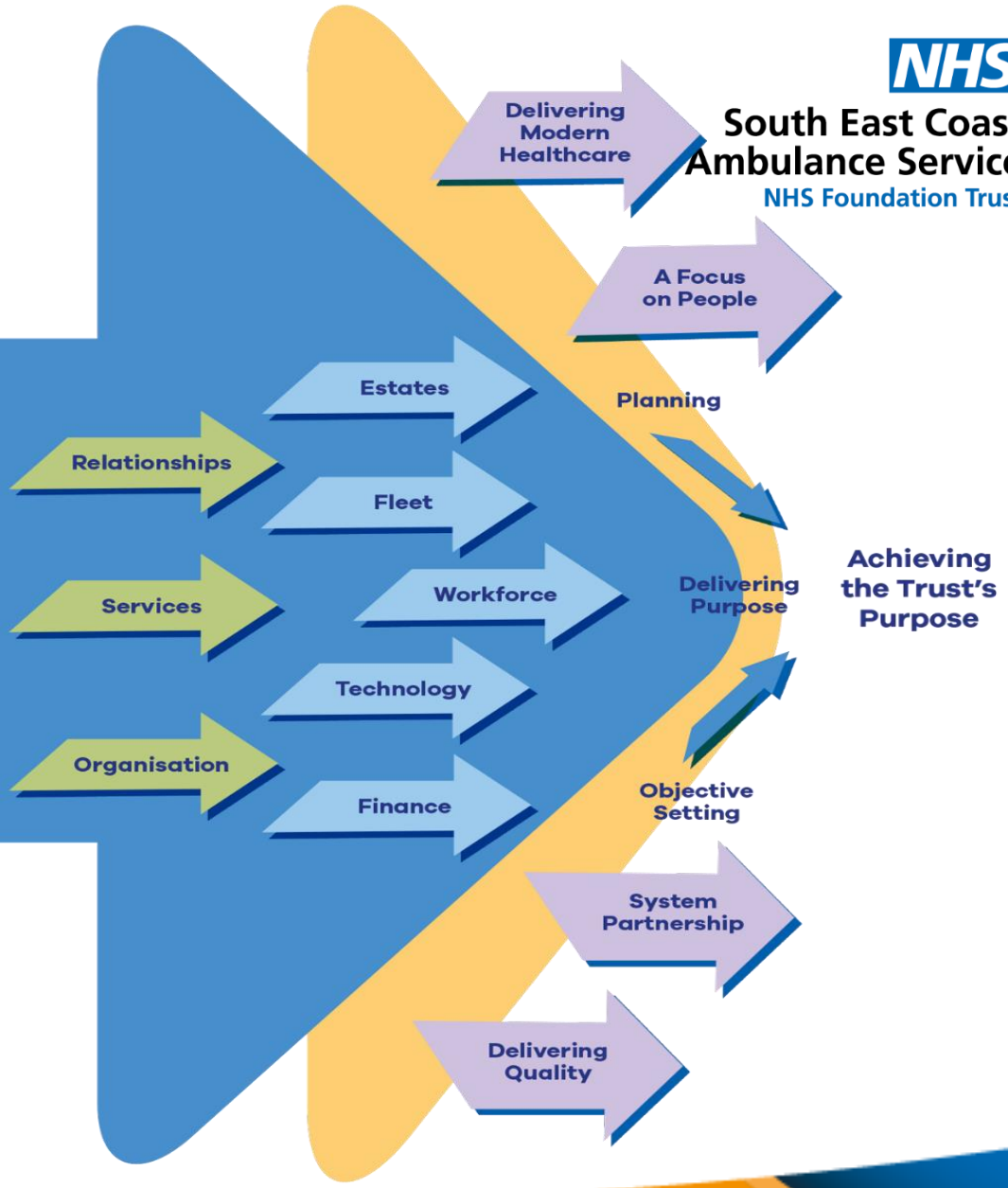
NHS Foundation Trust

The Trust Strategy - a summary:

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

SECAmb's Operating Environment
'Continuing financial and resource pressures to meet rising needs and demands. The pressure to migrate services from hospitals into community settings. Policy changes that require a radical and rapid restructuring of NHS commissioners and providers. A major shift in emphasis from 'activity' to 'population health' resulting in changes to the way that money is allocated and performance judged'.

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



The arrow above represents our Trust strategic direction. The table below shows how the Strategic Delivery Plan through the BBD portfolio delivers our strategy.

Our Improvement Journey

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Improving SECAmb

AIM

- ***The delivery of timely patient care through delivering our response targets (ARP)***

- ***Becoming an Outstanding organisation as measured by the CQC and our patients***

- ***And long-term resilience***

To move SECAmb away from being just a responsive, operational, delivery-based provider of 999 and 111 services, to a key partner in the Urgent and Emergency Care system.

This evolution means that we can start to co-design services based on our expertise, knowledge and reputation for excellence.

PRINCIPLES

- ***Getting the basics right first time***

- ***Standardisation of tasks and processes across our organisation***

- ***Strategic alignment so that we are all pulling in the same direction***

The BBD programme framework has defined three guiding principles for this change which should be clearly visible in each decision that is made.

In achieving these things and the benefits they bring, we will continue to enhance our ability to define our own future direction, including how we innovate and build our reputation as a trusted and excellent provider of Urgent and Emergency care.

WHAT WILL IT MEAN FOR PATIENTS AND STAFF

- ***Shorter waits and right response to patients first time***

- ***A better/ healthier working patterns for staff, with proper breaks, education opportunities, development, clear policies and processes and long-term resilience for the entire workforce***

We absolutely recognise at the start of this journey that it is the staff and volunteers, who work across our organisation, who understand best how to improve things and so over the coming months we want your ideas on new approaches to improve SECAmb.

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Getting involved

Performance Cell Transformation

SRO: David Ruiz-Celada

Programme Lead: Alex Croft

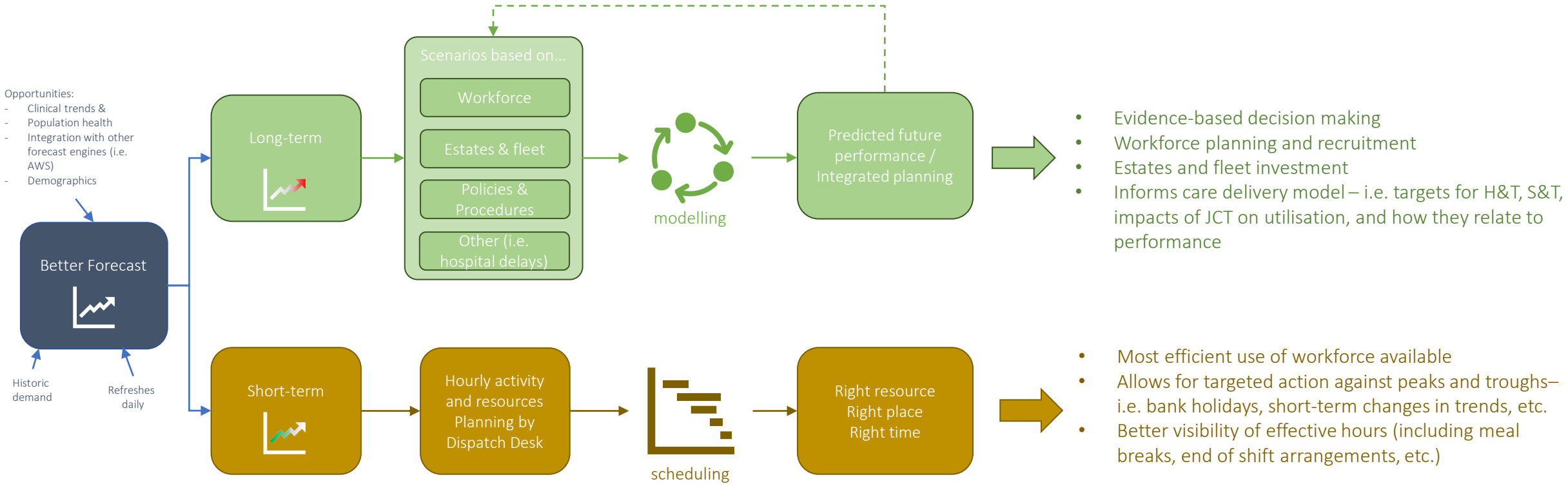
Delivery Manager: Claire Webster

Objectives (3 key workstreams)

- Create the capacity and infrastructure that will allow the Trust to forecast demand accurately and consistently
- Create the ability to consistently forecast the resource levels required to meet forecasted demand
- Create the ability to forecast probable performance outturn based on forecasted activity and anticipated resource availability and to identify gaps in provision of resources.
- Refresh the Trust's five-year frontline workforce plan (linked to Better by Design) over the next 18 months.
- To implement and develop the ability to scenario plan using predictive analytics software to ensure the impacts and consequences of future decisions on performance and resourcing are understood.
- To improve the quality and productivity of the Business Intelligence (BI) team and its output by Spring 2022. This includes but is not limited to a full review of our IPR, out data information strategy, and a review of our reporting approach

* resource with capital "R" – the vision is that all operational and non-operational resources, both people and non-people, can be predicted and quantified for effective business and scenario/impact planning

Planning Roadmap



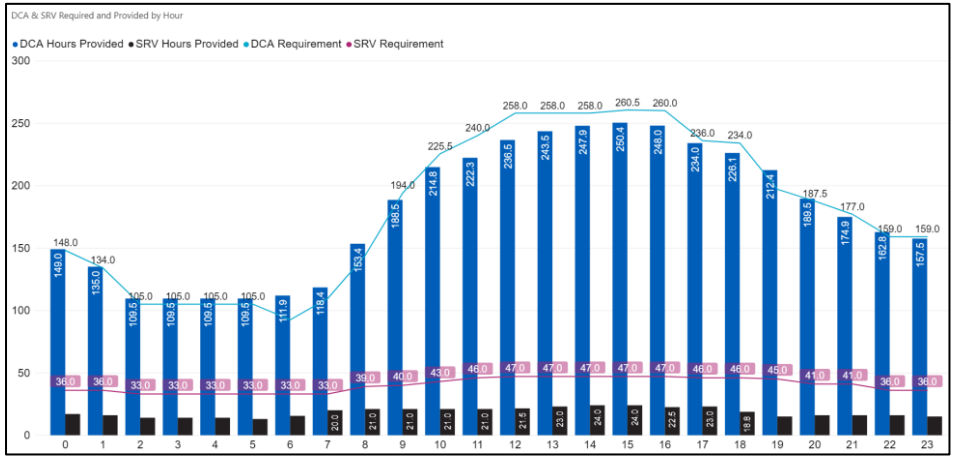
- Evidence-based decision making
- Workforce planning and recruitment
- Estates and fleet investment
- Informs care delivery model – i.e. targets for H&T, S&T, impacts of JCT on utilisation, and how they relate to performance

- Most efficient use of workforce available
- Allows for targeted action against peaks and troughs– i.e. bank holidays, short-term changes in trends, etc.
- Better visibility of effective hours (including meal breaks, end of shift arrangements, etc.)

Example – Demand led planning (6-weeks out)

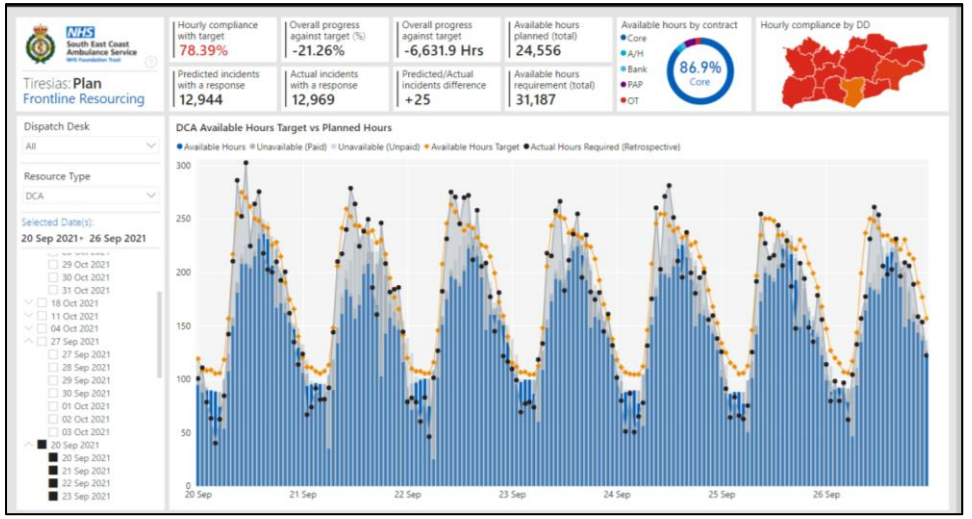
Implemented

- Previous forecast based on Demand and Capacity review from 2018 and (static)
- New forecast developed to >97% accuracy predicting incidents with a response every day and every hour (dynamic)
- Demand consistently exceeds establishment based on current processes, and we have seen a shift in demand to earlier in the day, leading to performance challenges
- Workforce scheduling focussed on managing the gap between existing rosters and new demand profile with incentives



Next Steps:

- Shift focus from reporting “hours vs target” to reporting “schedule score vs forecast demand”
- Review of staff rotas to alight to new demand profiles as a key enabler for 22/23
- Targeted recruitment and collaboration with PAPs to cover the gaps



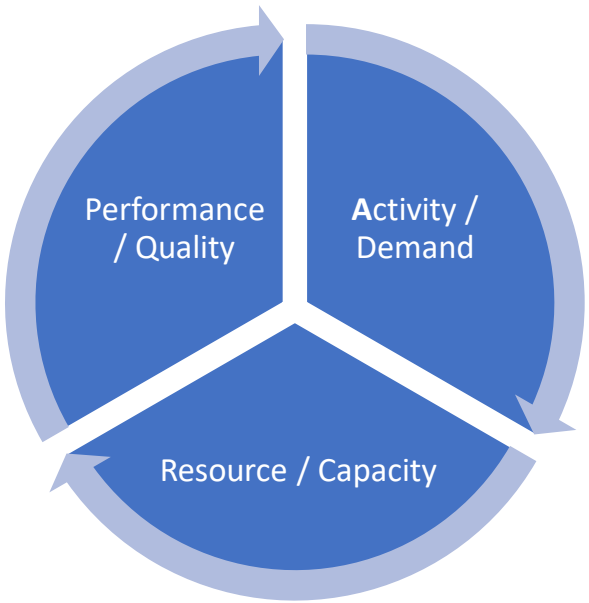
Example – Integrated Planning 22/23 (12 months out)

Implemented

- Integrated approach to planning, covering all core operational areas and support services
- Identification of key 22/23 priorities and enabling projects
- On-going use of analysis to support contract negotiation for 22/23

Next Steps

- Setting up of Annual Planning Working Group for monthly monitoring of delivery against plan
- Implementation of robust delivery plans – supported by a reviewed QIP



WTE Required to deliver performance	Internal Operational Efficiency (excludes Hospital Handover Delays - which is an additional assumed efficiency of around 2%)			
Abstraction	0%	8%	16%	Note
30%	2866	2633	2400	Current Budget
31%	2927	2694	2461	
32%	2974	2741	2508	
33%	3021	2788	2555	Target 22/23 position
34%	3068	2835	2602	
35%	3115	2882	2649	Most-likely 22/23 position

Likely averaged WTE required ~2900

Stretch recruitment cap

Target 22/23 end year position

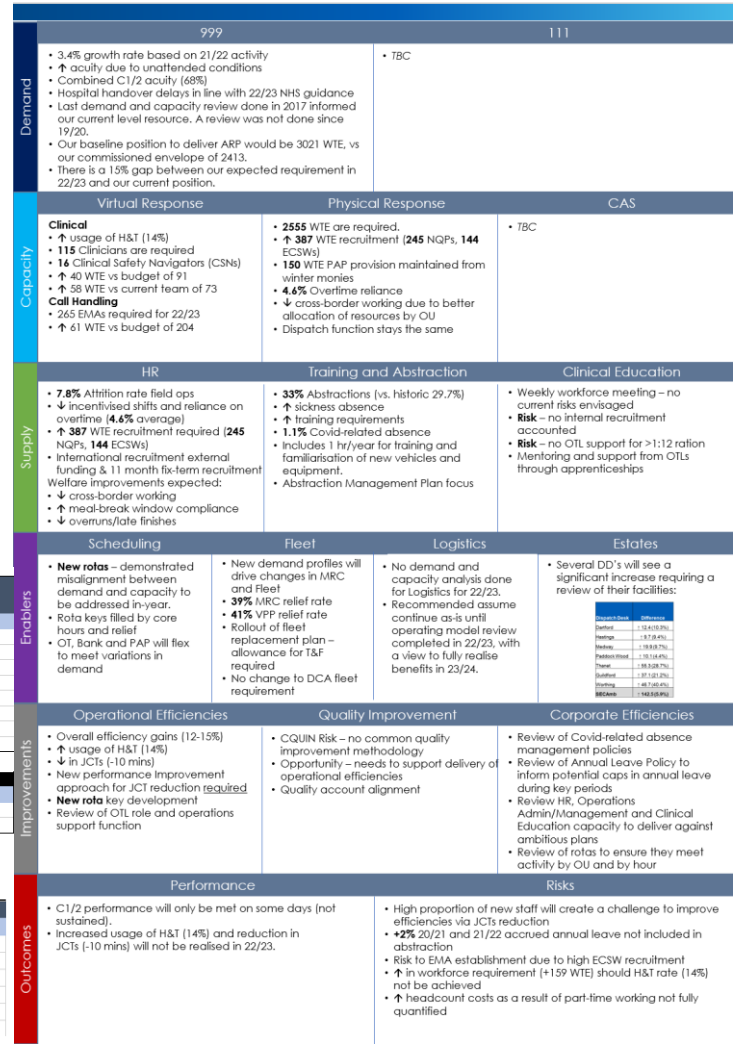
Most-likely 22/23 position somewhere aroudn ~4% for year average

Performance Gap Expressed as a function of % overall Resource shortfall				
	C1 Mean	C1 90th	C2 Mean	C2 90th
8%	8 - 9 min	14.5 - 16.5 min	23 - 31 min	45 - 62 min
16%	8.5 - 9.5 min	16 - 17 min	30 - 35 min	59 - 71 min

Projected C2 Mean based on 2555 WTE

2555	Internal Operational Efficiency (excludes Hospital Handover Delays - which is an additional assumed efficiency of around 2%)			
Abstraction	0%	8%	16%	Note
30%	24.2 - 29.2	18.6 - 23.6	12.9 - 17.9	
31%	25.3 - 30.3	19.7 - 24.7	14.1 - 19.1	
32%	26.3 - 31.3	20.8 - 25.8	15.3 - 20.3	
33%	27.3 - 32.3	21.9 - 26.9	16.4 - 21.4	
34%	28.3 - 33.3	22.9 - 27.9	17.6 - 22.6	
35%	29.3 - 34.3	24.0 - 29.0	18.8 - 23.8	

Scenario Planning for performance vs resources



	999	111
Demand	• 3.4% growth rate based on 21/22 activity • ↑ acuity due to unattended conditions • Combined C1/2 acuity (68%) • Hospital handover delays in line with 22/23 NHS guidance • Last demand and capacity review done in 2017 informed our current level resource. A review was not done since 19/20. • Our baseline position to deliver ARP would be 3021 WTE, vs our commissioned envelope of 2413. • There is a 15% gap between our expected requirement in 22/23 and our current position.	• *TBC*

Capacity	Virtual Response	Physical Response	CAS
	Clinical • ↑ usage of H&T (14%) • **115** Clinicians are required • **16** Clinical Safety Navigators (CSNs) • ↑ 40 WTE vs budget of 91 • ↑ 58 WTE vs current team of 73 **Call Handling** • 265 EMAs required for 22/23 • ↑ 61 WTE vs budget of 204	• **2555** WTE are required. • ↑ **387** WTE recruitment (**245** NQPs, **144** ECSWs) • **150** WTE PAP provision maintained from winter monies • **4.6%** Overtime reliance • ↓ cross-border working due to better allocation of resources by OU • Dispatch function stays the same	• *TBC*

Supply	HR	Training and Abstraction	Clinical Education
	• **7.8%** Attrition rate field ops • ↓ incentivised shifts and reliance on overtime (**4.6%** average) • ↑ **387** WTE recruitment required (**245** NQPs, **144** ECSWs) • International recruitment external funding & 11 month fix-term recruitment Welfare improvements expected: • ↓ cross-border working • ↑ meal-break window compliance • ↓ overruns/late finishes	• **33%** Abstractions (vs. historic 29.7%) • ↑ sickness absence • ↑ training requirements • **1.1%** Covid-related absence • Includes 1 hr/year for training and familiarisation of new vehicles and equipment. • Abstraction Management Plan focus	• Weekly workforce meeting – no current risks envisaged • **Risk** – no internal recruitment accounted • **Risk** – no OTL support for >1:12 ration • Mentoring and support from OTLs through apprenticeships

Enablers	Scheduling	Fleet	Logistics	Estates
	• **New rotas** – demonstrated misalignment between demand and capacity to be addressed in-year. • Rota keys filled by core hours and relief • OT, Bank and PAP will flex to meet variations in demand	• New demand profiles will drive changes in MRC and Fleet • **39%** MRC relief rate • **41%** VPP relief rate • Rollout of fleet replacement plan – allowance for T&F required • No change to DCA fleet requirement	• No demand and capacity analysis done for Logistics for 22/23. • Recommended assume continue as-is until operating model review completed in 22/23, with a view to fully realise benefits in 23/24.	• Several DD's will see a significant increase requiring a review of their facilities:

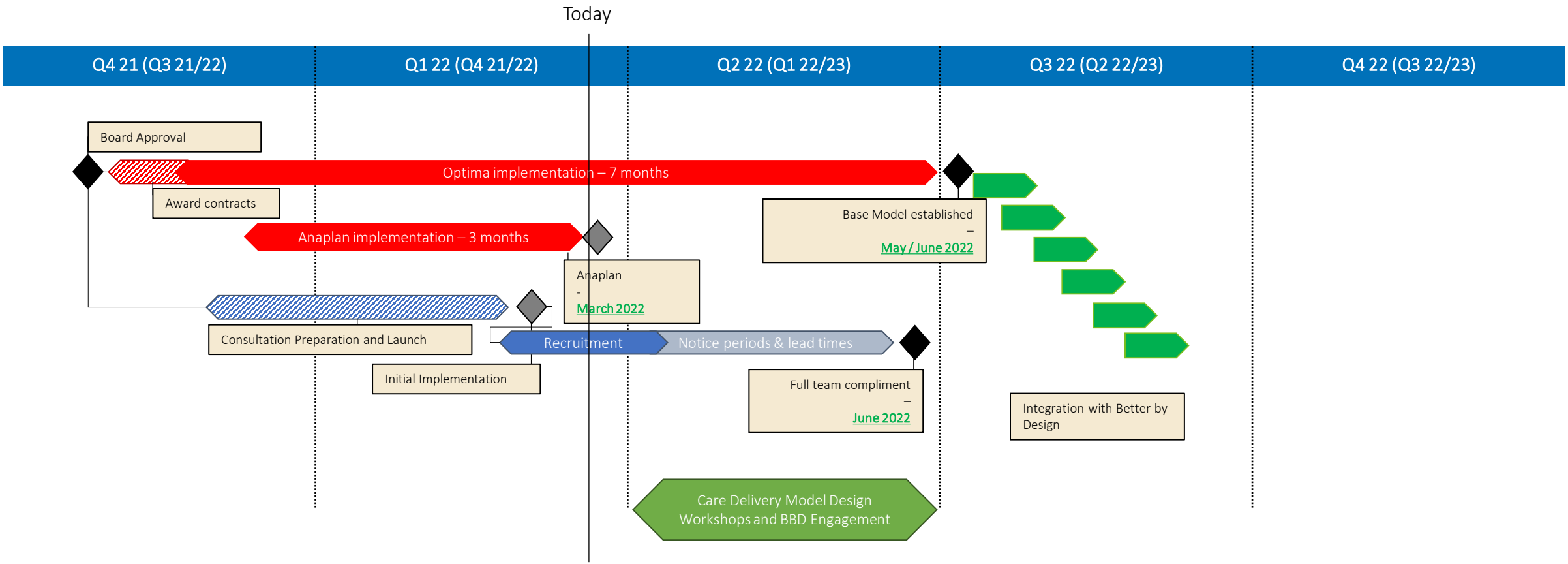
Improvements	Operational Efficiencies	Quality Improvement	Corporate Efficiencies
	• Overall efficiency gains (12-15%) • ↑ usage of H&T (14%) • ↓ in JCTs (-10 mins) • New performance Improvement approach for JCT reduction required • **New rota** key development • Review of OTL role and operations support function	• CQUIN Risk – no common quality improvement methodology • Opportunity – needs to support delivery of operational efficiencies • Quality account alignment	• Review of Covid-related absence management policies • Review of Annual Leave Policy to inform potential caps in annual leave during key periods • Review HR, Operations Admin/Management and Clinical Education capacity to deliver against ambitious plans • Review of rotas to ensure they meet activity by OU and by hour

Outcomes	Performance	Risks
	• C1/2 performance will only be met on some days (not sustained). • Increased usage of H&T (14%) and reduction in JCTs (-10 mins) will not be realised in 22/23.	• High proportion of new staff will create a challenge to improve efficiencies via JCTs reduction • **+2%** 20/21 and 21/22 accrued annual leave not included in abstraction • Risk to EMA establishment due to high ECSW recruitment • ↑ in workforce requirement (+159 WTE) should H&T rate (14%) not be achieved • ↑ headcount costs as a result of part-time working not fully quantified

Draft example from February "Plan on a Page" approach

Performance Cell Transformation:

Implementation Timeline



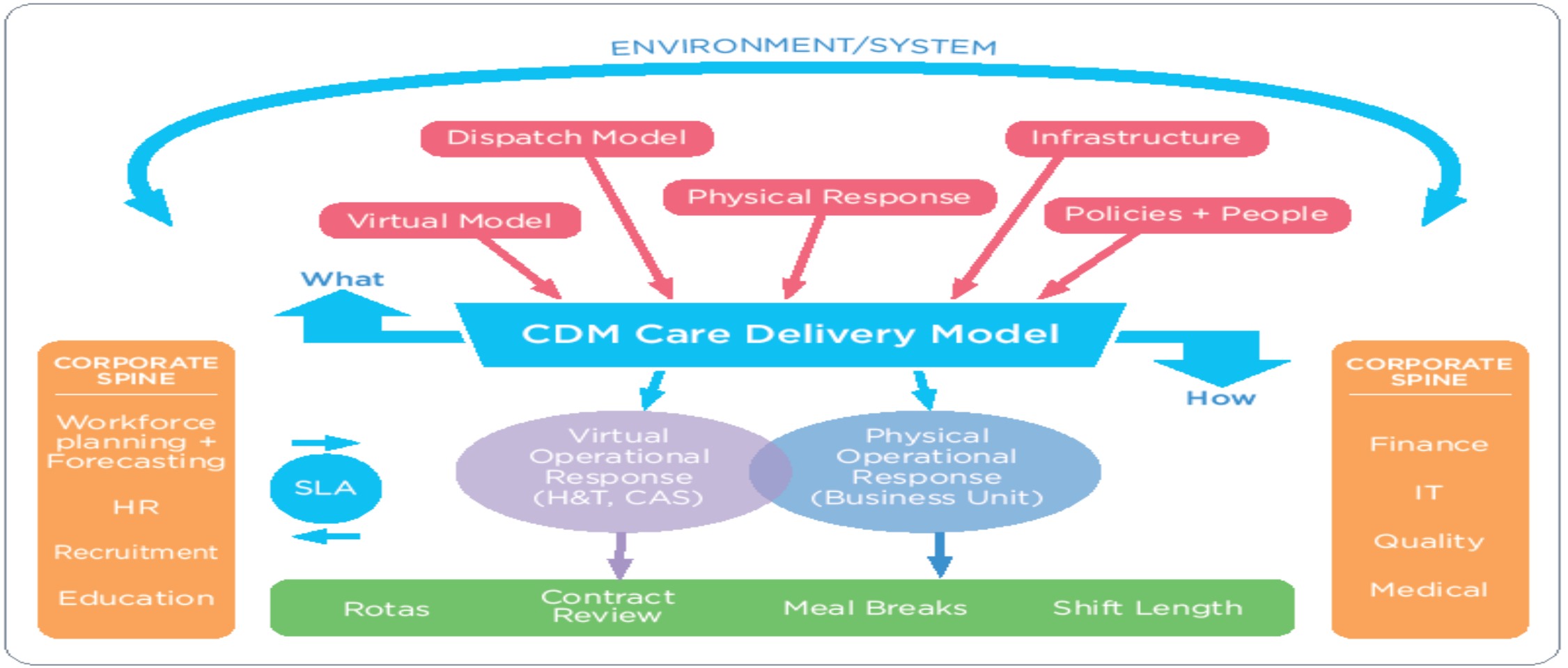
Care Delivery Model

SRO: Emma Williams

Programme Leads: Mark Eley, John O’Sullivan

Delivery Managers: TBC

New Care Delivery Model



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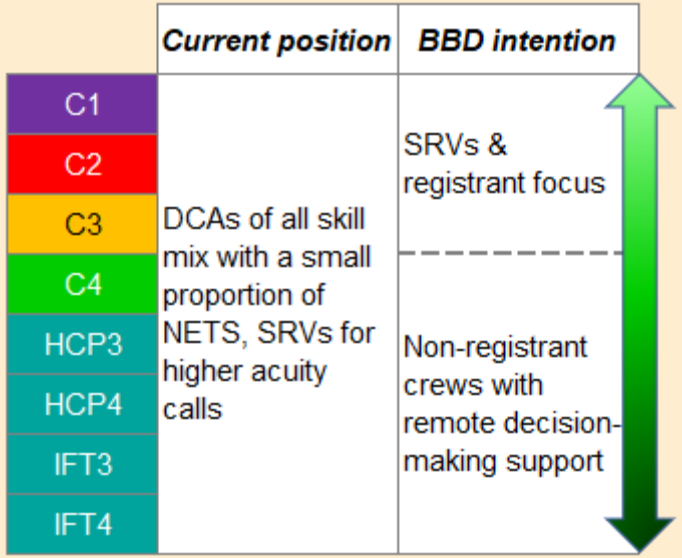
Virtual & Physical Model

		10%	30%	60%
Current position	Outcomes	H&T	S&T	S&C
	Staffing	EOC Clinicians	Field Ops clinicians	

		15%	10%	20%	5%	50%
BBD intention	Outcomes	H&T	Virtual S&T	S&T	S&C non-ED	S&C ED
	Staffing	EOC Clinicians + Field Ops Clinicians		Field Ops clinicians		



Key drivers:

- Clinical risk based approach to incident management
- Greater accessibility to virtual support for patient interaction
- Need to focus the higher trained & competent staff on the higher acuity patient need
- Availability, recruitment & retention of registrants
- Integration of opportunities across virtual & physical models – linked to the ‘hub’ model

Version One

better by design

SOUTH EAST COAST AMBULANCE SERVICE
Transformation Portfolio Framework

David Hammond Chief Operating Officer
Julia Hilger-Ellis Portfolio Director

getinvolved@secamb.nhs.uk

CONTENTS

1

Foreword from the Chief Executive Officer - Philip Astle

Our patients and our people are at the heart of everything we do. This Framework outlines the organisation-wide, integrated, transformation framework called Better by Design, the delivery of which will enable us to achieve our strategic objectives, and realise further benefits for patients and staff.

Better by Design will allow us to put together the different pieces of the complex organisation that is SECAmb by bridging the gaps in organisational alignment which currently exist. It will also allow us to challenge ourselves on the way we deliver our service.

Better by Design (BBD) also aims to facilitate the structural changes and continuous improvement which are needed to make SECAmb an organisation which is fit for the future.

It is a framework under which six key programmes (each owned by an Executive Sponsor) are brought together to ensure that their objectives and deliverables align to the Board's Strategic Delivery Plan.

By providing this working framework, we create an all-inclusive picture via a single transformational portfolio of programmes. This means that gaps are identified and addressed, and we can build on the many positive things which are already in place. The portfolio approach also enables a single platform of communication, engagement, and a common understanding and language.

To help to make this transformation successful, we want to answer a simple question which every member of staff, no matter what their role is, should keep on asking themselves and challenge each other, their managers, and colleagues:

'How can we work together to deliver excellent service?'

We all want to pull in the same direction to deliver excellent patient care, support our colleagues and go home at the end of the day feeling that we've done the best possible job. After the last few years of pandemic and continuous pressure, we recognise that this may seem very aspirational at the current time, but we understand that our staff are motivated by the difference they can make to patients, and the community they serve. As well as the quality of patient care, we need to proritise well-being and health of staff, the reduction of duplication and waste and the need to work together as an entire NHS system.

This Framework sets outs how we are going to do this.

It does not seek to answer all the questions but is a guiding document for everyone who works at SECAmb - be it front line clinicians, EOC colleagues, corporate services, or the Trust board members - and it is designed to challenge us all to think about the way we should work together to align the organisation to allow us to achieve all the aims we have set.

These aims are:

- *The delivery of timely patient care through delivering our response targets (ARP)*
- *Becoming an Outstanding organisation as measured by the CQC and our patients*
- *And long-term resilience*

If we achieve these aims, we will be able to move SECAmb away from being a responsive, operational, delivery-based provider of 999 and 111 services, to a key partner in the Urgent and Emergency Care system. This evolution means that we can start to co-design services based on our expertise, knowledge and reputation for excellence.

For example, if ambulance services can reduce the number of conveyances to Emergency Departments through better use of technology, virtual triage and co-designing better pathways, then the funding will follow the patient, and we are ultimately able to provide a better clinical service to the population we serve and become more resilient as an organisation.

We absolutely recognise at the start of this journey that it is the staff and volunteers, who work across our organisation, who understand best how to improve things and so over the coming months we want your ideas on new approaches to improve SECAmb.

Through BBD we want to deliver better/ healthier working patterns for staff, with proper breaks, education opportunities, development, clear policies and processes and long-term resilience for the entire workforce.

The BBD programme framework has also defined three guiding principles for this change which should be clearly visible in each decision that is made.

They are:

- *Getting the basics right first time*
- *Standardisation of tasks and processes across our organisation*
- *Strategic alignment so that we are all pulling in the same direction*

In achieving these things and the benefits they bring, we will continue to enhance our ability to define our own future direction, including how we innovate and build our reputation as a trusted and excellent provider of Urgent and Emergency care within the South-East and maybe ultimately further afield.

better by design

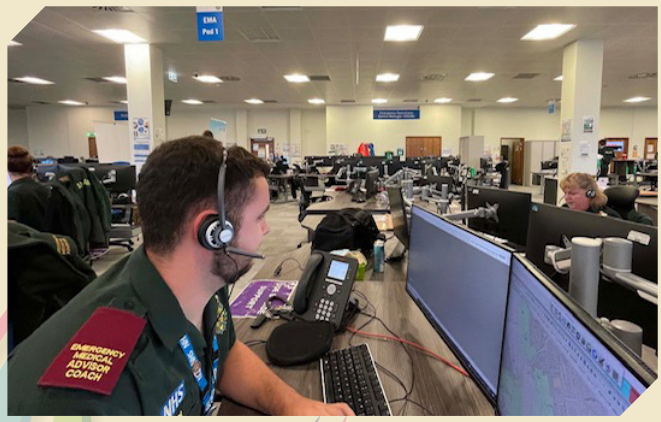
2

Executive Summary

This framework describes the portfolio of programmes, governance, leadership, engagement, change methodology and provides a high-level roadmap to success. It does not set out the answers as those need to be created by the whole organisation and not the overarching portfolio itself, which is just a framework for alignment.

Whilst the development of these answers will come from all stakeholders, the governance sits with the Trust Board. The framework outlines how this will be achieved including how the Executive Directors, as programme Sponsors for various key programmes, work with Trust staff from all areas. Better by Design will be led by the Chief Executive. It will be managed through the Executive Management Board and overseen by the Trust Board. A Trust Board subgroup has been set up with a clear remit to support and steer the work.

The framework sets out the six core areas or programmes which sit under the Better by Design Portfolio. These programmes and their dependencies are outlined within this document.



Along with these areas, within the whole portfolio there are some common areas (that we call the "Golden Threads") which underpin the overarching journey and they are:

- Engagement and communication with all staff. By engagement we mean creating opportunities for our staff to connect with their colleagues, managers, and wider organisation. It is also about creating an environment where we are all motivated to want to connect and participate to make things better. It is a concept that places flexibility, change and continuous improvement at the heart of what it means to be an employee of the Trust and an employer in a 21st Century workplace.
- The use of technology and advancements in machine learning and artificial intelligence to create a better service for all.
- A different way of thinking about change and innovation across the organisation, essential in building and sustaining a culture of quality.
- As the NHS, along with the rest of the country, moves towards a carbon-neutral target, it is part of all our role to ensure that our Trust contributes appropriately and our corporate social responsibility addresses environmental, social and supply chain or economic responsibility.
- The BBD portfolio framework itself. This is expected to provide the organisation with the tools it needs to operate effectively for many years to come and long after the portfolio is ended. If we get this right then the learnings from the BBD work should become standard practice.

3

Better by Design portfolio objectives aligned to the Board approved Strategic Delivery Plan

The Better by Design portfolio is not a standalone entity operating on the periphery of the organisation. It is in fact the complete opposite and the two questions for any future change should be:

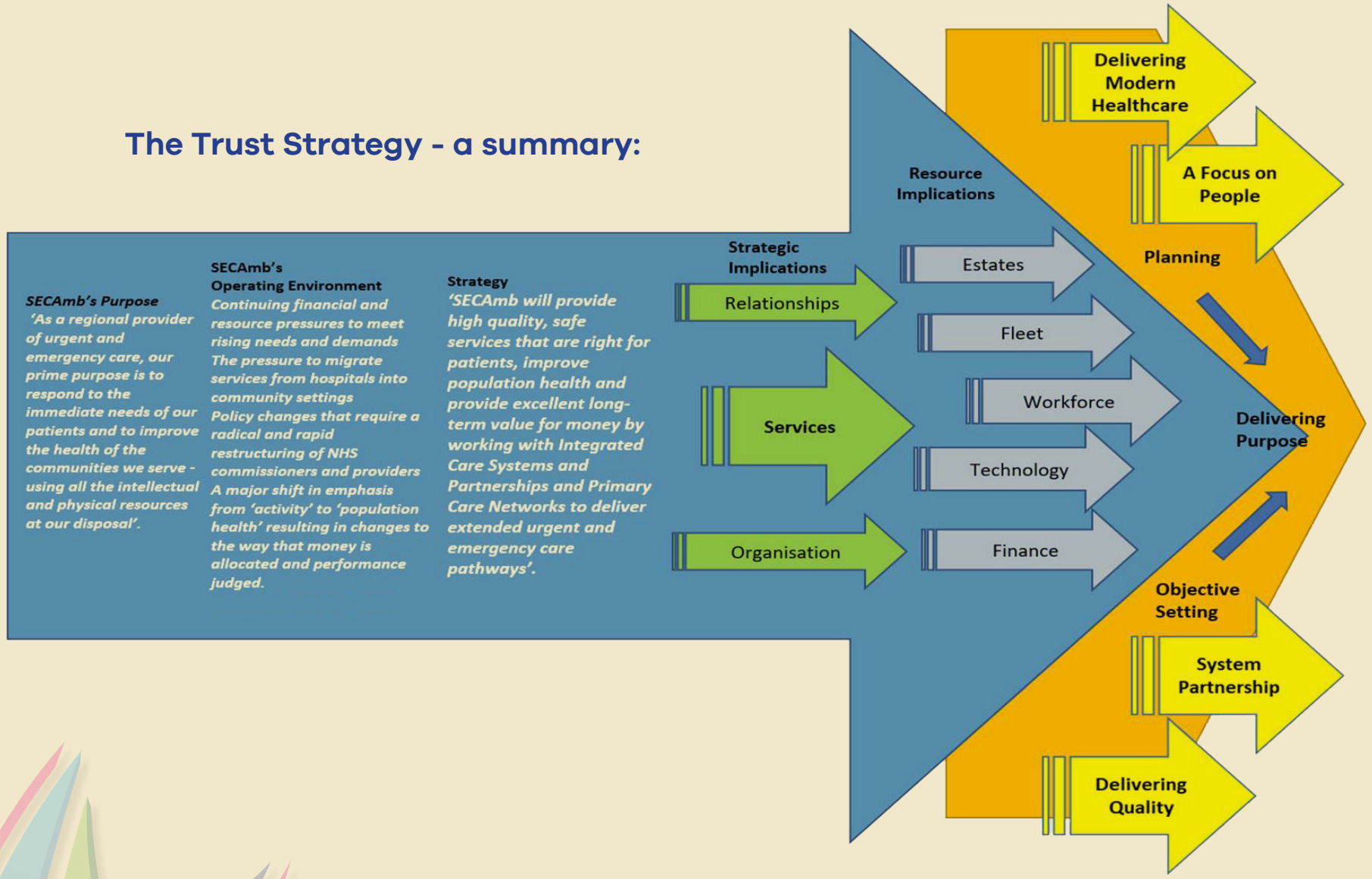
? *'Will this deliver the Trust's aim?*

? *'Is this part of achieving Better by Design?'*

As such, the BBD framework aligns directly to the Trust's Strategy and the subsequent Strategic Delivery Plan; the portfolio is simply the vehicle which will bring this to life. It pulls things together and gives alignment across the whole organisation and Executive Programmes.

better by design

The Trust Strategy - a summary:



Achieving the Trust's Purpose

The arrow above represents our Trust strategic direction. The table below shows how the Strategic Delivery Plan through the BBD portfolio delivers our strategy.

better by design

	Organisational Strategic Objective	Strategic Delivery Plan area	Better by Design Programme
1	Develop and deliver systematically driven resource plans required for our 999, 111 and other services including people, fleet, and other enablers to deliver high quality patient care.	System Leadership / Engagement	External Relationships, Contracting and External Finance Performance Cell and Predictive Planning
		Demand / Plan / Development	Care Delivery Model
2	Create, cultivate, and deliver a culture of continuous improvement and sustainability to provide a better, less resource intensive service to our patients.	Continuous Improvement	Better by Design Portfolio (All programmes) – Golden Thread
3	With other care providers and systems, develop improved urgent and emergency care pathways to improve the outcomes and experience for our patients and contribute to system sustainability.	System Leadership / Engagement	External Relationships, contracting and external Finance
		IUC and integration of 111 and 999	Care Delivery Model
		New Business / Compendium of services	Care Delivery Model
		Develop use of technology & digital, Inc. Informatics	Golden Thread
		Continuous Improvement	Golden Thread
4	Create and deliver a digital programme supporting integration and innovation to improve patient and staff experience, quality, and safety.	IUC and integration of 111 and 999	Care Delivery Model
		Develop use of technology & digital, Inc. Informatics	Golden Thread
5	Through partnership working with systems and providers, become the partner of choice for urgent and emergency care projects, to improve our core services and grow from them.	System Leadership / Engagement	External Relationships, contracting and external Finance
		IUC and integration of 111 and 999	Care Delivery Model
		New Business / Compendium of services	Care Delivery Model
6	Re-define our high performing ambulance process model and ensure our estates, fleet and other enablers support this model to improve the efficiency of all our systems.	Demand / Plan / Development	Performance Cell and Predictive Planning
		Continuous Improvement	Care Delivery Model
7	Develop, inspire and support our increasingly diverse workforce to become a clear employer of choice, with our people inspired to continually improve the quality and efficiency of patient care across our services.	People, Education & Organisation Development (OD)	Clinical Education Strategy Staff Development, Training and OD

4

Making change work

No matter where you work there will be several views and opinions of what the good management of transformational change looks like. Whilst it is true that there is a need to accommodate different priorities for departments, we will ensure that the overarching requirement for the change remains undiluted and clear, and we will continue to focus on the achievement of the core aims of the organisation. This means that all plans are integrated and aligned. To achieve this, we require an absolute honesty across the organisation, with robust challenge to make sure that we are looking at the right things and then an acceptance that the agreed end results will be adhered to.

For this change to be successful it needs to look and feel simple - complexity itself can be a deterrent as the recent response to the pandemic has shown. Many things that were considered 'too hard' prior to Covid-19 were delivered with pace and quality. This ability to deliver and learn at pace is a learning that BBD intends to adopt.

By bringing all the key plans under one overarching transformational portfolio, we will ensure that there is a clear critical path supporting the implementation of the organisational transformation. We will work with all areas so that the key change programmes and plans are identified and that inter-dependencies are highlighted and managed as part of the process. Finally, the programme oversight and governance will ensure that the Executive team is working in a single direction, ensuring that there is engagement throughout the organisation.

The illustration on the following page shows the programmes within the BBD portfolio and how these are dependent on each other. We differentiate between the structural change which is required in our approach to the future (planning and forecasting, our relationships with the Integrated Care Systems and the need to ensure that we are structured appropriately) and the elements below the red dotted line such as education and staff development, which are deemed to be continuous improvement (that is, they will always be a core part of our everyday business and by being better at each of these and by aligning them to work together rather than separately we will deliver better outcomes).

Research undertaken into leading companies that embarked on transformational change highlighted that successful change portfolios had developed approaches called the key "axes of change":

- **Top-down direction setting** to create focus throughout the organisation and develop the conditions for performance improvement.
- **Broad-base inclusive performance improvement** to get people at all levels to take a fresh approach to solving problems and supporting efforts to improve performance and ultimately patient care.
- **Cross functional core process redesign** to link activities, functions, and information in new ways to achieve breakthrough improvements in quality, timeliness, and costs as applicable.

These three approaches (axes of change) are already applied to the BBD portfolio and create a balanced integrated framework to bring together current critical initiatives into a coherent overall change portfolio.

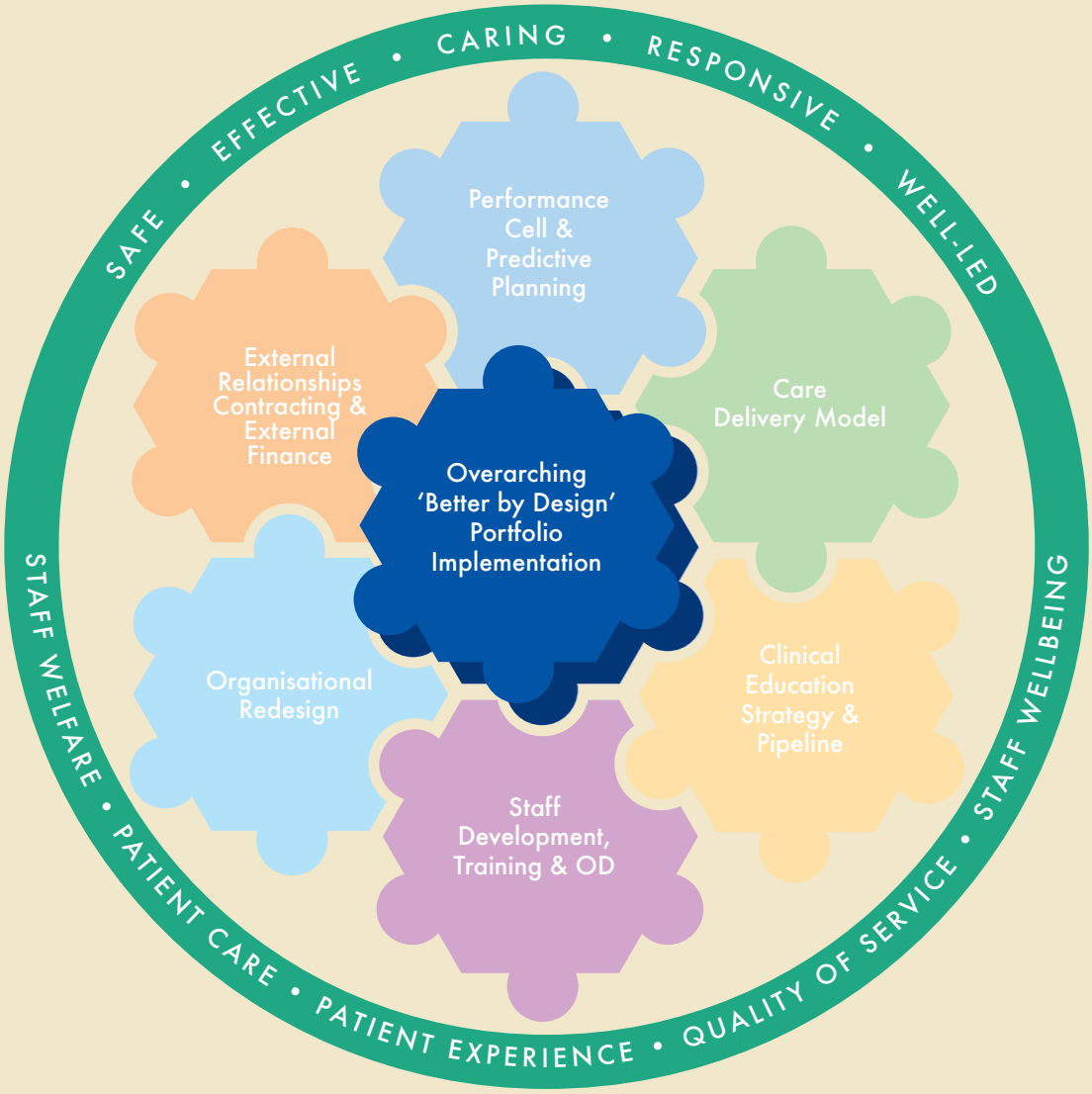
The BBD portfolio has already defined the three guiding principles for the organisational change:

- ***Getting the basics right first time***
- ***Standardisation of tasks and processes across our organisation***
- ***Strategic alignment so that we are all pulling the in same direction***

All key programmes currently progressing in the Trust should be aligned with all the above principles but are still operating independently.

5

Better by Design - the overarching integrated transformational portfolio implementation – the pieces of the puzzle



When designing the portfolio of programmes that sit within Better by Design, all the pieces need to fit together. The central piece of the puzzle therefore does not deliver a programme of work but rather pulls together and co-ordinates all the elements to ensure alignment, fit and that the golden threads are inherent within each of the six programmes of work.

Some of the programmes within the portfolio of Better by Design already exist within the organisation. Others, such as the Care Delivery Model and Performance Cell have been started recently as part of the work of BBD. The aim of the central piece of the puzzle is therefore to create a truly integrated roadmap and critical path to achieve the Strategy. The outputs of this piece will be a single set of agreed goals and success metrics for these key interdependent programmes with an ability to evaluate progress against each agreed milestone for each programme.

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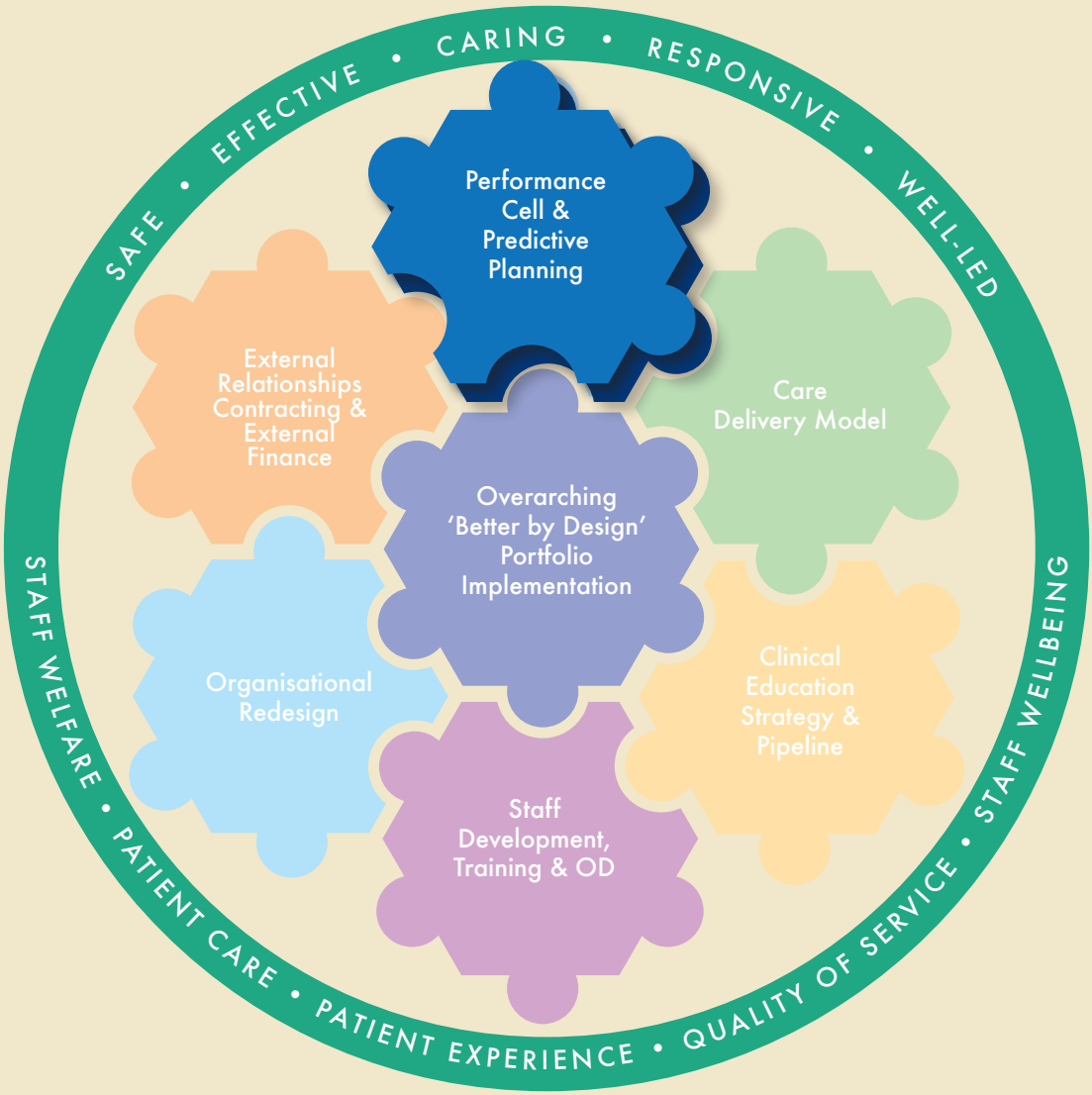
Bringing this number of internal change programmes together into a single and balanced integrated Transformation Portfolio is key. Whilst it is acknowledged that pockets of change initiated by an individual or a group within a department are good role models for the rest of the organisation, it has not been shown as a successful change model when used to initiate or manage organisational-wide change.

Combining all the key programmes into one framework or portfolio means that the Better by Design Portfolio Board will facilitate discussion and challenge the status quo.

In some ways the role of the framework is to create an Innovation office, dedicated to changing the existing status quos so that a new order can emerge. This may even include challenging the very attributes that makes the Trust successful. Transformation is hard work, and it will involve agendas the organisation may have difficulties with such as culture change, restructuring, human behaviour and others. It will require both change management and project/ programme management as outlined in this framework document. If done right it will support innovation across the Trust rather than just in certain areas.

5.1

Performance Cell & Predictive Planning - Sponsor: Executive Director of Planning



The Performance Cell will improve the quality and sustainability of our services through advanced analytics. This will be achieved by bringing together knowledge of our service, with the data, insights, and capability to anticipate our future demands and define how best to respond to them. This will support the design of the Care Delivery Model.

SECAmb has historically determined the resources required to deliver performance and maintain patient safety using a traditional planning approach. This is based on shift rotations that have been in place for several years, supplemented by relief shifts, private providers, overtime and other incentives. This traditional approach also currently takes place at a local level, meaning there is no coordination or consistency across the Trust.

Until recently, we were planning against a demand and capacity analysis conducted between 2016 - 2018. The world has moved on since then and the impacts of the pandemic have meant that the assumptions which underpinned this work are no longer as relevant.

This gap in our capability has already been recognised by the Board and the appointment of a new Director of Planning was the first stage in this process. Alongside this appointment, new structures have been created with the Performance Cell, Business Intelligence and Management Information and Operational Workforce teams aligned in one directorate.

By testing different forecast scenarios against different operational delivery models, using advanced analytics and simulation, we will be able to establish what the most optimised use of our resources is. This will define what our target Care Delivery Model is, and what the requirements for all enabling support services are, to ensure we put patients and staff first in the way we deliver our operation. This will include not only workforce plans and target skill mixes, but also inform what our strategies in fleet, logistics, estates, clinical education, recruitment, etc. need to deliver, to support our Care Delivery Model.

By better understanding the levels of resource which are required at each hour of the day, supported by changes in our processes and virtual model, we will be able to better match our demand requirements. This will not only improve patient care by ensuring consistent delivery of ARP, but will also in turn will help us to consistently provide timely meal breaks and significantly reduce end of shift over runs.

Our ability to use the technology, tools, and new expertise within the Performance Cell for medium and long-term planning will move SECAmb from being reactive to proactive in its planning and decision making.

The Performance Cell programme of BBD will work closely with all other programmes within the BBD portfolio ensuring that the outputs from each area are reflective of reality and start from a credible baseline upon which to test different ways of serving our patients and communities.

It is also expected that outputs of the Performance Cell will be shared with Commissioners as a basis for agreeing future contracts. This is a significant change for the Trust that will impact many parts of the organisation and provide resilience and hence is a component part of the Better by Design programme of works.

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5.2

Care Delivery Model (CDM) - Sponsor: Executive Director of Operations

The Care Delivery Model is a major focus of Better by Design and will drive changes in all areas of SECAmb. Our aim is always to provide the best possible care to each patient.

Within our organisation Operations should be seen as the internal "customer". We must design ourselves this way so that all effort and focus is aligned on supplying the customer with all that it needs to deliver the new Care Delivery Model. This means having the right number of staff, with the right infrastructure and equipment to deliver our patients' needs and having the right policies in place to support all staff throughout their shift.

In the longer term, SECAmb will be able to work with Commissioners and the local Health System to manage the way that demand presents itself to us. In the meantime, and with the constraints that the NHS is currently facing, we need our immediate focus to be on the way in which we plan resources to the demand we receive.

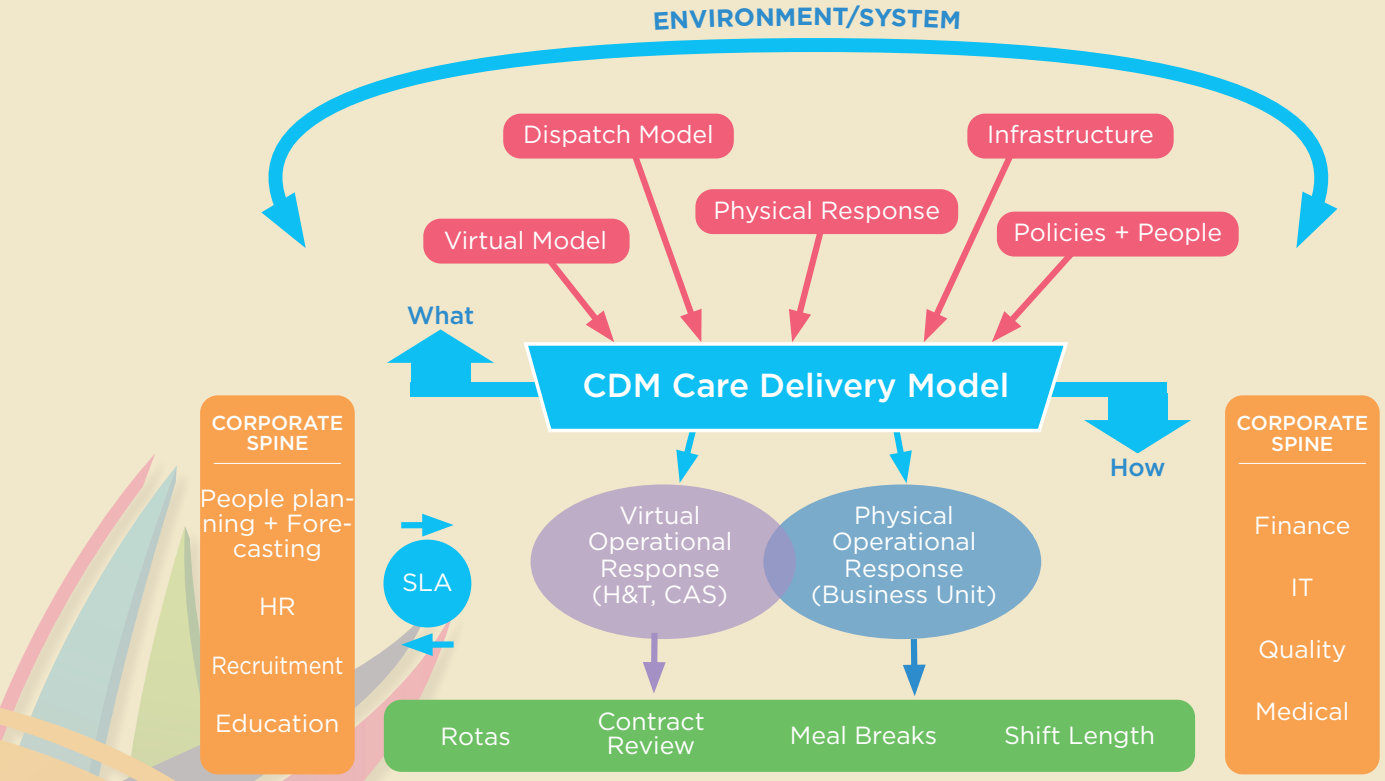
We know that:

- currently we deploy an ambulance to many calls that could benefit from a different type of response. This leaves other patients stranded in the community as we have no resources to send, staff frustrated and under pressure who then may need to respond to patients who have been waiting for hours.
- the NHS 10-year plan sets out clearly the need to reduce inappropriate conveyances and where possible use alternative responses and pathways.
- SECAmb is generally in the lower quartile of national performance measures but provides a clinically safe service. We also know that pre-pandemic, our performance metrics for the highest acuity patients in Categories 1 & 2 were relatively good but that could not be said for patients in Categories 3 & 4.
- historic, and unstructured changes of direction to the operating model mean that our policies and operating instructions are confused, often contradictory and, in some cases, obstruct timely patient care. This was not the intention but the layering of new policies and instructions over the existing ones has had unintended consequences.
- the recruitment of qualified front line staff is problematic and so most staff were recruited at the ECSW level (band 3). The ECSW to Paramedic pathway takes a minimum of six years and there is limited ability to train people to the levels required. Our skill mix is lower than we would like, and Paramedic vacancies remain (circa 52% paramedics in skills mix has been achieved to date).
- peer review of our dispatch model and processes has shown that they are overly complicated and inefficient. This is in part due to the volume of operating instructions which are layered on top of others.

By changing these things and aligning with the other elements of BBD such as future planning and better funding from our Commissioners, we will ensure that our new operating model is fully staffed and resourced and that we are managing our demand and supply in an efficient and effective way for the benefits of everyone.

The Care Delivery Model programme therefore looks at the need to change the way we do things. It will enhance our focus on virtual triage including virtual See and Treat via the enhanced use of video triage, for example. This will mean that when we do send a physical resource to a patient, it will be appropriate. Clinical supervision at all levels is also a key theme for this programme.

We will need to work with all areas of the Trust to change our infrastructure, education and the way we gain support from corporate services and with our system partners to change pathways and have more integration with Primary and Social Care to make this work.



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5.3

Clinical Education Strategy & Pipeline - Sponsor: Executive Medical Director

Clinical Education is a critical enabler for the organisation and in particular the new Care Delivery Model. Ensuring a consistent pipeline of staff at the right skill mix and aligned to the outputs of the Performance Cell's future planning is key to the delivery of all three aims of Better by Design.

We also recognise the need for continued professional development, especially within our patient facing roles, which must be achieved in the times of year when pressures are reduced. This will result in better prepared and more confident people and higher levels of morale. We will continue to work in partnership with Higher Education institutions which support the feed into the Paramedic pipeline and potentially also supports other professions and the development of our specialist professions.

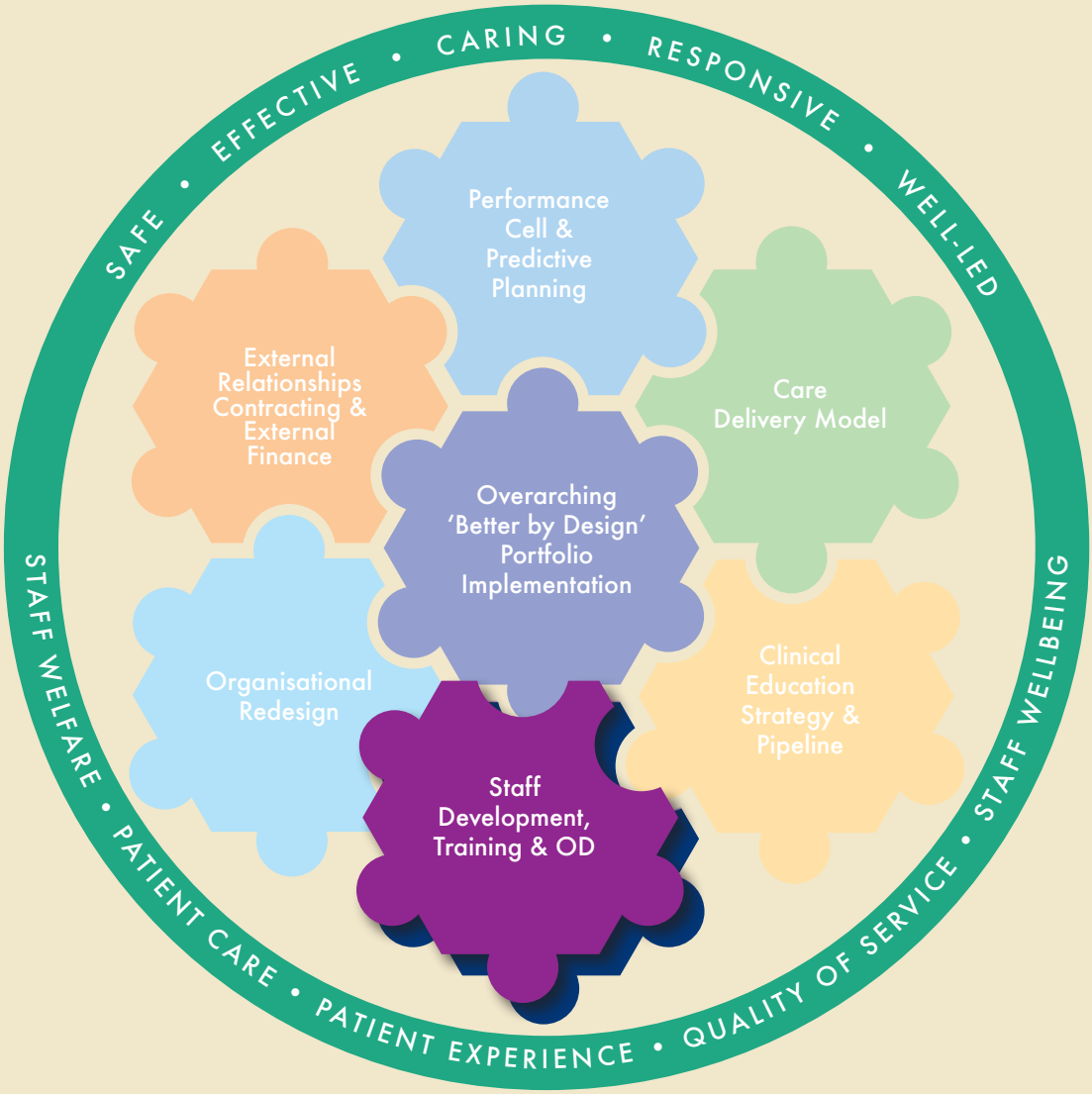
From our work in the multi-disciplinary 111 area during COVID-19, it is very clear that we will need to move to a more inter-disciplinary skill set which will also require training and supervision.

A Clinical Education strategy is already under construction. This aims to create an education department that meets the needs of the learners, the organisation and supports the Care Delivery Model.

As the annual planning cycle matures, the requirement of Clinical Education to meet the patient-led operational demand for people, clinical and driver training will be enhanced. It will also support much longer-term planning and investment decisions made.

5.4

Staff Development, Training & OD - Sponsor: Executive Director of HR and OD

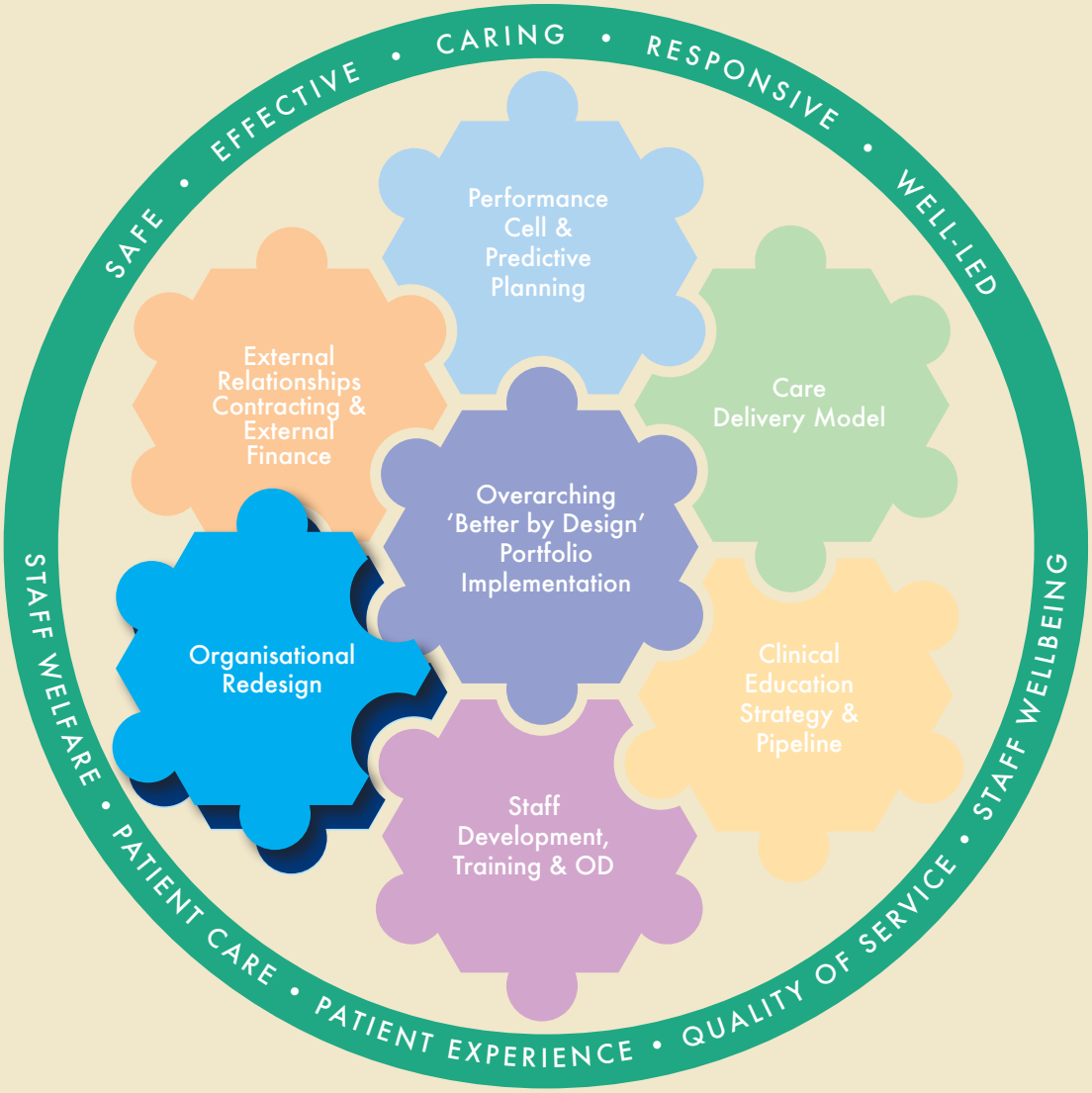


SECAmb, for many years, has not prioritised the development of its people. This programme will consider Learning and Development in this context and will additionally look at the approach to succession planning and talent identification. Included within this is how we can offer the right development and learning packages for everyone, including our aspiring managers and leaders of the future.

Work in this space has already commenced. The role of BBD is to ensure that it is aligned with the other areas of the programme to ensure that the outputs are resilient in the longer term. For example, how do we consistently manage the abstraction of staff to ensure that when it gets busy, we do not stop OD activities.

5.5

Organisational Re-design - Sponsor: Chief Executive Officer



As we redesign the way we deliver services we must also ensure that SECAmb is structured in a way that supports this. This programme is set up to ensure that our internal capacity is organised in the best way to do this and to ensure that we are resilient in the long term. As such, we will look at the organisation as a whole entity and assess how it needs to look to support our strategic ambitions and deliverables.

This journey has already started with a restructured top team including new roles in Planning and the introduction of a Chief Operating Officer for the first time.

We will, over time, look at all other roles within SECAmb and assess how they directly contribute to the achievement of our goals. It is important that everyone understands that this is not a cost cutting exercise, but rather an alignment of roles to organisational requirements, making sure that everyone is contributing to our stated aims and that there is no duplication.

Our aim for this programme is to have the right people, doing the right things in a way which benefits the population we serve.

5.6

External Relationships, Contracting & External Finance - Sponsor: Chief Operating Officer

This programme focuses on the environment in which SECAmb operates. The development of Integrated Care Systems and the move away from CCGs has made the operating environment far more complex for regional providers spanning multiple systems.

SECAmb is represented at many forums but not in a uniform way. The funding flows are changing and the opportunities under the NHS 10 Year Plan are plentiful. But this must all be aligned to the delivery of the Trust Strategy rather than piecemeal responses by individuals or departments.

When horizon scanning, the public spending reviews are expected to limit investment in services, and it is highly likely that Integrated Care Systems will have less funding to flow through to provider organisations. By integrating all aspects of the transformation, synergies and efficiencies will be made. This will mean in simple terms that we can demonstrate to the systems who commission our services that we are a trusted partner. This in turn will open (or re-open) opportunities such as Patient Transport Services (PTS).

It is also through this programme that the business development, place vs system and population health and prevention agendas can be matured and aligned to the requirements of the commissioners of services.

6

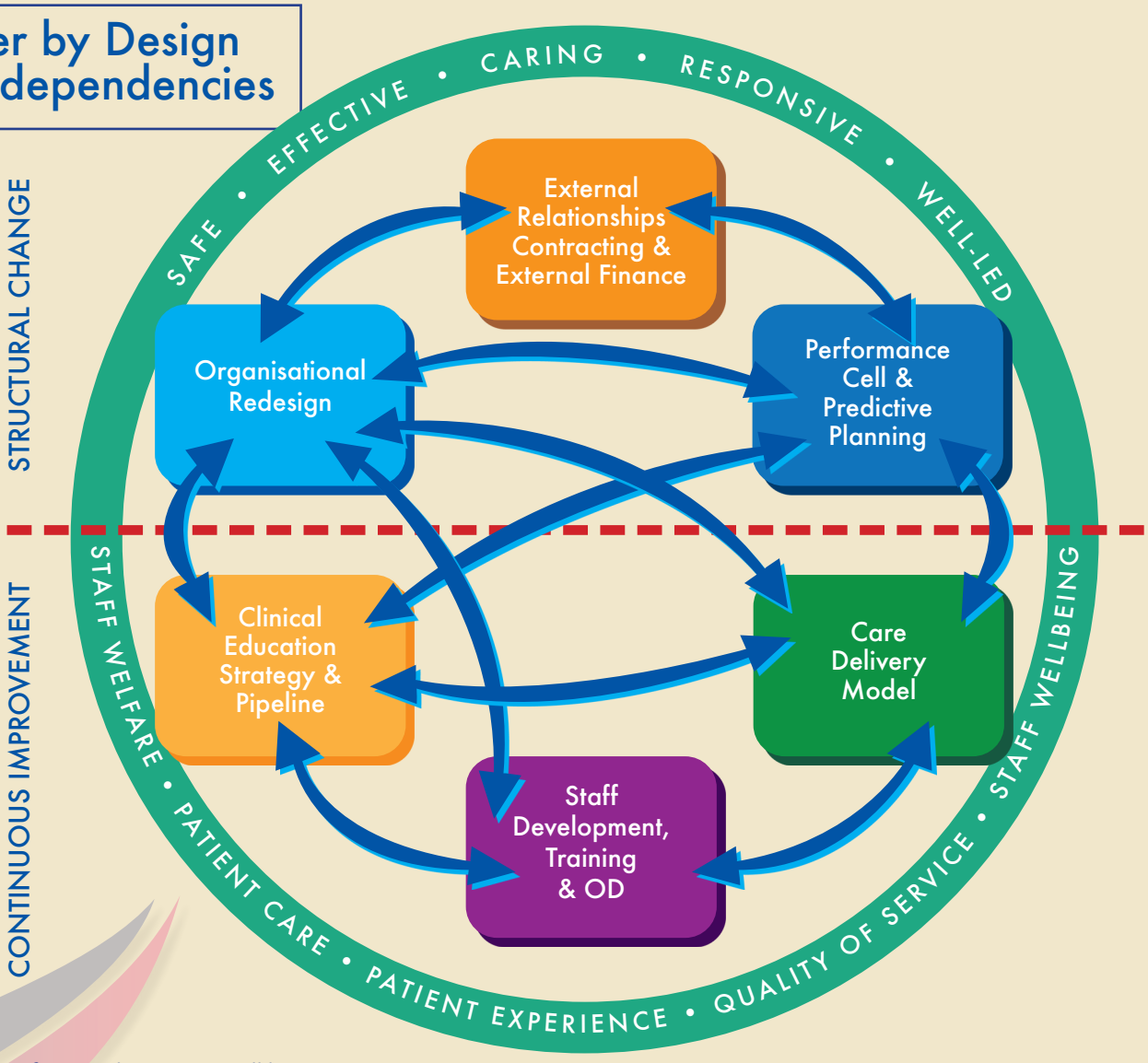
Better by Design Integrated Framework Programme Governance

Governance of the portfolio is important to ensure line of sight to each of the moving parts for the Executives and to provide assurance for the wider Board. EMB members will form a guiding coalition, where each Director is responsible for their programme and who will work with their teams and colleagues across departments to implement their programme.

The Better by Design portfolio enables us to ensure there is collaborative working rather than silo working and that interdependencies are captured and addressed.

By interdependencies we mean the identification and management of dependencies outside the direct control of a programme/project within the framework, for example between different workstreams within a programme or between the different programmes as shown on the illustration below. The dependencies (inputs/outputs) influence our planning and can even affect outcomes and will typically take the form of information shared, which means one programme cannot proceed until this information is received. They can also be a physical item (a product), business outcome or a benefit.

Better by Design interdependencies



**The Sponsor of Better by Design will be the driver and facilitator for EMB and Trust Board conversations so that there is one integrated tangible, effective (and manageable) portfolio of change.*

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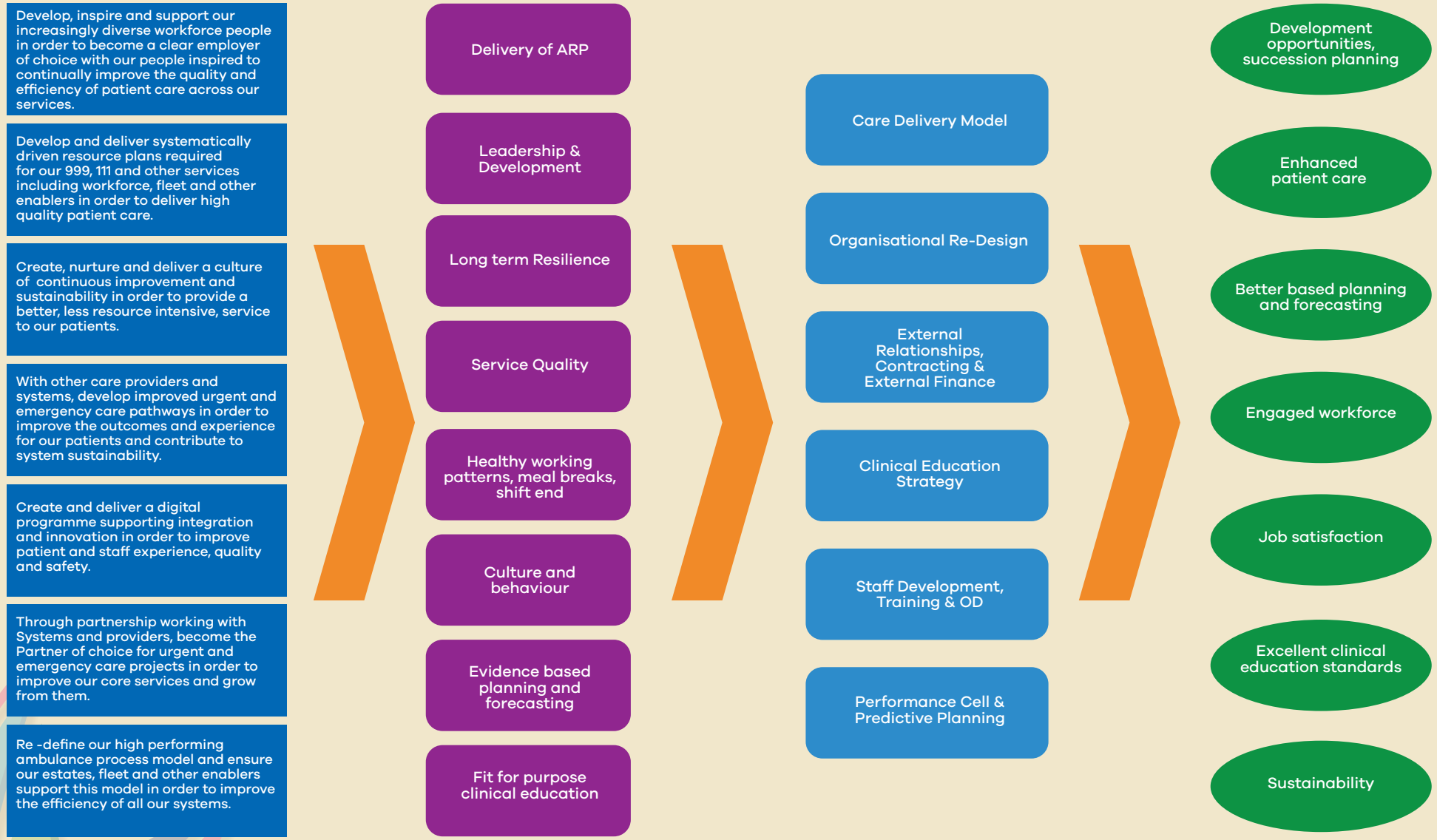
We will also be tracking the benefits outlined below:



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The illustration below shows how BBD fits into the normal internal governance arrangements of the Trust. BBD is not a duplicate management structure but is a key component of alignment, of making sure that the entire organisation is working in the same direction.

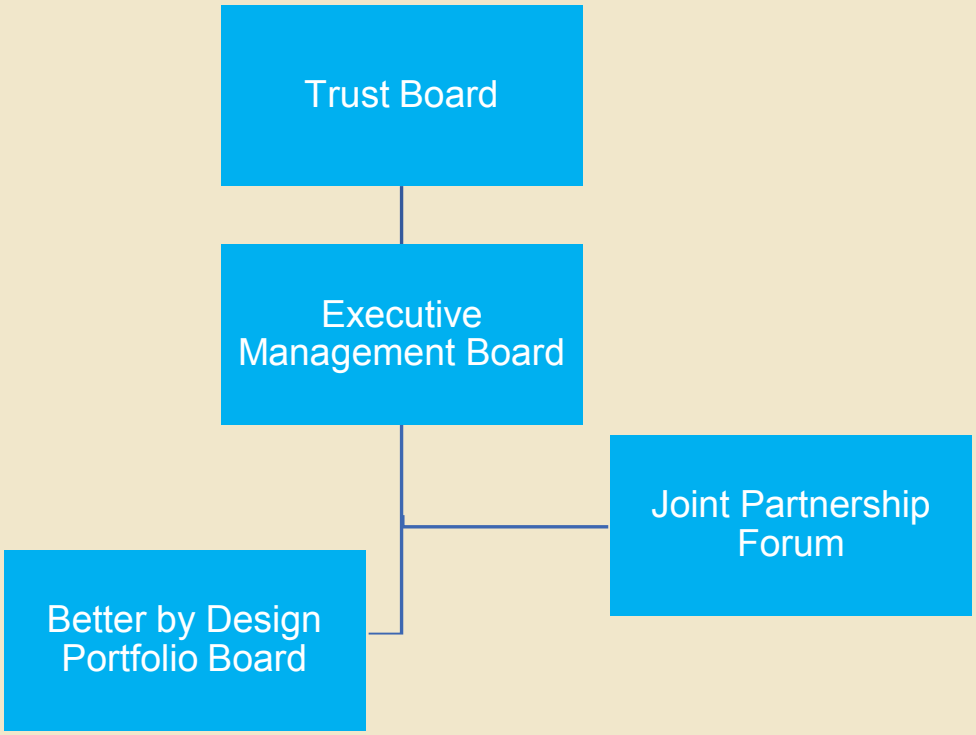
Better by Design will be led by the Chief Executive and will be managed through the Executive Management Board and overseen by the Trust Board.

The illustration below shows the governance within the BBD Portfolio. Each programme of BBD (led by an Executive Director) will report into the BBD Portfolio Board (chaired by the COO) which in turn reports into the Executive Management Board (chaired by the CEO).

The CEO will then report to the full Trust Board on the progress of the programme as an integrated part of the day to day running of the Trust.

A Trust Board subgroup has also been set up with the following remit:

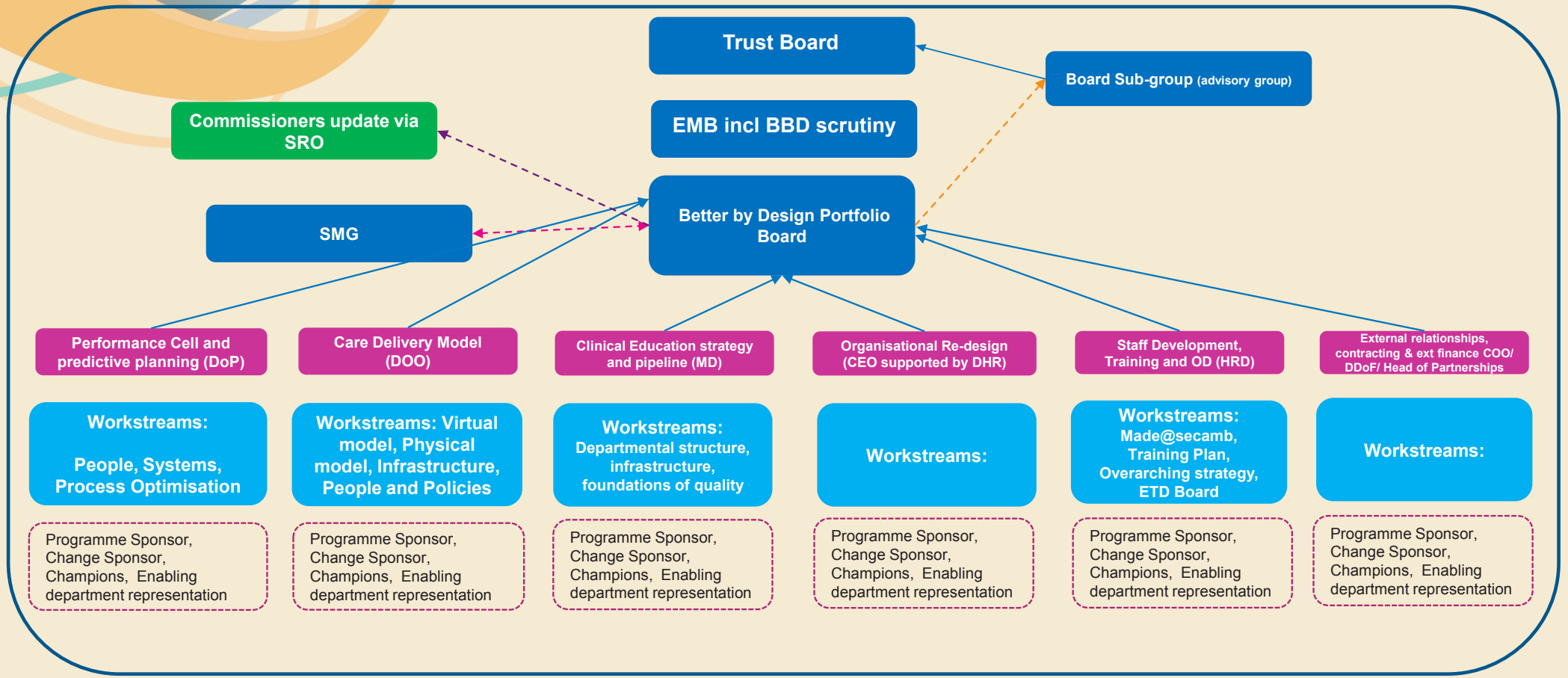
- To enable discussion of key points of the BBD framework
- To act as a critical friend
- To consider and discuss issues arising from the Portfolio to feedback to the Trust Board as appropriate.



Trust Strategy

EXTERNAL

INTERNAL



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

7

Engagement & Communication

This document is the first step of a wider engagement and communications plan for the Better by Design framework. We are acutely aware that this framework document may be the first time you have heard about Better by Design and certainly will be the first time that it has been shared in this detail.

The only way we can make this work is to encourage engagement with all, by all. This includes all staff having the opportunity to help design the programmes where appropriate, communicating our visions and expectations clearly to all, keeping all staff informed about Trust performance, and providing regular feedback. We want to make sure that everyone feels valued and respected, and that their ideas are being heard and understood. Good engagement will support staff in feeling that their work is meaningful, and we all have been entrusted with the delivery of the new SECAmb.

Communication is a critical part of creating and maintaining employee engagement. Engaged colleagues are more likely to be productive and higher performing. They also often display a greater commitment to our values and goals.

7.1

The Engagement Roadmap

8

Next Steps

Research suggests that about 70 percent of the time, efforts to fundamentally change the performance of an organisation don't work. The goals that are set are never accomplished, or perhaps they take too long, or the change is only temporary, and gains are frittered away after a couple of years.

Rarely do people misunderstand what needs to happen. More often, the issue is execution.

So how do we beat the odds?

We want to start quite simply with this fact: that old habits die hard and transformational change really does require individuals throughout the organisation to behave differently on a day-to-day basis. It often means changing processes and procedures that have been in place forever. We know this is going to be hard, because it's a natural human instinct to resist change. So, we have got to work together and address how people (all of us) think and act in their day-to-day work.

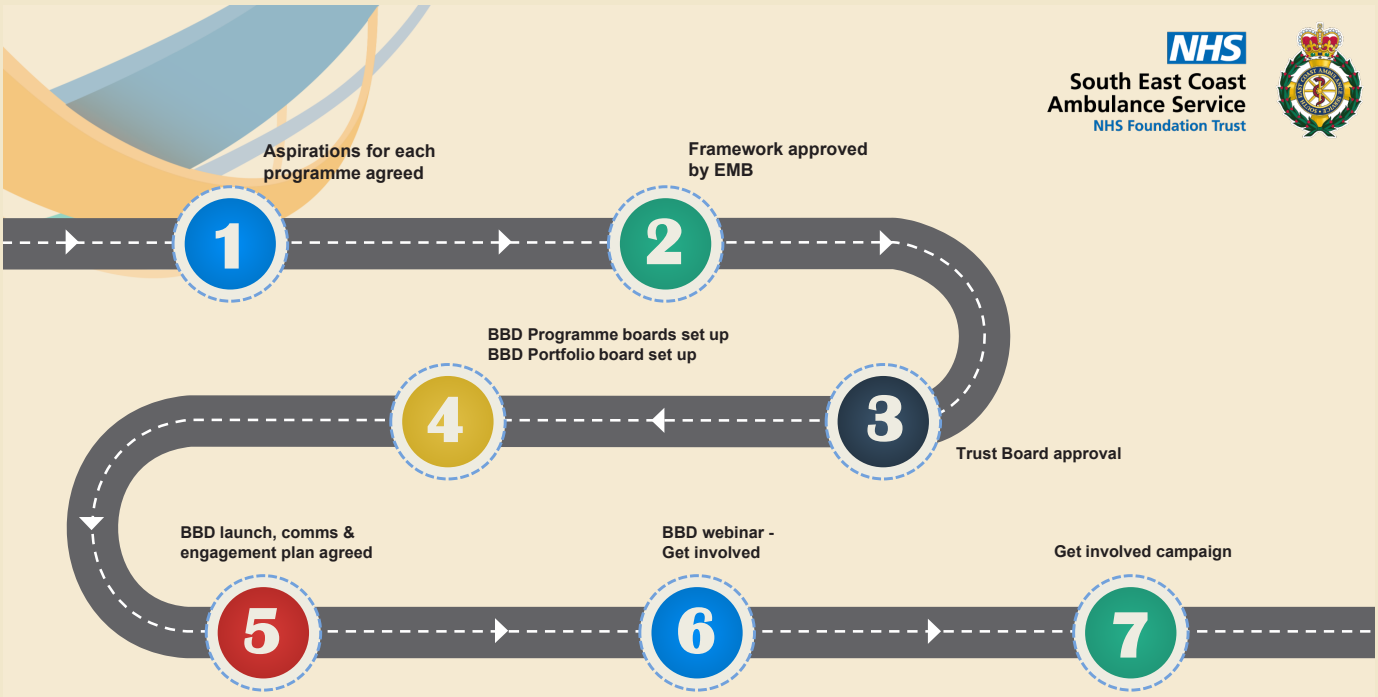
Our next steps: **Mobilise, Move Forward, and Sustain**

In addition to our engagement roadmap:

- We will be working with each Programme Sponsor to gather the right information to be able to identify key priorities and resources needed.
- We will start with a business case to ensure that we have the right and 'most importantly' enough people to manage this transformation.
- We will be advertising opportunities to get involved soon.
- Once the business case is agreed, the programmes will be able to develop their detailed plans and engage with staff across all areas to capture ideas and views.
- We want to create a sense of community and opportunities for people from all areas of the organisation to get involved and we will be using all forms of two-way communication to break down silos and improve cross-departmental collaboration.

We look forward to seeing you at a Better by Design event soon!

NHS
South East Coast Ambulance Service
NHS Foundation Trust



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

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Glossary of terms:

ARP	Ambulance Response Programme
BBD	Better by Design
SRO	Senior Responsible Owner
CQC	Care Quality Commission
PTS	Patient Transport Service
SLA	Service Level Agreement
OD	Organisational Design
QIA	Quality Impact Assessment
EA	Equality Assessment
EMB	Executive Management Board
OCG	Organisational Change Group
SMG	Senior Management Group

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	87-21
Name of meeting	Trust Board		
Date	31.03.2022		
Name of paper	Investments		
Author	Company Secretary		

There are three investment decisions for the Board to consider for approval. Each one has been reviewed by the finance and investment committee, which recommends their approval by the Board. A paper related to the DCA replacement plan is enclosed (Appendix A) and summary of two business cases (Appendix B & C) are summarised below:

OTL Establishment	
Whole Life Cost	**Source of Funding**
Total capital - £NIL Total operating cost - £1,823,011 Total Whole Life Cost - £1,823,011	From 2022/23 onwards two posts will be removed from Operations Management to part fund this increase, a saving of £156k against the total increase in cost in 2022/23 of £470k. There is no funding to cover the remainder of the increase.
Revenue Impact (Operating and Non-Operating Costs)	
In year revenue impact (2021/22) - £452k Next year's revenue impact (2022/23) - £314k	
Brief description of proposal	
The primary aim of this proposal is to address the discrepancy between the 2021/22 current OTL budget and the current OTL resourcing across the Trust. In addition, it is recommended that the methodology used for calculating the OTL establishment is revisited. In the absence of an agreed methodology, the financial workings have built in a 4% annual growth for OTLs. An offsetting saving has been identified through the disestablishment of two posts within Operations Management.	

Frontline Ops Covid-19 Response - H2	
Whole Life Cost	**Source of Funding**
Total Capital - £NIL Total Operating Cost - £3,757,986 Total Whole Life Cost - £3,757,986	The costs for the first half of 2021/22 financial year were fully reimbursed. The Trust has been allocated COVID-19 funding of £8.6m for the second

Revenue Impact (Operating and Non-Operating Costs) In year revenue impact (2021/22) - £3,758k Next year's revenue impact (2022/23) - £NIL	half of the year. This covers the Covid-19-related costs for our entire 999 and 111 activities, and the value is expected to cover the Operating Unit costs covered by this case.
Brief description of proposal Approval of additional operational resources to offset COVID-19-related abstractions in the frontline operational service to cover the period 1 October 2021 to 31 March 202.	
[redacted]	
Recommendations, decisions or actions sought	The Board is asked to consider for approval each of the three investments
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes – included in the business cases

Agenda No	87-21

Name of meeting	Board – Part 1
Date	31/03/2022
Name of paper	DCA Replacement Business Case Cover Page
Responsible Executive	David Ruiz-Celada, Executive Director for Planning and Business Development
Synopsis	The Fleet Strategy sets out our requirements to meet the Lord Carter recommendations of meeting a standard National Specification van conversion DCA. In addition, we have a target of not having vehicles older than 5 years for van conversion, and 7 years for box conversions. Based on this, 41% of our current fleet is exceeding the target age. This paper seeks approval of the year 1 costs of a 5-year business case plan enclosed to put the Trust on a trajectory to have all vehicles <5 years of age by 26/27. Whilst this is based on a van-conversion Fiat Ducato at the moment as the only compliant vehicle with the National Specification, more manufacturers are developing compliant vehicles and we are keeping the decisions under constant review. This plan does not commit us to procuring the same vehicle throughout.
Recommendations, decisions, or actions sought	Approve the year-1 costs of the DCA fleet replacement plan.

DCA Replacement Cycle

South-East Coast Ambulance Service

1 Background

1.1 The last approval for Ambulance DCA's was in July 2020 when the Trust approved the "Ambulance and Single Response Vehicles Replacement and Uplift Programme Business Case" that covered investment in 20/21 and 21/22. This included 124 DCAs to replace box conversion Mercedes over 7 years of age, and van conversion Fiats of over 5 years of age, as per recommendations in line with the Lord Carter review.

1.2 Our target DCA fleet is 398, and with a 5-year replacement cycle, we require a consistent commissioning and de-commissioning throughput of a target 80 DCAs a year by 2025. Currently, 41% of our fleet is exceeding the recommended age.

1.3 As part of the NHS Standard Contract, we must ensure all orders of new standard DCA ambulances comply with the National Ambulance Vehicle Specification. In addition, the Trust has committed to 57 new DCAs in 22/23 and 23/24 (subject to business case), via the National Ambulance Vehicle Supply Agreement coordinated via NHSE/I.

1.4 We are reviewing the reliability of vehicles, on-going sunk maintenance costs, and fuel consumption, for each of our vehicle types and relative to age. This may result on us adjusting our fleet replacement cycle or preferred van conversion type based on our own data rather that the recommendations from the Lord Carter report. This, in addition to the on-going Fiat Ducato DCA safety review, will be factors affecting the overall replacement business case on a 5-year basis, and progress will be reported to FIC on a regular basis.

2 Business case for 22/23 replacement recommendation

2.1 The 5-year business case seeks approval of a trajectory for capital and revenue spend associated to getting the Trust to a 5-year replacement cycle. This means that in the short term, some vehicles will be of excess age, and the % of exceeding age vehicles will reduce over time. By 26/27, all vehicles will be of less than 5 years of age.

2.2 Having a target replacement cycle ensures we have a consistent requirement for the commissioning technicians and enables better fleet replacement planning on an on-going basis. Whilst the demands may change over time as we review our Care Delivery Model, this offers a consistent starting basis which is in line with our current Fleet Strategy.

2.3 For 22/23, the Board are asked to approve the Year 1 costs and purchase of 57 DCA in line with the 5-year business case enclosed. The new vehicles will be ordered in April-22 and converted and delivered through Q3 and early in Q4 of 22/23. This is a total of £6.39m whole-life costs.

2.4 For years 2-5, subsequent approvals by the Board will be required through the normal approval routes.

South East Coast Ambulance Service NHS
NHS Foundation Trust

BUSINESS CASE TEMPLATE

Operational Team Leader Establishment for 2021/22

3 March 2022

Author(s): Andy Rowe, Imogen Banks
Executive Lead: Emma Williams, Executive Director of Operations
Directorate: Operations
Business Case Ref: 2021-22 - 48
Version: V0.9
Date of approved summary QIA: 4 March 2022

Final Decision:

Date proposal reviewed	By	Decision made

Document Control:

Version Control:

Please record all key changes made to the document and how these have been approved (either person or committee				
Version	Date	Author and title	Summary of key changes	Approval by
V0.1	21/02/22	Imogen Banks	Initial draft	
V0.2	22/02/22	Rachel Murphy	Finance review	
V0.3	23/02/22	Andy Rowe	Content updated	
V0.4	24/02/22	Rachel Murphy	Finance input	
V0.5	24/02/22	Neha Gupta-Balaji	Minor narrative update	
V0.6	24/02/22	Imogen Banks	Content added	
V0.7	24/02/22	Yemi Phillips	Finance narrative section completed.	
V0.8	03/03/22	Andy Rowe and Imogen Banks	Narrative updates after ADoF review	
V0.9	03/03/22	Rachel Murphy	Update to finance tables to include financial savings.	

Review and Approvals log:

Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal				
Version shared	**Person and title or Committee**	**Date reviewed**	**Recommendation**	**Rationale**
V0.5	HRBP – Neha Gupta-Balaji	24/02/22	Supported	
V0.5	Executive Sponsor – Emma Williams	25/02/22	Supported	
V0.9	Associate Director of Finance – Philip Astell	03/03/22	Agreed to go forward to BCG	
	Business Case Group			
	EMB			
	FIC			
	Board			

1. Proposal Overview

Provide a summary of the whole case and include a brief background of the relevant area, proposal aim, current state, business need, all options considered and why they have been discounted and the preferred Solution. State the whole life cost.

Background

All frontline operational staff - including employees on Annualised Hours contracts and Bank Agreements - are line managed by Operational Team Leaders (OTLs). Therefore, the number of OTLs is expected to keep pace with growth in frontline operational staff numbers.

A previous business case (see Appendix C.1) was submitted in March 2021 setting out the case for the number of OTLs required to support forecast frontline operational workforce numbers in 2021/22. The business case proposed a new methodology for calculating the OTL establishment to better reflect the growing expectations of this key management group. The business case did not receive full executive support at that time.

From an operational point of view, the situation is no longer sustainable in a do nothing form, hence the submission of this new business case with a refreshed, pragmatic proposal.

Aim

The primary aim of this proposal is to address the discrepancy between the 2021/22 current OTL budget and the current OTL resourcing across the Trust (see Current State, below). In addition, it is recommended that we revisit the methodology used for calculating the OTL establishment. In the absence of an agreed methodology, the financial workings have built in 4% growth for OTLs.

Current State

Budget

The 2021/22 budget for the OTL establishment across the Trust is 156.7FTE. However, the current level of OTL resourcing is 163FTE. This equates to a difference of 6.3FTE OTL's in post over and above the current budget.

Methodology

Historically, OTL numbers have been calculated, at Dispatch Desk (DD) level, using the following formula:

- Sufficient OTLs to ensure that Operational Command runs 24/7 in each DD area; this equates to 6.0FTEs per Dispatch Desk area (total 84.0FTEs at Trust level); plus
- 0.5FTE OTL for every 18 head count comprising frontline employees (inclusive of Annualised Hours) and Bank Agreements.

Whilst this calculation methodology does ensure a fair approach to the allocation of OTL establishment proportionate to the number of staff in the Dispatch Desk (DD) area, it does not overtly take account of:

- Other duties that OTLs are required to perform on a per-DD basis e.g. delivery of key skills training, medicines reconciliation checks
- Other duties that OTLs are required to perform on a per-OTL basis e.g. attend Team C & F meetings
- The fact that in smaller Dispatch Desk areas (such as Hastings) a full time OTL would need to spend a greater proportion of their time providing their share of the Operational Command function, leaving them very squeezed on the time they have available to manage frontline staff after the other 'must do' per-DD and per-OTL duties above have been performed
- The fact that in larger DD areas (such as Brighton), by contrast, a full time OTL would spend a smaller proportion of their time providing Operational Command,

yet still be squeezed on time to perform line management duties because of the other 'must do' duties

Business Need

Our OTL's are a vital management group who are responsible for supporting every single frontline operational member of staff. Through consultation with multiple operational management teams across the Trust, the core duties of the OTL have been defined. This provides a list of the OTL must-do's and paints a picture of a week in the life of an OTL. The full list of core duties can be found in appendix C.2 but listed below are some of the key functions that the role fulfils:

- 1 x 24/7 operational commander for each of the 14 dispatch desks
- 1 x 12-hour ride-out per year with each member of staff
- A 2-hour annual appraisal with each member of staff
- Acting as a second in command (IC2) for 10 hours per day per each 14 dispatch desks

Benchmarking

Every ambulance service has a slightly different model and therefore external comparisons are not straightforward. For example, the London Ambulance Service has two roles that cover the functions which SECAmb's OTLs do - an Incident Response Officer (who does the Operational Command element of the OTL role) and a Clinical Team Manager (who does the station and clinical shift elements).

Options

Option 1 – do nothing

- No change to current budget for OTL establishment 156.7FTEs
- No change to the methodology for calculating OTL establishment
- Await natural attrition and acceptance of team sizes greater than 18

Option 2 (preferred)

- Adoption of new methodology for calculating OTL establishment
- Increase in the current budget by 6.3FTE to make a total of 163FTE OTL in 2021/2022 which matches the current actual resourcing
- Approval of the 4% future growth factor

Option 3

- Adoption of new methodology for calculating OTL establishment
- OTL headcount is increased to match in full the calculation based on the new methodology
- This equates to total 215.3FTE OTLs in 2021/22, 58.6FTE more than budget 2020/21 (156.7FTE)

Preferred Option

Option 2 – increase the OTL 2021/22 budget in line with current resourcing, adopt the new methodology for calculating OTL establishment (see Section 4, Preferred Option), and approve the 4% future growth factor.

It is acknowledged that from a national perspective the NHS is constrained financially. Correspondingly, the Trust may not be able to fund the cost of increasing OTL headcount to match in full the numbers of frontline staff (using the new methodology).
This was an important factor in why the previous business case (C.1) could not be taken forward.

However, the current state is not sustainable from an operational point of view. Therefore, the preferred option outlined in this proposal (option 2) is to increase the OTL budget by

6.3FTE to match the current OTL resourcing (163.0FTE). This is feasible within the financial constraints of the Trust. However, it is important to note that this means the Trust will need to accept that not all the OTL duties (as articulated in appendix C.2) can be achieved within this OTL establishment. This is especially true given the increase in headcount due to the amount of our employees opting to work on a part time basis. It is therefore recommended that the OTL duties are reviewed with the aim of reallocating some duties and re-setting realistic expectations for the OTL management group.

We also include a 4% future growth factor in the finances to ensure the OTL establishment increases in line with our frontline workforce.

This is a measured option which accounts for the financial situation of the Trust whilst still showing support for the OTL role now and in the future.

Whole Life Cost
The whole life cost of the proposal is £2.4m over a recurrent five year period.

2. Strategic Case

a) What will happen if we do not support the proposal? Is it a must do i.e. due to a regulatory requirement? Please highlight if this relates to a risk on the Corporate Risk Register

The OTL first line management role is a large and complex role which has a significant impact on the front line of our organisation. We have identified within this business proposal several downsides associated with not appropriately resourcing the OTL function, including:

- all the knock-on impacts of demotivation and burnout
- delays in dealing with complaints and compliance requests
- disparity between Dispatch Desks, increasing the likelihood of growth in staff grievances
- ability to carry out appraisals and offer support to frontline staff on a 1-2-1 basis (as reflected in central reporting which shows inconsistency in compliance)

The Trust's Consultant Paramedics, Urgent & Emergency Care (East & West) commented that:

"It is essential that healthcare professionals have robust and accessible clinical supervision and professional leadership at all levels. This has been described in various publications and best practice approaches in all other healthcare professional roles and is the focus of the 'AHPs into Action' report which was published in 2017[1].

Providing sufficient number of first line leaders at each level of practice will demonstrate the commitment that the Trust makes to it staff and, by association, the importance it places on providing safe, high-quality care for patients "

b) How does the proposal fit with the Trust's current strategies and Trust Objectives?

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

The Trust's strategy recognises that it will be our people who will turn the Trust's ambition of delivering caring, compassionate, sustainable, and innovative healthcare into reality. It also says that the Trust remains passionately committed to the people who work in SECAmb.

[1] AHPs into Action report available at: https://www.england.nhs.uk/ahp/ahps-into-action/

The OTL first line management role is a fundamental pillar in the support structure for our operational staff at the front line of our organisation who are directly looking after our patients.

Approving a measured uplift in the OTL establishment which takes into consideration both the requirements of the role and the Trust's current financial position will support the following priorities identified during the recent review of the Trust strategy:

- A Focus on People: Everyone is listened to, respected, and well supported
- Delivering Quality: We listen, learn, and improve

3. Economic Case

a) What options have been considered? Please provide a high-level summary narrative of the options.

Options	*Brief description*	*Benefits*	*Risks*
Option 1 - Do Nothing	No change to current OTL calculation methodology (see section 1, current state) No change to current budget for OTL establishment, of 156.7FTEs Existing teams are already running at a headcount of above 18	No extra spend	Budget overspend - current OTL resourcing is 6.3FTE above establishment Risk of demotivation, burnout and failure to consistently achieve all OTL 'must dos' Delays in dealing with complaints and compliance requests Disparity between Dispatch Desks, increasing the likelihood of growth in staff grievances Disbenefits: • No change to OTL turnover or sickness absence • No reduction in staff disputes and grievances • No reduction in clinical negligence cases • No additional contribution to improved response time performance
Option 2 (preferred option)	Adopts the new methodology for calculating OTL establishment (see section 1, preferred option) A middle ground between the full requirement (see option	Current resourcing of in post OTLs secured for the future by an increased budget. A considered increase in spend on the OTL establishment No recruitment required in current year	Increased budget costs in 2021/22 and thereafter The new calculation methodology developed through consultation with OTLs and OMs identifies there will remain a gap of 13%

	3) and the current budget (see option 1) OTL budget increased to a total 163.0FTE OTL in 2021/2022 which matches the current actual resourcing This equates to 6.0FTEs more than current budget 2021/22 (156.7FTEs) and amounts to 87% of the minimum OTL requirement (188.2FTE) based on the new methodology This option will ensure that current team sizes per OTL remain at a manageable 16-18 staff	The new methodology improves the OTL establishment in respect of potential growth in frontline workforce	without any efficiencies put in place Requires a review of OTL duties with the aim of paring back some duties and re-setting realistic expectations for the OTL management group. This may involve re-allocation of duties to teams in other directorates
Option 3	Proposed new OTL establishment calculation methodology applied in budget-setting every financial year This equates to a total of 215.3FTEs OTLs, 58.6FTEs more than current budget 2021/22 (156.7 FTEs), and 56.3FTEs more than current in-post OTL numbers (163.0FTEs) Average 12.6 headcount per OTL (inclusive of employees and bank workers), at Trust level (range 10.1 to 14.2 at DD level) The new methodology will require OTLs to deliver several key inputs (see later), including: **For employees:** • A robust and consistent supervision framework which blends direct operational support	A fair and transparent approach to the allocation of OTL resource at Dispatch Desk level Appropriately resourced leadership and management function for frontline operational staff Appropriate clinical supervision and leadership arrangements for all clinical grades, including operational managers OTLs enabled to maintain clinical competence and confidence through provision of rostered frontline ride-out shifts Staff receive on-the-job coaching, mentoring and clinical supervision from their line manager during rostered clinical ride-out shifts, resulting in anticipated reduction in SIs and Near Misses (and potentially clinical negligence cases and costs) Improved compliance with Trust policies and procedures Larger scale recruitment into the OTL role offers scope to strengthen the diversity of	Increased OTL numbers and costs in 2021/22, and potentially every year thereafter as OTL numbers would increase in line with increases in frontline staff numbers Removal of up to 52.3FTE* experienced paramedics from frontline operations (*215.3FTEs – current actual 163.0FTEs) Perceptions, particularly among external system partners, that SECAmb management structure is inappropriately rich, at the expense of patient-facing resources (but which could be managed through explanation of the contributions OTLs would make to frontline operations in rostered shift ride-outs)

	and oversight with professional supervision activities within a budgeted framework which is protected from surges in demand. • Two 11.5-hour rostered shift ride-outs per year with each direct report (OTL would not be supernumerary, therefore contributing the equivalent of 42.1FTEs of Experienced Paramedic to frontline Operations) • Three 1-hour one-to-ones with each direct report. • One 3-hour appraisal with each direct report. **For bank workers:** • Bank workers capped, at the equivalent of 10% of employee headcount, at DD-level • One 11.5-hour rostered shift ride-out per year with each bank worker (as above) • Three 0.5-hour one-to-ones with each bank worker • One 3-hour appraisal with each bank worker.	the OTL staff group and Trust senior leadership team in due course OTLs enabled to be better line managers and develop their leadership skills for their own career development (4 days of leadership training per 1.0FTE OTL per year is included in the abstraction rate) An increase in OTL morale (and potentially a reduction in attrition and sickness absence) Complaints and compliance requests dealt with in a timely manner Probable reduction in the number of staff grievances Avoidance of unbudgeted OTL overtime for core duties, at cost of c. £200k per year May improve B6 & B7 retention and serve to attract Paramedics and PPs with a future interest in the role to return to the Trust.	

b) What is the Net Present Value (NPV) and Return on Investment (ROI) of each of the options? Net Cost/(Savings)

	Option 1 - Do Nothing	**Option 2 (Preferred Option)**	**Option 3**
Net Present Value (at 3.5%)	0	1,707,876	18,756,449

The above has been confirmed by:	*Yemi Philips*

4. Preferred Option *(all sections from now refer to the preferred option)*

a) Please expand upon the preferred option, by providing full details of the proposal and provide rationale for why this will be the best way forward. Include consideration to strategic fit, deliverability and ease of implementation. What resources are needed; will it affect any other departments. What is the proposals impact on the environment and sustainability?

Option 2 – Adopt the proposed new methodology for calculating OTL establishment, increase the current budget to match current resourcing, apply a future growth factor of 4%

The preferred option set out in this proposal represents a middle ground between the full OTL establishment (as calculated using the new methodology) and the current state which is no longer fit for purpose. The approach was developed through operations and finance working together to closely consider the operational and financial situation of the Trust.

Budget uplift

The proposed increase in the OTL budget is 6.3FTE. This would bring the current 2021/22 budget (156.7FTEs) in line with the current OTL resourcing (163.0FTE).

Proposed new methodology for calculating OTL establishment

The proposed new methodology calculates the OTL capacity required to provide the following key functions:

- Operational Command function
- Line management
- Clinical supervision activity (as per Trust Standard Operating Procedure, including action learning, Continuing Professional Development, MSF, direct supervision [ride-outs])

A summary of the OTL inputs into each of those three functions is set out in ***Table 1***, below, and concludes that 215.3FTE OTLs are required under Option A and 188.2FTEs under Option B.

Although the methodology calculates that the minimum requirement for the OTL establishment is 188.2FTE, we know that this is not achievable for the Trust at the current time. Instead, the proposal sets out an increase in OTL establishment (see Budget uplift, above) which in effect provides 86.6% of the minimum requirement. Consequently, it is important to note that it will be essential for efficiencies to be made. Either within the scope of the role, or through the reallocation of some duties to other functions of the organisation. It is anticipated that this would focus on administrative and non-specialist tasks which currently fall under the remit of the OTL.

Table 1: Breakdown of OTL inputs using the new methodology

	Option A	Option B
1 Operational Command	1 x 24/7 OTL vehicular response per Dispatch Desk area	As per option A
	Total: 83.7FTE	Total: 83.7FTE
2 Line Management: employees		
2.A Per employee (headcount) per year	2 clinical shift ride-outs, providing equivalent of 42.1FTEs Experienced Paramedic capacity to the frontline	1 clinical shift ride-out, providing equivalent of 22.1FTEs Experienced Paramedic capacity to the frontline
	3 one-to-ones 1 annual appraisal HR activities (e.g. sickness absence, return to work) Coaching Total 49 hours per head	3 one-to-ones 1 annual appraisal HR activities (e.g. sickness absence, return to work) Coaching Total 37.5 hours per head
2.B Per bank worker (headcount) per year	1 clinical shift ride-out	As per option A
	3 one-to-ones 1 annual appraisal HR activities (e.g. sickness absence, return to work) Coaching Total 19 hours per head	Total 19 hours per head
2.C Contribution to delivery of key skills training	Total 874 hours per Dispatch Desk area	As per option A
2.D Other OTL duties, per 1.0FTE OTL	Attend Team C and Team F meetings, Datix, medicines reconciliation, SIs, investigations, health and safety reviews, HR activities, admin, welfare	As per option A
	Total 359 hours per 1.0FTE per year	Total 359 hours per 1.0FTE per year
Abstraction rate	28.2% abstraction rate. Allowing 4 days per 1.0FTE OTL for leadership development, 2 days to receive key skills training and 1 day to receive statutory and mandatory training	As per option A
TOTAL REQUIREMENT	83.7FTEs for OpComm 89.4FTEs for line management 42.1FTEs clinical shift ride-outs TOTAL 215.3FTEs	83.7FTEs for OpComm 82.4FTEs for line management 22.1FTEs clinical shift ride-outs TOTAL 188.2FTEs

Table 2: Summary of changes under Options A & B

	ESTABLISHMENT (FTEs)		
	Budget	Proposed option A	Proposed option B
	2020/21	2020/21	2020/21
Operational Command	83.7	83.7	83.7
Line management	73	89.4	82.4
Clinical shift ride-outs	0	42.1	22.1
Total OTL Establishment	**156.7**	**215.3**	**188.2**
Increase in line mgmt capacity		16.4	9.4

In 2020/21, if OTLs are able to do any ride-outs they do it supernumerary (3rd man).
In 2020/21+, OTLs will do clinical shift ride-outs as half of a DCA crew (not supernumerary) and therefore they will reduce the need for 42.1FTEs (Opt A) or 22.1FTEs (opt B) experienced paramedics.

Future growth

We have also included a 4% future growth factor in the finances to ensure the OTL establishment increases in line with our frontline workforce. This reflects the direct correlation between OTL's and frontline operational staff whereby all our frontline workforce - including employees on Annualised Hours contracts and Bank Agreements - are line managed by OTLs. Therefore, the number of OTLs should be expected to keep pace with growth in frontline operational staff numbers.

This is especially true given the increase in headcount which is due to the amount of our staff opting to work on a part time basis.

Deliverability / ease of implementation

- The preferred option outlined in this proposal, in terms of real time OTL establishment, is already being delivered
- The review and reallocation of OTL administrative duties will be a separate piece of work which will require SME input from across the Trust
- We are confident that this is achievable and that we can bridge the 13% gap identified. This is based on wide consultation of current post holders which has already taken place to identify what the essential elements are to the role, as part of an informal time and study motion of multiple team leaders
- We now come out of the COVID pandemic with improved structures and tools which will help to ensure regular appraisals, ride-outs and 1-2-1 staff support can be maintained whilst the reallocation is worked through
- There is no recruitment required for the proposed change as the uplift will see the budget come into line with the current in-post OTL numbers

• Although there are initiatives in train e.g. BBD, that could result in a change in the way we provide operational management, NHS guidelines and our own polices are indicative of smaller teams, as per the extract in appendix C.

b) How will you measure the benefits of the preferred option? What Key performance indicators (KPIs) will you use? Please note that proposals will be rejected if there is no benefits realisation plan

No.	Benefit Description	Indicator and how is it recorded	Current and Target Measure and Change	Financial Saving if applicable	Timescale	Assumptions

1	Appraisals completed on time	Central reporting	Current this year is 32.09% Target is 100%	N/A	12 months	N/A
2	Ride outs completed ensuring effective clinical supervision	Local reporting	Current measure is sporadic Target is 1 per year per employee	N/A	12 months	N/A
3	Improved performance with reduced job cycle time	Local & central reporting	As per the Performance Improvement Plan	TBC	12 months	N/A
4	Timely response to complaints improving patient experience	Central reporting	As per reporting to statutory bodies	N/A	12 months	N/A
5	Timely investigation of incidents reducing the number of breaches	Central reporting	In line with Trust policy	N/A	12 months	N/A
6	Reduced sickness across the team increasing output	Central reporting	Currently running at 7.9% Target is 5% or less	TBC	12 months	N/A

c) When will the post project evaluation be completed?

The OTL role and establishment will be the subject of ongoing evaluation via the operations directorate governance structure. This will include continued review of KPIs and monitoring of expected improvements.

5. Financial Case - Analysis and Affordability *(of preferred option)*

Please include VAT, where not claimable, within all costs stated.

a) Whole life costs of the preferred option (Please specify what this spend is related to) Net Cost/(Savings). All possible costs should be included, a list of costs that you should consider is included at appendix B.

Whole Life Cost	Year 1 (2021-22)	Year 2 (2022-23)	Year 3 (2023-24)	Year 4 (2024-25)	Year 5 (2025-26)	Total
Operating Expenditure/(Savings)						
Additional OTLs - 6.3 WTE in 21/22 and 4% increase thereafter	440,994	458,633	476,979	496,058	515,900	**2,388,564**
Related Non-Pay Costs	11,074	11,460	11,917	12,392	12,884	**59,727**
Reduction in Band 8b from Resilience Management	0	(72,701)	(72,701)	(72,701)	(72,701)	**(290,804)**
Reduction in Band 8c from Regional Operations Management	0	(83,619)	(83,619)	(83,619)	(83,619)	**(334,476)**
Total Operating Expenditure/(Savings)	**452,068**	**313,773**	**332,576**	**352,130**	**372,464**	**1,823,011**
Whole Life Cost	**452,068**	**313,773**	**332,576**	**352,130**	**372,464**	**1,823,011**

b) Impact on the Trusts Statement of Comprehensive Income (please specify what this spend is related to and if operating or non-operating) Net Cost/(Savings)

Statement of Comprehensive Income, £	Year 1 (2021-22)	Year 2 (2022-23)	Year 3 (2023-24)	Year 4 (2024-25)	Year 5 (2025-26)	Total
Net Operating Expenditure/(Savings)	452,068	313,773	332,576	352,130	372,464	**1,823,011**
Non-Operating Expenditure						
Depreciation	0	0	0	0	0	**0**
PDC Dividend	0	0	0	0	0	**0**
Total Non-Operating Expenditure	**0**	**0**	**0**	**0**	**0**	**0**
Total Impact on I&E	**452,068**	**313,773**	**332,576**	**352,130**	**372,464**	**1,823,011**

c) Impact on the Trusts Cash Flow

Cash flow, £	Year 1 (2021-22)	Year 2 (2022-23)	Year 3 (2023-24)	Year 4 (2024-25)	Year 5 (2025-26)	Total
Capital	0	0	0	0	0	**0**
Net Operating Expenditure/(Savings)	452,068	313,773	332,576	352,130	372,464	**1,823,011**
PDC Dividend	0	0	0	0	0	**0**
Impact on Cash flow	**452,068**	**313,773**	**332,576**	**352,130**	**372,464**	**1,823,011**

d) What is the required funding source

There is no funding for this proposal identified.

The above has been confirmed by:	Yemi Phillips

e) Please provide answers to all the assessment categories, working with your relevant finance business partner. If not applicable, then insert N/A

Categories	Detailed answer:	Confirmed by
Has any capital expenditure been included in the current year's capital plan? If not, why was it not raised during budget setting?	N/A	Yemi Philips
Has any revenue expenditure been included in this year's planning, as a cost pressure? If not, why was it not raised during budget setting?	CP2122 – 073 has been agreed by SMG.	Yemi Philips
Has any external funding been sought?	No	Yemi Philips
Please state the virement required to cover any additional revenue expenditure, include financial coding.	None now	Yemi Philips
What savings will be generated because of this investment?	No cash releasing savings will be made.	Yemi Philips

f) Please include narrative of workings of costs, savings and all financial and activity assumptions

OTL Costing_4.xlsx

Option 2 of the business case proposed increment in Operational Team Leader (OTL) whole time equivalent (WTE) from 156.7 to 163 leaving a shortfall of 6.3 WTE.

All OTLs are a band 7 on the agenda for change.

OTLs 2021/22 annual budget for 156.7 WTE amounted to £10,968,844 at average salary of £69,999 per each Operational Team Leader (OTL).

Using average salary of £69,999 to calculate this extra cost;
Year 1 - £69,999* 6.3 WTE = £440,994 plus £11,074 non-Pay = £452,068.

In Year 2, OTL to be increase by 4% growth based on projected number of new recruits hence, year 2 pay = (£440,994* 1.04%) plus £11,460 non-Pay totalling £470,093.

Ops are giving up two senior management posts to offset some for the extra cost of the OTL BC. 1 band 8b in Resilience and 1 8c in Regional Operations Management

Same process applies to Year 3,4 & 5 as per below table.

	WTE	Annual budget	Average cost
Baseline	156.7	£10,968,844	69,999.00

		OTL Yearly Growt	1.04	1.04	1.04	1.04	
	WTE	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Pay	6.3	440,994	458,633	476,979	496,058	515,900	2,388,564
Non-Pay		11,074	11,460	11,917	12,392	12,884	59,727
Total Pay and Non Pay		452,068	470,093	488,896	508,450	528,784	2,448,291

Assumptions

1	Option 2 -OTL whole time equivalent (WTE) increased by 4% from Year 2 to cover expected additional recruit
2	Fringe and 22.53% unsocial hours added to costing
3	OTL numbers are calculated at Dispatch Desk (DD) level
4	Operational Command runs 24/7 in each DD area; this equates to 6.0FTEs per Dispatch Desk area (total 84.0FTEs at Trust level)
5	0.5FTE OTL for every 18 head count comprising frontline employees (inclusive of Annualised Hours) and Bank Agreements
6	Non-Pay elements added (Mobile and DBS)
7	3% approximate added to Non-Pay costing from Year 2

All relevant non-pay costs have been included in the whole life costs.

6. Quality Impact assessment (of preferred option)

Please embed the signed summary Quality Impact Assessment (QIA) below. The guidance and template can be found on the zone.

QIA - OTL Establishment Busines

Request QIR-184616 has been completed...

7. Equality Analysis (of preferred option)

Please embed the completed equality analysis below. The guidance and template can be found on the zone.

Equality Analysis - OTL Establishment BC

8. Risk Assessment (of preferred option)

Please ensure you undertake a thorough assessment of the risks associated with implementing the proposal and mitigating actions (using the Trust Risk Management Approach). Include the top five here

Risk Description	Mitigation	Likelihood (1-5)	Consequence (1-5)	Owner
There is a risk that the OTL duties will not be completed in full due to the establishment remaining 13% less than the minimum requirement as calculated using the new methodology.	The OTL administrative duties will be reviewed and reallocated where appropriate to ensure their capacity is focused on core functions.	4	3	Andy Rowe
There is a risk associated with the increase in budget for OTLs and the impact of this financial spend for the Trust.	The preferred option mitigates this risk by setting out a middle ground with a smaller increase in establishment than the new methodology suggests.	4	3	Andy Rowe

9. Commercial Case (of preferred option)

a) Commercial detail. Explain how you intend to deliver the proposal? Did you go through a tender process, acquire supplier quotes, who is the preferred supplier and what selection process did you go through.

There is no recruitment requirement for the preferred option.

A tender process is not required.

The delivery of this proposal, including the review of OTL duties and reallocation, will be managed internally through the portfolio of the ADO West's team which includes the recruitment, development, and performance of OTL's. Oversight will be via the operations governance structure and assurance will be provided through these forums and groups.

10. Management Case (of preferred option)

a) Project management detail. How will you track implementation, what governance group will the proposal report to during implementation and where does that group report into? What reports will be produced, what will they cover and how often will they be produced?

The oversight group tracking implementation of this proposal will be the operations directorate Teams A. The delivery of this proposal, including the review of OTL duties and reallocation, will be managed internally through the portfolio of the ADO West's team which includes the recruitment, development, and performance of OTL's. Teams A is a weekly meeting, and the type and frequency of reports will be determined following approval of the proposal.

b) Include a high-level implementation plan and key milestones and dates? This must be included otherwise the proposal will be rejected

Due to the value of this business case, it will require approval from the following groups:

- BCG (1 March 2022)
- EMB (date tbc)
- FIC (date tbc)
- Trust Board (date tbc)

As implementation of the preferred option would bring the OTL establishment in line with current resourcing, there will be no recruitment element to the implementation.

The budget for the current year would be amended to reflect the uplift in OTL establishment from 2021/2022 and the 4% future growth factor included in the budget setting for 2022/23 which is in process at the time of writing.

11. Stakeholder engagement/consultation (of preferred option)

a) Does the proposal require/have commissioner, STP or other external support? If yes, provide evidence of discussions

No, this is an operational matter and external support is not required. It is for the Trust to determine if the uplift is affordable from within the Trust's overall existing financial envelope provided by Commissioners.

b) Does the proposal have a requirement for consultation (staff/union/JPF/public)? If yes, what consideration have you given to enacting this? How have affected staff groups been engaged and how have their responses been considered.

No.

Appendix A

Checklist of affected departments

Department	Relevant Steering Group if applicable	Confirmation of support
IT	Digital Programme Board	
Estates	Estates Programme Board	
Procurement	Procurement Programme Board	
Human Resources	HR Steering Group	
Quality and Safety		
Medical		
Frontline Operations		
EOC/111		

Appendix B

Costs to consider

New Posts
Pay Costs
Enhancements (unsocial hours, on call rota etc)
High cost living allowance
incentive packages (R&R)
Non-Pay Costs
All Staff
Travel Expenses
Lease Cars
Training Costs
Laptop
Mobile
Landline
Software Licence
Advertising costs (how are these covered now, budget in HR?)
DBS checks (is this covered by a budget in HR?)
Estate costs (where will they be situated?)
Operational Staff
Personal Issue Assessment Kit
Uniform
Tablet
JRCALC licence
Vehicle requirement
Medical Equipment requirement

Relocation of Staff
Excess travel costs (4 years)
High Cost living allowance (6 months)
Estates costs
Potential Redundancy Costs

Removal of posts
Potential Redundancy Costs
Training costs

Appendix C

Reference	Title	Document
C.1	Previous Business Case – 18 March 2021	SECAmb Businesss Proposal - OTL establ
C.2	OTL Core Duties	OTL Core Duties.pdf
C.3	Appraisal's policy extract relating to team sizes	Appraisals Policy Extract.docx

South East Coast Ambulance Service NHS
NHS Foundation Trust

BUSINESS CASE TEMPLATE

Frontline Ops COVID-19 Response – H2

20 January 2022

Author(s): Andy Rowe

Executive Lead: Emma Williams

Directorate: Operations

Business Case Ref: 2021-22 - 43

Version: v6

Date of approved summary QIA:

Final Decision:

Date proposal reviewed	By	Decision made
	Trust Board	

Document Control:

Version Control:

Please record all key changes made to the document and how these have been approved (either person or committee				
Version	Date	Author and title	Summary of key changes	Approval by
V1	24/11/21	Mark Jetten	Updated financial costs for the second half of the year	
V2	25/11/21	Andy Rowe	Updated Narrative to support 2nd half of year	
V3	11/01/22	Rachel Murphy	Review – received on 05/01/22	
V4	20/01/22	Phil Astell	ADoF review	
V5	20/01/22	Rachel Murphy	Some updates to respond to comments	
V6	20/01/22	Priscilla Ashun-Sarpy	Updates to respond to comments	

Review and Approvals log:

Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal				
Version shared	**Person and title or Committee**	**Date reviewed**	**Recommendation**	**Rationale**
V3	Mark Eley – Deputy Director of Ops	14/01/22	Supported	
V3	Emma Williams – Executive Director of Ops	18/01/22	Supported	
V6	Associate Director of Finance – Phil Astell	20/01/22	Agreed to proceed to BCG	
V6	Business Case Group			
	EMB			
	FIC			
	Board			

1. Proposal Overview

Provide a brief description of the proposal, this should be in summary form and include a brief background of the relevant area, any link to performance targets, proposal aim, current state, business need, the options and the preferred Solution.

Background

Two Business Cases have previously been approved to cover Frontline COVID-19 costs:

1. 2019-20 – 23 – approved on 26/03/20 – covered period Jan 20 to Mar 20 - £3,676,386
2. 2020-21 – 08 – approved on 27/05/21 – covered period Apr 20 to Sep 21 - £12,742,454

Aim

Approval of additional operational resources to offset COVID-19-related abstractions to cover the period 1 October 2021 to 31 March 2022.

Options Considered

Do Nothing – this was ruled out as a response to COVID-19 was essential.
Option 1 - Additional resources to support operational service delivery during the second half of the financial year 2021/22.

Preferred Option

Option 1 is the preferred option. This will ensure that the Trust covers shifts affected by COVID-19 related absences and achieves the best possible compliance with national performance targets.

Whole Life Cost

The whole life cost of this proposal is £3.8m to cover the period 1 October 2021 to 31 March 2022.

2. Strategic Case

a) What will happen if we do not support the proposal? Is it a must do i.e., due to a regulatory requirement? Please highlight if this relates to a risk on the Corporate Risk Register

This proposal is in relation to national legislation, mandating staff from NHS Organisations to remain off work when they are either COVID-19 positive, symptomatic or been in close contact with a COVID-19 case. Increasing abstraction from the plan of 29.7 per cent to circa 34 per cent and the national mandate to maintain safe service to patients.

The Trust is seeing significant absence relating to sickness and self-isolation, via both the 111 and 999 services, and have been working closely with partner organisations across the Kent, Surrey & Sussex areas to deliver an appropriate response.

The Trust has seen large volumes of absence due to COVID-19 sickness, the requirement to self-isolate and, more recently, sickness due to the COVID-19 vaccinations. This has meant the need to provide cover, frequently at premium rates, to ensure the best possible achievement of performance targets.

b) How does the proposal fit with the Trust's current strategies, Transformation Programme and Trust Objectives?

This proposal is in line with the strategic intent to provide strong strategic leadership and working in innovative, integrated ways with partners to provide timely, safe and appropriate care for patients and the wider system.

3. Summary of options

a) What options have been considered? Please provide a high-level summary narrative of the options:

Options	*Brief description*	*Benefits*	*Downsides/risks*
Do Nothing	No change to the operational response.	None.	This option would fail to ensure safe delivery of the overall service.
Option 1 – (Preferred Option)	Additional resources to support operational service delivery during the second half of the financial year 2021/22.	Provision of resource hours sufficient to meet demand during this period. Resources provided to ensure that Trust locations are COVID-19secure for staff to work from with additional travel costs associated with overtime shifts etc.	Additional resourcing will need to be provided primarily through overtime (at a premium cost) with consideration given to ensuring staff welfare. These costs are required to ensure that staff can continue to operate out of SECAmb sites and undertake overtime shifts.

4. Preferred Option *(all sections from now refer to the preferred option)*

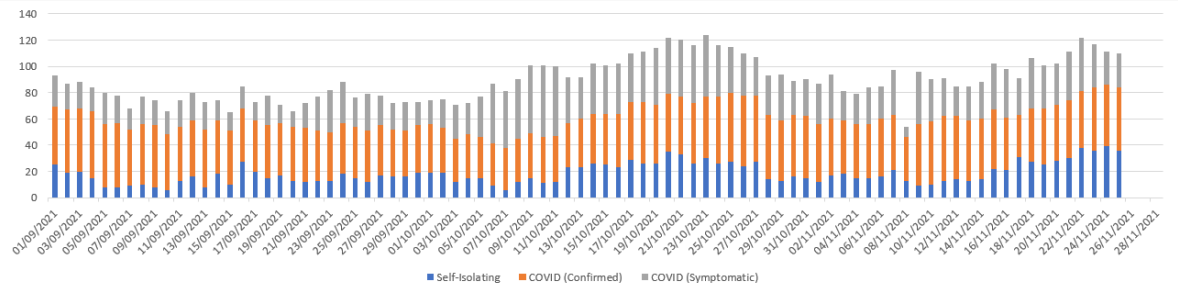
a) Please expand upon the preferred option and provide rationale for why this will be the best way forward. Include consideration to strategic fit, deliverability, ease of implementation, clinical, quality and financial benefits, and mitigation of risks

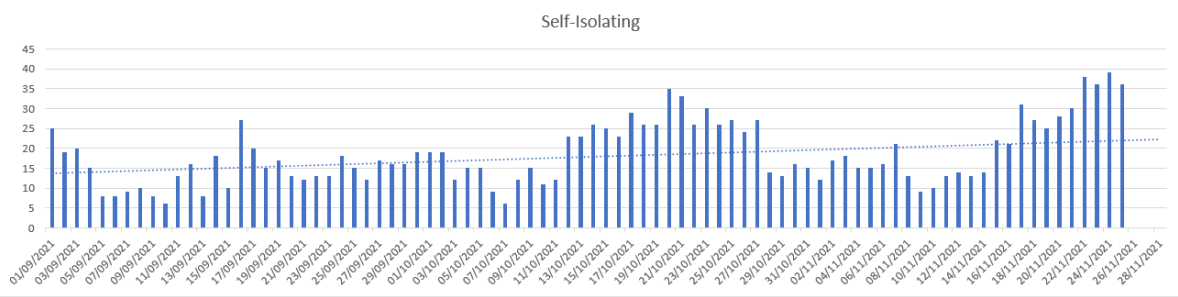
Undertake and deliver all the below modules of this service to ensure coordination of a safe, sustainable service in response to the Covid-19 national incident.

<u>Additional resources to support operational delivery during the second half of the financial year 2021- 2022</u>

- Additional resources to support operational delivery to the end of the financial year 2021-2022.
- Focus on delivery of additional hours of Double-Crewed Ambulance resource type to off-set higher than normal abstraction rates (because of Covid-19-related sickness, self-isolation etc), recognising the uncertainty of the disease progression, new variants, Government requirements and the impact of potential future waves.
- This additional capacity is required as, at the time of submission, variants of the COVID-virus are circulating widely across Europe, and the potential impact of these on the UK population is currently unknown.

- In addition, whilst staff take-up of the vaccine has been strong, a small proportion of staff have developed symptoms which has required them to take time off work following vaccination.
- Self-isolation and COVID-19 absence continue to increase and breach the budgeted abstractions within the organisation.





Additional non-pay costs

- Additional resources provided on an overtime basis are entitled to payments associated with travel.
- Additional protective clothing is required.

b) How will you measure the benefits of the preferred option? What Key performance indicators (KPIs) will you use? Please note that proposals will be rejected if there is no benefits realisation plan

No.	Benefit Description	Indicator and how is it recorded	Current and Target Measure and Change	Financial Saving if applicable	Timescale	Assumptions
1	To cover COVID-19 related sickness absence.	BI reports	Target is to cover all shifts.	N/A	Ongoing	
2	To assist towards the national performance targets.	BI reports	National Targets	N/A	Ongoing	

c) When will the post project evaluation be completed?

Reporting for these aspects is being managed using the BI portal with a bespoke tool developed via the BI team.

There is, and will continue to be, reporting delivered to NHSE, providing updates on the key metrics required.

5. Financial Analysis and Affordability *(of preferred option)*

Please include VAT, where not claimable, within all costs stated.

a) Whole life costs of the preferred option (Please specify what this spend is related to) Net Cost/(Savings)

	2021/22 Total Cost, (6 mths - October to March 22)
Operating Expenditure	
Staff Costs	
Core (bank cover)	**118,904**
Overtime	**2,567,507**
PAP	1,020,000
Total Staff Costs	**3,706,411**
Non Pay Costs	
Travel	3,875
Furniture & fitting	0
Protective Clothing	47,700
Total Non Pay	**51,575**
Grand Total	**3,757,986**

b) Impact on the Trusts Statement of Comprehensive Income (please specify what this spend is related to and if operating or non-operating) Net Cost/(Savings)

Statement of Comprehensive Income, £	**2021/22 H2 Total Cost, (October to March 22)**
Net Operating Expenditure/(Savings)	**3,757,986**
Non-Operating Expenditure	
Depreciation	0
PDC Dividend	0
Total Non-Operating Expenditure	**0**
Total Impact on I&E	**3,757,986**

c) Impact on the Trusts Cash Flow

Cash Flow, £	**2021/22 H2 Total Cost, (October to March 22)**
Capital	0
Net Operating Expenditure/(Savings)	3,757,986
PDC Dividend	0
Impact on Cash Flow	**3,757,986**

d) What is the required funding source

The costs for the first half of 2021/22 financial year were fully reimbursed. The Trust has been allocated COVID-19 funding of £8.6m for the second half of the year. This covers the costs for our entire 999 and 111 activities, and the value is expected to cover the Operating Units costs listed above.

The above has been confirmed by:	Priscilla Ashun-Sarpy

e) Please provide answers to all the assessment categories, working with your relevant finance business partner. If not applicable, then insert N/A

Categories	**Detailed answer:**	**Confirmed by**
Has any capital expenditure been included in the current year's capital plan? If not, why was it not raised during budget setting?	No	Priscilla Ashun-Sarpy
Has any revenue expenditure been included in this year's planning, as a cost pressure? If not, why was it not raised during budget setting?	No. Only the costs for the first half of the year were budgeted. Since the COVID-19 Pandemic has persisted, the funding has been extended until the end of the year to cover the cost of the second half of the year.	Priscilla Ashun-Sarpy
Has any external funding been sought?	Yes. The Trust's block contract income with the commissioners is supplemented by additional system funding to cover COVID-19 costs 2021/22 within this BC.	Priscilla Ashun-Sarpy
Please state the virement required to cover any additional revenue expenditure, include financial coding.	Various	Priscilla Ashun-Sarpy
What savings will be generated because of this investment?	N/A	Priscilla Ashun-Sarpy

f) Please include narrative of workings of costs, savings and all financial and activity assumptions

The detailed cost calculations are included in the spread sheet embedded below.

Businesss Proposal
- Frontline Ops Covi

6. Quality Impact assessment of preferred option

Please embed the signed summary Quality Impact Assessment (QIA) below. The guidance and template can be found on the zone.

This is the approved QIA from the previous BC, it does not require updating as the proposal covers the same items.

QIA COVID-19 Case Manager.xlsx

7. Equality Analysis of preferred option

Please embed the completed equality analysis below. The guidance and template can be found on the zone.

This is the approved EAR from the previous BC, it does not require updating as the proposal covers the same items.

EAR for COVID response.docx

8. Risk Assessment

Please ensure you undertake a thorough assessment of the risks associated with implementing the proposal and mitigating actions (using the Trust Risk Management Approach). Include the top five here

Risk Description	Mitigation	Likelihood (1-5)	Consequence (1-5)	Owner
Staff mental health issues due to continued level of demand.	Ensure wellbeing signposting is in place and adequate management support is in place for frontline staff.	3	3	Emma Williams
Staff unwilling to complete overtime shifts.	Incentives offered.	3	3	Emma Williams
PAP availability.	Stay in constant contact with the PAP suppliers to ensure that they keep up with demand.	3	3	Emma Williams

9. Commercial Case (of preferred option)

a) Commercial detail. Explain how you intend to deliver the proposal? Did you go through a tender process, acquire supplier quotes, who is the preferred supplier and what selection process did you go through.

Not relevant as all costs are staff related.

10. Management Case (of preferred option)

a) Project management detail. How will you track implementation, what governance group will the proposal report to during implementation and where does that group report into? What reports will be produced, what will they cover and how often will they be produced?

The Trust operational management structure will oversee and deliver against these modules, reporting into the Executive Director of Operations.

Implementation is being monitored via Teams A (Operations).

b) Include a high-level implementation plan and key milestones and dates? This must be included otherwise the proposal will be rejected

Operational resourcing hours, including additional provided via overtime are managed on an operating unit basis via the local management teams. For these hours there has been no additional plan, but the target to meet has continued to be the required hours per day.

Ensuring that the Trust premises are COVID19--secure has been done by operating unit and general management teams in conjunction with the Trust Infection Prevention Control teams. All sites were reviewed and inspected with any furnishing requirements addressed. Ongoing cleanliness of sites is monitored through existing contract management mechanisms between the cleaning contractor and local Trust teams.

11. Stakeholder engagement/ consultation

a) Does the proposal require commissioner, STP or other external support? If yes, provide evidence of discussions

Weekly calls with Commissioners review contracted resource provision and delivery against targeted/required hours.

b) Does the proposal have a requirement for consultation (staff/union/JPF/public)? If yes, what consideration have you given to enacting this?

Yes – Engagement with the unions has been undertaken as this work has developed, engaging with them around the writing of operational instructions, and implementation of the services described within this business proposal.