South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

28 May 2020
10.00-12.30

Via Video Conference

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Introduction					
01/20	10.00	Welcome and Apologies for absence	-	-	Chair
02/20	10.02	Declarations of interest	-	-	Chair
03/20	10.02	Minutes of the previous meeting: 30 January 2020	**Y**	Decision	Chair
04/20	10.03	Matters arising (Action log)	**Y**	Decision	PL
05/20	10.05	Board Story	-		
06/20	10.15	Chief Executive's report	**Y**	Information	PA
Covid-19 Response					
07/20	10.30	COVID Response Management Group Incl. IPC Assurance Framework	**Y**	Assurance	BH
Strategy					
08/20	10.50	Trust Strategy	**Y**	Decision	PA
09/20	11.05	Patient Experience Strategy	**Y**	Decision	BH
Break					
Quality & Performance					
10/20	11.15	Integrated Performance Report / Committee Escalation Incl. 2020/21 Budget	**Y**	Information	SE
11/20	11.45	Learning from Deaths Report	**Y**	Information	FM
Governance & Risk					
12/20	11.50	Health & Safety Annual Report	**Y**	Information	BH
13/20	11.55	Safeguarding Annual Report	**Y**	Information	BH
14/20	12.00	Audit & Risk Committee Escalation Report	**Y**	Information	MW
15/20	12.10	BAF Risk Report		Assurance	PL
16/20	12.20	Board Committee TOR / Annual Planning	**Y**	Decision	PL
Closing					
17/20	12.25	Any other business	-	Discussion	Chair
18/20	-	Review of meeting effectiveness	-	Discussion	ALL

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

Date of next Board meeting: 30 July 2020

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 30 January 2020

Trust HQ, Nexus House, Crawley
Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Philip Astle	(FM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Ali Mohammad	(AM)	Executive Director of HR & OD
Angela Smith	(AS)	Independent Non-Executive Director
Bethan Haskins	(BH)	Executive Director of Nursing & Quality
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Joe Garcia	(JG)	Executive Director of Operations
Laurie McMahon	(LM)	Independent Non-Executive Director
Lucy Bloem	(LB)	Senior Independent Director / Deputy Chair
Michael Whitehouse	(MW)	Independent Non-Executive Director
Steve Emerton	(SE)	Executive Director of Strategy & Business Development
Tricia McGregor	(TM)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Richard Quirk	(RQ)	Deputy Medical Director
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Paul Renshaw	(PR)	Interim Director of HR

Chairman's introductions

DA welcomed members and those observing and in particular AM to his first meeting. Acknowledging this would be their last meeting, DA then thanked AS for her support over the past three years and PR for his efforts in taking forward the transformation of HR. Finally, DA welcomed back RQ who is acting up for FM who is recovering from surgery.

85/19 Apologies for absence

Fionna Moore	(FM)	Executive Medical Director

86/19 Declarations of conflicts of interest

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

87/19 Minutes of the meeting held in public 28 November 2019

Subject to a minor amendment relating to a reference to LM as "she", the minutes were approved as a true and accurate record.

88/19 Action Log

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

89/19 **Board Story** [10.03 -10.13]

The Board watched the video which was a positive story, featuring a maternity case and the good care provided by staff. DA then reflected that it highlights both the excellent and compassionate care and the benefits of this expanded service (Midwives in EOC). The Board noted that this was developed as part of a collaboration with system partners, and while it is currently in just one part of region, it is accessed more widely.

90/19 **Chief Executive Report** [10.13 – 10.37]

PA highlighted the following areas from his report;

- Performance over Christmas / New Year – PA explained that our response to the majority of patients in Cat 2 is good. We struggle with Cat 3 and Cat 4, but in this period we have seen improvement. Overall, we have managed this period of high demand well, by ensuring more staff on duty than ever before. It is still not enough so we need to do more, especially with recruiting new staff. Call answer remains strong and much credit for this to JG and his team. In terms of 111 performance we are in and around the national average.

- Coronavirus – PA outlined the role the Trust is taking in line with NARU guidance to respond to suspected cases. The numbers are currently not high and to-date there has been no major impact on the business.

- Staff survey – early indications have been received with the full results due in March. The return rate has improved and in general the early findings indicate areas are more positive than before.

- D&C review – the refresh is imminent and Phase 1 results will be due in 8 weeks' time and will inform planning for next year.

- MRCs - the Brighton MRC has started and we aren't stopping there as we continue to roll out the make ready model where it makes operational sense; later today the Board will be considering business cases for both Medway and Banstead.

- Paramedic bursary - this will make a difference by attracting more people into the paramedic profession and, given the demand for paramedics, this is really important.

There were then some questions from the Board.

LB referenced the positive performance over the Christmas period and asked whether there were any significant Sis or trends. BH answered this by confirming that the main themes for incidents are handover delays, physical assaults and MSK injuries/manual handling. The number of SIs is consistent with the same period last year; there are no real themes or trends.

AR asked about the bursaries and whether we could tie this into employment with the ambulance service given the other services that will want paramedics. PR felt this might be unlikely but worth exploring. TP added that if we don't think about how we tie undergraduate paramedics others will be, and so we need to be clear in our workforce plan going forward.

91/19 **Delivery Plan** [10.37 – 11.22]

SE introduced the report drawing the Board to the executive summary and appendices. Directors then reported by exception:

Estates

DH confirmed that the Brighton MRC is progressing well, but there is some concern re Epsom due to the timeframes with which we need to vacate the premises; the solution is being agreed between estates and operations.

DH addressed a question about engaging Worthing staff on the timing of the plans there; he explained that there is a cross-directorate approach and the operational leaders/staff in Worthing are well-engaged.

Sustainability and Digital

The EPCR project closed on 29 January and is now being taken forward in business as usual. There has been a 75% uptake, which is significantly higher than expected at this point. The focus now is on the outliers and the final training is due to be completed soon.

LB referred to the issue arising from the IOS update, resulting in some functionality not working (camera), and asked how we mitigate this in future when it might be something more serious. DH acknowledged that we can't control updates from Apple and their impact isn't always clear. However, we have since this used our device management system to limit auto updates.

Action

Finance and Investment Committee to seek assurance that management is taking all reasonable measures to limit any adverse impact of IOS updates, on the use of IPADS.

JG added that the team are finding EPCR a valuable change in how to record patient data.

MW noted that while the Delivery Plan confirms where we are with the estate's projects, it does not describe where we sit against the estate's strategy. DH confirmed that we have 9 out of the 12 MRCS in the strategy and that the remaining three are the really difficult ones which require different thinking, because for example in Surrey the cost of land is so much higher. Kent and Sussex is almost complete. Surrey is only in phase 1, which is why Banstead is such an important step; the constraints in Surrey will be resource/cash.

Action

Finance and investment committee to review the progress with the estate's strategy; stress testing it against the workforce and demand and capacity assumptions and the capital plan etc.

Quality and Compliance

BH explained that NHSP Audit is RAG-rated Red due to an outstanding grievance delaying the planned restructure. In the meantime, all roles that cab be filled on an interim basis have been, but the full benefits of the business case won't be realised until the restructure can be fully implemented; the grievance is due to conclude by the end of February. This is being closely monitored by the executive.

The call answer project is now closed given the sustained performance. DA congratulated staff for this significant improvement.

Safe staffing is RAG-rated Red as some elements of the project have been paused due to winter pressures. Work continue to progress however with a focus on maximising EOC clinicians. Staffing in EOC (call answering) it good, demonstrated by the sustained performance. Staffing on the road remains challenging for the reasons already stated, but despite this we did still manage to get more hours over the Christmas period than at any other time in the Trust's history.

Clinical Education – DH chairs the programme board and confirmed that the FutureQuals audit result was 'level 2', which is good (levels are 1-5 with good being the best). The programme is moving along, but there are still lots of issues which are being addressed carefully with solutions that are sustainable.

TP clarified that the Ofsted re-inspection will be anytime from February 2020. He then reflected how impressed the workforce and wellbeing committee is by the depth and rigour of the work ongoing; he felt confident that we will come out of this much stronger and knowing more about the provision than probably any other ambulance trust. This will enable us to integrate more of our training and offer more pathways for people joining the service.

HR Transformation

PR updated on the work to-date as set out in the report. With regards e-expenses, we plan to go live with operations team from March, but as PA said in his report to the Board, we are in discussion with staff side about concerns they have.

The Board then had a more general discussion about the Delivery Plan and much of it moving into business as usual and the role of PMO going forward. PA confirmed that EMB is reviewing the whole delivery plan / use of PMO, as part of the development of the new Trust strategy. This will pick up concerns expressed by the Board about ensuring the capacity to deliver what is a priority; acknowledging we can't do everything.

92/19 Trust Strategy [11.22 – 11.28]

PA updated that work continues with the aim to review at the February Board development session, to confirm the priorities and objectives. The strategy will then be finalised for the March Board, for sign off and publication.

93/19 IPR / Board Escalation Report [11.28 – 12.25]

SE outlined the work ongoing to develop a new IPR, scheduled for review at the audit committee in March. He then introduced the report, asking directors to update anything by exception.

Clinical safety

RQ took questions.

TM asked first about the Acute STEMI bundle and whether we are seeing improvement since EPCR. RQ explained that for pain control documentation there is improvement in the recording of data and will expect to see this flow through the IPR in due course.

TP referenced the stroke data and, in the context of issues in Kent, asked whether we have any local data. RQ confirmed we do collect internal data, which we can publish; he suggested we consider this as part of the dashboard arising from the new IPR.

Quality

BH highlighted two areas; firstly hand hygiene where there has been a dip in compliance and then the spike in H&S incidents, which BH explained is a result of this being the period we went live with new incident categories; so these incidents weren't previously being reported.

There were no questions.

QPS Committee Escalation Report

TM took the Board through each item covered by the committee as set out in her report, including the action from Board for QPS to review safeguarding training. With regards NHSP audit, TP confirmed that the committee would be very concerned if this is delayed beyond the end of February.

The Board discussed clinical supervision and there was some acknowledgement that it will take some time and engagement to get right.

Operational Performance
JG pointed the Board to both the historical information and the more current data included in the report, taking time to highlight the improvement in some of the ARP metrics, in particular Cat 2 and Call answer. He was also pleased to report sustained recovery in 111 performance, since the interim service went live from April 2019.

There were no questions.

Finance
DH confirmed the position at month 9, which is still on plan and explained we are still in discussion with commissioners and are close to being able to agree the £2m income, which is the risk to year-end. As long as there are no surprises, we are expected to achieve the control total.

FIC Escalation Report
MW highlighted the areas of focus;

Operational performance – MW supports the analysis from PA and JG. The issues for the committee are the long-term sustainability and resilience to continue to improve. There is also concern about abstraction and the number of variables that impact the ability to ensure sustained high performance.

111/CAS – the committee reviewed the position on mobilisation and MW reinforced the risks the Board should be aware of, including e-prescribing and ongoing recruitment (close to resolving) and telephony whereby we need to integrate a single call pathway between us and IC24. The committee stressed the importance of being clear about what we can and cannot deliver from 1 April and is assured that the executive is being very open with commissioners who seem to be supportive.

Finance – the risk is as DH has just set out re the £2m income. The committee is assured we will make the control total but need to continually reinforce the need to review the finances in the context of a 3-5-year strategy.

AR asked about the fleet implementation plan and MW reiterated the committee's disappointment this was not provided; JG confirmed the aim is to have in place prior to 1 April 2020.

Workforce
PR confirmed the improved vacancy rate and, with regards appraisals, while we are behind where we were this time last year, there is much focus to get to the target by the end of March. He explained there is a new process piloting at the moment to be rolled out next year to make it simpler; the timeframes will be linked to start dates, so there will be a different set of reporting from April 2020.

PR also noted the turnover rate increase of 1% compared to last year, which equates to about 35 people. We are working with peers and NHSI/E to see what others to do improve this. This links to the retention strategy being developed.

WWC Escalation Report
TP reflected that much of what the committee has been reviewing has been touched on already during this meeting. He referred to workforce planning, which led to a discussion about being clear with commissioners about capacity to ensure the right abstraction levels are accounted for. TP clarified that the current plan is

based on assumptions at the time (2016) which are known now to need updating, which phase 1 of the demand and capacity review is about.

MW added that when we have revised workforce numbers, we need a clear plan to deliver this, which requires a well-developed supply chain.

JG reminded the Board that we have done quite well against the current plan demonstrated by providing more hours than ever before.

PA outlined the pressure our ICSs are under in cutting the deficit over the next few years and so the likelihood of them being able to fund what the demand and capacity review concludes is needed to meet APR is very low. We therefore need to agree to be resourced to a lower level, which will require clarity about expectations; this is a difficult message as national targets do not change.

[Break at 12.25 – 12.35]

94/19 Hospital Handover Programme [12.35 – 12.52]
JG introduced the paper which sets the context and describes the journey in developing partnerships to help drive improvement; this demonstrates a need for a whole system approach. The patient safety issue for those waiting in community is now much better understood and accepted.

The senior leadership and focus have been key in making this difference, as it has ensured better working between ambulance staff and A&E staff. There have been very positive improvements in some hospitals that demonstrate this.

Before opening up for questions, DA thanked JG for this very clear report.

TP agreed that this has transformed the way this is now seen as a system issue. However, the concern now is about how the sustainability of the improvement as the data isn't showing sustained improvement but instead a system that will address issues when there is resource and focus. JG added that when you look at the detail you see where this is sustained and where there is either no improvement or where things have got even worse; the latter are having national scrutiny. The point is that changes aren't across the board and PA stated that sustainability links very directly to individuals, therefore, in the long term we need to improve relations ensuring these are embedding through the OUMs as system-leaders. The Board agreed with this.

DA summarised that in light of our approach we have helped partners to better understand the wider patient safety issues; our leadership has helped with focus and will continue to ensure momentum is maintained. On behalf of the Board he thanked Gillian and other colleagues for their efforts.

95/19 Violence and Aggression to Staff [12.52 – 13.02]
BH outlined the structure and purpose of the paper, which is a review of incidents over the past 20 months. It shows an increase (seen nationally) and improved sanction rates in relation to physical assaults. BH highlighted three areas in particular;

1. The section on training identifies a need to review what we do; the recommendation nationally is now moving to verbal de-escalation and we are exploring how to introduce this.
2. More work is needed to capture psychological harm.
3. Body worn cameras is in the second phase of the national programme. This has significant cost implications to be worked through. JG added here that there are plans to pump prime pilots at Trusts for 1000 cameras. But this will bring challenges down-stream as once this is brought in it will

be difficult to take away; there are significant data management and financial implications, but of course lots of benefits too.

Some issues were explored by the Board, for example, whether staff would see body-worn cameras as being intrusive, and the GDPR issues.

Overall, DA summarises that the Board is assured management is taking this area seriously, but there is work to do. It asked for an update in 6 months, following scrutiny of WWC.

Action
In Q2 2020/21 WWC to review the steps being taken to reduce incidents of violence and aggression against staff and update the Board accordingly.

96/19 **Audit & Risk Committee Escalation Report** [13.02 – 13.06]
AS set out the focus of the committee as listed in the report, highlighting in particular data quality and the improvement over the past three years in the level of information available; the committee is assured that the Trust is a data-led organisation.

On whistleblowing, the committee is assured with the routes available, and later in the year will be reviewing how effective they are.

97/19 **BAF Risk Report** [13.06 – 13.08]
PL took the Board through the report, setting out how the committees of the Board use this report to inform its focus. The Board agreed the recommendations set out in the report and confirmed that this reflects the key risks facing the Trust.

98/19 **Charitable Funds Committee Escalation Report** [13.08 – 13.10]
AS spoke to the report, confirming that that the review of governance will be concluded during 2020.

99/19 **AOB**
On behalf of the Board, DA thanked AS again for her contribution over the past 3 years.

100/19 **Review of meeting effectiveness**
Board reflected that there has been a good range of discussion. LM felt there is a shift from quantitative to system relationships and how we move forward, which he felt is a healthy sign. AR felt that the scrutiny by committees allows this approach.

There being no further business, the Chair closed the meeting at 13.12

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

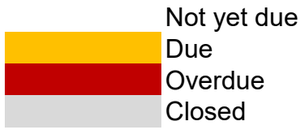
Date _____

_____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
24.01.2019	145/18a	The executive to review the structure of the Delivery Plan report, including how to reflect the dependencies on the Trust's strategic aims, to help the Board focus on the key areas.	SE	30.07.2020	Board	IP	This will be reviewed as part of strategy review as aims and objectives will be amended.
24.01.2019	145/18d	Confirm to the Board the timeline and approach to developing the CFR / Volunteer strategy.	JG	30.07.2020	Board	IP	The draft strategy was consider by QPS on 09.09.2019 and some feedback was provided to help strengthen the strategy. The plan was to bring this to Board in November, but a further workshop was held in October and so revisions will mean ti will not be ready until January 2020. 30.01.2020 - QPS reviewed the revised strategy and it will now come to Board in March - see QPS escalation report 10.03.2020 - Was planned for 26.03.20 but deferred to July 2020
25.07.2019	31 19b	The Executive to confirm the root cause of the decline in hand hygiene and through QPS Committee set out the steps being taken to address this.	BH	09.03.2020	QPS	C	Considered by QPS - see escalation report
25.07.2019	31 19c	As part of the review of the IPR, national comparators will be included for hospital handover delays, to show how we compare with other parts of the country.	SE	28.05.2020	Board	IP	Considered as part of the ongoing review.
26.09.2019	57 19	FIC to confirm that the fleet data has been transferred to the new fleet management system and confirm the same in its report to the Board.	DH	Q4 2019/20	FIC	IP	
28.11.2019	74 19	WWC to support the executive in agreeing a timeframe for the review of 12-hour shift patterns.	TP / AM	Q4 2019/20	WWC	IP	
30.01.2020	91 19a	Finance and Investment Committee to seek assurance that management is taking all reasonable measures to limit any adverse impact of IOS updates, on the use of IPADS.	PL	Q1 2020/21	FIC	c	Assurance received at the meeting in May
30.01.2020	91 19b	Finance and investment committee to review the progress with the estate's strategy; stress testing it against the workforce and demand and capacity assumptions and the capital plan etc.	PL	Q1 2020/21	FIC	IP	
30.01.2020	95 19	In Q2 2020/21 WWC to review the steps being taken to reduce incidents of violence and aggression against staff and update the Board accordingly.	PL	Q2 2020/21	WWC	IP	

Key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Due
Overdue
Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	06-20

Name of meeting	Trust Board
Date	28.05.2020
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Philip Astle
Synopsis	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

1.1 This report seeks to provide a summary of the Trust's key activities and the local, regional and national issues of note in relation to the Trust during April 2020 and May to date.

2. Local issues

2.1 Operational Performance

2.1.1 Despite the challenges of the COVID-19 pandemic, the Trust's Senior Operational Leadership Team is continuing to ensure that there is close monitoring of our 999 and 111 performance and that we are making the most efficient use of the resources we have available.

2.1.2 999 call answering performance has remained strong overall during this period, outside of specific short periods when we have seen a significant increase in call volume, for example following the initial national announcement regarding lock-down. Despite recent challenges, I am pleased that we continue to be among the best in the country for this measure.

2.1.3 In order to ensure we are able to respond as effectively as possible, despite the number of staff who need to self-isolate due to having COVID symptoms, shielding or because a member of their family has become symptomatic, the operational teams have continued to focus on ensuring that we are maximising the resources available. This has included careful use of overtime and Private Ambulance Provider (PAP) resources, as well as support from new colleagues who have joined us on the bank (see 4.1.9 below).

2.1.4 During the past eight weeks, we have understandably seen lower 999 demand from the public overall than for the same period last year. We have also seen a reduction in calls from Health Care Professionals (HCPs) and requests for inter-facility transfers, due to capacity & resources within both primary and secondary care being much more tightly managed. For the same reason, we have also seen a reduction in hospital handover delays. Combined with the focus on staffing, this has enabled us to deliver strong performance against all categories of call, especially during May 2020.

2.1.5 Analysis of our performance also shows that our 'see and treat' rate has increased during this period, due to the need to limit patients being taken to hospital wherever possible as well as the desire of patients to avoid hospitalisation. Whilst this will be temporary, we are keen to ensure that we continue to focus on this area, but as the wider system is starting to return to more usual operating practices, we are seeing the conveyance rate starting to return closer to the seasonal norm.

2.1.6 After unprecedented levels of demand for our NHS 111 service during February and March 2020, we have seen demand decrease during April and May, although it remains higher than expected levels. Demand also continues to be

heavily impacted by any national announcements made about how to access services or changes in process.

2.1.7 From mid-May onwards, we have supported the national campaign to encourage people to access emergency help if needed, following the significant drop in 999 calls. As I write, we are beginning to see 999 numbers increasing, prompted partly by an easing of some lockdown measures.

2.2 Executive Management Board (EMB)

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

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

2.2.3 During recent weeks, the focus of the EMB has been on the impact of COVID-19, the rapidly changing national picture and the impact on the Trust. In addition to the main weekly meeting, we have introduced short daily Exec 'huddles' during the pandemic, to ensure that there is a frequent opportunity for issues to be raised and discussed and action taken where necessary. We have also introduced a new, 'Executive-heavy' group – the COVID Response Management Group – which has been meeting daily including at weekends although latterly we have reduced the frequency of these meetings to five days a week. There is more detail on this important governance change in Section 4 below.

2.2.4 Other issues covered by the EMB during this period include:

- Scrutiny of the year-end financial position and budget setting for the new financial year
- Progress of work-streams under the HR Transformation Programme
- On-going preparation, with IC24, for the mobilisation of the new NHS 111/CAS contract
- Advancement of key infrastructure projects, including Brighton Make Ready Centre

2.2.5 The EMB has also continued the joint programme of development with the Senior Leadership Team (SLT) during this period, including monthly joint sessions.

2.3 Revised Trust Strategy

2.3.1 Following presentation of the Trust's refreshed Strategy at today's Board meeting, we will be working hard to socialise this over coming weeks with a wide range of internal and external stakeholders, although there will not be a formal 'launch' at this stage.

2.3.2 Our engagement plan will include ensuring that our new Strategy is accessible to all audiences, that the key points are widely shared and that internal stakeholders are able to clearly identify how they have influenced its development.

2.4 Sad news

2.4.1 During recent weeks, we have very sadly lost two serving members of staff – Paramedic Practitioner Rhod Prosser and ECSW Rosie Hales. We also lost a recently-retired colleague – Ricky Powell – and Paramedic Practitioner Peter Hart, who had previously been a long-standing SECAmb employee and who continued to work on the bank for SECAmb, although his primary role was at East Surrey Hospital.

2.4.2 The current situation has made it difficult for their colleagues locally to pay their respects, as they would do normally but I have been proud to see our managers work with staff to find different and very touching ways to do this during this period.

2.4.3 We have ensured that all staff who have been affected by these losses, including local managers, are being supported and will continue to ensure this happens.

2.5 Engagement with local stakeholders and staff

2.5.1 Despite the COVID-19 pandemic, I have continued my on-going programme of meeting with local stakeholders, although this has obviously been carried out virtually in most cases.

2.5.2 The Chair and I have commenced a programme of virtual meetings with our local MPs and during this period have engaged with almost all of them, either individually or in small groups. We have used the Trust's Common Operating Picture, which provides a summary of current performance and other key issues, as a basis for these discussions and have also been able to provide timely updates on our response to the pandemic.

2.5.3 These meetings have been largely positive, and we have received good feedback from participants. We have a plan in place to continue this programme moving forward as the format and approach seems to have worked well.

2.5.4 Without breaking social distancing restrictions, I have also continued my programme of visiting Trust sites and regularly meeting with staff, including spending time at Crawley and Coxheath EOCs, Ashford 111, Banstead, Chertsey and Sittingbourne.

3. Regional Issues

3.1 Delay to implementation of new NHS111/CAS contract

3.1.1 In the light of rising pressure on the Trust due to COVID-19 and in particular on the NHS 111 service, discussions took place with our commissioners in the Spring and a system-wide decision was taken to postpone the launch of the new NHS 111/CAS contract planned for 1 April 2020.

3.1.2 Following this decision, we are continuing to work on our mobilisation plans for the new service, together with our partners, and are continuing to closely monitor the situation before specifying a precise go-live date. As stated, we expect to launch the new service before the winter, however, in the meantime, the current NHS 111 service continues as normal.

4. National issues

4.1 COVID-19 outbreak

4.1.1 Like the rest of the NHS and our ambulance colleagues nationally, SECAmb has been and continues to be significantly impacted by the current COVID-19 outbreak. I remain extremely impressed with the way the whole Trust has risen to the challenges placed on us and remained focussed on delivering the best service possible, despite the circumstances.

Governance

4.1.2 We have established a robust governance framework to support the Trust's response to the pandemic, including the establishment of the COVID Response Management Group (CRMG). The CRMG is led by Bethan Eaton-Haskins as our Lead Director for COVID, supported by David Hammond who chairs the meeting on her days off. This has become the key group that supports and directs our response to the pandemic, ensuring that all COVID-related decisions and actions are considered appropriately.

4.1.3 As we move through the pandemic, we have also now established the COVID Recovery, Learning & Improvement Group, led by David Hammond. This group covers several key workstreams, including those focussing on our people, estates, IT utilisation and new ways of working. It is important that we utilise our experiences during the pandemic – the things that have worked well as well as those that haven't – to improve how we conduct our business in the future. I look forward to seeing tangible outputs from this work that will bring lasting improvements for patients and staff.

Personal Protective Equipment (PPE)

4.1.4 Understandably, the supply and utilisation of PPE during the pandemic has been a key area of concern for many of our staff. Our Logistics Team have worked incredibly hard to source and distribute enough numbers of the right equipment, as well as managing a wide range of donated PPE from external businesses.

4.1.5 In common with all ambulance services, we are following the guidance provided by Public Health England (PHE) as to which PPE should be worn by staff in different clinical scenarios and this is reflected in our Trust guidance. However, our guidance also allows all staff to undertake a risk assessment and wear the PPE that they feel is appropriate to the situation at the time.

Mutual Aid Support to London Ambulance Service (LAS)

4.1.6 In late March 2020 we received a request via the National Ambulance Coordination Centre to provide mutual aid support to our colleagues at London

Ambulance Service for a two-week period, as they were under particular pressure at that time and needed to significantly increase the number of crews they had available each day.

4.1.7 Despite the very short deadlines involved, we had many staff volunteer to be part of the mutual aid team and so were able to send a ‘cell’ of ten ambulances and staff to support LAS from 6 April 2020 onwards.

4.1.8 From speaking to the team involved, I know that it was a challenging but also rewarding experience. Our colleagues at LAS were grateful for our support and were extremely complimentary about the contribution from the SECAmb team.

Increasing our staff numbers

4.1.9 To ensure that we are well placed to respond to the on-going challenges of the pandemic and have resilience within our workforce, we have worked hard to attract a range of new colleagues into the Trust during this period.

4.1.10 We have been joined by several staff on our ‘bank’ from different organisations, including a significant number from Virgin Atlantic, who have joined our EOC and 111 teams in Crawley to provide additional resilience. Following a specific appeal, over 50 of our former operational colleagues - paramedics, technicians and ECSWs – have also re-joined SECAmb.

4.1.11 In addition, we have enjoyed excellent support from our own CFRs in a range of roles, as well as from paramedic students from our partner universities. I am also pleased to see us receiving very practical help from our Fire & Rescue Service colleagues, including their assistance with the distribution of supplies.

Testing

4.1.12 During the past eight weeks, we have been providing, under a formal Memorandum of Operations (MOU), the facility for the testing of staff and patients within the community, working with acute and community providers to undertake testing of suspected COVID patients in their homes. This has included providing the regional co-ordination service for testing on behalf of the system and the communication of test results to patients and staff. More recently, this has been expanded to also include the specific testing of patients in care and nursing homes.

4.1.13 In terms of staff testing, up until recently we have been facilitating the testing of symptomatic staff only, or their symptomatic household members, through a number of testing sites in our area. However, this week we have seen the start, as a small pilot initially, of testing for asymptomatic staff ahead of a national move towards more frequent and regular testing for all front-line NHS staff.

4.1.14 Evidence from pilot sites in other parts of the country has suggested that about 2% of frontline staff tested positive without displaying any symptoms. This pilot has been a useful opportunity to test the process and ensure we get it right before it is rolled out more widely.

Impact of COVID on particular groups

4.1.15 As reported through the media, evidence is indicating that COVID-19 is having a disproportionate impact on sections of our communities – those with underlying health concerns and people from Black, Asian and Minority Ethnic (BAME) communities.

4.1.16 Whilst we await the outcomes of the national review, we have taken steps locally to provide assurance to our staff where possible. We have asked the leads for Aspire, our cultural diversity network and Enable, our disability and carers network, to make contact with all staff within these groups (BAME, and those who are shielding due to pregnancy, age or underlying health conditions) to undertake a welfare check and discuss any concerns that they may have. In line with national guidance, this will now allow be followed up with specific risk assessments where necessary.

4.1.17 In order to keep our staff safe and to enable social distancing we have enabled those that do not need to be in a specific location to perform their roles from home. This has enabled us to spread out the EOC and some 111 staff across the first floor of Nexus House to ensure that staff keep metres apart. This is a significant change for our HQ staff and I want to thank everyone for adapting so willingly to these new ways of working. We note that it will take a significant amount of time to reverse – if appropriate – post COVID.

Communications and engagement

4.1.18 We have worked especially hard during the pandemic to ensure that we are communicating regularly with our colleagues. In addition to utilising all of our existing internal mechanisms, we have also introduced a daily up-date call, led by Joe Garcia or his deputy Emma Williams and including updates from the Executive Team, which is joined by more than 100 first-line and middle managers every day. We are also holding a weekly live webinar, open to all who wish to join, again involving the Executive Team and which allows staff to ask questions ‘live’ during the session. This is also proving to be very popular.

4.1.19 I have been pleased that we have been able to take forwards a number of suggestions made by staff during this period, including the recent competition for children to create ‘designs’ for the side of an ambulance and a request for ‘rainbow’ hoodies for staff.

4.1.20 As I said above, I am very proud of the hard work and dedication that has been put in by staff across the Trust to responding to this situation. It has been challenging due to the speed at which the situation has developed, however there has been real focus on the safety of staff and patients which has been great to see.

4.2 Mental Health Awareness Week

4.2.1 National Mental Health Awareness week commenced on 18 May 2020, with the theme this year of kindness. We have undertaken a range of activities, both internally and externally, to support this work, including a real focus on ensuring that all our staff are aware of the breadth of options available within SECAmb to support them.

4.2.2 As part of this work, we were pleased to share two short films that focus on mental health within the ambulance sector. One was produced by the Association of Ambulance Chief Executives (AACE) and features colleagues from across the country and one features our own staff talking about their experiences. Both provided very a real insight into the experiences of staff, who talked bravely and openly about their own personal challenges and the journeys they are on to move forwards.

5. Recommendation

5.1 The Board is asked to note the contents of this report.

Philip Astle, Chief Executive Officer

20 May 2020

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	07-20
Name of meeting	Trust Board	
Date	28th May 2020	
Name of paper	COVID-19 Response Management Group Assurance	
Author name and role	Bethan Eaton-Haskins, Executive Director of Nursing & Quality	
Synopsis	The COVID-19 Response Management Group was formed in March 2020 to ensure a consistent governance approach to all decisions being taken during the COVID-19 Business Continuity Incident. This paper outlines the function of the group and associated governance requirements.	
Recommendations, decisions or actions sought	The Board is asked to note the contents of this report	

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

COVID-19 Response Management Group Assurance

Introduction

This report details the establishment of the COVID-19 Response Management Group.

On the 31 December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On the 12 January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

On the 3rd March 2020, NHS England declared a national level four incident in relation to the COVID-19 Pandemic.

On the 20th March 2020, South East Coast Ambulance NHS Foundation Trust declared a Business Continuity Incident in relation to the COVID-19 Pandemic.

In a pandemic outbreak, leadership challenges can introduce high levels of uncertainty during the initial response phase, requiring flexibility, rapid adaptability of plans and increased pressures and demand on services, which may be exacerbated by staff absence. The Executive Management Board approved the creation of a COVID-19 Response Management Group at the beginning of March 2020 in order to mitigate these risks and challenges.

The CRMG does not replace or manage day to day operational issues which remain the responsibility of the Trust Strategic Commander, who continues to use the existing command arrangements (e.g. pre-determined triggers in the surge plan).

During business hours, 08.00 to 18.00hrs, Monday to Friday, COVID-19 related decision-making and governance have been carried out via the existing and established routes and chaired by the Trust responsible Executive Director for the COVID-19 response.

The responsible Executive Director has been supported by the COVID-19 Management Group (CMG) which is made up of senior managers from all areas of the Trust and subject matter experts, including those from the existing COVID-19 Operational Management Team based at SECAmb Headquarters.

Out of hours, 18.00 to 08.00hrs, Monday to Friday, and for a period of 24-hours on Saturday, Sunday and bank holidays, the COVID-19 Management Group has continued to undertake this role by means of an on-call provision, chaired by the responsible Executive Director for COVID-19, or nominated deputy (Executive Director of Finance and Corporate Services).

The aim of this modified governance structure has been to:

- support the organisation in responding to the COVID-19 outbreak;
- provide comprehensive and aligned governance of all COVID-19 related measures being implemented by the Trust;
- ensure that the most senior directors are signing off all decisions made;
- take into consideration, for each decision being made, the wider system, political, governance and economic implications which need to be assessed alongside the internal day to day operational issues;
- identify and manage identified risks, issues or blockers that may impact on the Trust ability to deliver a safe and effective service.

The reporting line for this modified governance structure is illustrated within the diagram shown on the right and below.

COVID-19 leadership and governance overview

	STRATEGIC COMMANDER	COVID-19 OPERATIONAL MANAGEMENT TEAM	COVID-19 MANAGEMENT GROUP (CMG) (Weekdays 08.00 – 18.00)	COVID-19 MANAGEMENT GROUP (CMG) (Out of Hours)
Over-arching purpose	To undertake the duties of the Strategic Commander and run day to day operations. All COVID-19 issues require sign off by COVID-19 Management Group.	To manage day to day Trust operational response to COVID-19, including: COVID-19 Command Hub and COVID-19 Coordination Service To deliver against the COVID-19 MoU(s) and operational procedures.	Chaired by the Executive Director responsible for COVID-19 response (Bethan Eaton-Haskins). To oversee the contingency arrangements, routine and emergency response delivery for any patients with symptoms of COVID-19 whether suspected or confirmed.	Chaired by Executive Director responsible for COVID-19 response or nominated deputy. Command and Control function for the Trust during out-of-hours periods throughout the COVID-19 business continuity incident.
Authority	As defined by existing Trust Command and Control procedure, and Surge Management Plan.	As outlined by the CMG.	Decision making forum. All actions and activity will take place in accordance with the principles set out in the associated Terms of Reference.	Advisory function in-hours and defers to the CMG. All decisions outside of normal business hours should be taken through this route.
Structure	As set out by within the existing Trust Command and Control procedure.	**COVID-19 Ops. Mgt. Team** x1 OUM, x1 Business Performance Manager, x3 Staff Officers, + PMO support. **COVID-19 Command Hub** 24/7 tactical command provision supported by a Staff Officer, Loggist, Dispatcher, EMA and senior manager. **COVID-19Co-ordination Service (9am – 5pm, daily)** x1 Coordinator, x8 Administrators (reduced to x4 Saturday-Sunday).	Chaired by the Executive Director of Nursing and Quality who is also the Director responsible for the Trusts COVID-19 response. Membership as set out in the Terms of Reference.	• Executive Director • Staff Officer / Administrative support • Strategic Medical Advisor Quality (AD, 2x direct reports of Director of Quality) • Comms (via existing rota) • HR Business Partner • COVID-19 Operational Management Team representative

Meeting Format, Structure and Membership

The CRMG is chaired by the Executive Director of Nursing and Quality, with the Deputy Chair being the Executive Director of Finance and Corporate Services. The group initially met at 10.00am seven days a week during the initial phase of the BCI and over time this has reduced to full meetings three days a week and escalation meetings over the weekends and Bank Holidays.

The group make decisions and agrees actions for all COVID-19 related issues or activity. CRMG does not replace any existing trust governance processes and ensures that these have been followed before making a decision.

The CRMG reports directly to the Executive Management Board and provides a weekly update in relation to decisions taken as well as escalations required.

The group has a broad senior membership to ensure all key areas are represented during the decision-making process.

The standing agenda items considered at each meeting of the CRMG are as detailed below;

- Action and Decision Log
- Escalations from the Previous Day
- Escalations from NHS 111
- SECAmb Action Card Review
- Communications Update / Escalations
- Care Home Escalations
- Common Operating Picture
- Workforce and Recruitment
- Staff Testing and Community Testing
- EPRR (Emergency Preparedness, Resilience and Response) Escalations
- COVID-19 Hub Escalations
- COVID-19 Co-ordination Cell Escalations
- Logistics and Fleet Escalations
- REAP (Resource Escalation Action Plan) Level Review

Weekly the following items are tabled for assurance or discussion;

- Weekly Harm Review
- Weekly Safeguarding Update
- Weekly Patient Transport Service Update
- Full REAP level review
- Weekly Risk Register (COVID-19 specific) Review

At each meeting scrutiny items are then tabled for decision in addition to the standing agenda items. Since the inception of the group, over 2000 items have been presented for consideration.

Each action and decision taken through the CRMG is formally logged and recorded centrally by the EPRR function in addition to the recording of individual meetings.

Out of Hours Arrangements

During the COVID-19 Business Continuity Incident, it has been necessary to make decisions out of hours at times that are unable to be deferred to the next CRMG. The out of hours decision making process has been strengthened to ensure that all decisions can be made with a multi-disciplinary senior team in place and all governance requirements followed.

Associated Governance Requirements

Every decision taken or action agreed through the CRMG is subject to the existing trust governance arrangements and requirements. Consideration of a Quality Impact Assessment (QIA), Equality Impact Assessment (EIA), Data Protection Impact Assessment (DPIA) and Business Case or Business Brief are given for each decision. These processes remain in place and have become more agile in nature / meeting more frequently due to demand.

Communication Channels

In addition to reporting to the Executive Management Board on a weekly basis, the Quality and Patient Safety Committee have received weekly assurance in relation to all areas within their purview and the Workforce and Wellbeing Committee have also held an additional meeting to receive similar assurance.

The Executive Director of Nursing and Quality, Executive Director of Operations and Executive Director of HR and OD have met weekly with Staff Side colleagues to discuss the week ahead and seek views or signpost colleagues accordingly so input can be made prior to any decision making.

Open and transparent timely communication with staff has been a key focus for the group and there has been a trust wide call seven days a week at 4.00pm where staff are updated accordingly and in addition, a weekly trust webinar every Friday afternoon has been undertaken focussing on a specific topic each week.

Limitations of the Group

The lifetime of the CRMG has been determined as the lifetime of the SECAmb Business Continuity Incident which is in turn linked to the NHS England national incident level.

The CRMG deals with operational and current decisions and actions not future plans and learning. The Trust has established a COVID-19 Recovery, Learning and Improvement Group for this purpose reporting directly to the Executive Management Board.

Summary

The Executive Management Board responded rapidly to the altered needs of the organisation as a result of COVID-19 and established the CRMG to govern all actions and decisions in a co-ordinated trust wide process.

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	08-20
Name of meeting	Board of Directors		
Date	28 May 2020		
Name of paper	Trust Strategy		
Author	Philip Astle, Chief Executive		
Synopsis	During 2019 there was significant engagement with internal and external stakeholders in the refresh of the Trust's strategy. This informed a review by the Trust Board when it became clear that a new strategy was emerging. The plan was to launch the new strategy in March 2020 but due to the COVID crisis this was postponed. This paper therefore outlines the new strategy and, over the coming weeks a delivery plan will be established, using some of the outputs from the COVID Recovery Learning & Improvement Group, to be monitored by the Trust Board at each of its meetings, from July 2020.		
Recommendations, decisions or actions sought	The Board is asked to formally approve the new Trust strategy, including the strategic objectives (Appendix 1)		

‘Sustainable SECAmb’
Our Strategic Position
‘Best placed to care, the best place to work’

Introduction

The unitary board of an NHS Foundation Trust has, as one of its three principle functions, the development of a sustainable strategic direction for the organisation. The SECAmb Board take this responsibility seriously and prompted by the developments across the NHS, launched a strategy review in early 2019. A series of meetings and workshops were held involving the whole board as well as extensive engagement with our personnel and system stakeholders. This paper lays out the key points from this engagement.

In addition, the Trust’s future includes a vital system leadership role in integrated care, cooperation and interoperability with many partners to deliver improvements in population health. The system in which the Trust operates is evolving; commissioning arrangements are transforming, and new patient populations are being defined within Integrated Care Systems (ICSs) and Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs) footprints.

Why revisit our established strategy?

The Trust had a well-rehearsed five-year strategy that was in the process of being ‘refreshed’. Although refreshing an old strategy might be appropriate when an organisation is operating in a relatively stable environment, the turbulence caused by changes in need, the relentless pressure on funding and radical shifts in the way that health and care is organised, managed and financed required are acknowledged triggers for a review of our strategy and have led to a fundamental review of SECAmb’s strategic direction. As mentioned above, this has been completed with extensive involvement of our people and stakeholders.

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 Purpose

Our Trust is continually improving and as such we want the people that we serve to see SECAmb as an organisation that delivers caring, compassionate, sustainable and innovative healthcare. People across the South East will trust SECAmb and know that they can rely on us to be there for them, 24/7. We will be a learning and evidence-based organisation which is constantly working to improve in everything it does.

The Trust remains passionately committed to the public, our patients, our values and the people who work in SECAmb. In addition, the Trust is the provider of urgent and emergency care services across four STP/ICSs. If we are to deliver our public purpose it is essential that we are more clearly recognised as the leader of extended urgent and emergency care pathways in the region.

To do that we need to show that we provide our patients with 999 and 111 services of the highest quality and value as well as be fully engaged in the shift to integrated care systems founded less on treatment and more on population health. As such, the Trust's strategy embraces the need to continue to improve our core services which includes 999 services and latterly, with the award of the KMS 111CAS contract, an imperative to successfully mobilise this new service in April 2020.

What follows is an expression of our enduring purpose that encompasses the shift to population health:

'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 Operating Environment

We recognised that our strategy had to enable us to pursue this purpose in the context of our operating environment and that there were several critical forces and drivers that need to be considered. Principal of these are the rising needs and demands for SECAmb services with continued funding pressures and the Trust and our commissioners' desire to ensure that patients can access the most appropriate care pathways for their needs. Policy changes including 'integrated healthcare' require a radical and rapid restructuring of NHS commissioners and providers and their relationships with local government. There is a need the need to shift from 'competitive' to 'collaborative' behaviour across the system and a major change in emphasis from 'contracted activity' to 'population health' resulting in changes to the way that funding maybe allocated, and performance assessed. The system is already creating plans and reviewing legal, financial and organisational enablers to move to a 'system by default' operational model.

To fulfil our *purpose* in this new operating *environment* our strategy might be expressed as:

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

Implications for SECAmb

Adopting this strategy has several high-level *strategic implications* relating to the way the Trust is organised. This may include services we provide and the working relationships we have with other stakeholders in the system. These in turn will have implications for the decisions we take about investing or disinvesting in our key resource areas; estates, fleet, technology, workforce and finance.

Managing Strategic Change

The implications that have been identified must drive the managerial process of creating plans, identifying objectives, timescales for delivery and that of setting goals for management functions and for individuals within them.

Priorities

During our review, 4 priority areas have emerged which build on and acknowledge the work of the Trust to date. These include:

- **Delivering Modern Healthcare for our patient**s – A continued focus on our core services of 999 & 111CAS
- **A Focus on People** – They are listened to, respected and well supported
- **Delivering Quality** – We listen, learn and improve
- **System Partnership** – We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care

Based on these priorities, the Executive has created organisational objectives (Appendix 1) aligned with these areas and the way in which we deliver our objectives will always be underpinned by the Trust's values. It is also intended that the Trust's strategic planning will be proactively managed at Trust Board level and, where required, priorities and objectives revisited to continue to meet our Purpose and Strategy. For example, the Trust must continue to recruit, retain and nurture an ambulance workforce in its traditional sense but also has the ambition to be the recognised provider of a paramedic workforce for the system.

From Purpose to Action and Delivery

The diagram below illustrates the ideas expressed in this document.

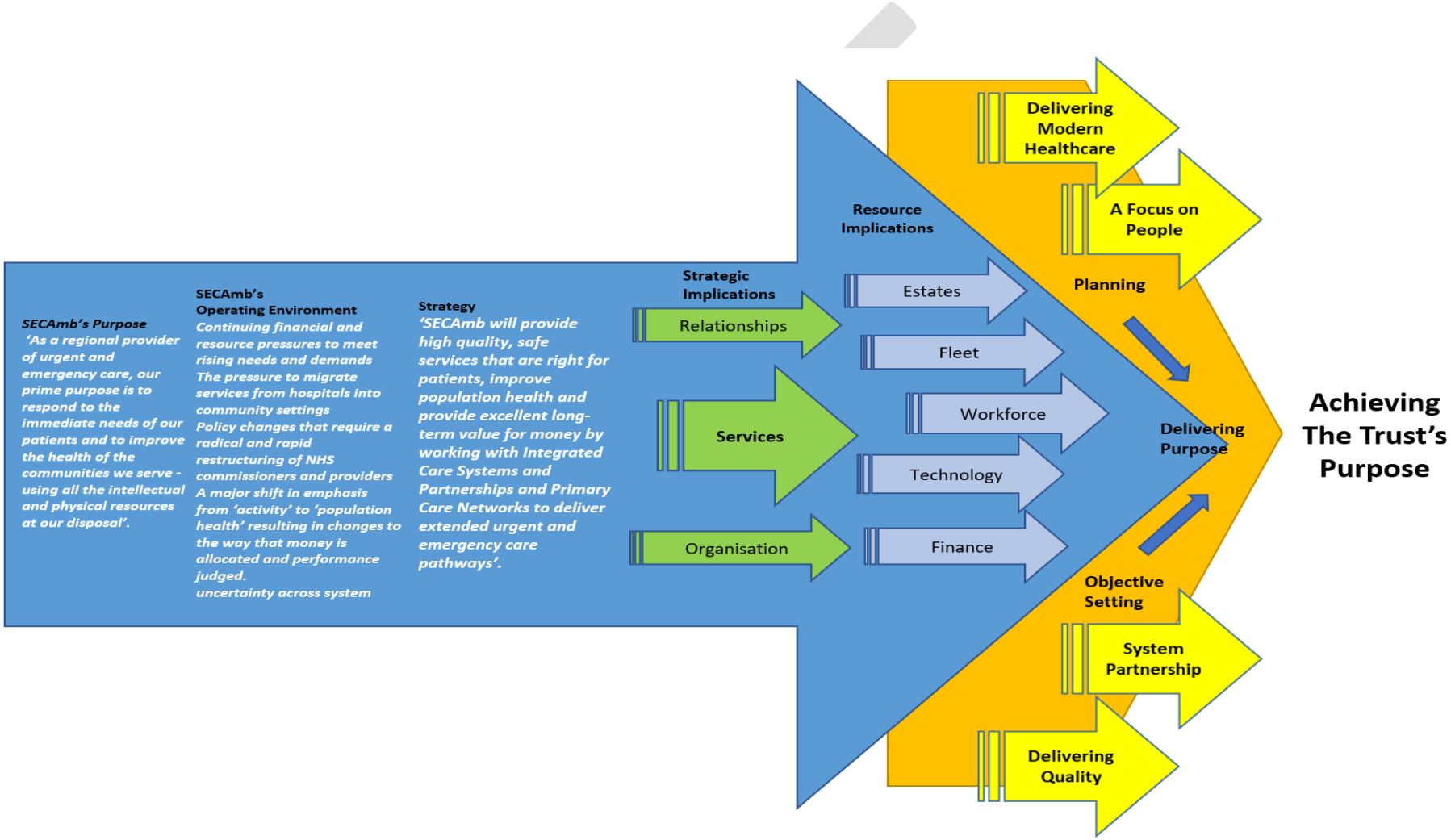
On the left we have the revised expression of our purpose that recognises our aspirations for our patients and the wider public and our responsibilities to the people who work with us.

To pursue our purpose in the operating environment will need the strategy described here which has implications for three strategic areas:

1. Our services
2. Our organisation
3. Our relationships
4. Which in turn will guide the decisions we take about the investment and disinvestment in resources

The Trust will plan and deliver against its stated priorities which then leads to the managerial processes of planning and objective setting to enable SECAmb to deliver satisfactorily on its purpose.

From Purpose to Action and Delivery



Appendix 1

Strategic Objectives
We will develop and deliver overarching resource plans required for our 999, 111 and other services including workforce, fleet and other enablers in order to deliver high quality patient care. By the end of year 1 these processes will be embedded into annual and monthly planning cycles
In order to continually improve our 999 and 111 services for patients we will create, nurture and deliver a sustainability culture. This will be achieved by continuous improvement of all aspects of the way services are delivered to patients, the way in which change is managed and acknowledge our corporate and social responsibility
We will deliver our core services and continue to improve these through the creation of innovative and improved urgent and emergency care pathways that better meet the needs of our patients. As the service matures it will be increasingly integrated into the other urgent and emergency care providers and systems
We will plan and deliver a digital programme supporting integration and innovation to improve patient and staff experience, quality and safety
We will become the Partner of choice for urgent and emergency care projects and trusted to lead change in that space. This will include making the best of opportunities to build and expand from our core services
We will define our high performing ambulance process model and ensure our estate and other enablers support this model
We will set out and deliver a People Strategy which develops, inspires and supports our aim to become a more representative and diverse workforce which is regarded as a clear employer of choice and is best placed to continually improve the quality and efficiency of patient care across our services
We will identify the learning from our response to the COVID crisis to improve the way we provide services

South East Coast Ambulance Service
NHS Foundation Trust

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	09/20

Name of meeting	Trust Board
Date	26th March 2020
Name of paper	Patient and Family/ Carer Experience Strategy
Responsible Executive	Bethan Eaton-Haskins– Executive Director of
Author	Judith Ward– Deputy Director of Nursing and Quality
Synopsis	This paper supports the attached Patient and Family / Carer Experience Strategy. The strategy has been co-developed with key partners including patients, carers, our staff, the Inclusion Hub Advisory Group, Council of Governors, Clinical Commissioning Groups and Health Watch. The methodology is set out in the strategy. The strategy sets out a 5-year strategy and plan which is based on the NHS Improvement (NHSI) Patient Experience Improvement Framework. NHSI have supported the development.
Recommendations, decisions or actions sought	The Board are requested to approve the attached strategy.

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 QIA and EIA completed.**

Patient and Family/Carer Experience Strategy 2020 - 2025

South East Coast Ambulance Service
NHS Foundation Trust

Living our Values:

Our values are the standards which everyone working at our Trust is expected to live up to. They help us to make the right decisions and guide how we treat our colleagues, our patients and their family and friends.

Demonstrating Compassion and Respect
Supporting our colleagues, and those we serve, with kindness and understanding.

Acting with Integrity
Being honest and motivated by the best interests of those we serve

Striving for Continuous Improvement
Seeking and acting upon opportunities to do things better.

Taking Pride
Being advocates of our organisation and recognising the important contribution we make to its success.

Assuming Responsibility
Having ownership of our actions and a willingness to confront difficult situations.

Contents

Introduction

Director of Nursing & Quality

I am very pleased to introduce the first Patient and Family / Carer Experience Strategy for South East Coast Ambulance NHS Foundation Trust. The experience of our patients is central to providing high quality care. Our patients clearly told us that the experience of their families / carers is also central to patient experience and, therefore, this strategy takes a more holistic approach to experience.

I would like to thank all those who have been involved in the development of this strategy As a Trust we have been delighted with the engagement of our patients, their families and carers, our staff, and external partners, including Health Watch across the region, to co-develop this strategy. Our vision is that this strategy will be co-delivered with our partners and anticipate that over the next 5 years we will see an increasing influence from patients and their families / carers in the care that we provide. We are also grateful to the support from NHS I/E to develop this strategy.

The development of our strategy has helped us to identify areas that we currently do well in addition to those where we need to change how we do things. We will build on our existing good practice. We recognise that we need to be ambitious in order to truly improve the experience of our patients and their families / carers. We will take a Trust wide approach to examining our culture, leadership, patient and staff engagement and how we measure experience

The format of this full strategy document is not helpful to patients who want a quick and easy reference. We have had to obtain a balance between governance requirements of the Trust and information which is accessible to patients. Therefore, following endorsement by our Board, we will develop a shorter one page more accessible format which clearly defines the elements of our strategy. This will also be made readily available throughout our Trust.

Bethan Eaton-Haskins, Executive Director of Nursing & Quality

About this Strategy

Patient experience, on the face of it, can seem quite simple, however, we all experience things slightly differently and each experience is itself made up of a number of experiences or 'moments' that are all measured against our original expectations. Patient Experience is what the process of receiving care feels like for the patient, their family and their Carers. It is a key element of quality alongside clinical excellence and safer care. Patient experience has many facets including, how a telephone call is answered, to the way the patient is examined or treated, to how our staff explain what is happening to our patients.

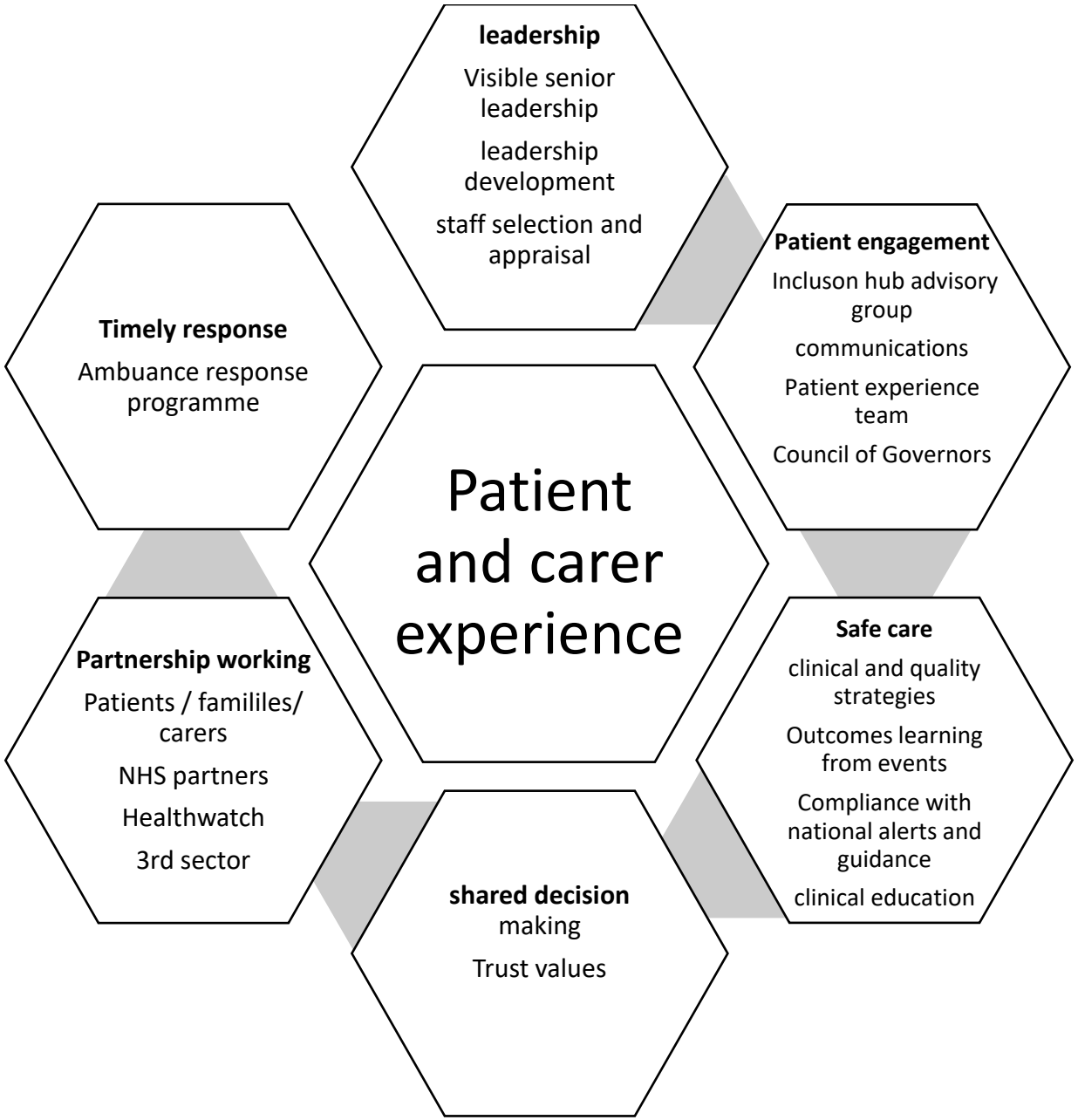
Understanding and improving patient experience is not simple. As well as effective leadership and a receptive culture, a whole- systems approach is required to collecting, analysing, using and learning from patient feedback for quality improvement. Without such an approach it is almost impossible to track, measure and drive quality improvement[1]. This strategy will guide the organisation's development in terms of patient experience, ensuring that our approach is pro-active, in partnership with our patients and their Carers, and meets the Trust's statutory responsibilities.

This Strategy has been developed in collaboration with our patients, their Carers and other key stakeholders including members of our Council of Governors, Our Inclusion Hub Advisory Group, our commissioners, local Health Watch and our staff.

An initial scoping exercise was undertaken in 2019 with a smaller group of stakeholders which identified many varying expectations. In order to, manage the wide-ranging expectations and attempt to offer as many stakeholders as possible the opportunity to contribute, an online survey, followed by three wider face to face stakeholder events where held during July and August 2019 in Kent, Surrey and Sussex. Both focussed on the question "what matters most to our patients". 282 responses were received to the online survey. Whilst rudimentary, this supported us to obtain views across the wide geography covered by the Trust. In addition, patients and families / carers provided feedback about the service we currently provide. As appropriate, key learning has been embedded into this strategy and other work within the Trust. We are grateful to our partners in Clinical Commissioning Groups and Health Watch who were pro-active in advertising and supporting our work. The online survey also enabled a greater number of our operational staff to contribute.

A positive patient experience cannot be achieved by one workstream within an organisation. It requires a Trust wide approach. The following diagram represents many of the co-relationships.

[1] Patient Experience Improvement Framework. NHS Improvement June 2018


leadership
Visible senior leadership
leadership development
staff selection and appraisal
Patient engagement
Incluson hub advisory group
communications
Patient experience team
Council of Governors
Timely response
Ambuance response programme
Patient and carer experience
Partnership working
Patients / famililes/ carers
NHS partners
Healthwatch
3rd sector
Safe care
clinical and quality strategies
Outcomes learning from events
Compliance with national alerts and guidance
clinical education
shared decision making
Trust values

Background and policy context

There is a strong body of evidence which demonstrates benefits in improving patient experience, including better outcomes for patients[2], improved service delivery and more efficient services, organisational reputation, and staff development and satisfaction.

In 2008, the work of Lord Darzi[3] signalled a need to consider patient experience alongside safety and quality. In addition, the Francis Report[4] highlighted the importance of culture and leadership in terms of patient experience.

In 2013 NHS Constitution was strengthened in terms of patient experience[5]

The NHS Outcomes Framework[6] includes measures across the NHS to measure patient experience. The Friends and Family Test (FFT)[7] is a requirement for all providers that hold an NHS Standard Contract. It is a national feedback tool which supports the principle that people who use the NHS should have the opportunity to provide feedback on their experience. From April 2020, the national FFT (patients) guidance allows ambulance services to consider whether they will continue with the Friends and Family Test but are required to run a co-produced patient experience project on an annual basis. The NHS Staff Friends and Family Test will continue. The Trust NHS 111 service plans to use a text messaging service to access patient experience, which will be developed during mobilisation of the service prior to April 2020. Past evidence suggests this is a successful methodology for this service.

In 2019, The Care Quality Commission report on South East Coast Ambulance Service NHS foundation Trust noted that the Trust had systems in place to learn from complaints. In addition, "Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated people. People reported that staff go the extra mile and their care and support exceeds their expectations. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People's emotional and social needs were seen as being as important as their physical needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment". This strategy will continue to support the high-quality care already provided by our staff.

[2] Feeling better? Improving Patient Experience in hospital
[3] High Quality Care for all : NHS Next Stage Review Final report. 2008
[4] Report of the Mid Staffordshire NHS Foundation Trust Inquiry, 2013
[5] Updated NHS Constitution NHS England 2013.
[6] NHS Outcomes Framework NHS digital
[7] Friends and Family Test NHS England 2019.

Background and policy context

The Patient Improvement Framework supports NHS trusts and Foundation Trusts to achieve good and outstanding ratings in their Care Quality Commission (CQC) inspections.

The framework enables organisations to carry out an organisational diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes. The framework integrates policy guidance with the most frequent reasons CQC gives for rating acute trusts 'outstanding', as identified in the NHSI review of CQC reports in January 2018. South East Coast Ambulance Service NHS Foundation Trust is working towards for a CQC registration graded as outstanding by 2022.

The Framework focuses on key areas which will form the basis of this strategy:

- Leadership
- Organisational culture
- Collecting feedback: capacity and capability to effectively collect feedback
- Analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other quality measures
- Reporting and publication: patient feedback to drive quality improvement and learning: the ability to use feedback effectively and systematically for quality improvement and organisational learning.

A gap analysis aligned to the framework identified that the organisation has many of the required elements in place (some of which need strengthening) and some gaps. This has been used to identify the direction of this strategy.

The work of South East Coast Ambulance Service NHS Foundation Trust

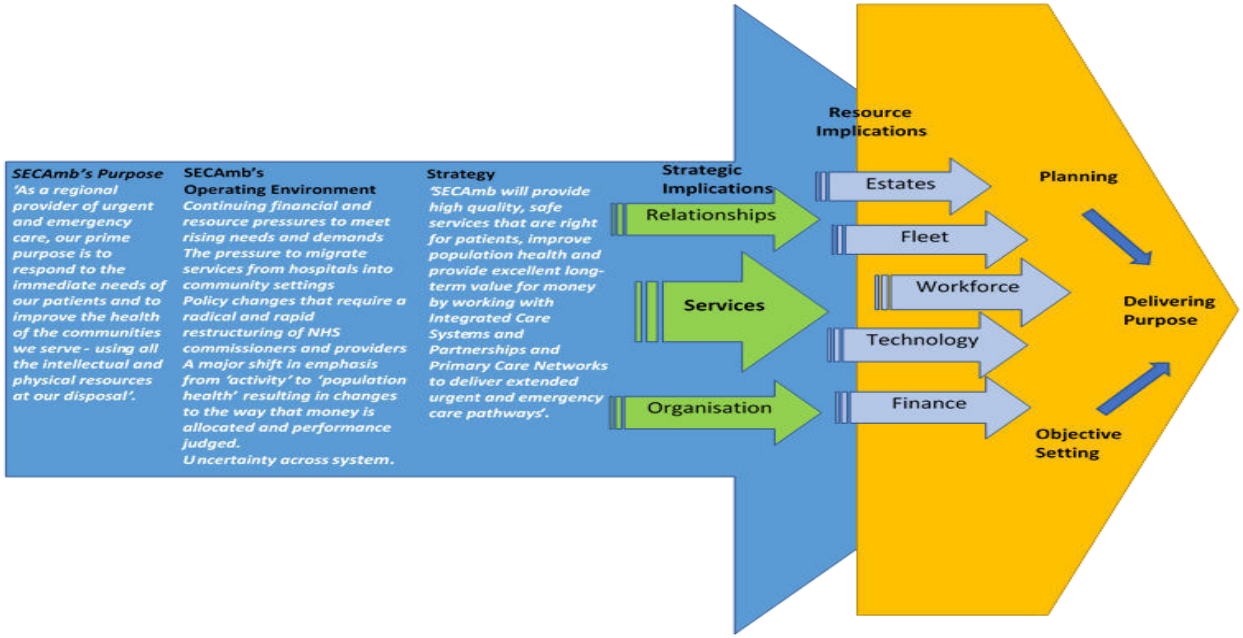
The Trust provides services to a diverse catchment of 4.7 million people. The area that we cover is 9,400 square kilometres and includes Kent, Surrey, Sussex and North East Hampshire.

We receive and respond to 999 calls from the public and health care professionals; receive and respond to 111 calls; and provide the regional Hazardous Area Response Team (HART) which responds to specialist emergency challenges.

To ensure we can deliver our services we employ over 3,500 staff, 85 % of whom are directly involved in patient care.

As a Trust we are committed to learning from our patients and our staff and to embed Trust wide change as a result of this learning.

The diagram below demonstrates how our organisational strategy supports our purpose.



This Patient and family / carer experience strategy supports the organisational strategy and outlines our approach to patient experience for the next 5 years. In developing this strategy, we have considered our responsibilities under the NHS Constitution and our commitment to work in partnership with our patients, their families and their carers.

Our vision and values for patient experience

Our Vision South East Coast Ambulance Service is taking a whole organisation approach to patient experience. By applying the term 'patient experience' we refer to the patient, their family and their carer.

Patient experience will have a focus in all departments within the Trust and at all levels of the organisation. This will be underpinned by robust governance arrangements which will help us to understand what it is like to be a patient or carer.

Our values as an organisation we continue to learn and develop. Feedback from our patients, their families and their carers is central to understanding the care we deliver and continually working towards improvement.

Our patient experience strategic themes

Our strategic themes for patient experience focus on the themes within the Patient Experience Framework outlined earlier in this document.

Our objectives

This strategy has several objectives, which will be underpinned by a development plan. The overarching development plan will be monitored by our Patient Experience Group.

Leadership

- We will strengthen our governance arrangements in terms of relationship between the patient and experience group and the wider arrangements within the Trust to ensure that themes and risks are identified early and that staff at all levels of the organisation understand what it feels like to be a patient or carer.
- Our patient and Carer strategy will be driven and overseen by our Patient Experience Group. The Terms of Reference and Membership will be reviewed to ensure that the group is supported to challenge effectively and contribute to some of the workstreams to deliver this strategy.
- Senior clinicians within the Trust will be involved in decision making which may impact on patients, and patient experience will continue to be an integral element of this assessment.
- We will provide an Annual Patient and Carer Experience Report to Board which will be developed over the next 5 years to ensure that is easily understood. This will be co-produced with our Patient experience group.
- We will increase the visibility of our senior leadership team, including to patients and their Carers.
- We will develop strong leadership within the Trust. Patient and Career experience will be central to this and will include the involvement of patients in key staff selection and recruitment; feedback from patients and carers in regular management of staff; and leadership training.

Organisational culture

- We will continue to develop a listening culture which engages with and listens to our patients and their families/ carers.
- The Trust will continue to embed a safety culture which learns from patient feedback and can demonstrate effective change as a result.
- The Board will continue to value and celebrate innovation by frontline staff to improve the experience of patients and specifically staff who demonstrate they consistently exceed patient expectation, and always deliver individualised care. Whenever possible patients and carers will be involved in selection of the winners of the Annual Trust Awards.
- We will continue to celebrate our organisational values, and these will be incorporated into complaints investigation, recruitment and management oversight of staff.
- The Trust will continue to express its commitment to patients through all its communications by ensuring that information provided to patients is easily accessible and easy to understand (without jargon).
- The Trust will continue to support staff to share decision making about care and treatment with patients, and actively support staff to involve carers. Staff will be trained to understand the fundamentals of shared decision making.

- We will continue to offer our staff a wellbeing and a Chaplaincy service in order to support their wellbeing and spiritual needs, thereby supporting our patients and their carers

Collecting feedback: capacity and capability to effectively collect feedback

- We will explore and develop innovative ways in which we can engage with our patients and their families/ carers to obtain feedback. This will include collaboration with external partners such as Health Watch.
- The Trust will assess its mechanisms for collecting patient and carer feedback on an annual basis and make improvements year on year. Patients will be offered a range of ways in which they can feedback.
- The Trust will have a patient friendly complaints process which adheres to national guidelines. This will be accessed within 2 clicks on our website.
- We will audit our complaints process on an annual basis in terms of adherence to national guidelines, including the quality of our investigations and our response.
- The Trust will participate in all mandated patient / carer surveys and will publish learning in an easy to read format.
- The Trust will monitor key elements of the NHS Staff survey which provides insight into patient experience and will strive for year on year improvement.

Analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other measures

- The Trust will continue to develop effective mechanisms for analysing and triangulating feedback from patients and carers and will review this on an annual basis. The Patient Experience Group will receive regular reports identifying themes and risks.
- The Trust will use patient and carer feedback to inform a dashBoard which demonstrates an early warning of deteriorating care.
- The Trust will use quality improvement methods and tools to try to continuously improve quality of experience of care and outcomes for patients.
- We will use analysis of patient and carer feedback as an integral element of any service change or redesign. We will involve patients or carers directly in this decision making whenever possible.

Reporting and publication: patient feedback to drive quality improvement and learning; the ability to use feedback effectively and systematically for quality improvement and organisational learning

- The Trust will routinely publish transparent and publicly accessible information about the feedback patients have provided, and our response to feedback and will ensure this information is available through multiple routes).
- The Patient Experience Group will develop a supporting process to disseminate information to patients and carers in collaboration with our communications department.
- The Trust will support a model of co-production. In particular, the Trust will move to co-produce the Annual Patient and Carer Experience Report.

Our Development Plan for Patient Experience

The Trust development journey in terms of patient and carer experience will be monitored by our Patient Experience Group and will develop throughout the period of this strategy.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
Leadership				
The Board has a strategy to deliver improved patient experience and regularly engages with groups of patients and other key stakeholders. The organisation uses the output from such engagement to inform its plans to deliver the strategy.	The organisation has a patient experience strategy coproduced with patients and frontline staff, consulted upon, and signed off by the Board.	(Strategy to be developed with key stake holders signed off by Board March 2020).	We will start to review our strategy in year 4 in readiness to publish a reviewed strategy in year 5.	Publish revised strategy end of year 5.
	The trust also has a delivery plan, impact measures and review timetable and carries out an annual review of progress towards achieving the strategy.	Development plan to be agreed and monitored by patient experience group.	Annual review of Development plan.	Annual review of Development plan.
Patient experience is embedded in all trust leadership development work (including that undertaken by operational managers and clinical staff).	Leadership training will include and support patient experience.	We will embed 'Always Events' within our leadership training.		
		We will undertake a training needs analysis for all levels of the organisation which will include (but not exclusive to), investigation training, report writing to a standard patients understand, difficult	We will embed the findings of our training needs analysis into training throughout the year at all levels of the organisation.	We will continue to embed the findings of our training needs analysis into training throughout the year at all levels of the organisation.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
		conversations, understanding of NHs constitutional requirements, impact of our behaviour and comments on patients and their carers.	Training will include vignettes based on feedback from patients and / their carers.	Training will include vignettes based on feedback from patients and / their carers.
		Our Board development sessions will include a focus on patient and carer experience.		
		Staff working exclusively within, or oversight of, services directly related to patient experience (e.g. patient experience, incidents and serious incidents) will receive dedicated training to support their roles.	Training will continue.	
		We will continue to significantly strengthen the relationship between our patient experience group and key partners within the Trust to engage with patients and capture a holistic view of what it feels like to be a patient / carer. This will include incidents and serious incident processes; communications team, inclusion hub advisory group.		
	Patients are involved in assessment and appraisal processes for staff. (for example, patient feedback data or other forms of involvement		Appraisals and one to one meetings will look at compliments, complaints and testimonials.	

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	including complements, complaints, testimonials).			
			We will explore and start to include patients and carers in recruitment interviews.	
There is visibility of the senior leadership team with an identified executive lead accountable for leading quality improvements in patient experience, who routinely presents reports and leads discussion with Board colleagues on patient experience.	The executive lead for patient experience routinely provides the Board with reports and proactively leads this area of work within the organisation. Patient stories are routinely used at Board meetings and other trust settings.	We will continue to provide an annual patient experience report to Board which will be easy to understand. This will be published on our website.	We will explore how our senior leadership team engages directly with patients.	
		We will continue to show patient stories at Board meetings. In addition, we will use patient stories at internal governance meetings and team meetings.		
	The senior leadership team is accessible and visible in the organisation and routinely engages with patients and frontline staff.	We will continue to ensure that our senior team has opportunities such as quality assurance visits and A & E visits to engage with our front-line staff.		
There is clear clinical leadership from the medical director and director of nursing and engagement of clinicians in the	All clinicians are engaged and provide input into the development of services and efficiency changes and how	We will continue to undertake a quality impact assessment, an equality impact assessment and a data privacy impact		

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
development of the quality strategy and clinical strategy which provides momentum in terms of quality, patient experience and safety.	change impacts on patients and front-line staff.	assessment on all service changes to understand the impact on patients. These will be signed off by senior clinicians or subject matter experts. In addition, clinicians and patients will be involved in the design of service changes which may impact on patients.		
	There is clear medical engagement in patient experience as an equal facet of the quality agenda alongside patient safety and clinical effectiveness.	We will review the terms of reference for our patient experience group to ensure equitable medical engagement alongside Nursing & Quality.		
Organisational Culture				
The Board values and celebrates innovation by frontline staff to improve the experience of patients and specifically staff who demonstrate they consistently exceed patient expectation, and always deliver individualised care.	Staff are supported to listen and act locally as a response to patient feedback and the organisation routinely captures analyses and reports on the outcomes from this.	We will review our operational governance structures to ensure that patient feedback is reported and discussed at all levels of the organisation. The structures will facilitate early discussion of risks and themes emerging relating to patient and career experience at all levels in the organisation and facilitate staff on the ground to escalate thematic concerns easily.		
	There is a process in place to identify and celebrate achievements of staff who consistently exceed patient expectations and the Board is	Our annual staff awards will continue to recognise and celebrate staff who exceed patient's expectations.	We will include patients and their carers in our decision-making group for the staff awards.	

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	engaged and fully involved in the process.			
		The patient experience team will start to collate information on potential nominees for the staff awards. Our patient experience group will nominate staff for our annual awards ceremony.		
	Staff are engaged in the process of setting staffing levels and in developing their own workforce.	We will undertake a gap analysis against the NHSI/E safer staffing guidance when published and implement necessary changes.		
	Staffing level escalation processes are well defined and embedded throughout the organisation to ensure safe staffing.			
	Staff give care that is compassionate, involves patients in decision-making and provides good emotional, spiritual and religious support to patients.	We will continue to provide a wellbeing service to support our staff which has a clear remit. In addition, we will continue to offer a Chaplaincy service to our staff.	We will provide training to ensure that our staff understand specific spiritual and religious requirements.	
Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concern and believe they will be listened to and supported.	The organisation has developed, with patients and staff, a set of values, articulated NHS Constitution. The organisation has a process for ensuring values are owned by staff through all corporate documents.	We will continue to embed and celebrate our organisational values and embed our values into complaints investigations.		
	The organisation has in place a	We will embed our values-based		

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	values-based recruitment and appraisal system.	recruitment into practice.		
The organisation expresses its commitment to patients through all its communications, and routinely offers to provide copies of clinical correspondence.	The organisation's website and other externally facing communications are accessible and clear and patients would judge them 'patient friendly'. They also articulate commitment to patients.	Our organisation website will have information on how to provide patient feedback within two clicks. We will work with external partners such as Healthwatch to ensure that our communication is accessible and clear.	Review of website and engagement exercise re usefulness of site	
	The trust has a process of testing its communications to patients with patients, prior to publication	We will review our communications oversight process to ensure that crucial patient facing information is tested with patients prior to publication.	Review of communications strategy in relation to patient experience and engagement	
	Patients are routinely offered copies of correspondence about them in an accessible format (Accessible Information Standard)	We will work with key stake holders including our patient experience group and Healthwatch to review our correspondence including responses to complaints and serious incident reports to ensure that they are clear and understandable for patients.		
Collecting feedback				
The organisation participates in all mandated surveys (including where applicable the National Patient Survey Programme, the Friends and Family Test and systematic local surveys) and works with commissioners to	Full compliance with all mandated surveys, and a comprehensive programme of seeking rapid, real or near real time from patients using the most up to date technology available to them.	Our 999 service will run an annual co-produced patient experience project on an annual basis. This will be reported at Board level, published on our website and included in our annual quality account.	Our 999 service will run an annual co-produced patient experience project on an annual basis. This will be reported at Board level, published	Our 999 service will run an annual co-produced patient experience project on an annual basis. This will be reported at Board level, published

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
develop and implement rapid/real, or near real-time patient feedback.		In addition, our 111 service will use technology to gather and understand the experience of patients. We will also review our staff, friends and family survey on an annual basis to understand the impact of our care on patients.	on our website and included in our annual quality account.	on our website and included in our annual quality account.
The trust has a patient friendly complaints process, which complies with national guidance.	The organisation has an accessible user-friendly complaints process.	We will review our information on the complaints process to ensure that it is user friendly.	We will review our information on the complaints process to ensure that it is user friendly.	We will review our information on the complaints process to ensure that it is user friendly.
	Complaints information is clearly displayed on the Trust's website and available within two clicks.	We are developing our organisation website. This will include information on how to provide patient feedback within two clicks.		
	Complainants are offered a face-to-face meeting, supported throughout the process and their feedback sought on completion of dealing with the complaint.	We will continue to offer complainants a face to face meeting and will aim to increase the number of face to face meetings for level three complaints year on year. In addition, we will agree a process for feedback following completion of a complaint. Feedback will be reported to our patient experience group.		
	Feedback about how the complaint was handled is routinely gathered.	We will undertake an annual audit cycle of our complaints process which looks at:	Continue annual audit and embed learning.	Continue annual audit and embed learning.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
		▪ Timeliness of response ▪ Quality of investigation ▪ Quality of response This audit will be undertaken with key stakeholders including Healthwatch and our patient experience group. This will be reported to our patient experience group.		
	There is evidence that practice has changed following complaints and improvements have been sustained.	We will review our processes for sharing learning on an organisational wide basis and will strengthen our governance processes to ensure that learning is embedded.		
Frontline staff take ownership of, and deal with, issues raised by patients, and only where necessary refer on to others. When patients express a wish to complain clear information is provided and support given. The Duty of Candour is followed.	Frontline staff are supported by managers and their teams to address concerns raised by patients, and there is a process for teams to share and learn from this.	One to one's will include a review of patient feedback. All team meetings will include a review of patient feedback.		
	Duty of Candour regulations are well understood and embedded. The organisation's processes are clear and transparent.	We will review the quality of our current training to ensure that the principles are understood by all staff, and managers are supported to have difficult conversations.		
	The importance of patient	Our annual training programme	Our annual training	Our annual training

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	feedback is embedded in the organisation's approach to staff training.	will continue to be informed by themes arising from patient feedback and incidents affecting patients.	programme will continue to be informed by themes arising from patient feedback and incidents affecting patients.	programme will continue to be informed by themes arising from patient feedback and incidents affecting patients.
Patients are given information about the range of ways they can provide feedback (which might include paper-based surveys, comment cards, web, text, devices, kiosks, and apps) and are supported by staff to use these. Approaches offered take account of the needs of patients who are less able or less willing to feedback.	The organisation employs a range of methods to collect patient feedback, based on patient need and preference. Staff are familiar with these and encourage and support patients.	We will review the methods we use to collect patient feedback directly. In addition, we will work with external partners to understand how we can engage with processes for system wide learning and initiatives such as citizen advocates. This will include feedback from carers.	We will review the effectiveness of our feedback mechanisms and embed any required changes.	We will review the effectiveness of our feedback mechanisms and embed any required changes.
Analysis and triangulation				
The organisation has a systematic way of analysing patient feedback in all its forms, including complaints. The organisation also has dedicated analytics and intelligence support for its patient experience data, which produces clear helpful reports.	The organisation routinely and systematically analyses feedback, brings together all strands and identifies themes which it acts on.	We will continue to include patient and carer feedback within our monthly thematic analysis which also included incidents and serious incidents. We will also include litigation and coronial findings.	We will continue to include patient and carer feedback within our monthly thematic analysis which also included incidents and serious incidents. We will also include litigation and coronial findings.	We will continue to include patient and carer feedback within our monthly thematic analysis which also included incidents and serious incidents. We will also include litigation and coronial findings.
		When themes are identified we will continue to investigate using appropriate methodology.		
		We will develop systems which inform local understanding of		

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
		themes. These will be developed in collaboration with operational managers.		
The organisation produces reports that demonstrate the correlation between improving patient outcomes, patient safety and patient experience. This is also routinely triangulated with staff and the staff survey.	Reports highlight themes where patient experience correlates with other quality measures (for example patient safety and clinical outcomes) and Board reports clearly articulate the relationships and the quality improvement actions arising.	The Terms of Reference for the patient experience group will be reviewed and strengthened to ensure oversight of patient and carer experience alongside clinical outcomes and patient safety.	We will review Terms of Reference for patient experience group on annual basis.	We will review Terms of Reference for patient experience group on annual basis.
The organisation is able to use patient experience data effectively to identify and locate deteriorating performance, and to enable quick action to address the causes.	The organisation effectively uses patient experience data to provide an early warning system for deteriorating standards of care that enables leaders at a range of levels to spot when there are concerns, using quality improvement approaches.	We will start to develop a dashboard to reflect deteriorating performance which is impacting on patient and carer experience.	We will review our dashboard and amend as appropriate.	We will review our dashboard and amend as appropriate.
The organisation uses quality improvement methods and tools to try to continuously improve quality of experience of care and outcomes for patients.	The organisation is using data related to patient experience to understand variation. Patient experience is both fully aligned with and integral to quality improvement.	Patient and carer experience data will inform quality improvement initiatives. We will use quality improvement methodology to support changes which positively impact on patient and carer experience.	Patient and carer experience data will inform quality improvement initiatives. We will use quality improvement methodology to support changes which positively impact on patient and carer experience.	Patient and carer experience data will inform quality improvement initiatives. We will use quality improvement methodology to support changes which positively impact on patient and carer experience.
	The organisation performs	Our performance monitoring	Our performance	Our performance

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	above peer in the NHS Mandate goal to 'improve the percentage of NHS staff who report that patient and service user feedback is used to make informed improvement decisions.	will include key questions within the NHS Staff survey.	monitoring will include key questions within the NHS Staff survey.	monitoring will include key questions within the NHS Staff survey.
The organisation supports staff to share decision making about care and treatment with patients, and actively supports staff to involve patients in their care.	Staff demonstrate a good understanding of the theory and practice of shared decision making, its principles are underpinned through training programmes.	We will review our training and develop a plan.	We will review our training plan	
	Patients and their families are involved in their care and understood what is expected in relation to their care.	We will develop ways of collecting and analysing patient feedback in relation to this.	We will continue to collect and analyse patient feedback.	We will review our collection methodology and continue to collect and analyse patient feedback.
	The organisation performs above peer in the NHS mandated national survey questions asking if patients felt involved in decisions about care and treatment.	We will review our results and implement learning.	We will review our results and implement learning.	We will review our results and implement learning.
The organisation uses staff appraisal to identify training needs and based on need, implements training for staff so they able and confident to use feedback to improve services using quality improvement methods and tools.	The organisation has a systematic approach to identifying staff training needs related to using patient feedback to improve services.	We will continue to include themes arising from patient and carer experience within our annual 'key skills' mandatory training	We will continue to include themes arising from patient and carer experience within our annual 'key skills' mandatory training.	We will continue to include themes arising from patient and carer experience within our annual 'key skills' mandatory training.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
All proposals for service change, project initiation document and business cases are accompanied by evidence of their potential impact on the experience of patients.	Patients and service users have been involved in the design stage of any service change. There is evidence of coproduction.	We will explore how we can involve patients and their carers in service design or change when appropriate.	We will use patients and carers to support pathway development.	
Reporting and Publication				
The organisation routinely publishes transparent and publicly accessible information about the feedback patients have provided, and its response to feedback (and ensures this information is available through multiple routes).	Information is available and accessible to patients and the public.	We will explore the use of "you said – we did" methodologies to publicise our responses and learning arising from patient and carer feedback.		
		We will work with external stakeholders to evaluate our organisation against the accessible information standard and implement changes.		
		We will publish the progress of our patient and carer experience strategy and associated improvement plan within our Annual Quality Report and Account.	We will publish the progress of our patient and carer experience strategy and associated improvement plan within our Annual Quality Report and Account.	We will publish the progress of our patient and carer experience strategy and associated improvement plan within our Annual Quality Report and Account.
		We will use thematic analysis and patient stories to support system wide decision making relating to services. This will include Integrated Urgent Care Clinical Governance meetings	We will use thematic analysis and patient stories to support system wide decision making relating to services. This will include Integrated	We will use thematic analysis and patient stories to support system wide decision making relating to services. This will include Integrated

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
			Urgent Care Clinical Governance meetings.	Urgent Care Clinical Governance meetings.
	We will provide an annual Patient Experience Report to Board	We will continue to provide an annual patient experience report to Board on an annual basis.	We will co-produce our Annual Patient Experience report with our patient experience Group. This report will accurately reflect what it is like to be a patient or carer. The Annual Report will be written in an easy to understand format.	We will review the format of our report and the engagement of our patient experience group in the process and implement learning.
			Our Annual patient experience report and Annual Quality Report and Account will describe the progress of our 999 patient experience improvement project.	
The organisation supports a model of co-production and supports patients and staff to deliver this approach.	Co-production is widely used, and the organisation can cite examples of co-production, including the use of specific improvement methodologies, where staff have worked in partnership with patients to improve services.	The delivery of this strategy will be delivered in partnership with our patient experience group and our inclusion hub advisory group. We will make a sincere commitment to designing changes to our service which impact on patients in partnership with patients and carers.	The delivery of this strategy will be delivered in partnership with our patient experience group and our inclusion hub advisory group. We will make a sincere commitment to designing changes to our service which impact on patients in	The delivery of this strategy will be delivered in partnership with our patient experience group and our inclusion hub advisory group. We will make a sincere commitment to designing changes to our service which impact on patients in

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
			partnership with patients and carers.	partnership with patients and carers.

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South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services

Aspiring to be
Better Today and
Even Better Tomorrow
For our people and our patients

Board Meeting

May 2020

Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents Summary

Chart Key

Data Point	This represents the value being measured on the chart
Run of 3 above average Run of 3 below average	These points will show on a chart when the value is above or below the average for 3 consecutive points. This is seen as statistically significant and an area that should be reviewed.
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.
AVERAGE	This line represents the average of all values within the chart.
UCL LCL	These lines are set two standard deviations above and below the average.
Target	The target is either and Internal or National target to be met, with the values ideally falling above or below this point.

SECAmb CQC Rating and Oversight Framework

Use of Resources Metric (Financial Risk Rating)	**1**
Segmentation	**Segment 3**
IG Toolkit Assessment	Level **2** - Satisfactory
REAP Level	**3** although the Trust had considered and taken action via COVID-19 governance to reduce to 2 on 20 04 20 and subsequently 1

SECAmb Executive Summary

Overview

This report sets out performance data with supporting narrative to provide the Trust Board with assurance that the Executive Directors review historic information and data reflecting performance and service delivery across a number of domains, including the key risks and issues to delivering our principle objectives. The Trust Board is asked to note the Trust's performance in each area.

The Senior Leadership Team are currently working to redesign this report and are consulting with Board members on the future format.

Data included in this report covers:

- March 2020 and contemporary operational data to give the Trust Board an indication of historic and current performance
- Clinical data as of January 2020
- Other Directorate data for March 2020

This report should be read in the context of the Trust declaring a BCI in March 2020 in order to effectively plan and respond to the COVID-19 Pandemic. This situation has resulted in a number of actions in response to Government guidance that have required the Trust to adapt to increasing numbers of personnel self isolating, working in an agile manner and supporting the delivery of front line operations. The Trust's ongoing response is reviewed daily to ensure alignment with national guidance and as learning is identified. This will also inform the work underway within the Trust to consider organisational and system recovery, learning and improvement.

As the pandemic evolves over the coming months, operational challenges will require NHS providers to be responsive and versatile. SECAmb has demonstrated these qualities during the first two months of this public health emergency, and will continue to support the public and the health system in these exceptional circumstances.

SECAmb 999 Operational Summary

Overview

Operational performance fell short of the targets at month end against all ARP metrics apart from C1 90th. Almost all of the increase of call volume came via the 999 system, with only an additional 84 calls originating from 111 (compared to February data). Whilst overall demand was both up on February (by 3.4%) and on last year (2.7%) there was a marked downward trend in total incidents and those needing a response from the 11th March. This downward trend in overall demand was tracked by the C2 volume but the C3 volume ran contrary to this with an overall increase over the same period. When considering the % split of call types, C2 and C3 showed a marked increase with the HCP & IFT volumes dropping significantly (-15.7% and -28.2% respectively) - this latter position is likely to be a result in the declaration of the pandemic whereby the capacity & resources within both primary and secondary care were being much more tightly managed, in addition to a decreasing desire for members of the public to attend hospitals/clinics.

The month started with cyclical patterns of escalation and de-escalation within the SMP framework, however for the first 11 days post the declaration of the Covid-19 pandemic activity increased dramatically which resulted in a far greater proportion of the higher levels of SMP being seen. Within the same timescales, a very clear trend of a decrease in the see and convey rate, matched by a reciprocal increase in the see and treat rate was seen - which, on the 28/03 resulted in both rates being almost equitable. In addition, whereas previously the hear and see rates had remained at approx. 6-8%, for the 3 days of 13-15/03 (the first 3 days of lockdown), this rate increased to in excess of 10.5%.

Overall handover wrap-up time was compliant but noting significant variation between hospitals in terms of average handover time. Volumes of patients transported were reduced towards the latter part of the month, in line with the reduction in the see and convey rate - all acute trusts also reported a similar drop in the number of overall ED attendances. CFR activity was reduced when compared to February - this was not unexpected as individuals chose to reduce any potential risk to COVID-19 by reducing their shift take-up.

All but 2 operating units delivered on or above the total level of resources required for March. Usually approx. 80+% of all hours put out are through core shifts, however from shortly after the announcement of the pandemic, this proportion reduced to a low of 60.5% on 29/03/20. The differential between these level of core resources was picked up primarily through a substantial increase in overtime - minimal differences in the resource provision through bank or private ambulance providers (PAP) was seen. This drop in core hour provision can be clearly attributed to the significant number of staff who went into self-isolation following the announcements made by the government in the second week of March - the number of staff in this category increased throughout the rest of the month. No fleet issues were reported for any front-line vehicles or 'swabulances'.

SECAmb 111 Operational Summary

Overview

All NHS 111 service's faced unprecedented pressures during March as a result of WHO declaring a global pandemic status for COVID-19. SECAmb collaborated extensively with other Trusts and service's, NHSE, resilience forums and COVID-19 Management Groups across the operating area to manage the demand.

Calls reached 162,194 which was double the previous December activity and performance in call answering within 60 seconds fell to 16.5% (National average was 28.6%) and the abandonment rate exceeding 50%. There is evidence to suggest that patients decided to contact the wider Urgent Care System to discuss their health concerns (as partially demonstrated by '999 Hear and Treat' rate).

To maintain call handling resilience SECAmb deployed a 'Public Health Emergency' team of Service Advisors to handle asymptomatic COVID-19 related calls via a new interactive voice recognition option.

The latest official version of NHS Pathways was updated numerous times which compounded the effect on performance.

The clinical-based disposition outcomes achieved by the service reflects the ability of maintaining quality and clinical care. The Ambulance and A&E referral rates fell significantly (AMB rate almost 1% below national average) attributable to ongoing efforts and planning during Q3 of 2019/20.

SECAmb Performance

March 2020

	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	3937	00:07:52	00:14:55
C1T	00:19:00	00:30:00	2408	00:09:28	00:17:32
C2	00:18:00	00:40:00	32719	00:21:25	00:41:01
C3		02:00:00	19776	01:45:06	04:01:21
C4		03:00:00	265	02:10:57	04:56:29
HCP 3			1036	02:18:19	04:58:01
HCP 4			870	03:08:38	07:17:59
IFT 3			396	02:23:32	04:54:58
IFT 4			106	03:29:17	09:02:04
ST	All Incidents		23881	37.16%	
SC	All Incidents		34984	54.43%	
HT	All Incidents		5403	8.41%	
Count of Incidents			64268		
Count of Incidents with a Response			58865		
999 Mean	Call Answer Target 00:05		77883	00:07	
999 90th	Call Answer Target 00:10			00:12	
Trust EOC 999 Abandoned Calls			185	0.2%	

SECAmb Productivity

Week commencing 2nd March 2020

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.06	01:38:44	97.38%	65,082	4.2%	2.5%	93.3%
Target	1.09	01:29:00	100%	70,400	3%	0%	97%

Week commencing 9th March 2020

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.07	01:38:40	96.74%	63,447	4.0%	2.7%	93.3%
Target	1.09	01:29:00	100%	70,400	3%	0%	97%

Week commencing 16th March 2020

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.07	01:37:49	96.44%	62,986	3.4%	2.2%	94.4%
Target	1.09	01:29:00	100%	70,400	3%	0%	97%

Week commencing 23rd March 2020

	RPI	Job Cycle Time	Qualified Shift Cover	Staff Hours Booked On	SRV Staff Hours	NET Staff Hours	DCA Staff Hours
Actual	1.07	01:37:33	96.79%	64,784	3.2%	2.4%	94.3%
Target	1.09	01:29:00	100%	70,400	3%	0%	97%

SECAmb Benchmarking Data

Response & Call Answer Performance March 2020

	C1	Mean
	England	00:08:07
1	North East	00:06:47
2	West Midlands	00:07:08
3	South Western	00:07:10
4	South Central	00:07:47
5	North West	00:07:50
6	South East Coast	00:07:52
7	East Midlands	00:07:59
8	Yorkshire	00:08:01
9	East of England	00:08:23
10	Isle of Wight	00:09:51
11	London	00:09:52

	C2	Mean
	England	00:32:06
1	West Midlands	00:14:46
2	South Central	00:19:21
3	South East Coast	00:21:26
4	Yorkshire	00:23:53
5	Isle of Wight	00:26:03
6	North East	00:27:22
7	South Western	00:27:53
8	East Midlands	00:28:14
9	East of England	00:31:25
10	North West	00:37:37
11	London	01:01:22

	C3	90th
	England	03:39:42
1	West Midlands	01:53:44
2	Yorkshire	02:14:44
3	Isle of Wight	02:33:45
4	South Central	02:38:01
5	North East	03:08:04
6	South Western	03:41:59
7	East Midlands	03:57:42
8	South East Coast	04:00:52
9	East of England	04:09:42
10	North West	05:58:20
11	London	07:17:16

	C4	90th
	England	04:36:37
1	West Midlands	02:36:57
2	Yorkshire	02:54:15
3	South Central	03:16:07
4	North East	03:28:15
5	North West	04:30:09
6	East Midlands	04:36:53
7	South Western	04:38:57
8	Isle of Wight	04:40:40
9	South East Coast	04:56:30
10	East of England	05:15:43
11	London	09:55:28

	Call Answer Times	Mean
	England	49
1	South East Coast	7
2	South Western	7
3	West Midlands	8
4	East Midlands	11
5	Isle of Wight	11
6	North East	11
7	North West	12
8	Yorkshire	13
9	East of England	15
10	South Central	17
11	London	201

Clinical Outcomes November 2019**

	Proportion discharged from hospital alive (All Patients)	%
	England	7.8%
1	West Midlands Ambulance Service NHS Foundation Trust	11.9%
2	South Western Ambulance Service NHS Foundation Trust	11.6%
3	London Ambulance Service NHS Trust	7.8%
4	Isle of Wight NHS Trust	7.7%
5	Yorkshire Ambulance Service NHS Trust	7.3%
6	North West Ambulance Service NHS Trust	6.8%
7	East of England Ambulance Service NHS Trust	6.6%
8	South Central Ambulance Service NHS Foundation Trust	6.4%
9	North East Ambulance Service NHS Foundation Trust	6.0%
10	East Midlands Ambulance Service NHS Trust	5.9%
11	South East Coast Ambulance Service NHS Foundation Trust	5.1%

	Proportion discharged from hospital alive (Utstein comparator group**)	%
	England	26.7%
1	Isle of Wight NHS Trust	50.0%
2	West Midlands Ambulance Service NHS Foundation Trust	31.4%
3	East Midlands Ambulance Service NHS Trust	30.4%
4	Yorkshire Ambulance Service NHS Trust	30.4%
5	South Central Ambulance Service NHS Foundation Trust	29.2%
6	London Ambulance Service NHS Trust	28.6%
7	East of England Ambulance Service NHS Trust	26.0%
8	South Western Ambulance Service NHS Foundation Trust	25.9%
9	South East Coast Ambulance Service NHS Foundation Trust	21.7%
10	North West Ambulance Service NHS Trust	20.6%
11	North East Ambulance Service NHS Foundation Trust	20.0%

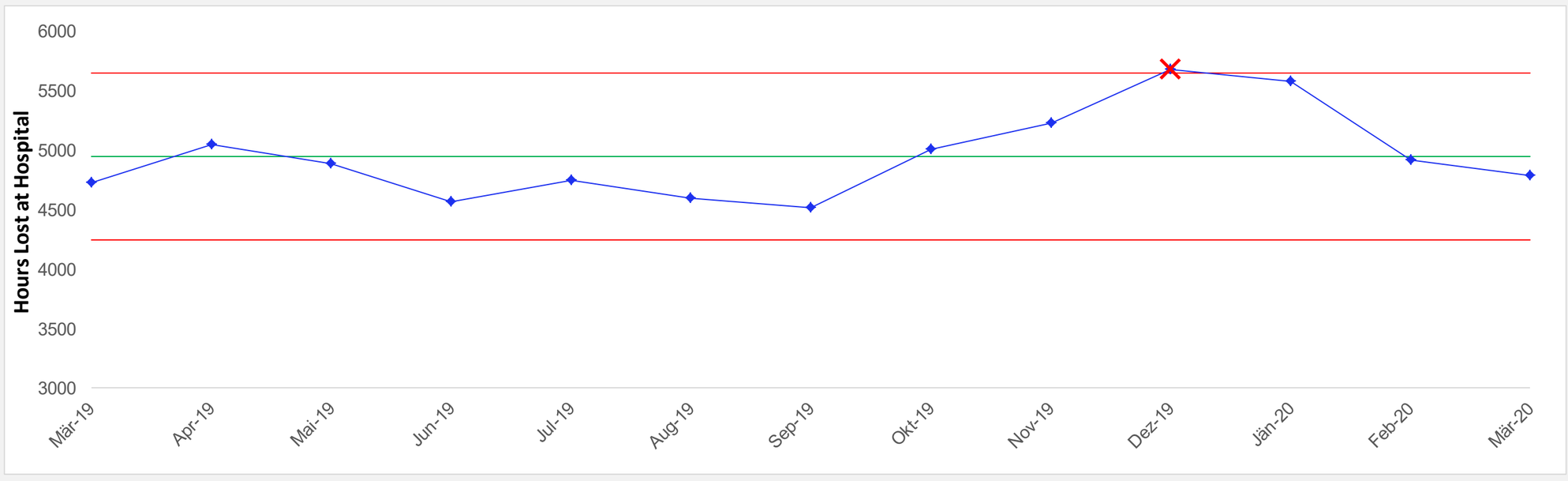
	Call Answer Times	90th centile
	England	147
1	South East Coast	12
2	South Western	16
3	North East	26
4	West Midlands	27
5	Isle of Wight	29
6	East Midlands	37
7	North West	45
8	Yorkshire	46
9	East of England	52
10	South Central	57
11	London	595

*** National Clinical Outcomes data is collected & published 5 months behind the 999 performance data.*

SECAmb Handover Delay Reporting

March 2020

Hospital	No. of Transports	No. of Handovers	Handover Button Compliance	Sum of HO < 15mins	HO < 15mins %	Sum of HO > 60mins	HO > 60mins %	Hours Lost Through Handover
Conquest Hospital	1730	1281	74.0%	271	21.2%	13	1.0%	177.19
Darent Valley Hospital	1947	1751	89.9%	570	32.6%	5	0.3%	182.96
East Surrey Hospital	2880	2778	96.5%	714	25.7%	16	0.6%	331.97
Eastbourne DGH	1594	1108	69.5%	163	14.7%	31	2.8%	229.39
Epsom Hospital	1168	1071	91.7%	305	28.5%	1	0.1%	113.33
Frimley Park Hospital	1822	1736	95.3%	452	26.0%	5	0.3%	184.71
Kent And Canterbury Hospital	119	89	74.8%	63	70.8%	0	0.0%	3.86
Maidstone Hospital	1322	1210	91.5%	633	52.3%	5	0.4%	79.35
Medway Maritime Hospital	3136	2749	87.7%	1037	37.7%	113	4.1%	480.61
Princess Royal Hospital	660	576	87.3%	152	26.4%	10	1.7%	75.59
Queen Elizabeth Queen Mother Hospital	2555	2470	96.7%	1274	51.6%	3	0.1%	131.42
Royal Surrey County Hospital	1275	1197	93.9%	663	55.4%	3	0.3%	73.19
Royal Sussex County Hospital	2565	2162	84.3%	936	43.3%	34	1.6%	232.14
St Peter's Hospital	2333	2220	95.2%	731	32.9%	8	0.4%	186.39
St Richard's Hospital	1706	1560	91.4%	699	44.8%	10	0.6%	135.89
Tunbridge Wells Hospital	2122	1977	93.2%	987	49.9%	9	0.5%	142.07
William Harvey Hospital	2813	2650	94.2%	881	33.2%	20	0.8%	314.69
Worthing Hospital	2086	1907	91.4%	836	43.8%	6	0.3%	118.12



SECAmb Clinical Safety Scorecard

Cardiac Return of Spontaneous Circulation (ROSC)-Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	52.0%	50.0%	55.3%	
Previous Year %	45.2%	41.5%	52.9%	
National Average %	53.6%			

Cardiac ROSC - ALL

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	26.6%	23.2%	27.7%	
Previous Year %	19.1%	25.9%	29.5%	
National Average %	28.8%			

Cardiac Survival - Utstein

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	21.7%	28.9%	33.3%	
Previous Year %	14.3%	18.4%	22.6%	
National Average %	26.7%			

Cardiac Survival - All

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	5.1%	8.1%	9.9%	
Previous Year %	6.6%	7.2%	9.7%	
National Average %	7.8%			

Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	62.5%	65.0%	70.9%	
Previous Year %	58.7%	65.0%	53.6%	
National Average %				

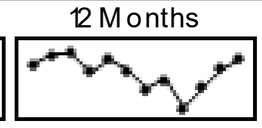
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography

	Nov-19	Dec-19	Jan-20	12 Months
Mean (hh:mm)	02:14			
National Average	02:16			
90th Centile (hh:mm)	03:09			
National Average	03:09			

Stroke - call to hospital arrival

	Oct-19	Nov-19	Dec-19	12 Months
Mean (hh:mm)	01:26	01:30		
National Average	01:25	01:28		
Median (hh:mm)	01:12	01:10		
National Average	01:13	01:15		
90th Centile (hh:mm)	02:25	02:24		
National Average	02:13	02:18		

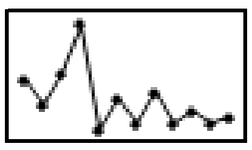
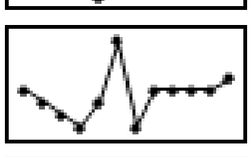
Stroke - assessed F2F diagnostic bundle

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	94.2%	96.0%	97.0%	
Previous Year %	97.1%	94.9%	97.4%	
National Average %	96.9%			

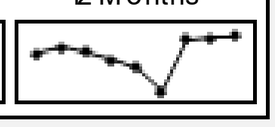
Post ROSC Care Bundle

	Nov-19	Dec-19	Jan-20	12 Months
Actual %	81.7%	75.0%	80.0%	
National Average %				

Medicines Governance

	Jan-20	Feb-20	Mar-20	12 Months
Total Number of Medicines Incidents	149	165	135	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	6	4	5	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	3	3	4	
Total Number of CD Breakages	21	21	11	
Key Skills Medicine Governance	72.1%	77.0%	87.1%	

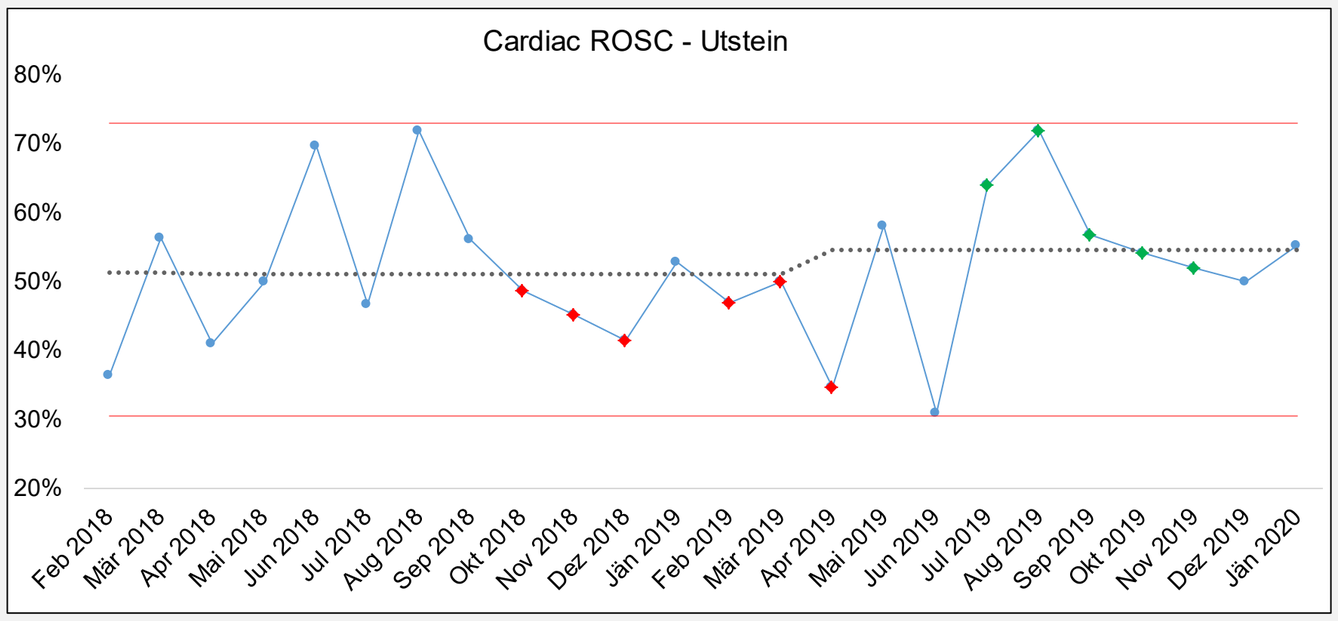
Sepsis Care Bundle Compliance

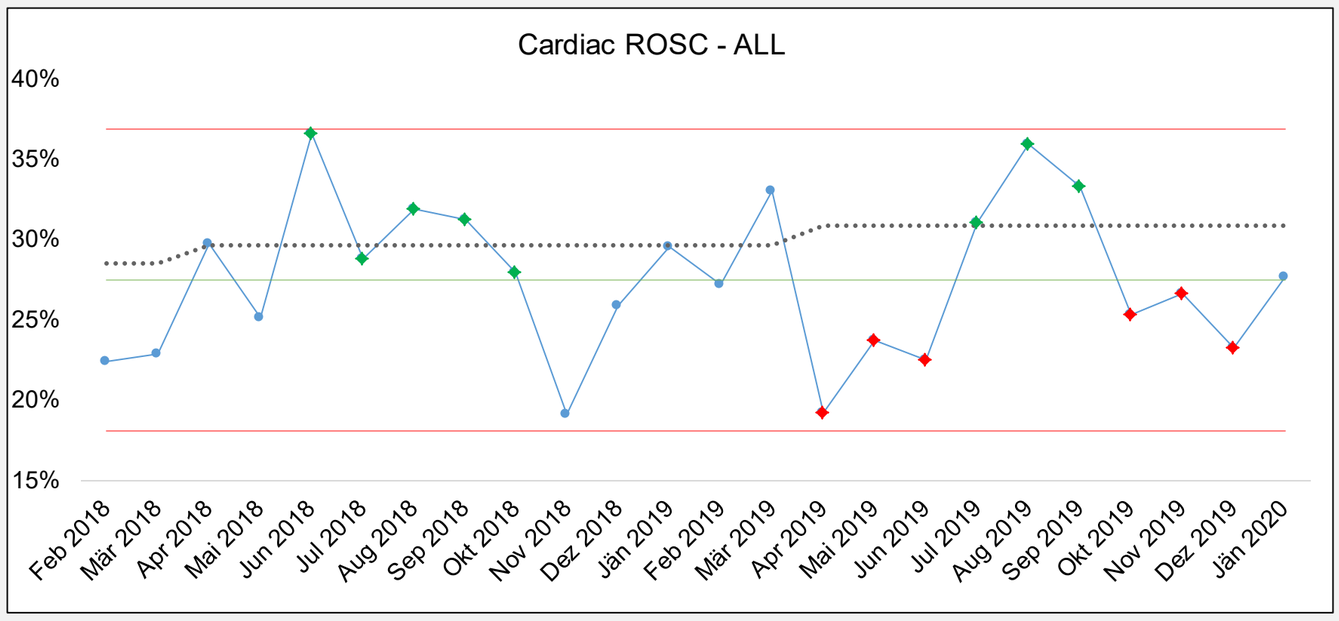
	Nov-19	Dec-19	Jan-20	12 Months
Actual %	85.6%	86.6%	87.4%	

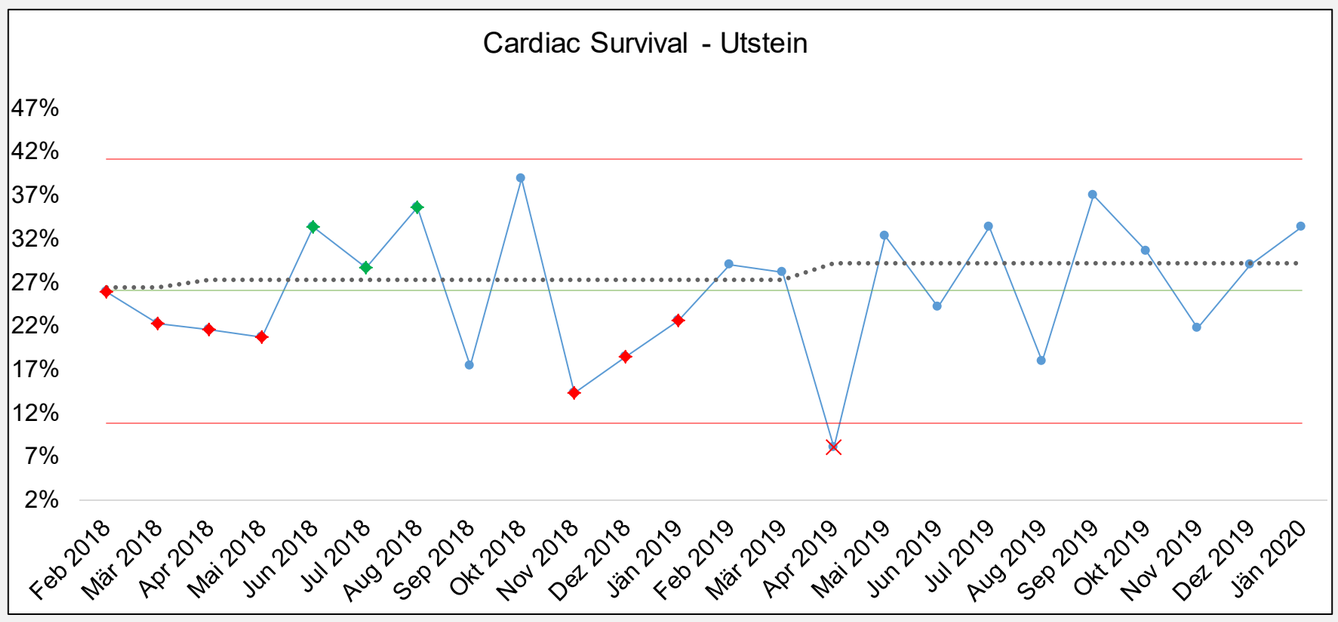
Medicines Management

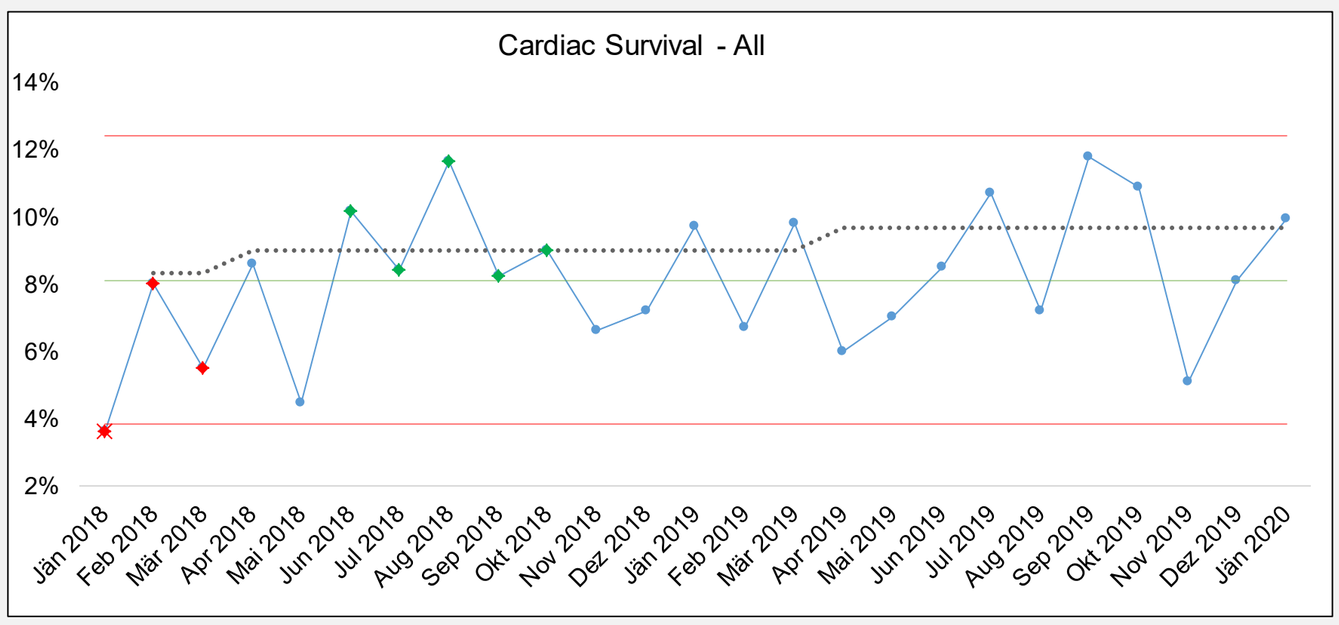
	Jan-20	Feb-20	Mar-20	12 Months
Number of Audits	189	173	171	
Percentage of Audits	99.1%	99.1%	99.3%	

SECAmb Clinical Safety Charts







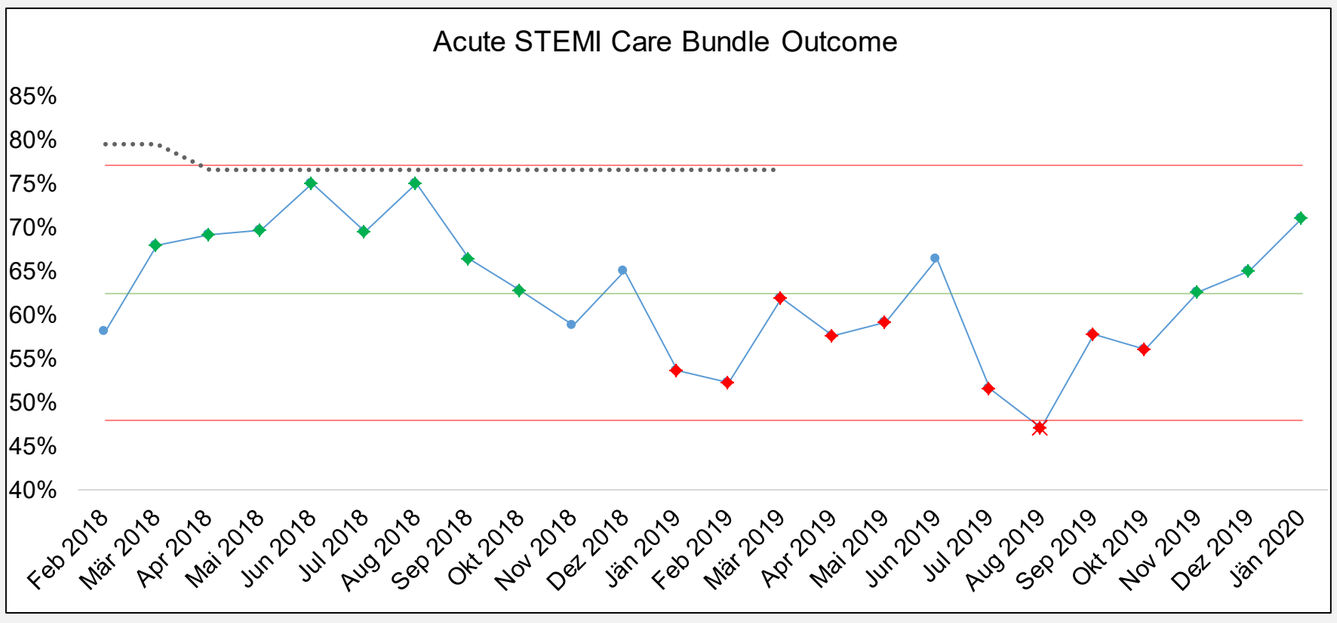


The cardiac arrest charts show the proportion of patients who had a ROSC at hospital and the proportion who survived to be discharged from hospital after resuscitation was attempted.

The data continues to show normal levels of variation. Each cardiac arrest is reviewed and no concerns relating to individual care have been identified.

In February and March, there were fewer patients matching the Utstein criteria (witnessed arrest, with bystander CPR, presenting in a shockable heart rhythm). These measures typically include few patients and so the percentages are affected by small fluctuations.

A full day of resuscitation training is currently being delivered to staff through the 2019/20 Key Skills training programme. The cardiac arrest download programme has been paused to focus on the COVID-19 response, it is expected to resume in June 2020.

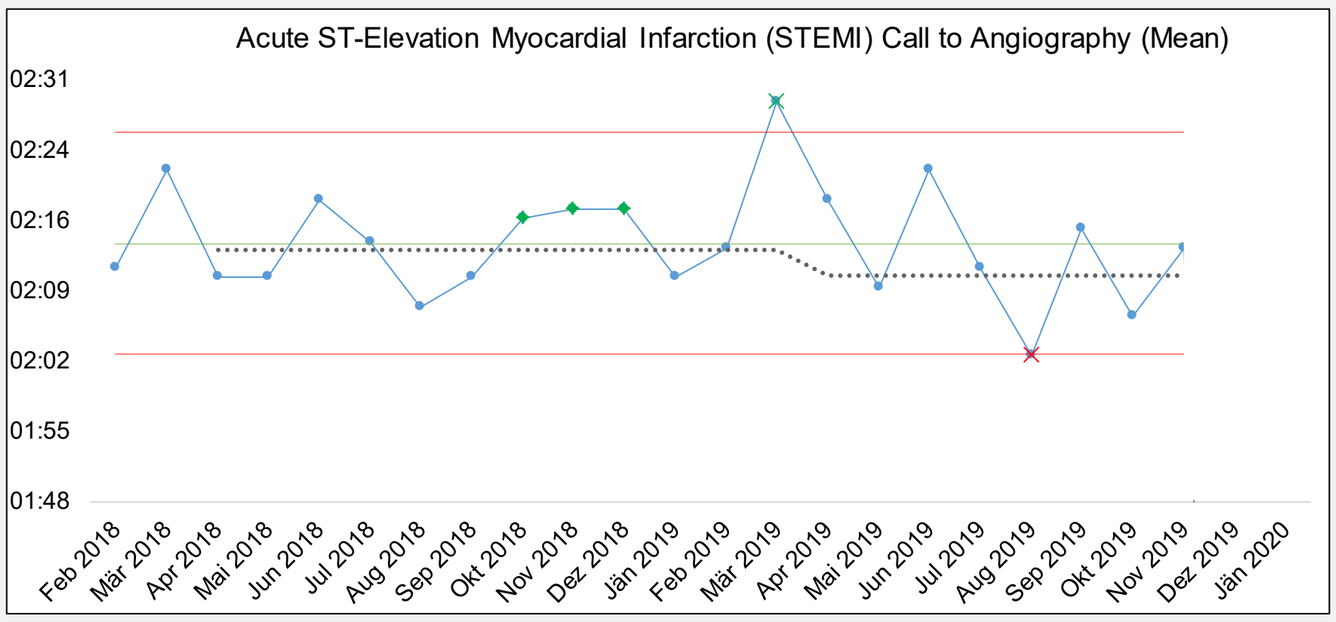


This chart shows the proportion of patients who were suffering a suspected STEMI and received a full care bundle.

There has been a month on month improvement against this measure since August 2019. This can be attributed to the delivery of individual feedback to each clinician who care for a STEMI patient and the introduction of changes to ePCR that support clinicians to document care more effectively.

In March, there were 112 patients with suspected STEMI and 82 of these received a full care bundle.

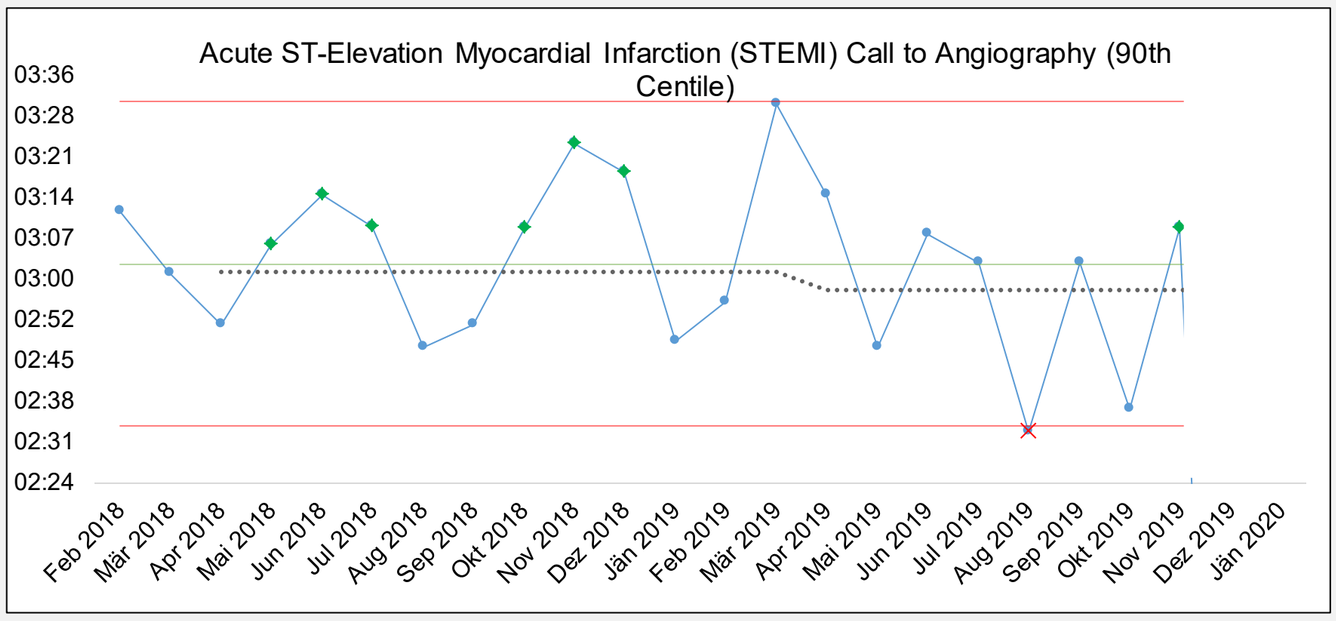
SECAmb Clinical Safety Charts

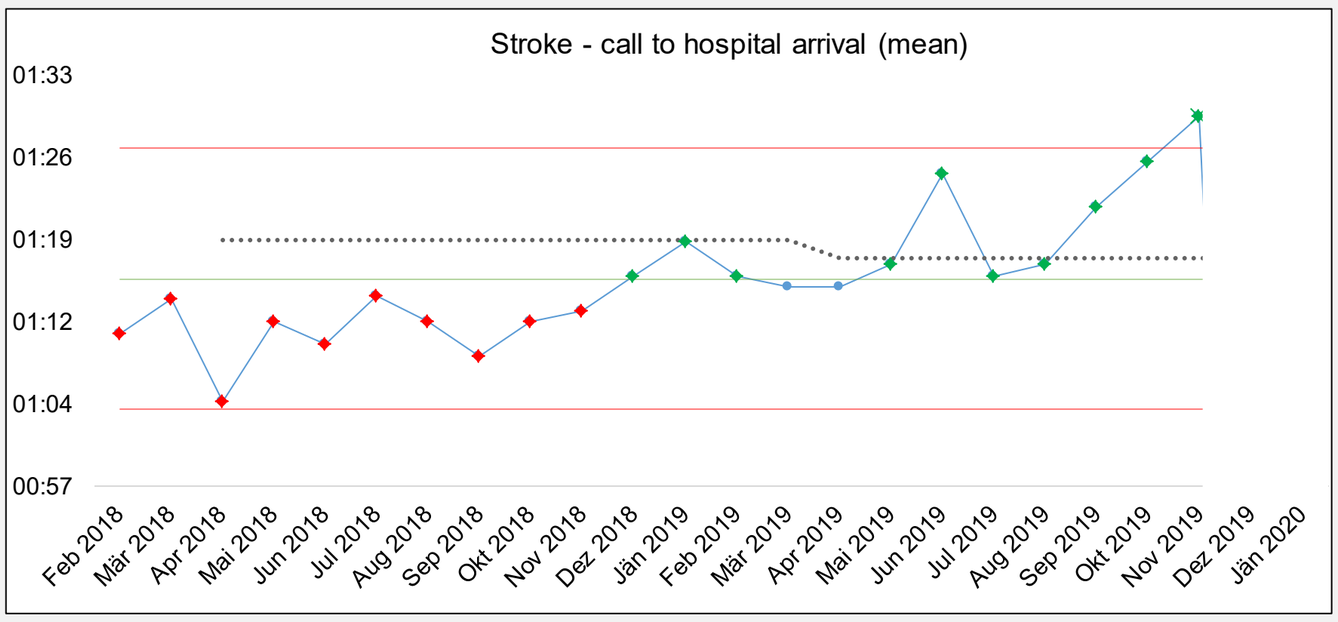


STEMI timeliness charts show the mean and 90th centile call to angiography time for patients who are suffering STEMI.

This includes the whole patient pathway, including any time awaiting angiography at the heart attack centre. Trust performance is broadly in line with national averages.

This data is no longer collected by SECAmb and is released in arrears by NHS England. As such, the latest available data is from November 2019.

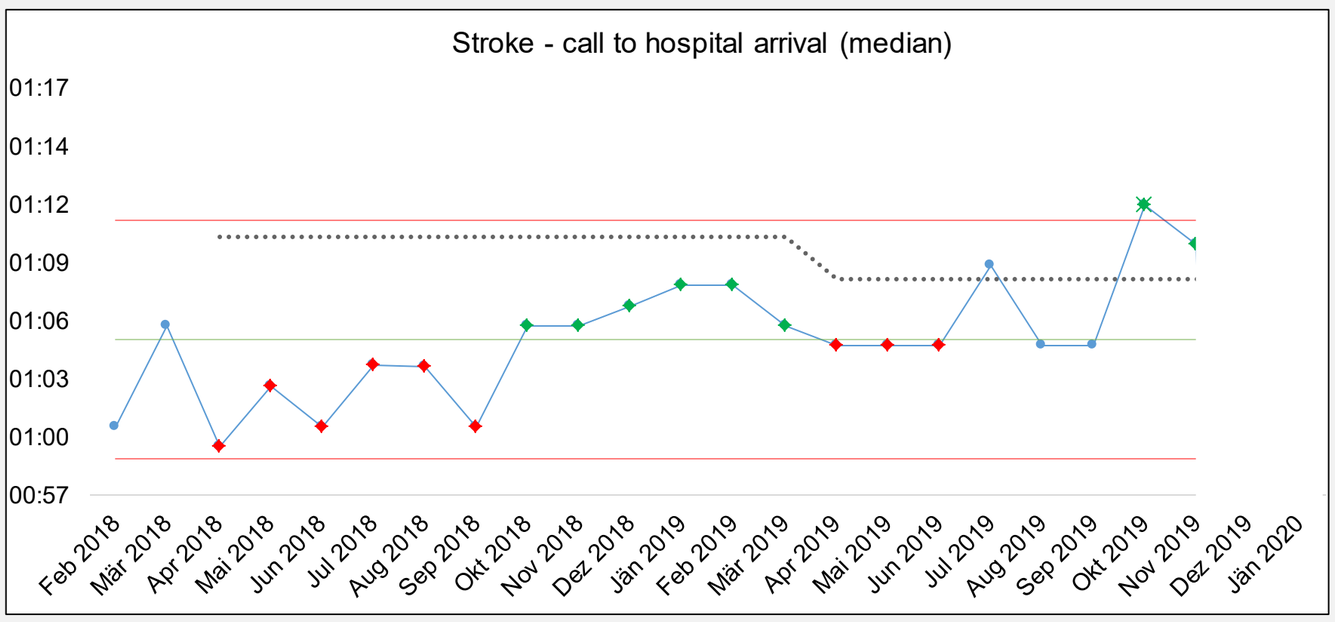


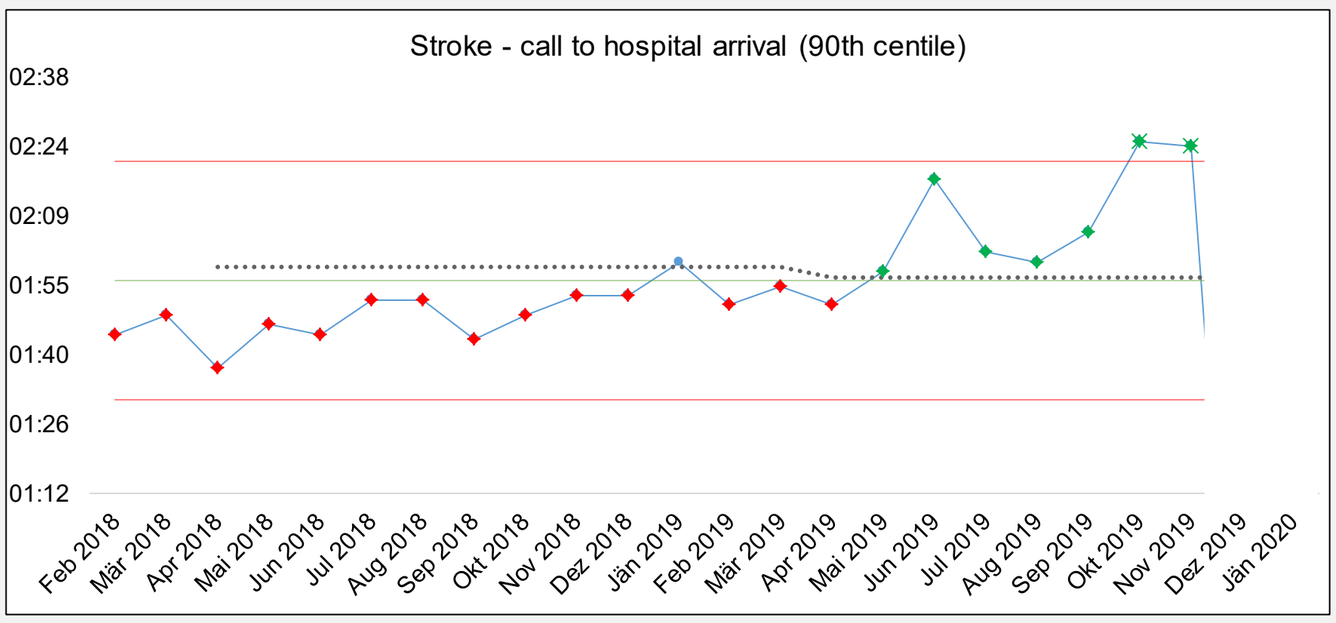


Stroke timeliness charts show the mean, median and 90th centile call to door time for patients who are suffering stroke.

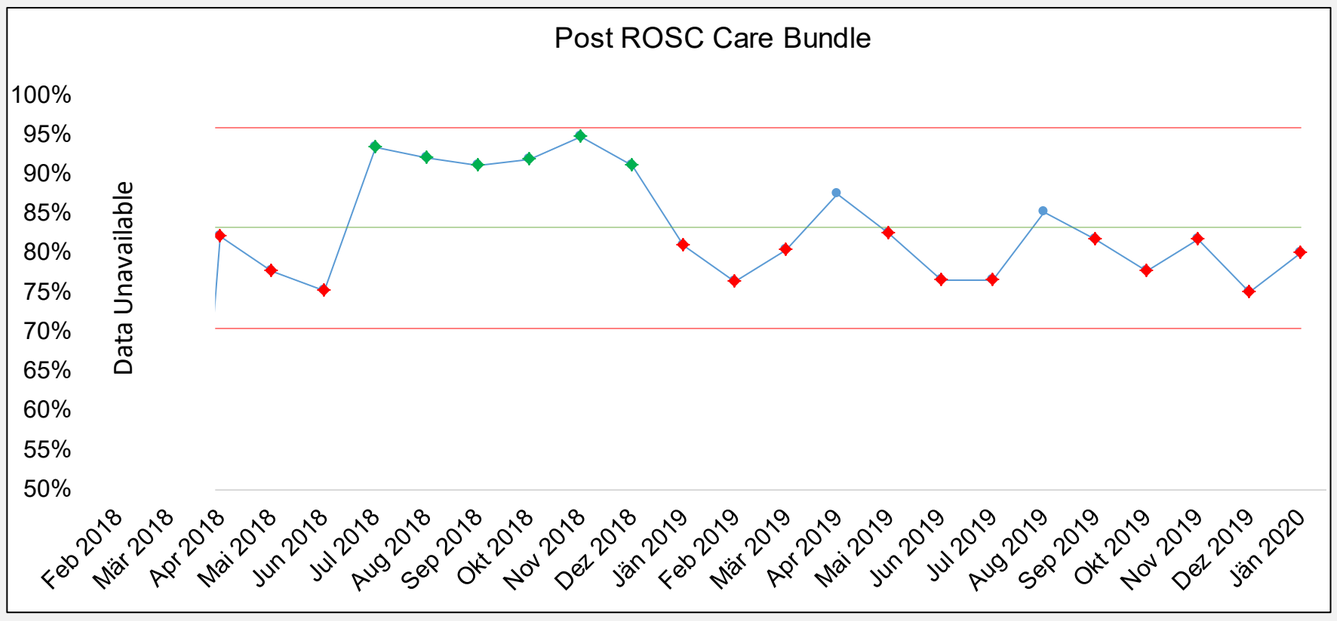
The data shows a general increase in the time from call for help to arrival at definitive care. Work is underway to improve recognition of stroke during telephone triage to ensure all suspected stroke patients are categorised appropriately.

This data is no longer collected by SECAmb and is released in arrears by NHS England. As such, the latest available data is from November 2019.





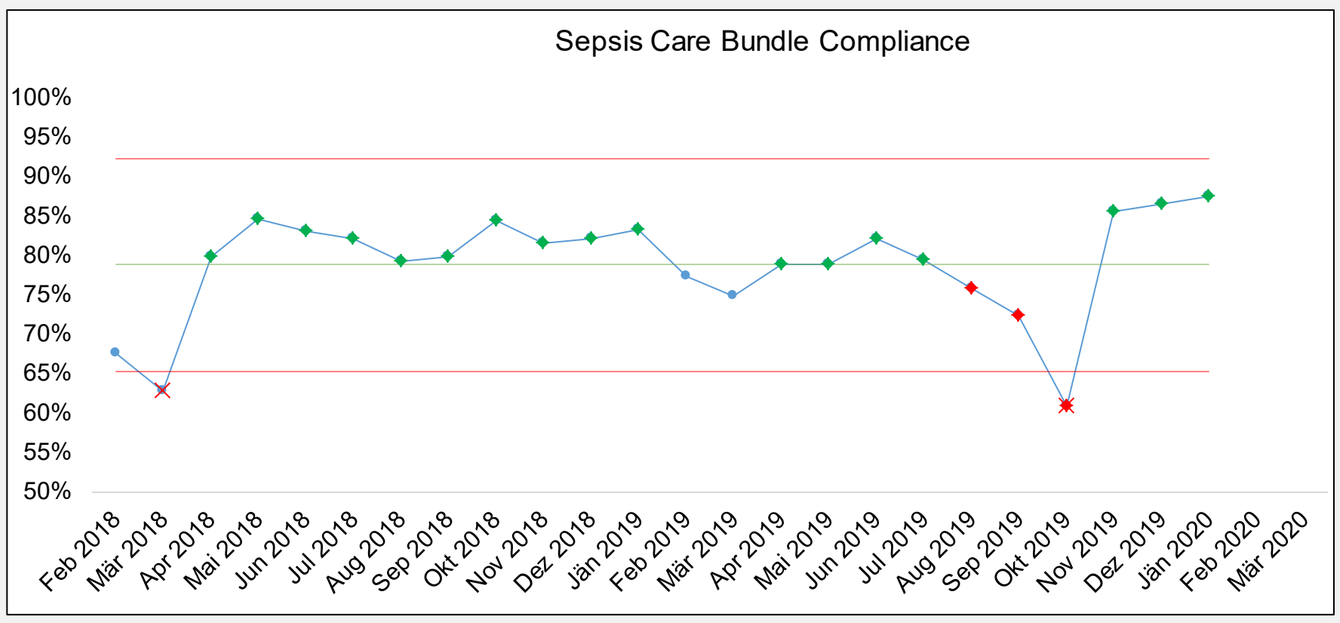
SECAmb Clinical Safety Charts



This chart shows the proportion of patients who received a full bundle of care after ROSC was achieved.

The data continue to show normal levels of variation. SECAmb continues to perform above the national average.

In March, 64 patients had ROSC at any time and 50 of these received a full care bundle.

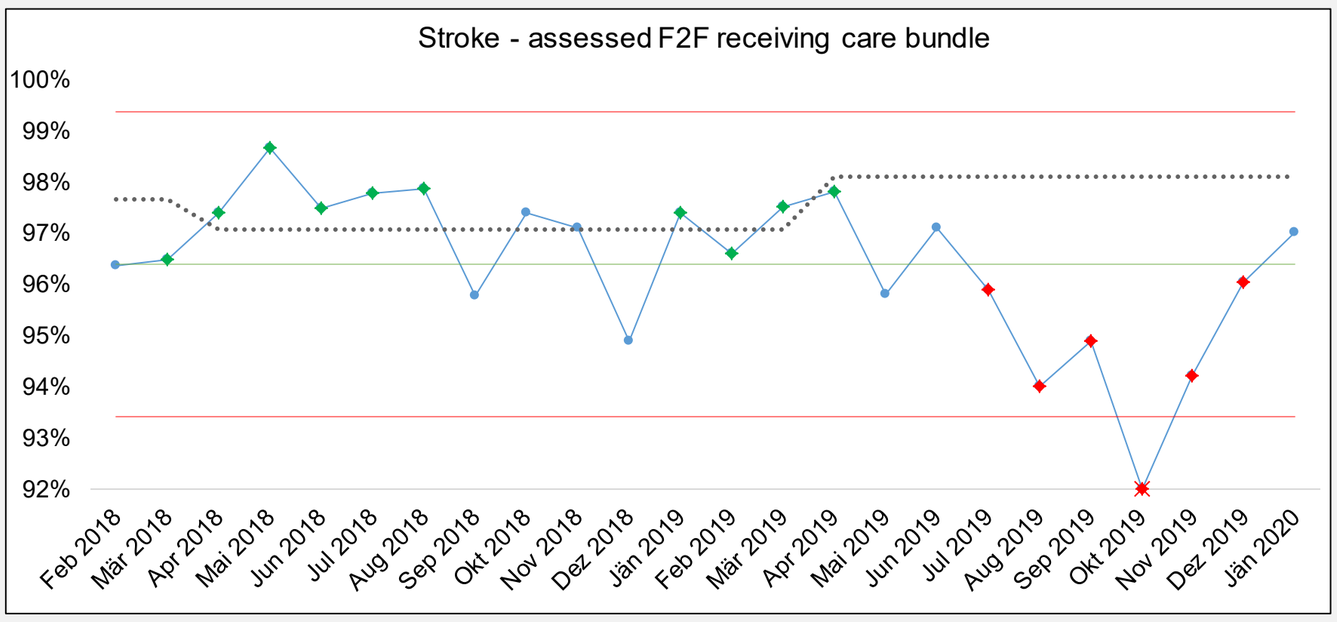


This chart shows the proportion of patients who were suffering suspected sepsis and received a full bundle of care.

This measure has shown a significant improvement since a fix was applied to ePCR in November 2019 that guides clinicians to document care effectively.

SECAmb continues to perform above the national average.

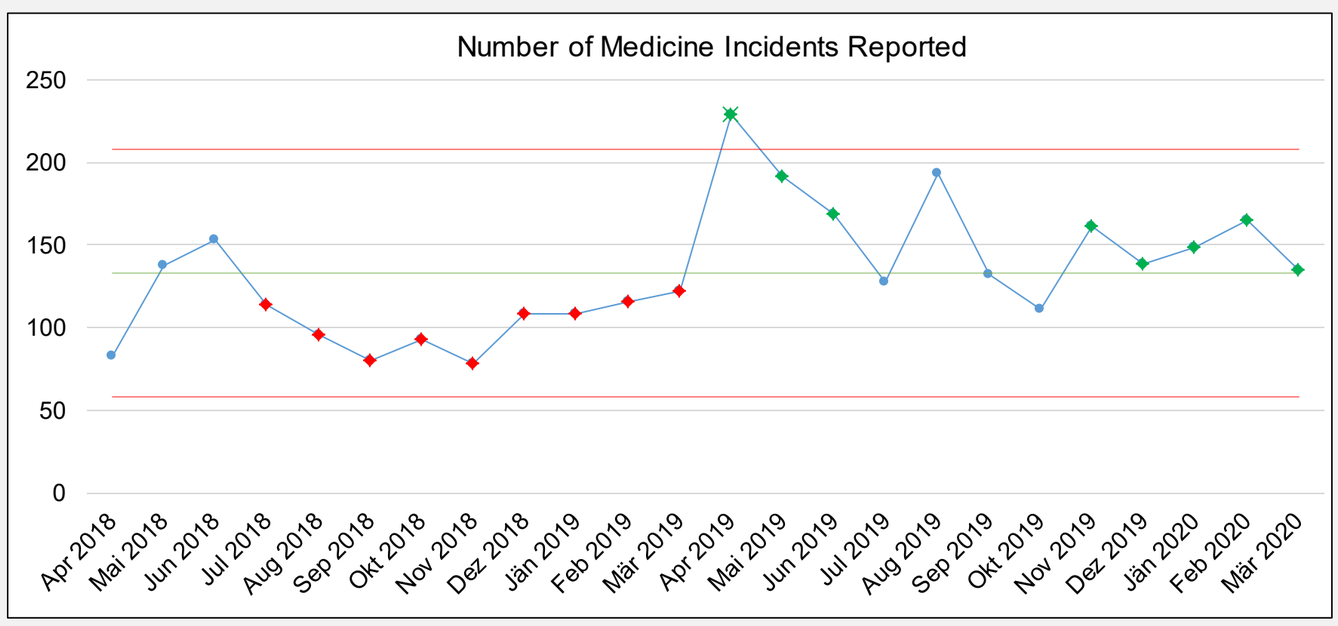
In March there were 792 cases of suspected sepsis and 686 of these met the full care bundle.



This chart shows the proportion of patients with a suspected stroke who received a full diagnostic.

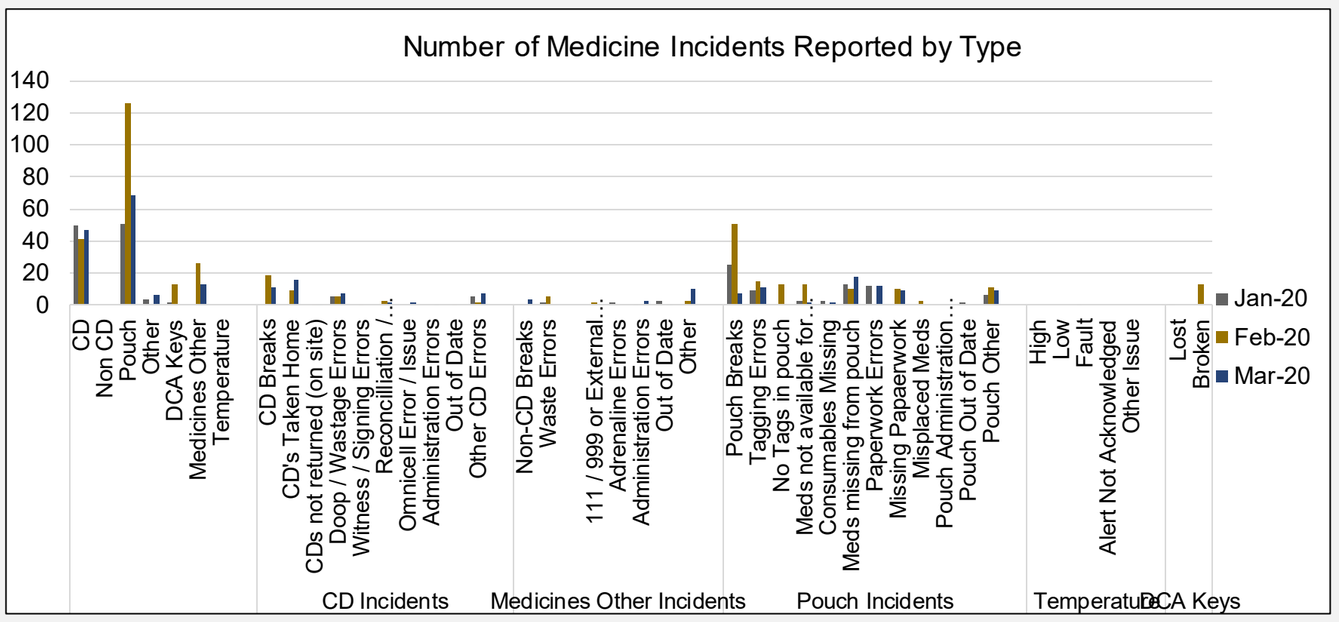
This measure has shown improvement since updates were made to the Trust's ePCR platform in November that encourage clinicals to document the essential elements of care.

In March, there were 1109 suspected strokes and 1080 received a full diagnostic bundle.



Rate of incidents and incident reporting remain similar to those seen in previous months

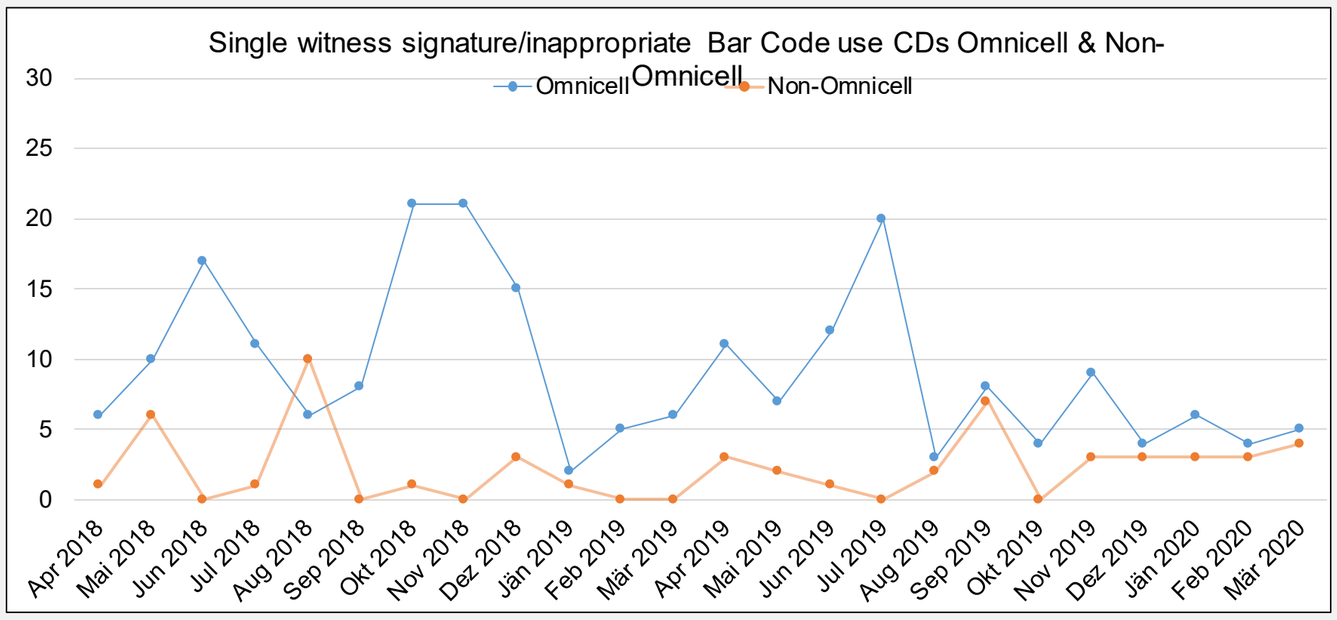
QI hub continue to highlight during their weekly conference call the administration errors and the need for learning around incidents



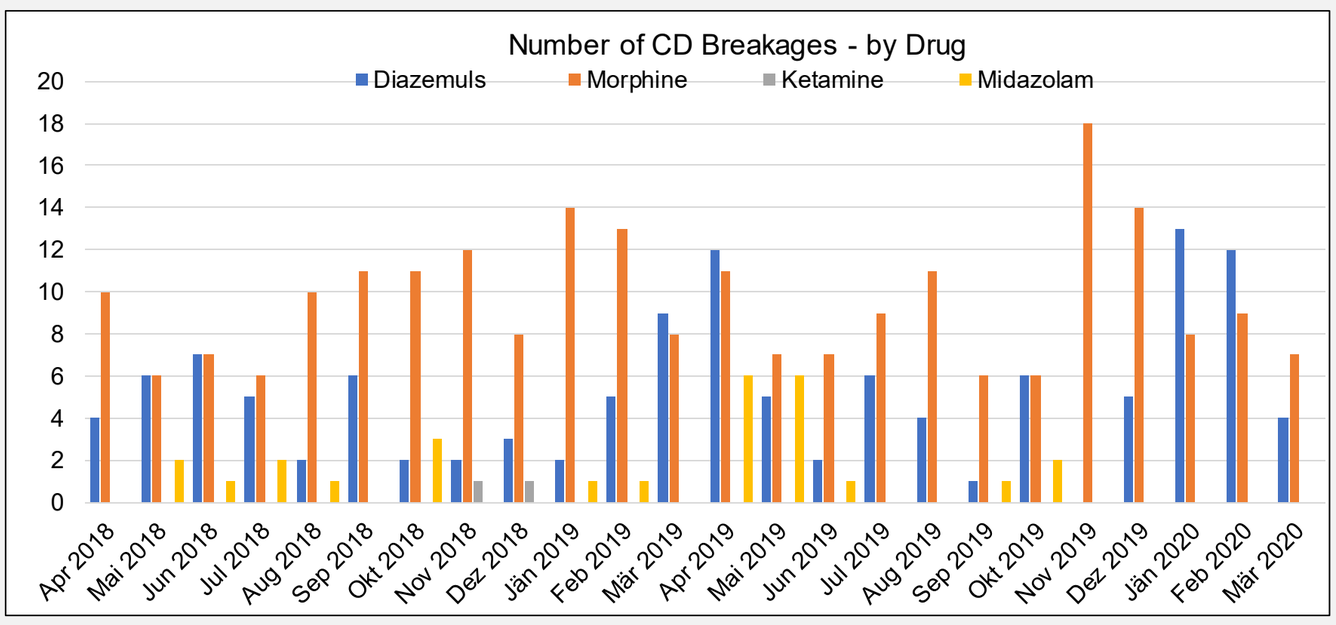
Pouch errors continue to be the most frequent error type and although the specific number appear high, these need to be considered in light of total number of pouches in use across the trust.

On-going review of pouch contents aims to reduce the number of medicines stored in some pouches, which will reduce the chance of breakages.

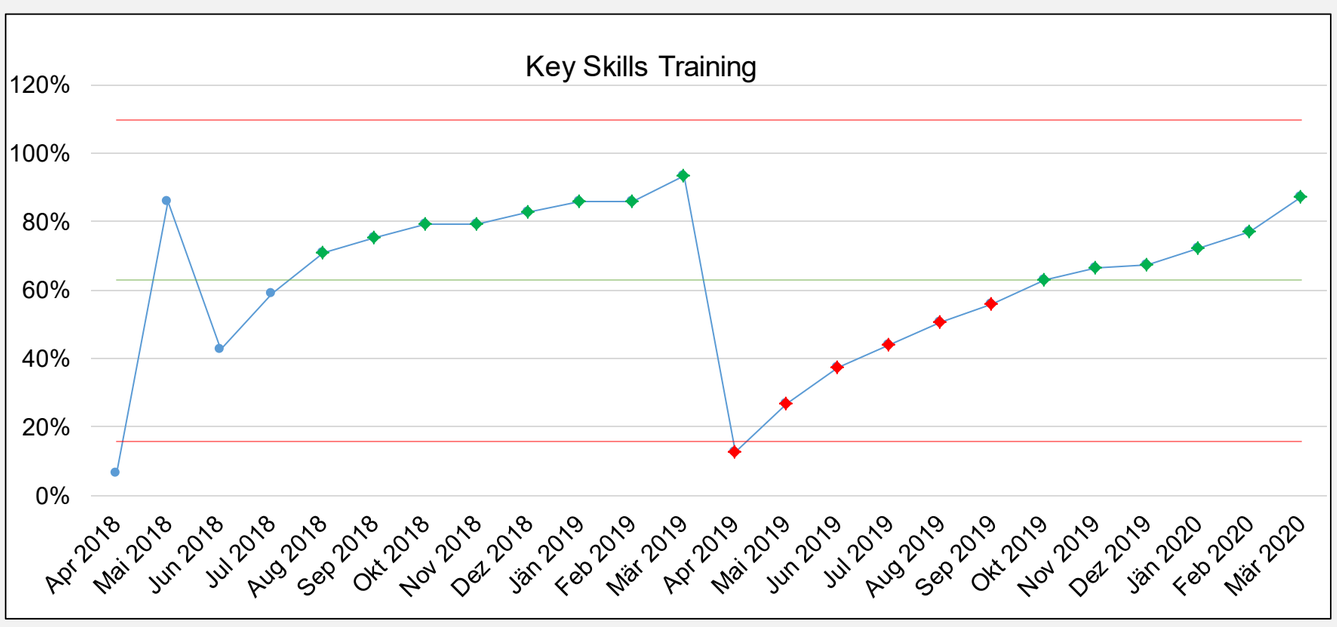
SECAmb Clinical Safety Charts



Recent update of Omnicell system has allowed OTLs to identify and follow-up occasions where CDs are not returned within 16 hours of being issued.



Morphine is most frequent CD breakage, but this is in line with its widespread use. Ketamine and midazolam are only used by specialist paramedics.



SECAmb Clinical Safety Mental Health

Mental Health Report Extract April Report (March 2020 Data)

During March 2020, there were 143 Section 136 related calls to the 999 service. 111 (77.6%) of these calls received a response ((72.2% in February) resulting in a conveyance to a place of safety by an ambulance on 101 (70.6% of total calls) of these occasions. (In February 68.1% of total calls).
The overall performance mean shows a Cat 2 response time across the service as 00:21.03 (February 00:18:56). Against the 90th centile measure, the response was 00.45.35 (February was 00:37:32).
There were 32 occasions when SECAmb did not provide a response. This is down from 42 in February. This is in relation to responses against calls taken.
Against incidents responded to there were 10 occasions that did not result in a conveyance and were classified as see and treat. This report RAG rates against **both** mean ARP standards within Cat 2; these being 18 minutes and the 90th percentile within 40 minutes. It also details were other categories were used.
There were 10 incidents classified as see and treat.

Rag Ratings:

Within ARP Cat 2 18 mins	**= GREEN**
Outside Cat 2 ARP 18 mins, up to 40 mins	**= AMBER**
Outside Cat 2 ARP 18 mins, beyond 40 mins	**= RED**
Within 90th Percentile 40 mins	**= GREEN**
Outside 90th Percentile 40 mins, up to 1 hour	**= AMBER**
Outside 90th Percentile 40 mins, beyond 1 hour	**= RED**

Overall RAG Rating = 🟡

The mental health indicator has been rated **AMBER** as the mean response measures are outside of the cat 2 standard on the 18-minute response and the 40 minute 90th centile response.

Performance by OU

Ashford had 4 incidents resulting in 4 responses.
Mean response against Cat 2 18mins 00:13:09 **GREEN** (from **AMBER**)
Response against 90th centile 40mins 00:22:30 **GREEN** (from **RED**)

Brighton had 6 incidents resulting in 6 responses.
Mean response against Cat 2 18mins 00:23:54 **AMBER** (from **GREEN**)
Response against 90th centile 40mins 00:49:46 **AMBER** (from **GREEN**)

Chertsey had 4 incidents resulting in 4 responses.
Mean response against Cat 2 18mins 00:19:56 **AMBER** (from **GREEN**)
Response against 90th centile 40mins 00:25:50 **GREEN** (static)

Dartford and Medway had 26 incidents resulting in 26 responses.
Mean response against Cat 2 18mins 00:21:41 **AMBER** (static)
Response against 90th centile 40mins 00:48:30 **AMBER** (static)

Gatwick and Redhill had 14 incidents resulting in 14 responses.
Mean response against Cat 2 18mins 00:17:09 **AMBER** (static)
Response against 90th centile 40mins 00:35:37 (**GREEN** (static)

Guildford had 9 incidents resulting in 9 responses.
Mean response against Cat 2 18mins 00:19:09 **AMBER** (from **GREEN**)
Response against 90th centile 40mins 00:34:29 **GREEN** (static)

Paddock Wood had 22 incidents resulting in 20 responses.
Mean response against Cat 2 18mins 00:25:50 **AMBER** (static) * 2 Cat 3
Response against 90th centile 40mins 00:49:17 (from **GREEN**)

Polegate and Hastings had 5 incidents resulting in 5 responses.
Mean response against Cat 2 18mins 00:13:54 **GREEN** (static)
Response against 90th centile 40mins 00:18:21 **AMBER** (from **GREEN)**

Tangmere and Worthing had 8 incidents resulting in 8 responses.
Mean response against Cat 2 18mins 00:30:15 **AMBER** (static)
Response against 90th centile 40mins 01:08:07 **RED** (from **AMBER**)

Thanet had 13 incidents resulting in 12 responses.
Mean response against Cat 2 18mins 00:16:09 **GREEN** (static) * Cat 3
Response against 90th centile 40mins 00:27:04 **GREEN** (static)

SECAmb Quality and Patient Safety

Quality and Patient Safety Report :

Incidents: The Trust reported 1028 incidents during March 2020. The highest reporting sub-category was Covid-19 - Informed post patient contact; the Covid-19 category was a new addition to Datix at the end of January 2020. The highest reporting area was EOC Clinical.

Serious Incidents (SIs) and Duty of Candour (DoC): 2 SIs were declared during March 2020; 6 SI were closed by the CCG, and 1 was de-escalated from SI status. The Trust achieved 100% compliance with DoC requirements for SI's; this reflects the amount that were undertaken within timescale. Overall compliance continues to be monitored weekly by the Serious Incident Group.

Patient Experience: The Trust received and opened 56 complaints during March 2020, which shows a reduction from the previous month. The Trust responded to 90% of complaints within the 25 working day timescale this month. The Trust recorded 197 compliments during March.

Clinical Audit: The Trust's 2019/20 Clinical Audit Plan has been approved internally and shared with CQRG. Measurement of NEWS2 is being reported into the Clinical Audit and Quality Sub-Group (CAQSG) each month as part of the suspected sepsis ambulance quality indicator. The clinical audit team are currently testing a new documentation audit that includes measurement of NEWS2. An audit of the mental capacity assessment and best interest decisions was recently completed. Following this an entry was made on the Trust risk register, regarding non-compliance with Trust processes. This risk is being managed through the Safeguarding Sub-Group. A business case has recently been approved to significantly increase the size of the EOC audit team, in order to improve NHS Pathways audit compliance. A consultation to change structures and increase the team size is in the planning phase. The Trust's Patient clinical record completion audit has been redesigned and is being tested following the roll-out of ePCR. This audit will be migrated to the Trust's new electronic audit system, 'Doc-Works'. The 19/20 plan is on track for delivery.

Learning from Deaths: The new Learning from Deaths policy has been approved by the Trust Board. Due to report first quarterly figures and learning for the period January 2020 – March 2020 in Q1 of the new financial year. Meetings with the Audit Team to arrange the collection of data on deaths from the 1st January 2020. Current plans are for the Deputy Medical Director to undertake the Structured Judgemental Reviews of the twenty deaths per month, as the staff who were previously undertaking these reviews were now on maternity leave.

Our People

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Jan-20	Feb-20	Mar-20	12 Months
Actual	1019	1043	1028	
Previous Year	838	761	810	

Number of Incidents Reported that were SI's

	Jan-20	Feb-20	Mar-20	12 Months
Actual	7	9	2	
Previous Year	18	12	14	

Duty of Candour Compliance (SIs)

	Jan-20	Feb-20	Mar-20	12 Months
Actual %	100%	90%	100%	
Target	100%	90%	100%	

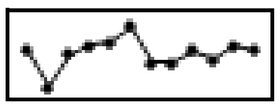
Number of Complaints

	Jan-20	Feb-20	Mar-20	12 Months
Actual	79	66	56	
Previous Year	81	96	63	
Complaints Timeliness (All	72.0%	78.0%	90.0%	
Timeliness Target	95%	95%	95%	

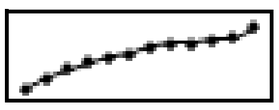
Compliments

	Jan-20	Feb-20	Mar-20	12 Months
Actual	213	187	197	

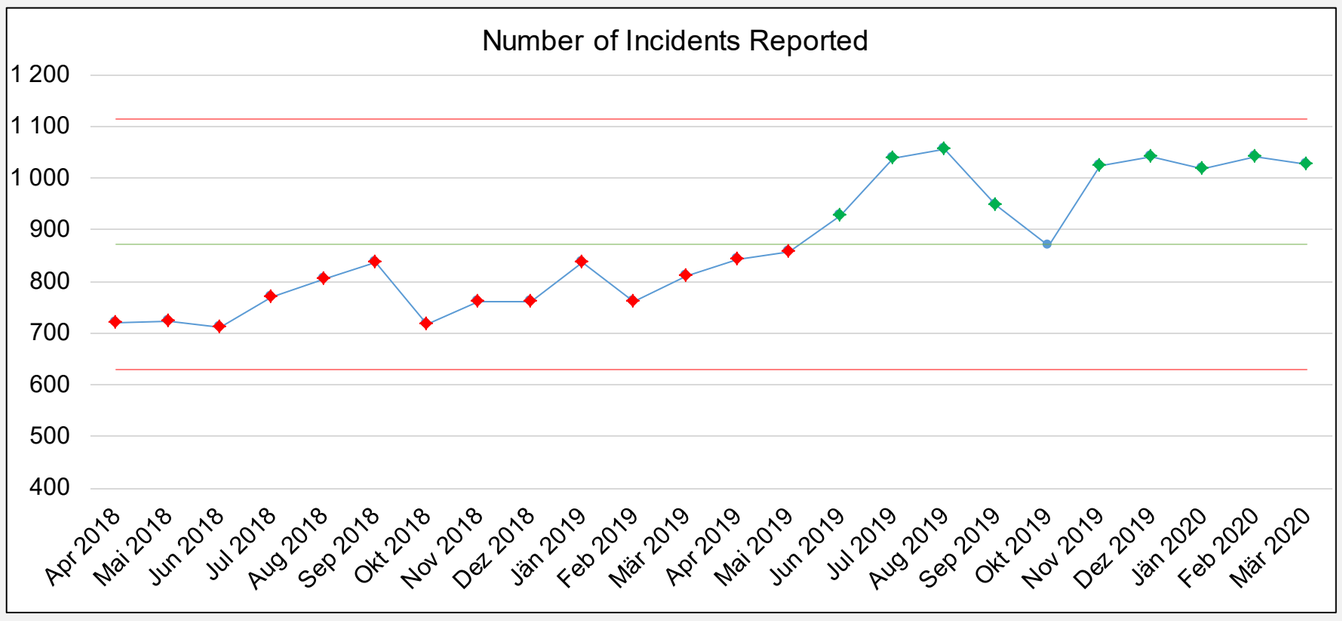
Hand Hygiene

	Jan-20	Feb-20	Mar-20	12 Months
Actual %	90%	93%	92%	
Upper Target	95%	95%	95%	

Safeguarding Training Completed (Children) Level 2

	Jan-20	Feb-20	Mar-20	12 Months
Actual %	69.77%	72.29%	86.94%	
Previous Year %	86.50%	88.62%	94.08%	
Target	85%	85%	85%	

SECAmb Clinical Quality Charts

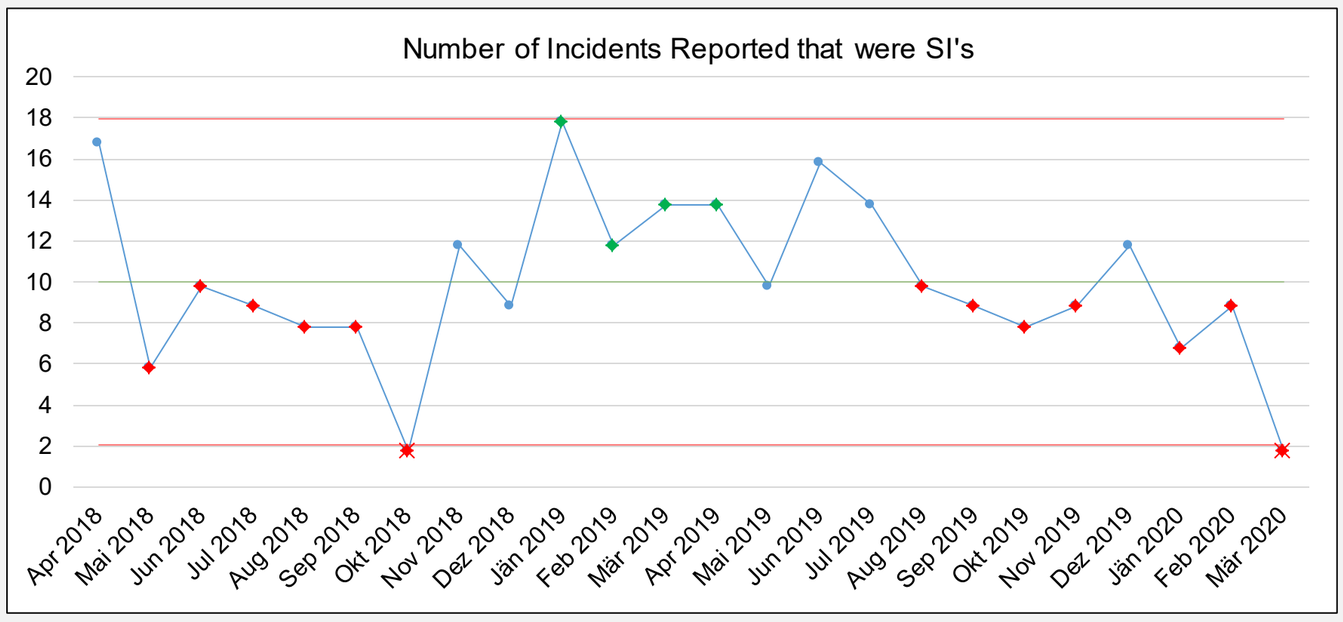


The number of incidents reported was 1028 for March 2020

The most reported area was EOC Clinical with 137 incidents.

The most reported sub-category in March 2020 was COVID-19 Informed Post Patient Contact.

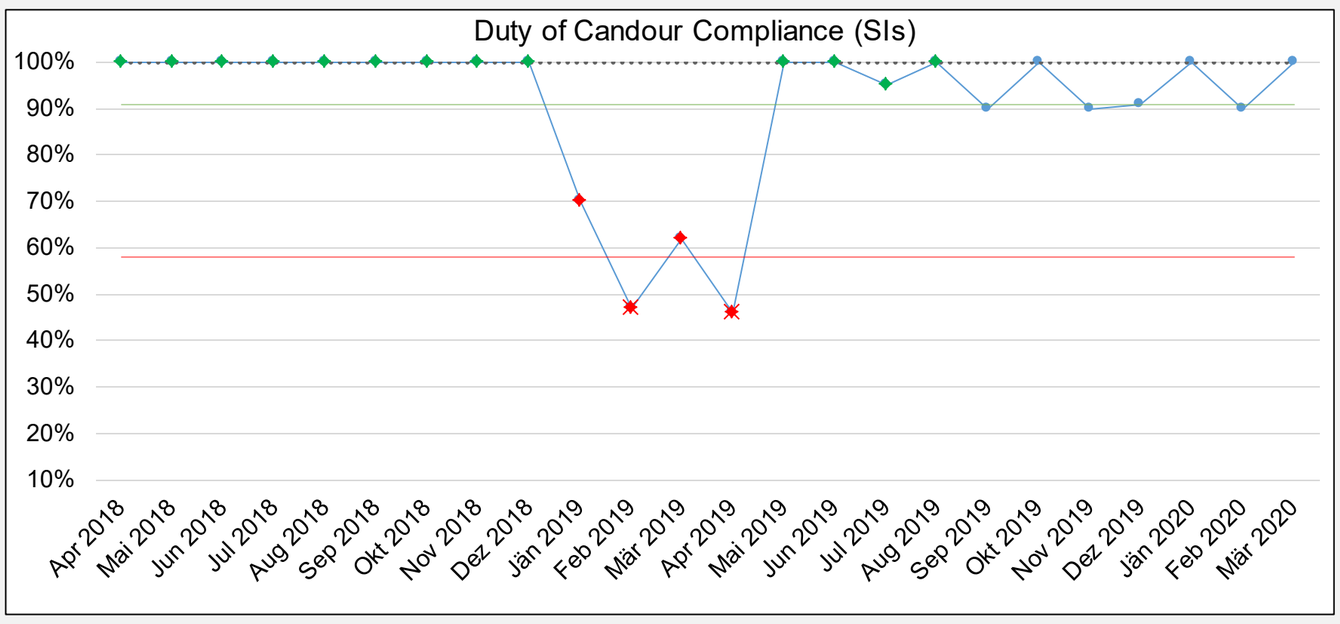
The Trust reported 1016 no harm/near misses or low harm incidents, this means that 99% of our reported incidents are within the NHS target of 96% of incidents being no/low harm for March 2020.



2 Serious Incidents were reported in March 2020.

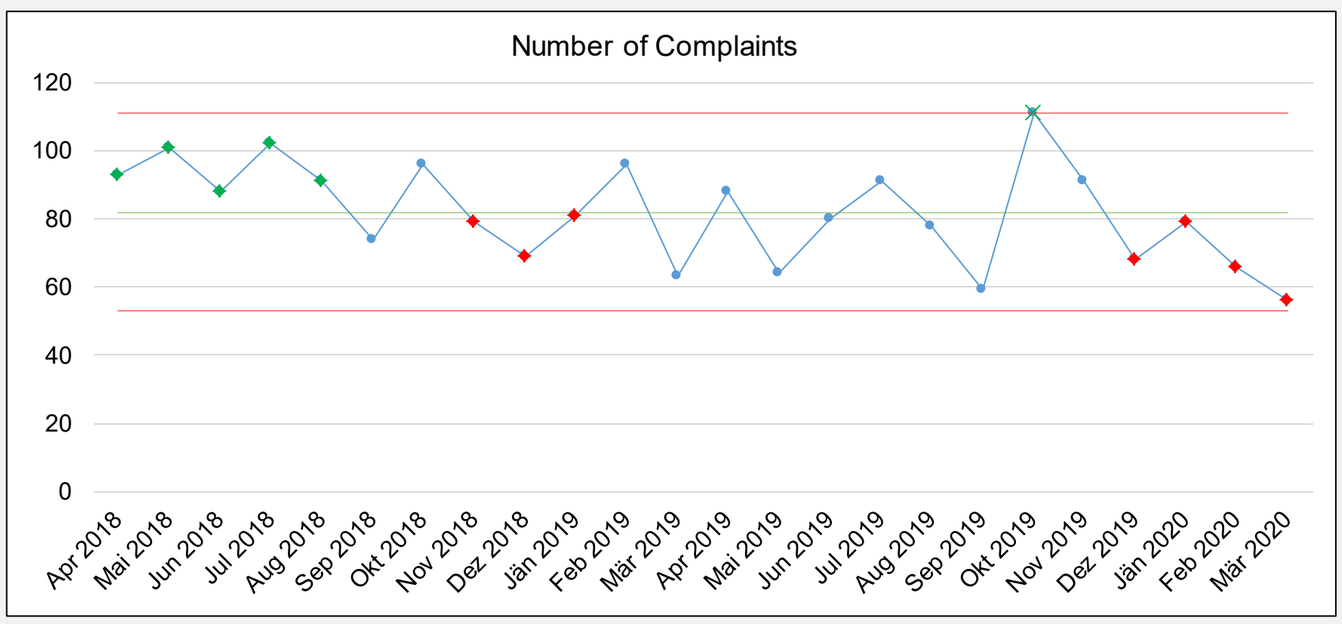
Delayed Dispatch / Attendance x 1
Treatment / Care x 1

6 SIs overall were closed on STEIS in March with another 1 de-escalated from SI status.

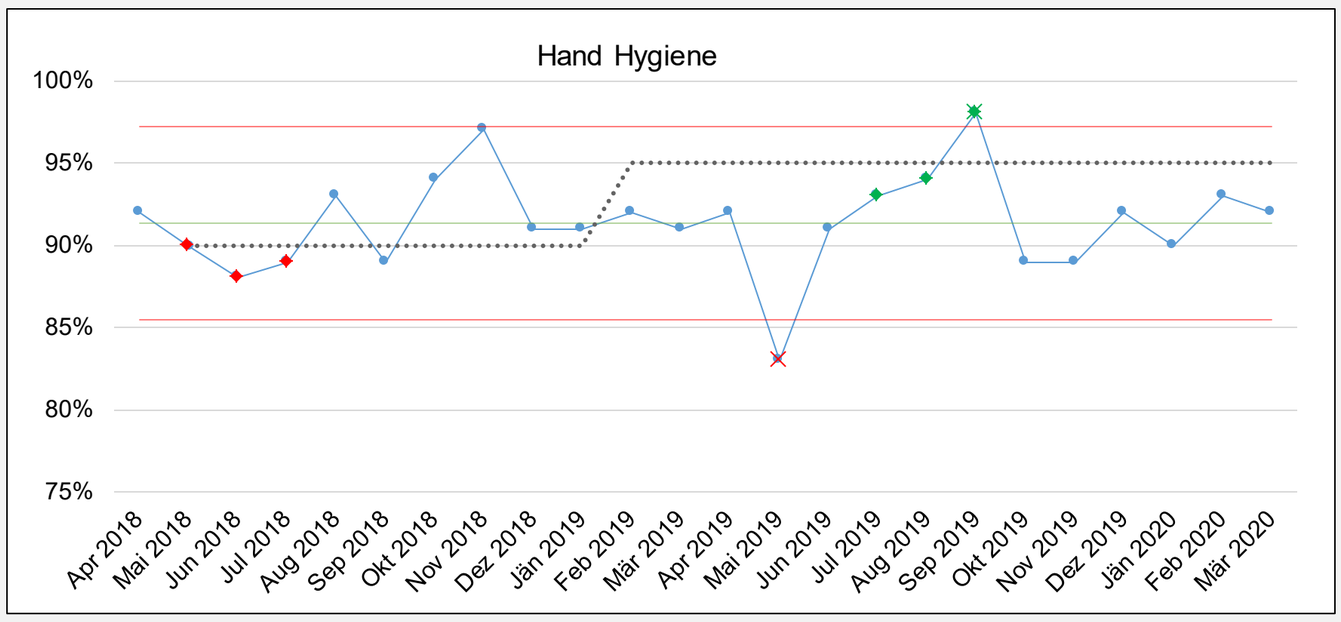


Compliance with DoC for SIs where DoC was required in March 2020 is: 2

DoC made/attempted within 10 working day deadline - 2 (100%)



The Trust received and opened 56 complaints during March 2020, and responded to 90% complaints within the 25 day target timescale. The number of complaints received has dropped again, and the number responded to with 25 days continues to increase month on month.



Hand hygiene compliance was 92% during March so still within the lower and upper limits.

Clinically Ready went up to 94%.

The IPC Team have returned three members of the team back to daily IPC work and they are now visiting Operating Units on a regular basis to discuss all areas of IPC with staff. The main focus is on support for our IPC Champions who are working with us in informing staff of the need for compliance at all times.

Health & Safety Audits

The annual Health & Safety audit programme was postponed in March 2020 due to COVID-19.

Violence and Aggression Incidents - See Figure 1 below
Violence and Aggression incidents towards staff in March 2020 were 42. The data below is a break down of the incidents reported by category type.

- Physical Assaults (10)
- Direct verbal Abuse (10)
- Anti-social behaviour/aggression (15)
- Attempted physical assault/ non-physical (5)
- Sexual assault (2)

Manual handling Incidents - See Figure 2 below
Manual handling incidents reported in March 2020 were 24 which is a decrease of 6 incidents from the previous month.

Health & Safety Incidents - See Figure 3 below
Health and Safety incidents reported in March 2020 were 32 which is a decrease of 6 incidents from the previous month.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - See Figure 4 below
RIDDOR incidents reported in March 2020 were 12 with 7 incidents reported on time to the Health & Safety Executive.

Figure 1

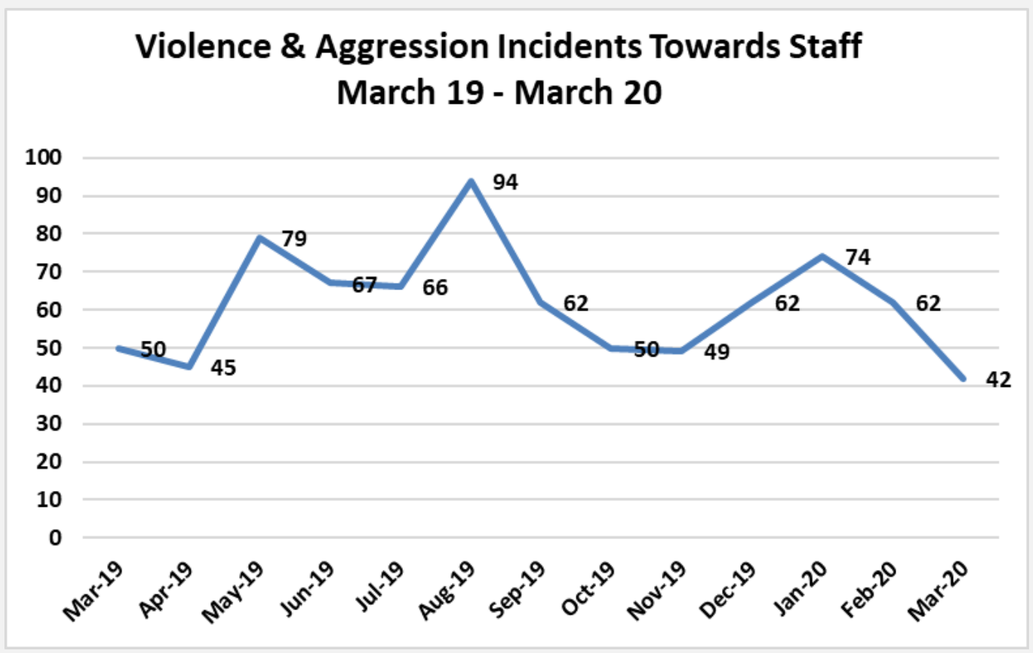


Figure 2

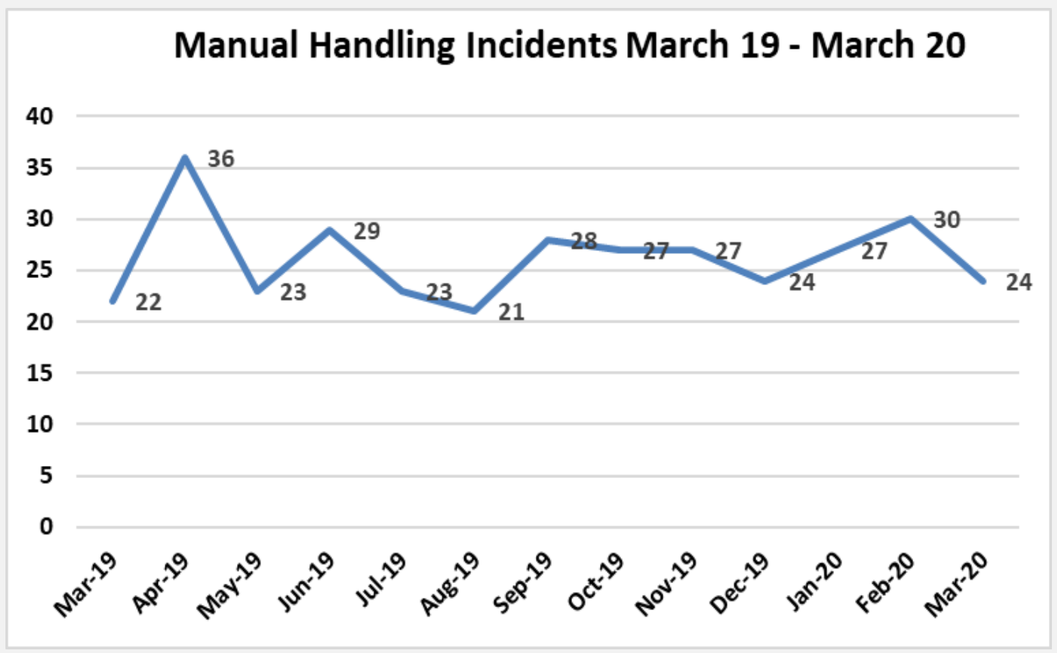


Figure 3

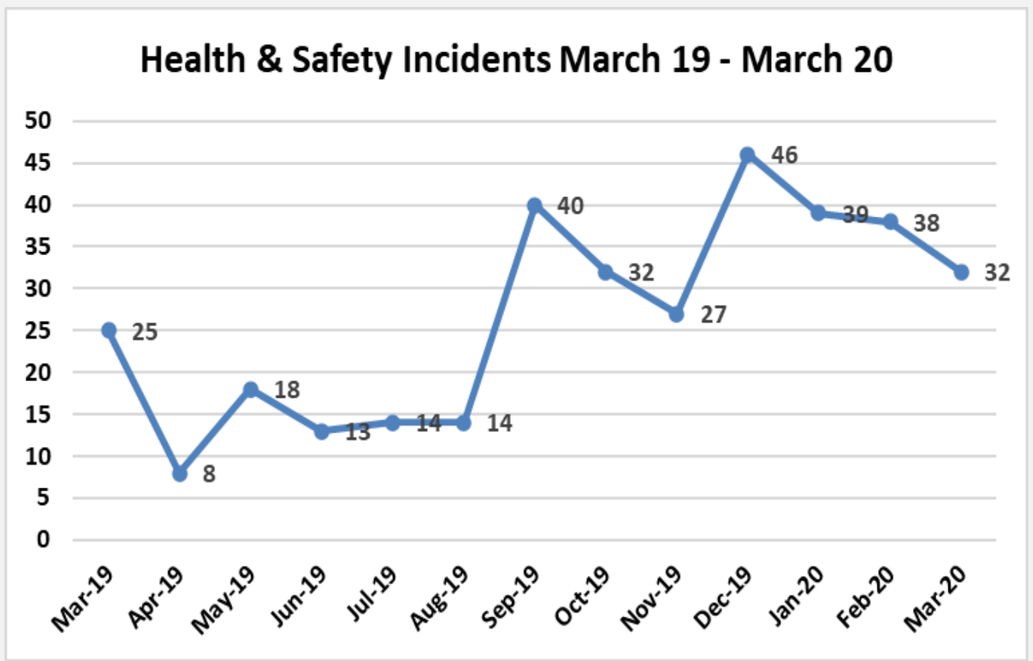
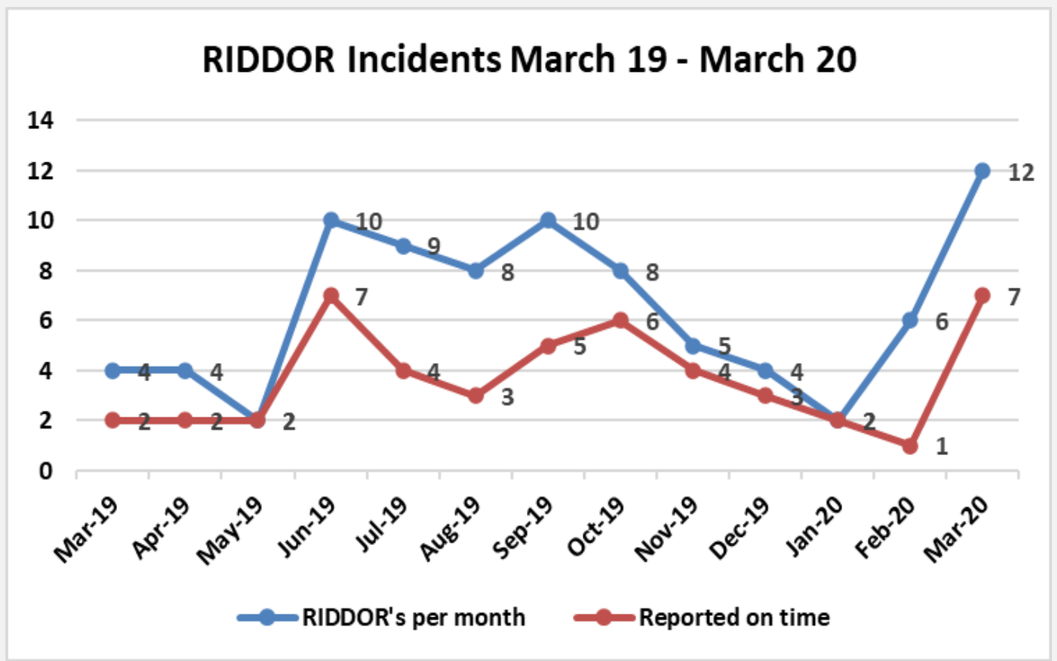


Figure 4



SECAmb 999 Operations Response Time Performance Scorecard

Call Handling

	Jan-20	Feb-20	Mar-20	12 Months
5 Sec Performance (95% Target)	98.6%	91.0%	91.1%	
Mean Call Answer Time (secs)	2	2	7	
95th Centile Call Answer (Secs)	1	2	47	
National Mean Call Answer	4	5	49	
National 95th Centile Call Answer	14	30	203	

Category 1 Performance

	Jan-20	Feb-20	Mar-20	12 Months
Mean (00:07:00)	00:07:36	00:07:43	00:07:52	
90th Percentile (00:15:00)	00:13:59	00:14:30	00:14:55	
Mean Resources Arriving	1.56	1.53	1.53	
Count of Incidents	4334	4013	3937	
National Mean	00:07:08	00:07:19	00:08:07	

Category 1T Performance

	Jan-20	Feb-20	Mar-20	12 Months
Mean (00:19:00)	00:09:22	00:09:26	00:09:25	
90th Percentile (00:30:00)	00:17:14	00:17:44	00:17:32	
Mean Resources Arriving	1.55	1.52	1.52	
Count of Incidents	2857	2603	2407	
National Mean	00:12:30	00:10:33	00:11:28	

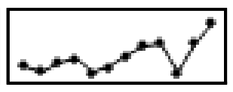
Category 2 Performance

	Jan-20	Feb-20	Mar-20	12 Months
Mean (00:18:00)	00:18:06	00:19:15	00:21:26	
90th Percentile (00:40:00)	00:34:10	00:36:29	00:41:02	
Mean Resources Arriving	1.06	1.06	1.05	
Count of Incidents	33738	31456	32731	
National Mean	00:21:05	00:22:07	00:32:06	

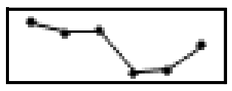
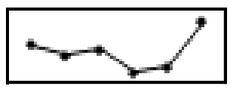
Category 3 Performance

	Jan-20	Feb-20	Mar-20	12 Months
Mean	01:15:05	01:31:28	01:44:49	
90th Percentile (02:00:00)	02:50:33	03:25:09	04:00:52	
Mean Resources Arriving	1.05	1.05	1.04	
Count of Incidents	20348	18743	19732	
National Mean	00:57:34	01:07:18	01:30:07	

Category 4 Performance

	Jan-20	Feb-20	Mar-20	12 Months
Mean	01:32:13	02:05:39	02:11:09	
90th Percentile (03:00:00)	03:33:38	04:46:32	04:56:30	
Mean Resources Arriving	1.03	1.04	1.01	
Count of Incidents	489	373	264	
National Mean	01:15:00	01:38:41	01:55:50	

Health Care Professional / Inter-Facility Transfer

	Jan-20	Feb-20	Mar-20	12 Months
HCP Level 3 Mean	01:50:21	02:00:42	02:18:26	
HCP Level 3 90th Percentile	03:53:48	04:09:57	04:59:29	
HCP Level 4 Mean	02:32:29	02:49:16	03:08:44	
HCP Level 4 90th Percentile	05:44:15	05:44:04	07:17:56	
IFT Level 3 Mean	01:53:53	01:56:39	02:18:26	
IFT Level 3 90th Percentile	04:11:58	04:15:30	04:54:57	
IFT Level 4 Mean	02:33:33	02:39:50	03:29:17	
IFT Level 4 90th Percentile	05:30:27	05:50:10	09:02:04	

Call Cycle Time

	Jan-20	Feb-20	Mar-20	12 Months
Avg Allocation to Clear at Scene	01:15:08	01:15:55	01:19:00	
Avg Allocation to Clear at Hospital	01:50:35	01:50:08	01:51:21	
Turnaround Hrs Lost at Hospital (> 30mins)	5576	4916	4787	
Number of Handovers >60mins	550	437	292	

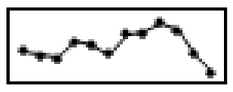
Voluntary Attendances

	Jan-20	Feb-20	Mar-20	12 Months
Community First Responders	1185	1051	785	
Fire First Responders	427	261	243	

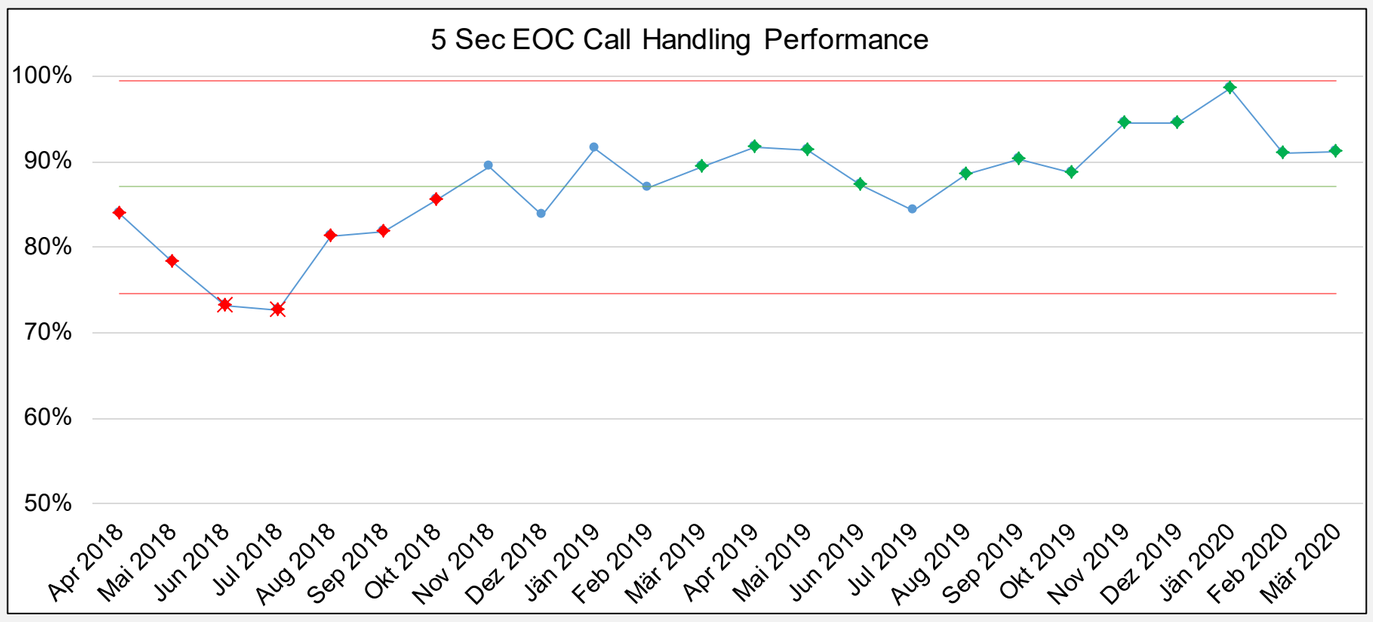
Incident Outcome AQI

	Jan-20	Feb-20	Mar-20	12 Months
Hear & Treat	5.6%	6.5%	8.4%	
See & Treat	31.5%	31.8%	37.1%	
See & Convey	62.9%	61.7%	54.4%	

Demand/Supply AQI

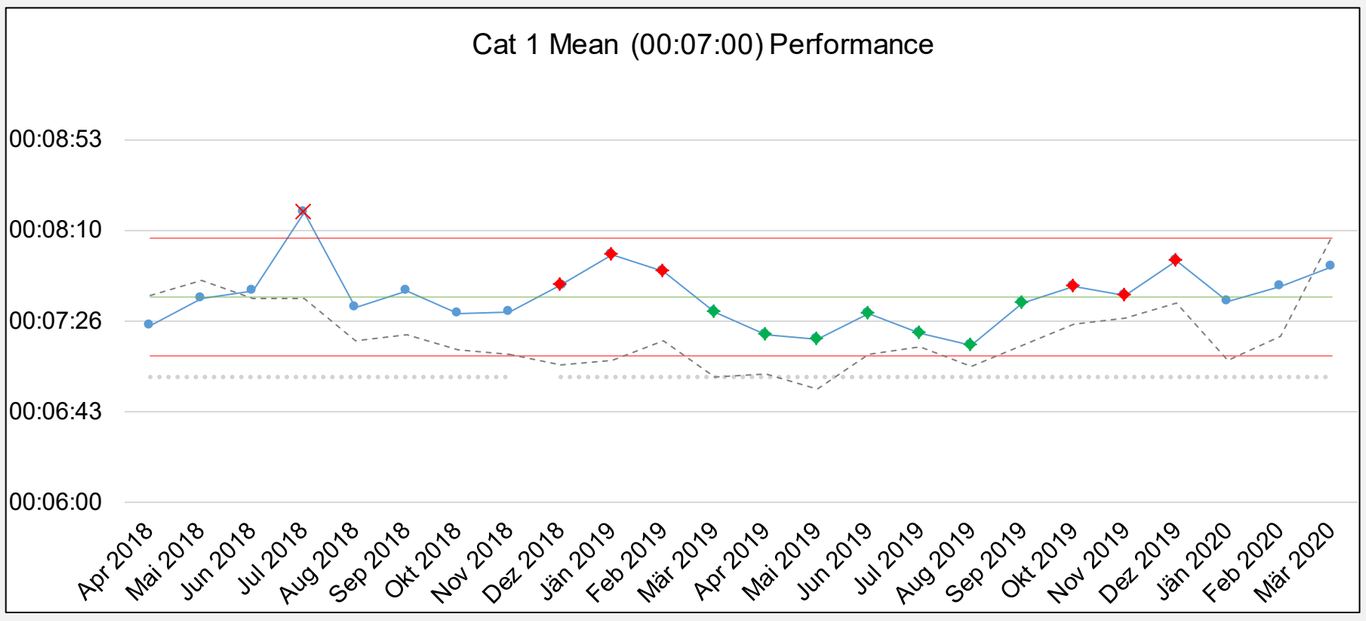
	Jan-20	Feb-20	Mar-20	12 Months
Calls Answered	65125	63620	77690	
Incidents	65363	61110	64209	
Transports	41132	37749	34961	

SECAmb 999 Operations Response Time Performance Charts



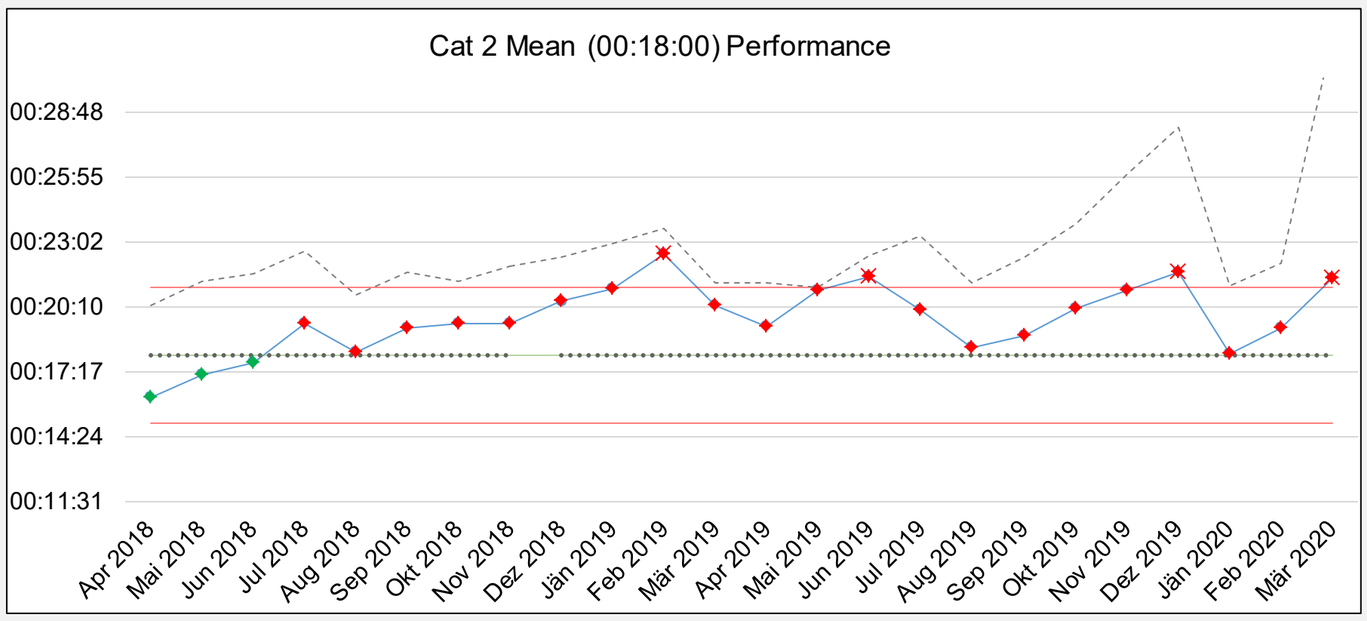
In March 2020 call volume increased dramatically form the preceding month, from 63,620 to 77,690. This is the highest level in at least 24 months, and the mean call answer time fell to 7 seconds from 2.

The challenges of a much higher call volume were experienced by all ambulance services in this reporting month. Nationally SECAmb continues to topped the national table since November 2019 for both the mean and 90th centile call answer times, and in March 2020 the Trust ranked 3rd for the 95th centile and 4th for the 99th centile.



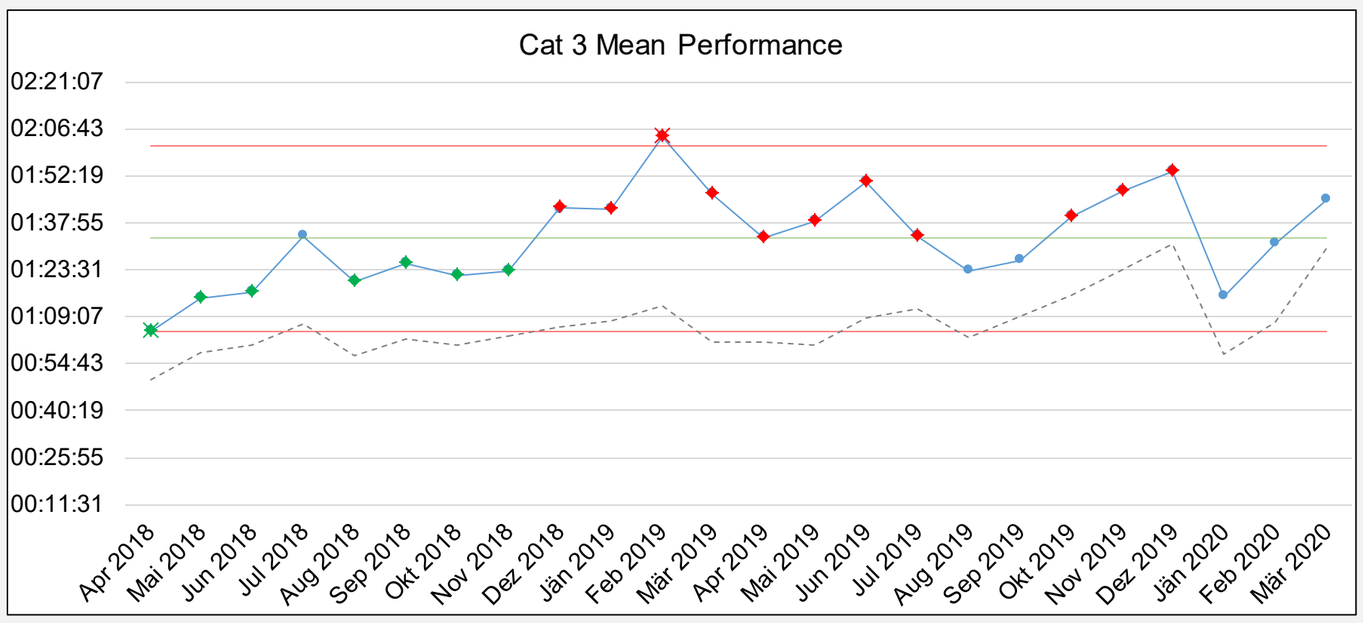
In March 2020 the count of incidents remained relatively steady. Mean performance, at 07:52 continued to present a challenge, but the Trust met the C1 90th centile target, achieving 14:55. A meaningful temporal or qualitative analysis is not possible this month, as on the 23rd national restrictions were imposed on movement.

Nonetheless the Trust was able to improve and gained places nationally, moving from 9th in both mean and 90th centile performance to 6th and 8th respectively. SECAmb continued to deliver its C1T Mean and C1T 90th centile against ARP standards and improved in ranking to 4th nationally for both measures.



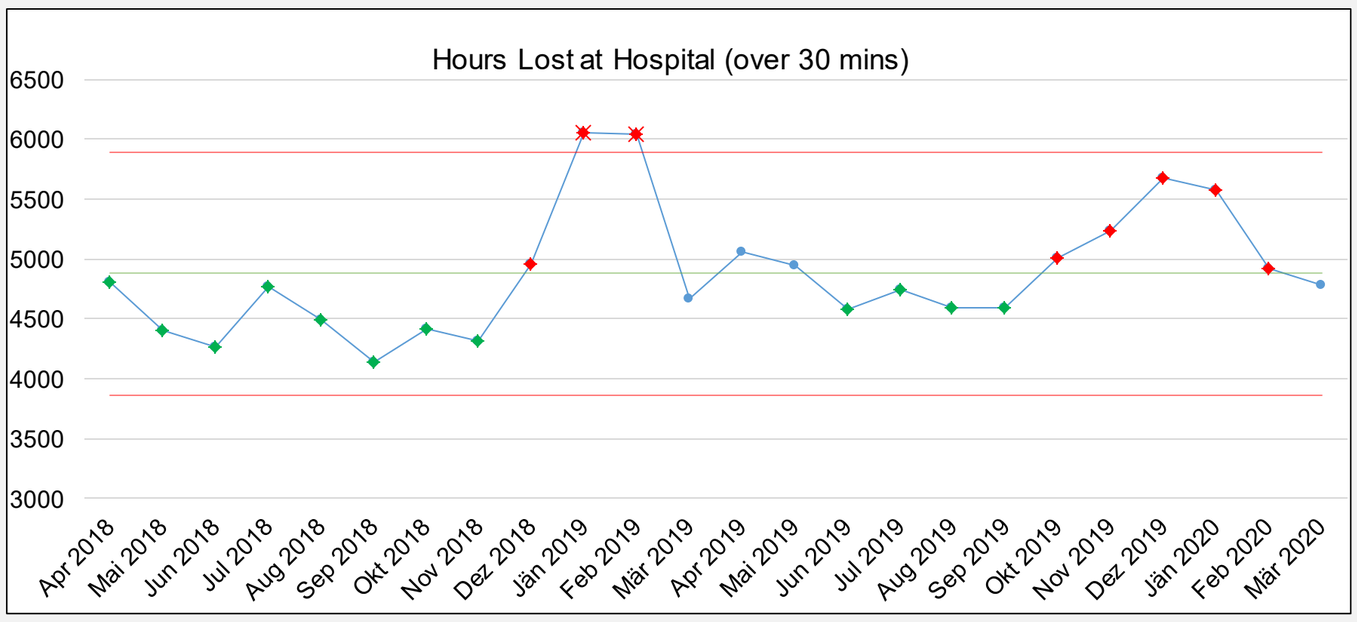
In March 2020 the count of Cat 2 incidents increased nominally, from 31,456 to 32,731. There was however slippage in both the Mean Actual (21:26) and 90th Centile Actual (41:02) performance. The Trust ranked 3rd nationally for both of these measures.

Mean Resources Arriving was 1.05; this continues the general downward trajectory over a 24 month period.



SECAmb was unable to meet Cat 3 performance objectives in March 2020, the 90th Centile Actual performance deteriorated to just over 4 hours. At 04:00:52 this is 35 minutes longer than the preceding month. The count of incidents increased slightly from 18,743 to 19,732.

Relative to its counterparts, the Trust did gain places in the national table, moving one spot to 9th for the C3 Mean, and gaining 2 places to 8th for the 90th centile. This positive result is tempered given the actual performance data on this metric. However any detailed level of analysis must take into account the impact on demand and activity from the national restrictions on movement imposed toward the end of March 2020.



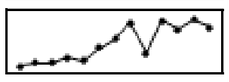
In March 2020 there was a decrease of 160 hours lost >30 minute turnaround compared to February 2020 .
Comparing overall hours lost >30 minute turnaround to March 2019 there was 1% increase in hours lost >30 minute turnaround.

There was also 46% decrease in the number of patients waiting >60 minutes (540-292) and there was a 9% decrease in the numbers of patients waiting >30 minutes (4098-3644) comparing March 2019 with March 2020 .
The ambulance handover steering group continues to meet and local joint hospital and SECAmb operational meetings are also continuing.
The steering group is also linking in with the national programme, and is receiving support from the regional NHSE/I

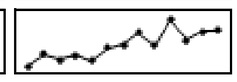
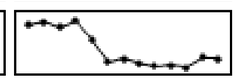
SECAmb unvalidated weekly Response Time Performance

SECAmb Weekly Operational Performance - W/C 11th May 2020

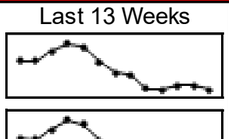
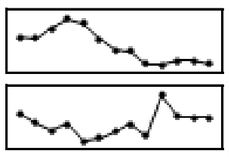
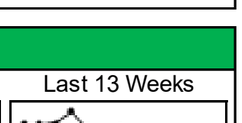
CAT 1

	27/04	04/05	11/05	Last 13 Weeks
Mean	00:06:58	00:06:44	00:06:52	
90th Centile	00:13:00	00:12:43	00:12:43	
RPI	1.63	1.67	1.64	
Count of Incidents	708	786	756	

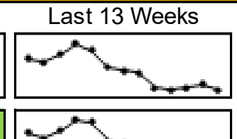
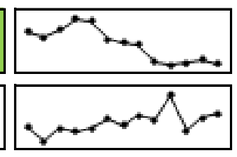
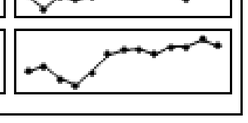
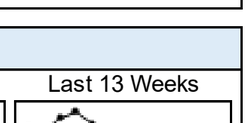
CAT 1T

	27/04	04/05	11/05	Last 13 Weeks
Mean	00:07:39	00:07:53	00:07:48	
90th Centile	00:14:02	00:14:04	00:13:46	
RPI	1.61	1.65	1.66	
Count of Incidents	385	439	434	

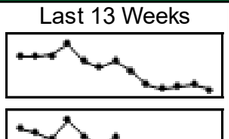
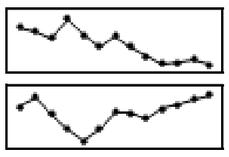
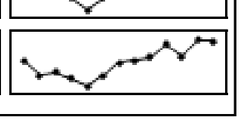
CAT 2

	27/04	04/05	11/05	Last 13 Weeks
Mean	00:14:14	00:14:19	00:13:19	
90th Centile	00:26:30	00:26:33	00:24:51	
RPI	1.06	1.06	1.06	
Count of Incidents	6034	6097	5722	

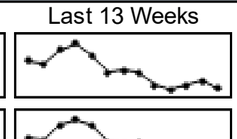
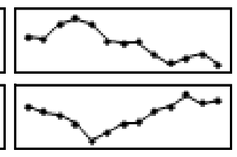
CAT 3

	27/04	04/05	11/05	Last 13 Weeks
Mean	00:38:50	00:45:32	00:35:27	
90th Centile	01:27:52	01:41:18	01:20:23	
RPI	1.05	1.05	1.05	
Count of Incidents	5172	5390	5200	

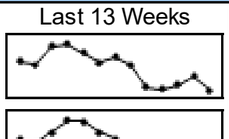
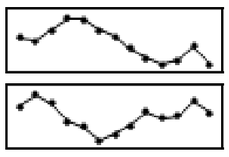
CAT 4

	27/04	04/05	11/05	Last 13 Weeks
Mean	00:54:19	00:59:15	00:46:07	
90th Centile	01:59:12	02:20:58	01:46:08	
RPI	1.05	1.06	1.07	
Count of Incidents	95	125	122	

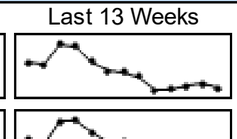
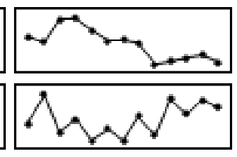
HCP Level 3

	27/04	04/05	11/05	Last 13 Weeks
Mean	01:04:01	01:15:12	00:55:32	
90th Centile	02:24:25	02:43:21	01:51:03	
Count of Incidents	370	334	346	

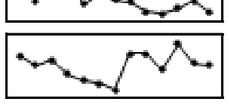
IFT Level 3

	27/04	04/05	11/05	Last 13 Weeks
Mean	01:05:52	01:25:25	00:54:37	
90th Centile	02:29:45	03:25:46	02:10:16	
Count of Incidents	103	127	107	

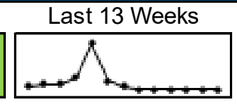
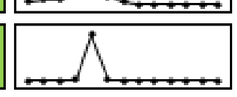
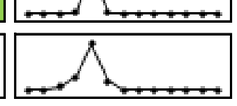
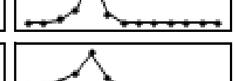
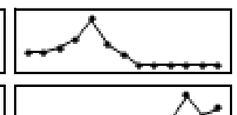
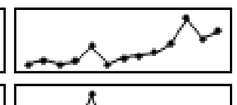
HCP Level 4

	27/04	04/05	11/05	Last 13 Weeks
Mean	01:24:56	01:35:09	01:17:19	
90th Centile	03:26:41	03:50:30	02:56:18	
Count of Incidents	227	249	237	

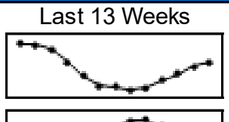
IFT Level 4

	27/04	04/05	11/05	
Mean	01:33:11	01:40:27	01:14:53	
90th Centile	03:23:24	04:35:52	02:45:20	
Count of Incidents	40	30	29	

999 Call Handling

	27/04	04/05	11/05	Last 13 Weeks
Mean Call Pickup Time (Seconds)	1	1	1	
Call Pickup Time 90th Percentile (Seconds)	1	1	1	
Call Pickup Time 95th Percentile (Seconds)	1	1	1	
Call Pickup Time 99th Percentile (Seconds)	2	2	2	
Average Call Length (seconds)	448	408	422	
Abandon Rate	0.02%	0.02%	0.03%	
Staff Hours Provided Vs 4783 target	118.1%	113.4%	104.3%	

Incident Outcome

	27/04	04/05	11/05	Last 13 Weeks
See and Convey	52.9%	55.1%	56.5%	
See and Treat	41.5%	39.4%	37.8%	
Hear and Treat	5.6%	5.5%	5.7%	

Call Cycle Time

	27/04	04/05	11/05	Last 13 Weeks
Clear at Scene	01:21:39	01:20:28	01:19:48	
Clear at Hospital	01:48:46	01:48:34	01:47:11	
Hours Lost at Hospital	849	870	791	

Community First Responders

	27/04	04/05	11/05	Last 13 Weeks
Volume of Incidents Attended	0	0	0	
Hours Provided	496	507	486	

Demand/Supply

	27/04	04/05	11/05	Last 13 Weeks
999 Call Volume	12268	12862	11578	
Incidents	13433	13817	13213	
Transports	7336	7760	7549	
Staff Hours Provided Vs 70400 target	98.6%	99.0%	100.0%	

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Jan-20	Feb-20	Mar-20	12 Months
Actual	75904	85080	162194	
Previous Year	98477	92883	78251	

Calls answered in 60 Seconds

	Jan-20	Feb-20	Mar-20	12 Months
Actual %	86.3%	61.5%	16.5%	
Previous Year %	78.1%	68.0%	83.8%	
Target %	95%	95%	95%	

Calls abandoned - (Offered) after 30secs

	Jan-20	Feb-20	Mar-20	12 Months
Actual %	1.9%	8.0%	50.2%	
Previous Year %	4.1%	6.1%	2.6%	
Target %	5%	5%	5%	

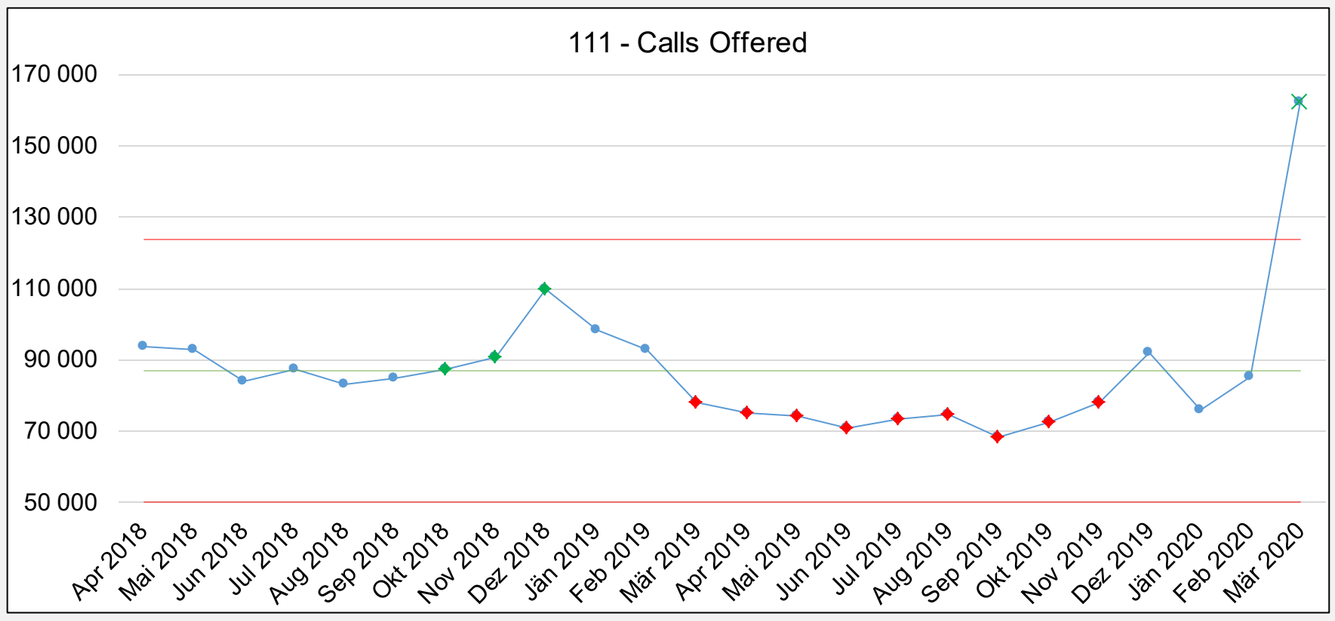
A&E Dispositions

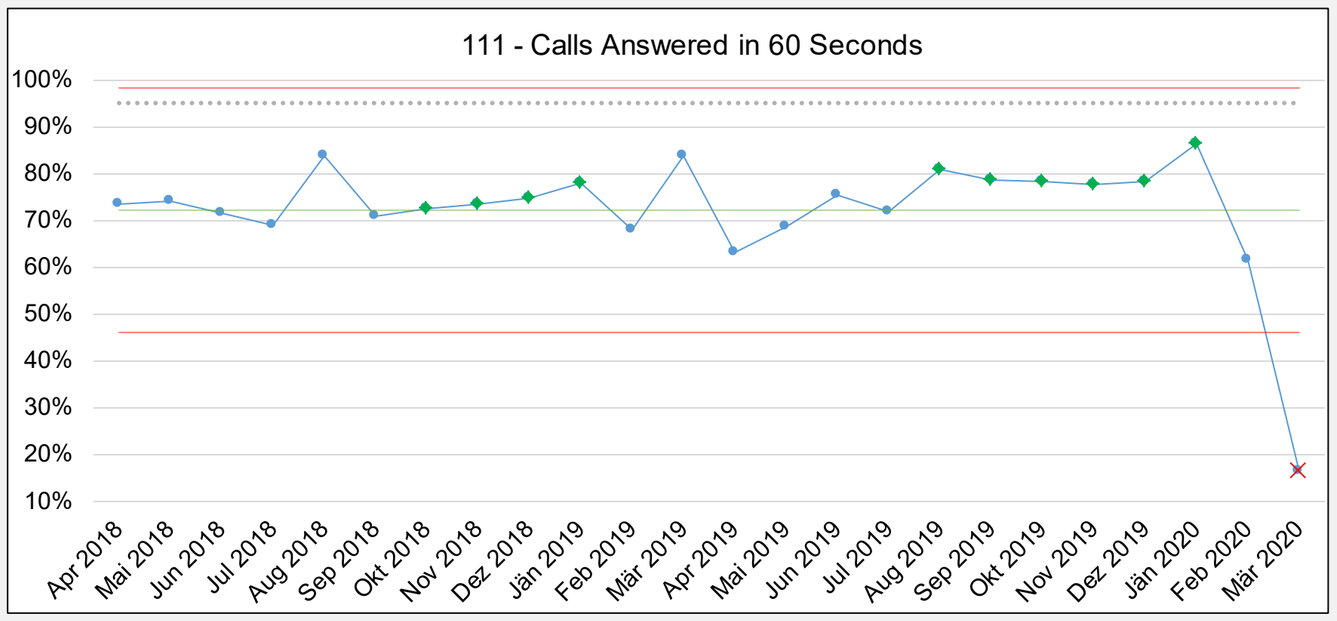
	Jan-20	Feb-20	Mar-20	12 Months
A&E Dispositions % (Answered Calls)	10.7%	9.7%	6.0%	
A&E Dispositions (Actual)	6443	6047	3316	
National	9.5%	8.9%	5.9%	

999 Referrals

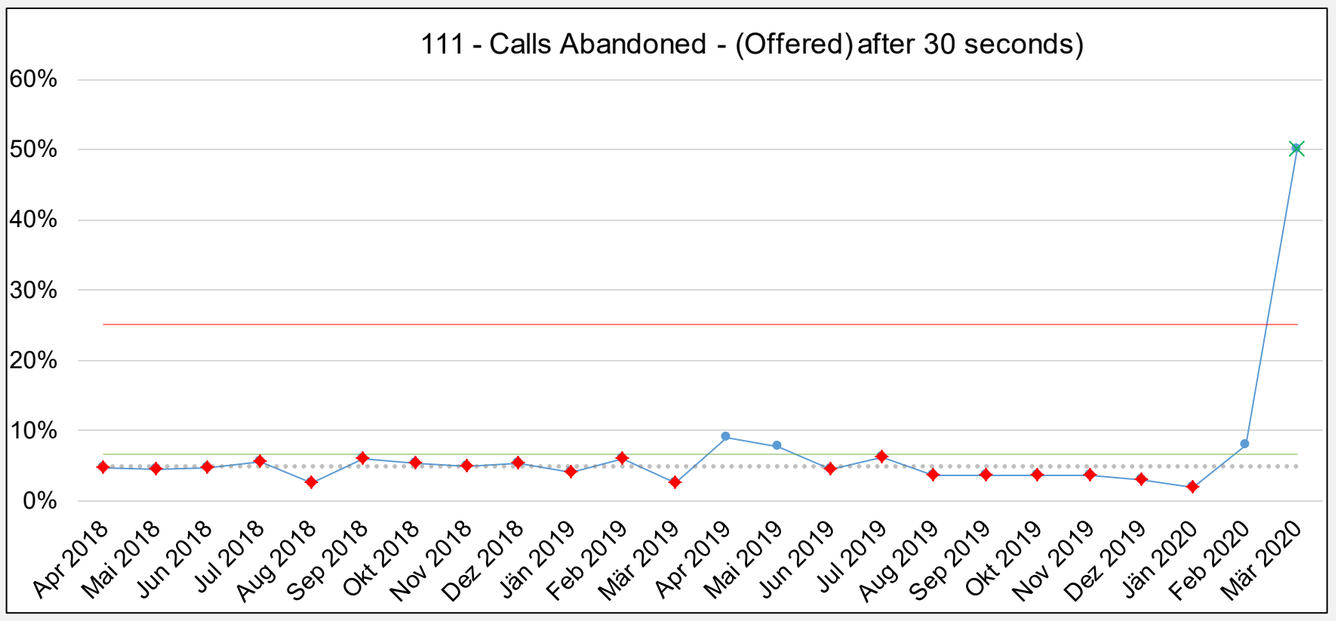
	Jan-20	Feb-20	Mar-20	12 Months
999 Referrals % (Answered Calls)	14.5%	12.7%	9.8%	
999 Referrals (Actual)	8726	7960	5443	
National	13.3%	12.2%	10.5%	

SECAmb 111 Operations Performance Charts

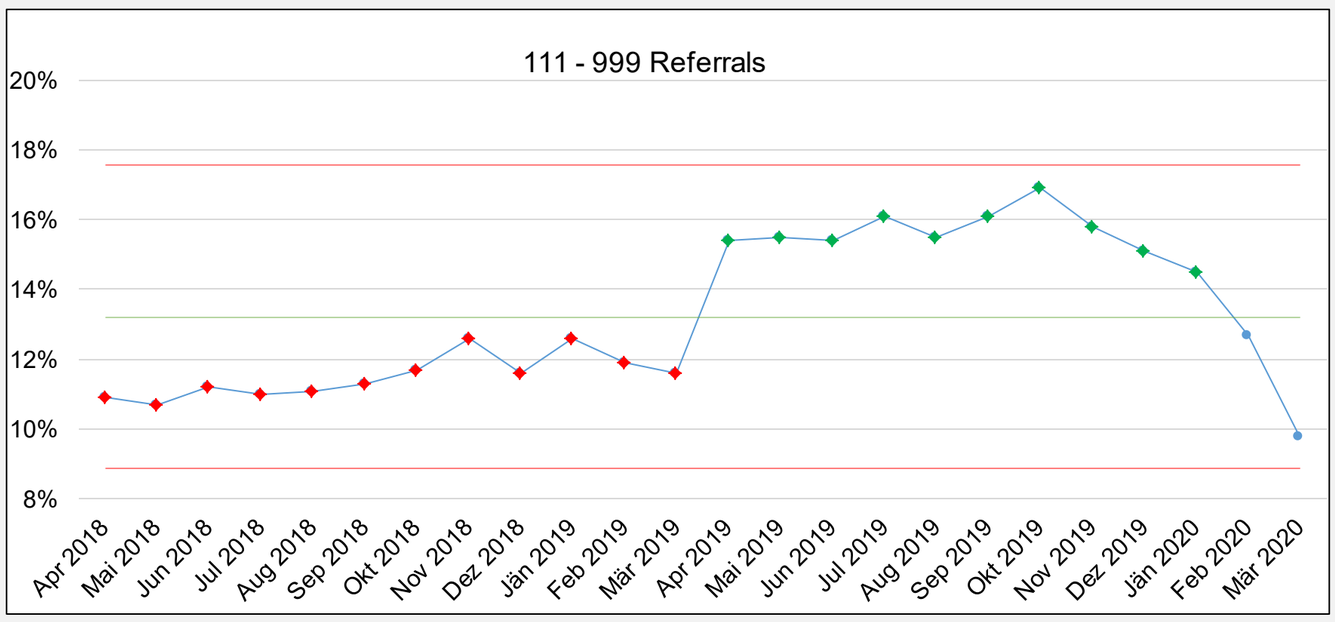




The SEC 111 service achieved a Service level of 63.59%. The month was challenging as expected due to the introduction of new cohorts to the operation. The key focus was Easter, for which we achieved a higher service level than the KMSS service achieved at Easter 2018.



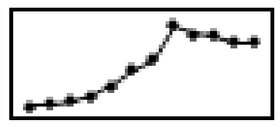
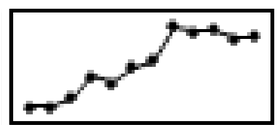
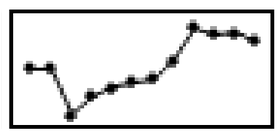
The Call Abandonment rate of 8.79% was high but saw a downward trend throughout the month. The Average Speed to Answer was 124 seconds.



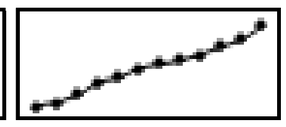
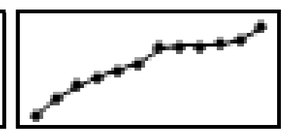
The 999 referral rate is high due to the service acting in a risk adverse manner in the early stages of the new operating model. In addition, the relatively short tenure of our Health Advisors contributed to this referral rate. This is expected to reduce throughout May and June.

SECAmb Workforce Scorecard

Workforce Capacity

	Jan-20	Feb-20	Mar-20	12 Months
Number of Staff WTE (Excl bank & agency)	3685.8	3667.9	3667.1	
Number of Staff Headcount (Excl bank and agency)	4020	4001	4005	
Finance Establishment (WTE)	3920.43	3924.43	3905.55	
Vacancy Rate	5.99%	6.54%	6.11%	
Vacancy Rate Previous Year	10.99%	11.29%	11.29%	

Workforce Compliance

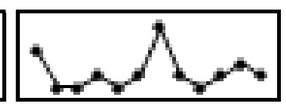
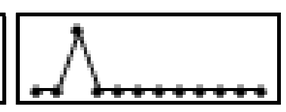
	Jan-20	Feb-20	Mar-20	12 Months
Objectives & Career Conversations %	56.22%	61.26%	71.74%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	72.12%	76.97%	87.09%	
Target (Stat & Mand Training)	95%	95%	95%	
Previous Year (Stat & Mand Training) %	61.63%	88.62%	93.58%	

* Objectives & Career Conversations and Statutory & Mandatory training has been measured by financial year. The completion rate is reset to zero on 01/04/2019

Workforce Costs

	Jan-20	Feb-20	Mar-20	12 Months
Annual Rolling Turnover Rate %	15.58%	15.88%	15.83%	
Previous Year %	14.06%	14.12%	14.07%	
Annual Rolling Sickness Absence	5.70%	5.74%	5.82%	
Target (Annual Rolling Sickness)	5%	5%	5%	

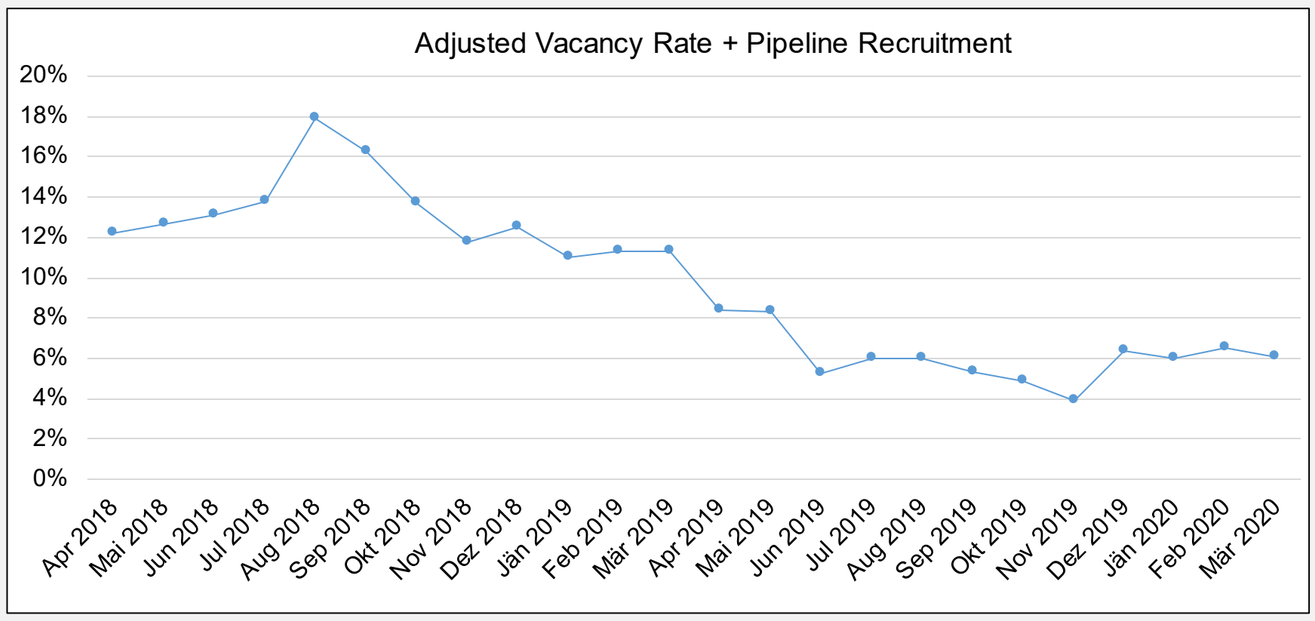
Employee Relations Cases

	Jan-20	Feb-20	Mar-20	12 Months
Disciplinary Cases	6	5	2	
Individual Grievances	8	8	6	
Collective Grievances	1	2	1	
Bullying & Harassment	2	1	2	
Bullying & Harassment Prev Yr	2	2	2	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	0	0	0	

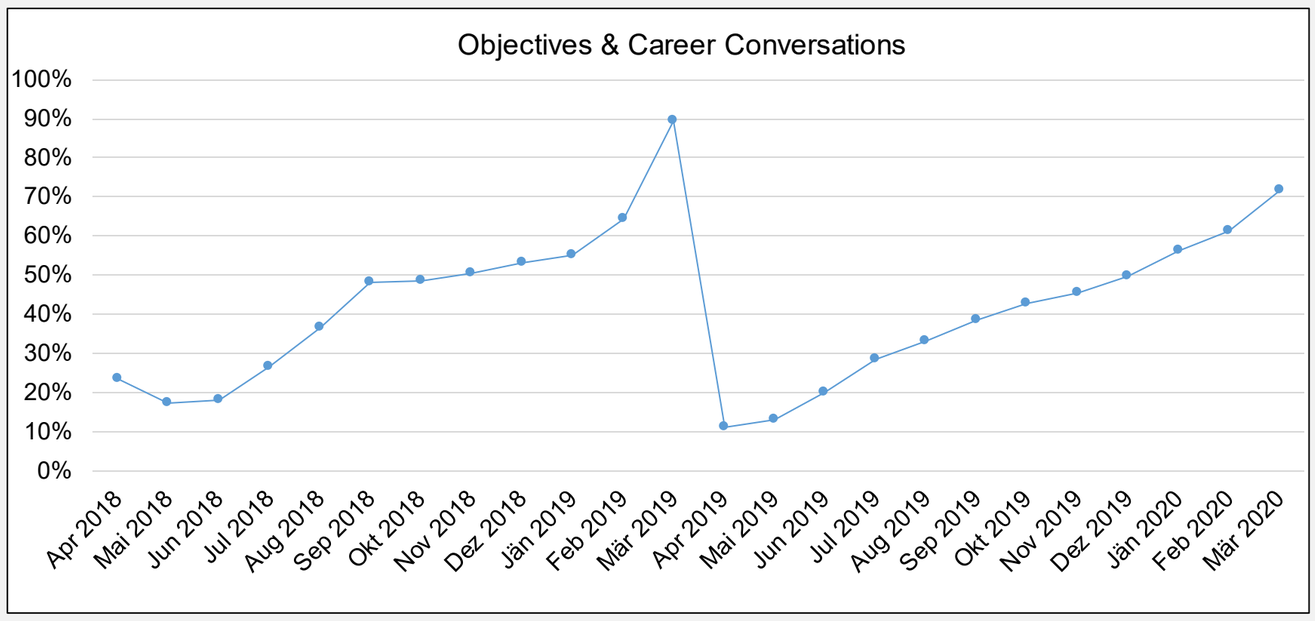
Physical Assaults (Number of victims)

	Jan-20	Feb-20	Mar-20	12 Months
Actual	39	35	15	
Previous Year	18	22	18	
Sanctions	10	3	5	

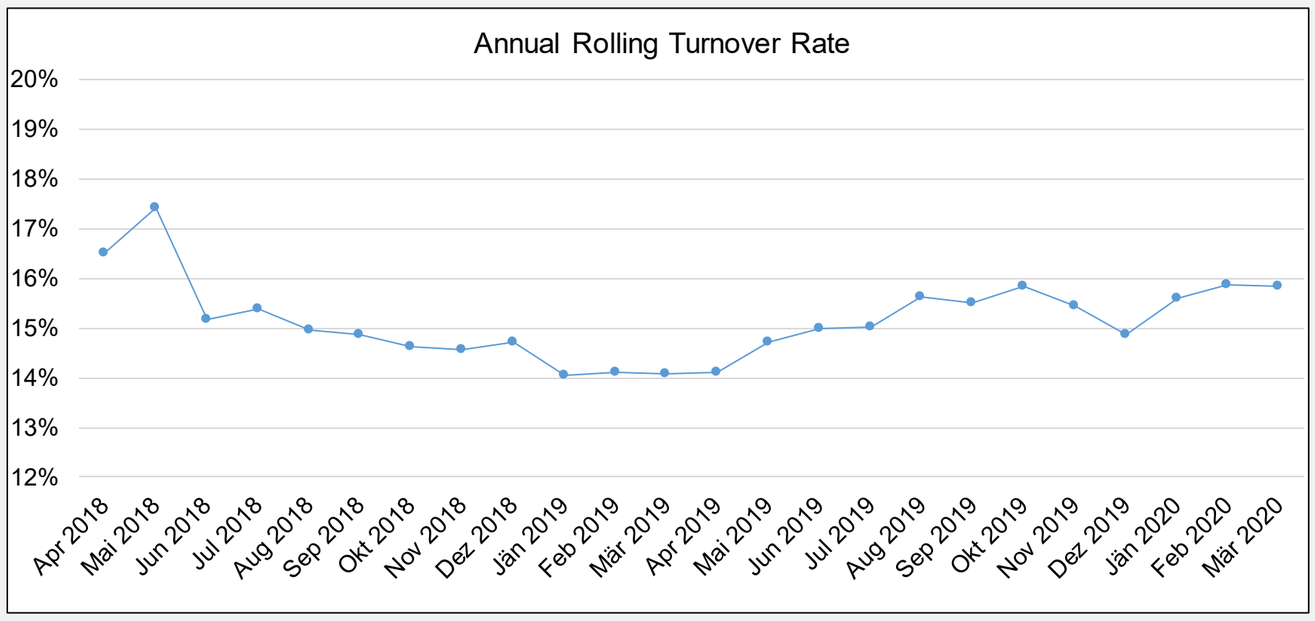
SECAmb Workforce Charts



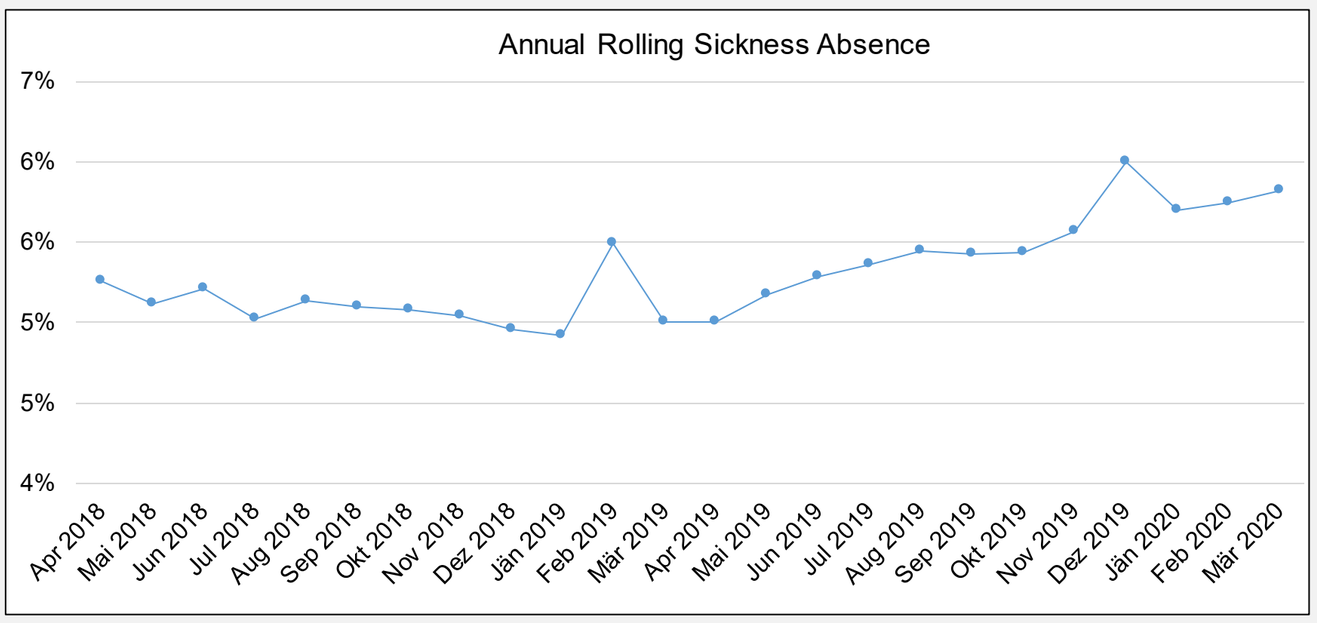
Establishment - ECSW recruitment is now on hold to enable focus on AAP and Paramedic recruitment. 18 external AAPs will start on 14th April.



As at end of March 2020 appraisals completed is 71.74% compared to (89.57% for March 2019). There could be a number of reasons for this decrease including COVID-19 focus, the new pay progression scheme and 2018/19 figures being based on staff in post on 31/2017. We will be taking a fresh approach to ensuring staff are having meaningful appraisals.

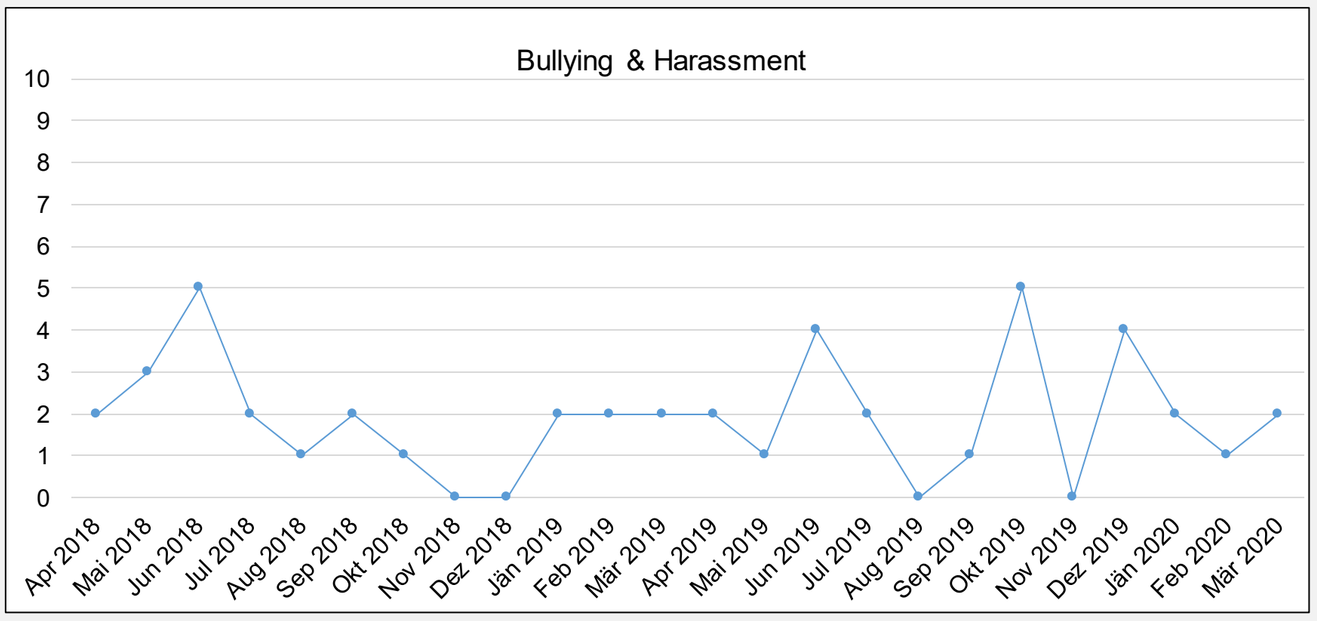


Throughout January and February, the HR population have confirmed a fit for purpose Retention Strategy:-
The role out has now been completed and we have engaged with over 300 colleagues and we have received over 100 comments to help improve the strategy - this was taken to EMB 9th March
- New simplified appraisal process went live just before Christmas
- The first line manager training programme (Fundamentals) launches in 2020.
- The new exit interview process is in the final stages of development
- Our retention strategy will come to WWC in March.
- The rotational paramedic model is well under development and has been discussed with Clinical Commissioning Groups, and will shortly be discussed with other NHS healthcare providers



EOC EAST- Saw an increase of 0.18% on last months absence Mar total 6.71%.
EOC WEST Saw an increase of 0.06% Mar total 7.25%
111 Saw an increase of 0.41% - Mar total 9.78%-
Out of 10 OU's only one unit achieved their absence % - Paddock Wood. Short 2.61% and Long-term 3.44%.
We are sitting at 6.05% for the whole trust.

We continue to manage absence on a weekly basis, with HRA's meeting with their stakeholders through, coaching and supporting the Line. DC will be working with HRBP's to set absence % targets for them to achieve.



We have 11 open cases across the trust. - EOC East 1, WEST OPS - 4 and East OPS -5. Central Functions 1.
Fundamentals training which commended roll-out during March 2020 will support the reduction in B & H Cases. This is mandatory training for all Band 7 managers which will equip our teams with the right management skills.(this is obviously on hold at present due to COVID-19.)

SECAmb Finance Performance Scorecard

Income

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 21,049	£ 19,410	£ 23,189	
Previous Year £	£ 20,428	£ 19,491	£ 22,057	
Plan £	£ 20,859	£ 18,826	£ 20,403	

Expenditure

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 20,227	£ 19,428	£ 22,281	
Previous Year £	£ 19,580	£ 19,762	£ 19,683	
Plan £	£ 20,045	£ 18,849	£ 19,689	

Capital Expenditure

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 851	£ 1,012	£ 1,860	
Previous Year £	£ 2,578	£ 2,663	£ 2,660	
Plan £	£ 1,787	£ 1,797	£ 8,220	
Actual Cumulative £	£ 11,774	£12,786	£14,646	
Plan Cumulative £	£21,677	£23,474	£31,694	

Cost Improvement Programme (CIP)

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 575	£ 700	£ 776	
Previous Year £	£ 872	£ 949	£ 1,786	
Plan £	£ 781	£ 750	£ 750	
Actual Cumulative £	£ 5,606	£ 6,306	£ 7,082	
Plan Cumulative £	£ 7,112	£ 7,862	£ 8,612	

CQUIN (Quarterly)

	Q4 18/19	Q1 19/20	Q2 19/20
Actual £	£ 1,088	£ 648	£ 646
Previous Year £	£ 2,745	£ 871	£ 870
Plan £	£ 870	£ 654	£ 654

*The Trust anticipates that it will achieve the planned level of CQUIN

Surplus/(Deficit)

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 822	-£ 18	£ 908	
Actual YTD £	-£ 618	-£ 634	£ 274	
Plan £	£ 814	-£ 23	£ 714	
Plan YTD £	-£ 639	-£ 662	£ 52	

Cash Position

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 25,758	£ 26,577	£ 28,326	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 15,813	£ 18,844	£ 20,582	

Agency Spend

	Jan-20	Feb-20	Mar-20	12 Months
Actual £	£ 358	-£ 145	£ 146	
Plan £	£ 255	£ 251	£ 247	

SECAmb Finance Performance Chart

The Trust recorded a surplus of £0.9m in March. This was £0.2m better than planned.

Cost improvements (CIPs) of £0.8m were delivered in the month, as planned. £7.1m of CIP schemes have been delivered for the year, this was £1.5m lower than planned.

The Trust's Use of Resources Risk Rating (UoRR) for March is 1, which is better than planned level of 2.

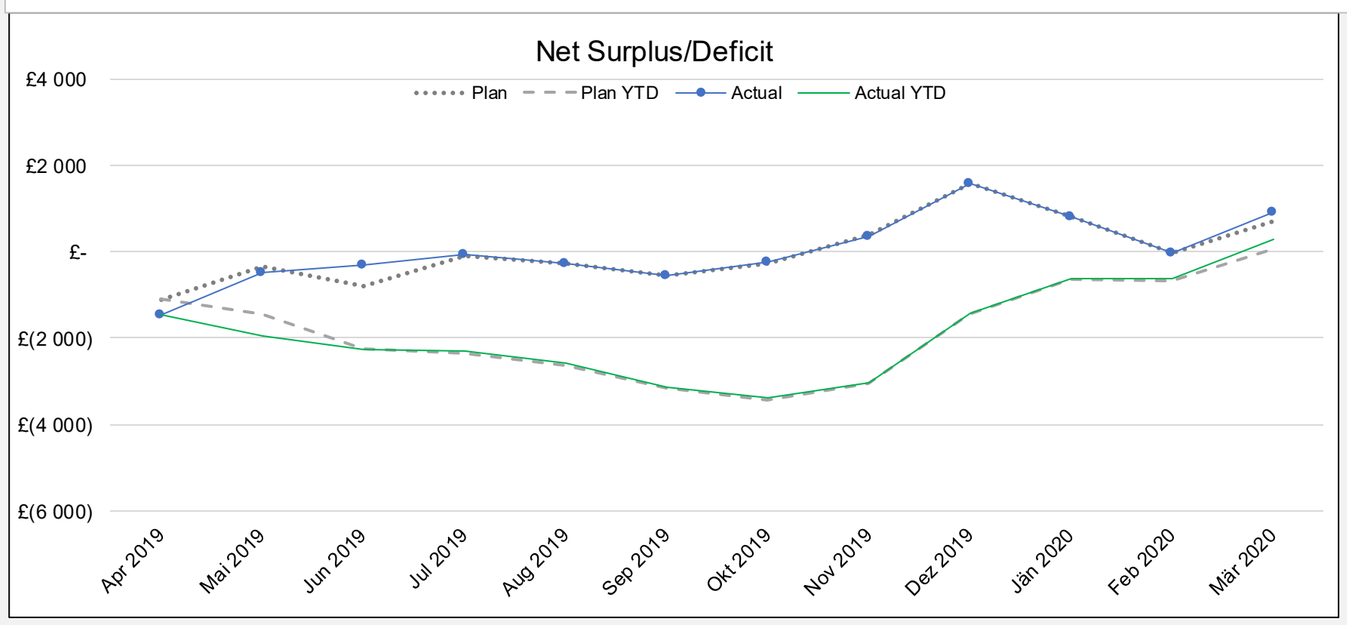
The Trust's financial risks in 2019/20 have been largely managed, although a number of these are ongoing, those being:

- Impact of COVID-19 on resources to deliver performance.
- Achievement of contractual income if activity demand and performance trajectories are not met.
- Delivery of recurrent, cash-releasing cost improvements that are essential to ensure financial sustainability.
- Governance and control of costs to ensure value for money and avoid overspending

The Finance Team continues to work with budget holders and service leads to mitigate risks as far as possible.

Provider Sustainability Funding (PSF) of £1.8m is expected to be received in full for 2019/20 and the Trust has received confirmation that it has achieved its control total for the year.

Further details of financial performance are included in this report. A more detailed reporting pack is provided to directors, senior managers and regulators and the financial position is closely monitored through the Finance & Investment Committee, a subcommittee of the Board.

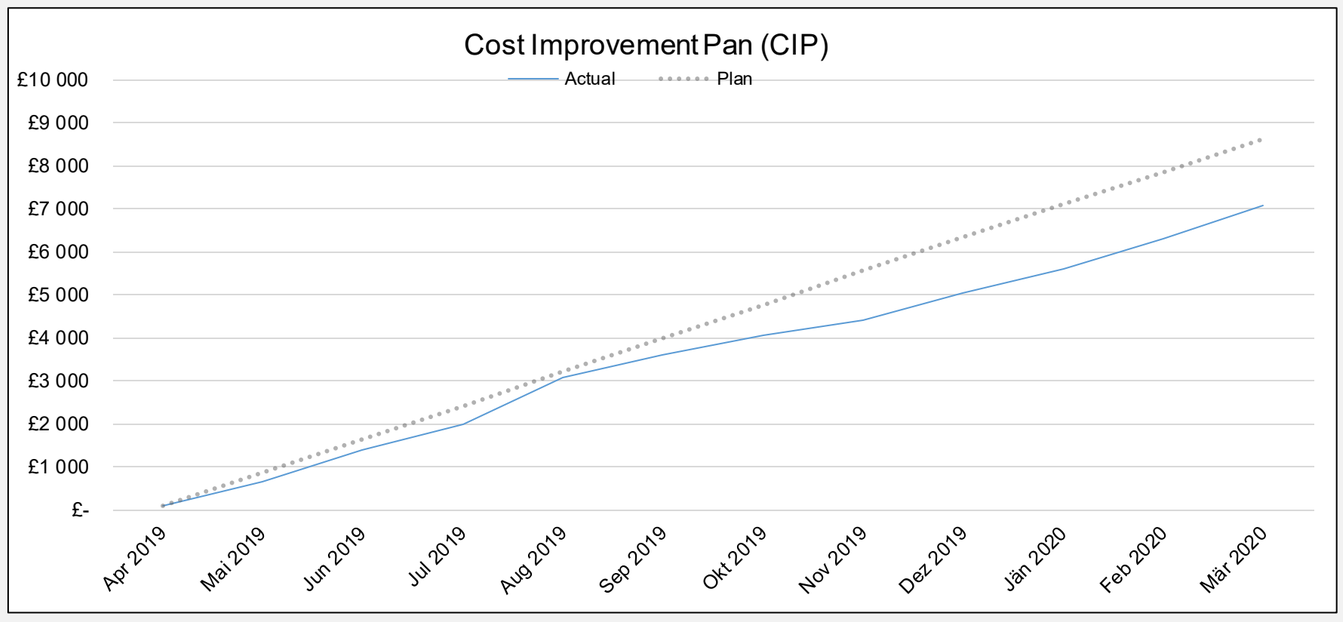


The Trust's Income &Expenditure position in Month 12 was a surplus of £0.9m, which was £0.2m better than plan.

Full year surplus was £0.3m, £0.2m better than planned.

The shortfall on planned 999 income has been partly mitigated by non-recurrent vacancies and reduced PDC (Public Dividend Capital) Dividend.

£1.0m of additional Covid-19 costs have been funded centrally.



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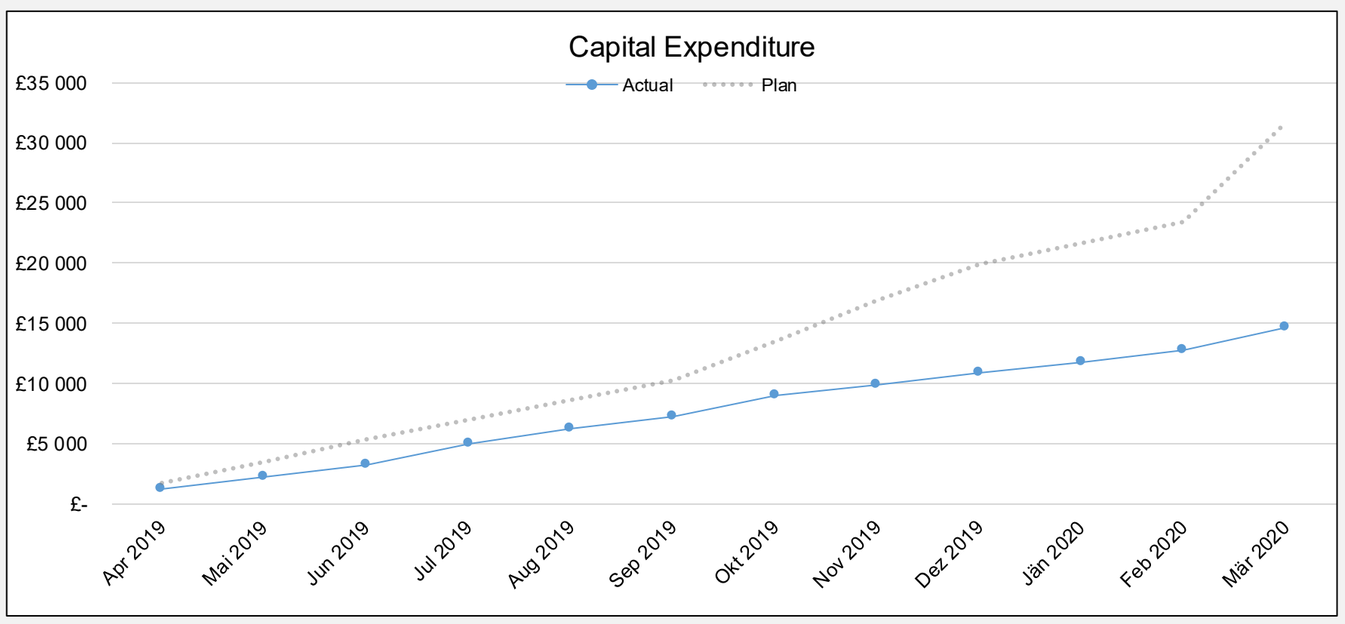

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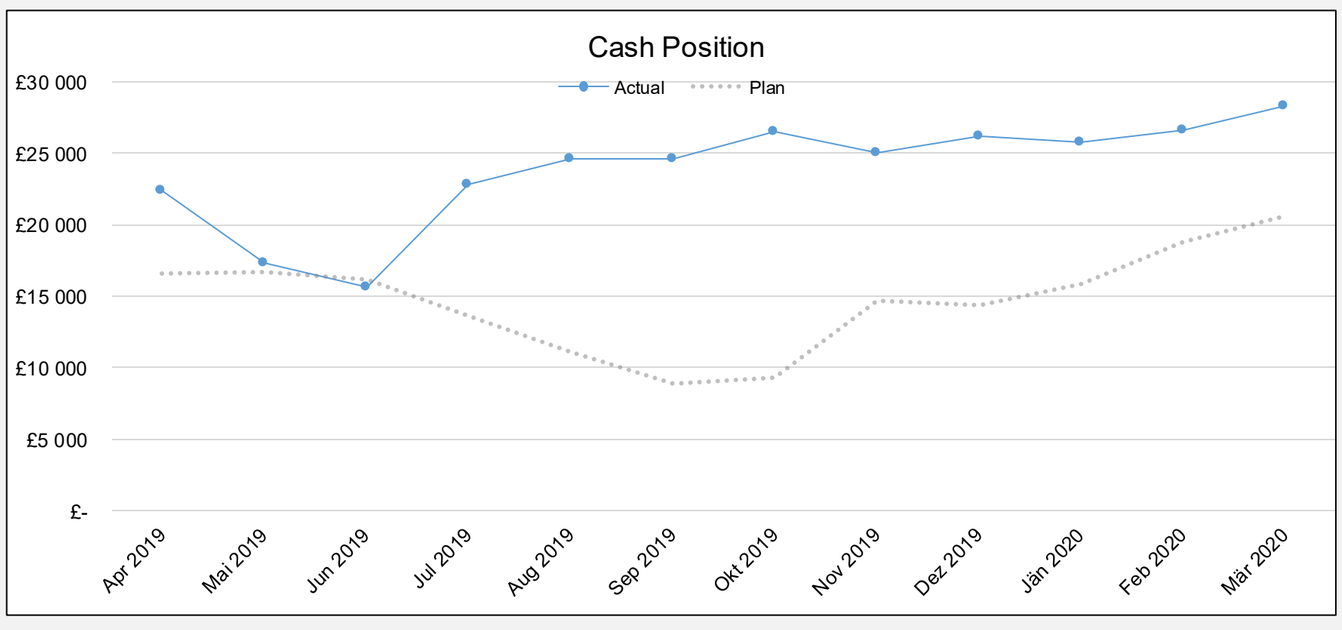
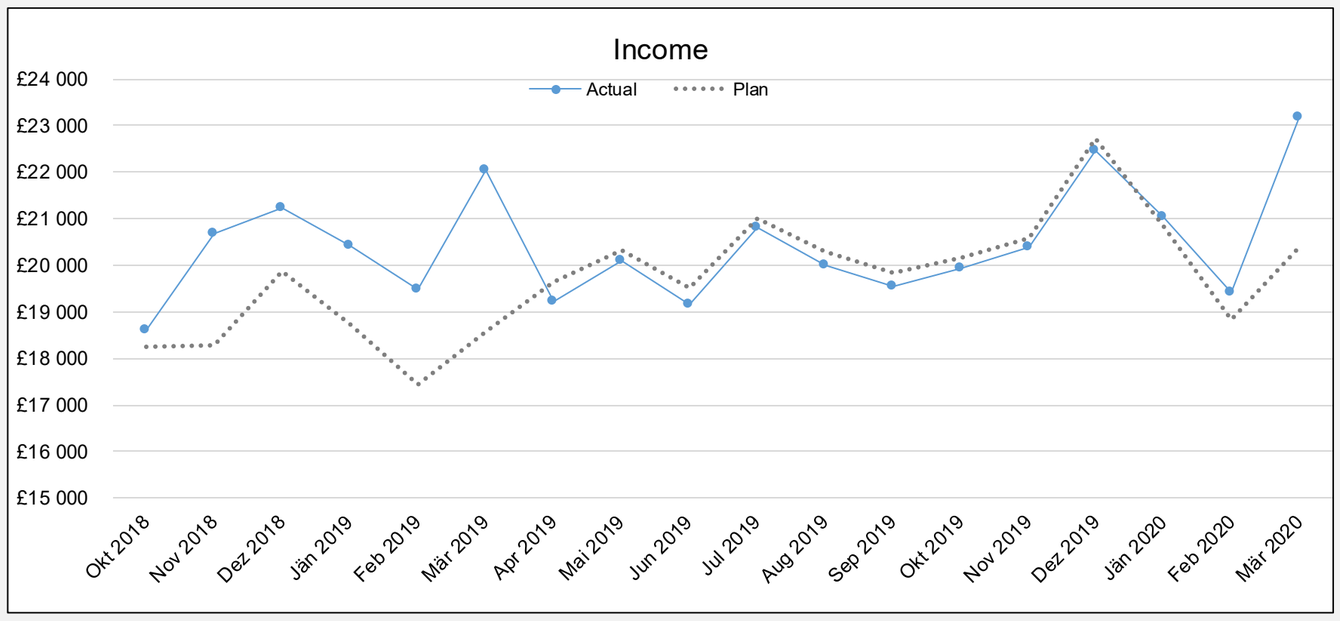


The cash position as at 31 March 2020 was £28.3m, £7.7m greater than planned. The £1.7m increase in March included £2.9m additional 999 receipts, following the year end settlement with commissioners, partly offset by increased pay expenditure of £1.2m, mainly relating to private ambulance provider payments.

Performance for the year to date against the 'Better Payment Practice Code', measured by payment of suppliers within 30 days of a valid invoice, was 95.6% by value against a target of 95.0%.

SECAmb Finance Performance Charts



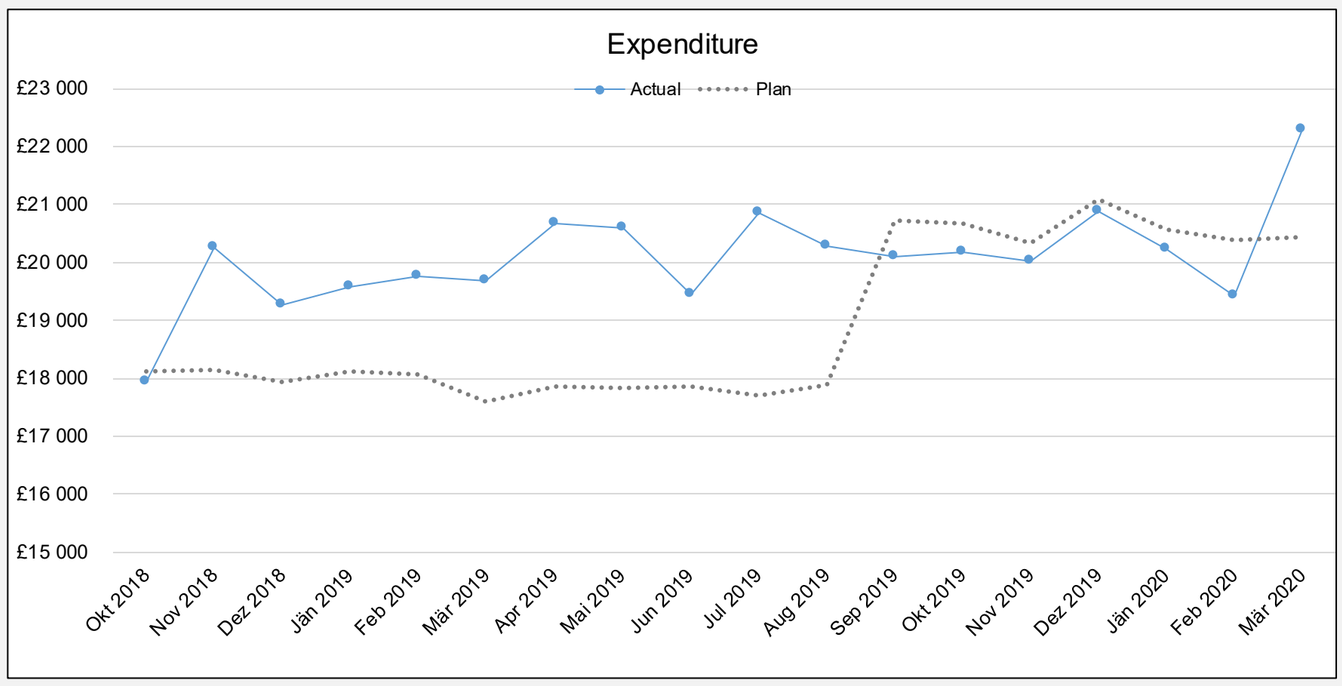
Income for the month of March was £23.2m, which was £2.8m better than plan.

Year to date income was £245.2m, £1.0m above plan.

The main reason for the positive variance is £1.0m of income to offset Covid-19 additional costs. A shortfall of £2.5m in 999 income as a result of activity being less than planned is offset by favourable variances in other income, mainly training.

999 activity plan is based on the Demand and Capacity Review. By increasing resources through the investment it has received, the Trust has managed to attend an additional 39,338 incidents (+5.5%) in comparison to last year.

Note: Annual Accounts income is £7.2m greater than reported here due the funding of additional NHS Pension contribution costs borne by DHSC.



Total expenditure for the month of March was £22.3m, which was £2.6m greater than planned. Full year expenditure was £225.0m, £0.8m above plan.

Pay costs were £0.9m higher than planned in the month and £0.3m higher for the year. This is mainly due to the backdated holiday payment for shift overruns arising from the 'Bear Scotland' legal judgement. £0.3m of Covid-19 pay expenditure was incurred in March, funded centrally.

Non pay costs were £1.9m in excess of plan in the month and £0.8m higher for the year. This is due to a review of balance sheet provisions. £0.7m of Covid-19 non pay expenditure was incurred in March, funded centrally.

Financing costs are £0.4m lower than planned for the year from the benefit of reduced PDC (Public Dividend Capital) Dividend arising from lower capital expenditure and improved cash.

Note: Annual Accounts expenditure includes an additional £7.2m for NHS Pension contributions funded by DHSC.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**14 May 2020**
Overview of issues/areas covered at the meeting:	The meeting started with a discussion about its approach to hearing about how managers are engaging with their staff, in a way that does not narrowly focus on the annual staff survey, as this is just one measure. The committee wants to create a supportive environment where the focus is on how we can support managers, and at the same time gather intelligence on what it feels like for staff throughout the Trust. The meeting then considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **HR Workstreams Update** **Partially Assured** DBS: For current starters (2020) we are broadly compliant with a robust process in place. In terms of retrospective checks (every 3 years) there is an increase in numbers in the checking process; a number of final reminders have been issued to staff inviting them to a disciplinary meeting. P Files: The Board will recall that a new plan was developed due to go live in March but was then paused because of COVID. This involves a different approach whereby HR staff are based within OUs to carrying out the checks/scanning to the quality required. The committee reinforced the need to resolve this promptly and despite the lockdown restrictions challenged the executive to deploy this project as soon as possible. E-Expenses / Driving Licences: There have been regular meetings with unions about their concerns with the impact of e-expenses in checking driving licenses and agreed that managers can and should be asking for driving licenses, using the existing policy until we have the E-Expenses system in place. The committee asked that at its next meeting it receives a clear timeline for completion, noting that this is being set by OU. E-Time Sheets: The implementation of this project is due to start imminently, firstly with support services then by OU. **Clinical Education Review and Annual Training plan** **Partially Assured** The committee reviewed progress with the action plan that is in place to ensure readiness for the FutureQuals quality assurance audit in early June. There were some gaps in assurance identified in March and since then measures have been taken, including changes in leadership. The medical director felt confident that with implementation of the plan we would achieve level 1 (from level 2).

The training plan was also reviewed; this has been revised (delivery models) in light of the restrictions of COVID.

Workforce Planning and Delivery Partially Assured
A presentation was provided setting out the workforce planning numbers for 2020/21. The committee explored the need for planning to meet future demand and overall was assured there are detailed plans on the numbers and the next step is to bring back details of how this will be implemented.

Supporting BAME and vulnerable staff during COVID19 Assured
There is lots of evidence emerging on the disproportionate impact of COVID on BAME staff. This has been reviewed by the COVID management group and, in addition to welfare calls and an overarching risk assessment, we will be undertaking a national pilot of testing 125 asymptomatic front line clinical staff prioritising BAME staff. The expectation is that this will become mandated sooner than later so we will be using the learning from this pilot.

The committee is assured by the steps taken to-date.

The committee also received reports under its section on *Monitoring Performance*, including:

HR Dashboard
WWC noted in particular:

- The significant increase in recruitment during the past few months
- COVID - focus on stat man training for staff working from home, in particular, and ensuring staff are taking annual leave.

Wellbeing Update
The committee is assured by the initiatives being taken forward. It noted that the strategy is being developed and that this will take account of a review of the cost benefit.

Health & Safety – Annual report
This report sets out the work during the year, including the completion of the improvement plan, which has increased compliance with legislation and supported the embedding of a H&S culture. The report is on the Board agenda and, in addition the H&S Internal Audit review concluding 'reasonable assurance', the committee asks the Board to note the following, in particular;

- There is ongoing education to support real-time reporting so RIDDOR reports can be reported on time.

- Manual Handling incidents have increased with the majority from paramedics, so there is targeted work to better understand the causes.

	• H&S audits were newly implemented and over 100 were completed in-year. The actions from these will be continually monitored. The committee explored the outcome of the audits and accepted the H&S Manager's confidence, with the current outcomes being on average circa 80%, demonstrating reasonable compliance. • The committee supported the ISO45001 aspiration and left it with the executive to agree the best timing. The committee noted the significant impact of Amjad Nazir, H&S Manager and how his leadership has led to the significant improvement in H&S over the past year.
Any other matters the Committee wishes to escalate to the Board	The **BAF risks** linked to the committee were reviewed and there was support for the removal of the H&S risk. As described above, the committee challenged the executive to ensure we achieve the target score for P Files as soon as possible. The committee received a verbal update that the **payroll contract** will be reviewed in year to test the market. This will be a critical change programme with opportunities to bring about improvement. The committee is assured we are looking at this important area. In planning for the July meeting, there was a good discussion about our approach to grievances and the committee will be spending time in July exploring the level and 'cost' of grievances, comparing with other parts of the NHS. This will help to highlight where there are difficulties and where we aren't learning. Finally, the committee will be meeting more regularly during the year (circa 4-6 weekly) to ensure oversight and support of the number of key issues under its purview.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	14 May 2020
Overview of key issues/areas covered at the meeting:	The meeting considered several ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **999 Operational Performance** **Partial Assurance** The committee explored how the resources are being utilised and while there is currently good compliance with ARP performance this is in the context of lower demand due to COVID. The extent to which this level of performance can be sustained as 'normal' activity returns is uncertain, and while there is work underway to use the lessons from this period, the director of operations is clear that the current good performance is impacted more by the different type of demand we are seeing, rather than by any significant change in approach. **111 / CAS Mobilisation** **Partial Assurance** There was a good update on the progress being made with the mobilisation for this new service. There are some significant issues being worked on and some key meetings are scheduled ahead of the Board meeting to help establish viable solutions. The aim is to mobilise by November and the committee noted the challenge of this timetable, compounded by the possible second COVID peak predicted for this period. It therefore reinforced the importance of ensuring robust due diligence checks to avoid optimism bias. A project plan is being developed and will be closely scrutinised by the committee; this includes a 12 week countdown to Go-Live and the Board will have the opportunity to approve the commencement of this and well as Go Live itself. **Procurement** **Assured** The committee received a paper providing an overview of current procurement activity within the Trust; how it aligns with the direction of the Procurement Strategy (in development); and how the Trust conducts its purchasing activity and increases the efficiency and effectiveness in purchasing and supply management. This was received noting the Internal Audit review that recently concluded 'Reasonable Assurance'. While overall the committee was assured by the governance and controls in place, it explored the extent to which procurement ensures cost reduction, especially in the context of having in excess of 2000 suppliers. There is good focus on reducing the number of suppliers - including private Ambulance providers and from getting the most from contracts. Assurance was also received by the high percentage of purchase orders; we are not committing to expenditure without first getting the proper approvals, and by the introduction of three new contracts managers to support the management of contracts more proactively than before.

20/21 Budget Assured
A review was undertaken of the budget for the year, which is based on published guidance. At the time of the meeting there was still some work to finalise, but no material changes were expected.

Overall, while there are some risks these are considered to be reasonably manageable and the committee asks the Board to note the following.

The committee explored the steps being taken to improve productivity, through the utilisation of people, e.g. core hours/overtime/BANK/PAPs, and challenged the executive to ensure greater productivity and efficiency improvements.

It noted the vulnerability with the £7.3m top up assumption (a large part of this is inflation so unavoidable), and with regards the 2.1% CIP target expressed some concern with the approach to pro rata across directorates, suggesting the executive gives greater priority to the Productivity Group to look more holistically across the Trust.

The committee supports the budget and recommends it to the Board.

The committee also received reports under its section on *Monitoring Performance*, including:

Financial Performance M12/Forecast
Performance and M12 supported the overall achievement of the control total for 2019-20, and the committee confirmed no significant issues have arisen from external audit. The use of resources risk rating is now 1 (from 2). This is a really positive outcome and demonstrates good financial control.

CIP/Overview of Schemes for 2019/20
The target was not achieved, but the committee is assured that that the framework for delivering CIPs is robust, supported by an Internal Audit review that concluded 'significant assurance'. However, as stated earlier, the committee challenged the executive to take a more holistic approach to CIPs for 2020/21.

COVID – Update on Spend
An update was received on COVID-related expenditure and there is reasonable expectation that a significant majority of costs will be recovered. The committee noted that the executive is ensuring regular review of decisions that have been taken to ensure they remain valid.

COVID – Recovery, Learning & Improvement Group Update
A presentation was provided on the approach of this group, which has recently been established by the Chief Executive to ensure we use the learning from COVID across a number of workstreams. The committee supported the Group, reinforcing the Board's challenge in April to ensure there is good engagement with staff who have had to work in different ways and will know what has / has not worked well.

	I.T Update This is the regular update the committee receives outlining the current digital pipeline and associated programmes / project activities. Of note is the 60% increase in demand since COVID, in large part due to the number of staff working from home.
Any other matters the Committee wishes to escalate to the Board	The committee asked that the 5-year plan update comes sooner than initially scheduled and will receive a first draft in July. The committee also asked that over the next 6 months or so, there is a review bringing together the fleet, people, and estates strategies, rather than looking at them in isolation. It suggested perhaps undertaking a review at a Board development session. There was also a review of the BAF risks linked to the committee and there was support for the reduction in risk score for 123 (ARP) and 178 (Control Total). The committee felt the risk this year for the control total is lower than last year given the approach of the system. It then agreed there ought to be a new BAF risk related to 111 mobilisation. Finally, the committee reflected that it is starting to get a much broader view than just finance numbers, which is helping it to better understand the risks and opportunities.

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Planning Update

Philip Astell
14 May 2020

Aspiring to be ***better today*** and even ***better tomorrow***

Planning Update

South East Coast Ambulance Service NHS Foundation Trust

- COVID-19 interim guidance received 17 March 2020 – supersedes national planning
- Interim 4-month block contract (working assumption: will be extended for full year)
- Interim block contract based on 2019/20 billing plus inflation
- 'National top-up' ('Top-up 1' - see next slide) based on average other income and costs between November 2019 and January 2020 plus inflation = £5.2m
- 'Retrospective top-up' ('Top-up 2' - see next slide) to cover balance of costs required to achieve break even = £7.3m
- New 111 contract paused for 6 months
- CIPS target set at £5.5m (2.1% of operating expenditure) to break even
- Reserves of £2.0m and Contingency of £1.0m
- Reasonable Covid-19 expenditure to be reimbursed in full (£4.1m spend included in plan)

Planning Update – Top-Ups

South East Coast Ambulance Service NHS Foundation Trust

- **Top-Up 1**
  - Enhances block contract that is based on 2019/20 billing
  - 'National' top-up based on average other income and costs November 2019 to January 2020 plus inflation = £5.2m available from the outset
- **Top-Up 2**
  - Described as 'retrospective' top-up in the guidance
  - Will be assessed based on actual costs incurred less income received in 2020/21 in order to ensure break even in providers
  - Trust to maintain strong governance on spend (hence continuing focus on CIPs)
  - Planning assumption = £7.3m to be reimbursed retrospectively

Planning Update - CIPs

South East Coast Ambulance Service NHS Foundation Trust

- Planned CIPs £5.5m - 2.1% of operating expenditure
- CIP requirement remains to deliver value for money and improve productivity recurrently
- Target is allocated to directorates proportionately by deduction from directorate budgets
- Executive Directors are required to own their targets and apportion them against specific budgets within their directorate
- Finance Business Partners will support directors and budget holders to identify schemes
- The Operational Productivity Finance Group will identify high-level themes that present the best opportunities for improvement in operational productivity and spend
- CIP delivery will be monitored by monthly meetings with Finance and accountability maintained through regular Executive-led governance meetings

Planning Update - Analysis

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- The following slides summarise the proposed plan, showing a summary I&E, income sources, expenditure budgets by directorate and separate waterfalls of income and expenditure
- The income waterfall starts with the 2019/20 total income £245.2m, shows the effect of moving to a block and the two types of 'top-up'; 6 months' of additional 111 income from the new contract is added, projected Covid-19 reimbursement is shown and redundant income sources (including PSF) are removed to arrive at new total income of £ 261.9m
- Expenditure starts at £245.0m, expected inflation is added, as are planned cost pressures, notably Fleet leases, approved business cases, 111 costs and Covid-19 costs; the last two are largely matched by income. Cost pressures identified at budget setting are not included; these will have to be met from the Reserve of £2.0m; a contingency of £1.0m has also been set aside for material unknowns. CIPs of £5.5m are removed, resulting in a total cost of £261.9m

Summary I&E Plan

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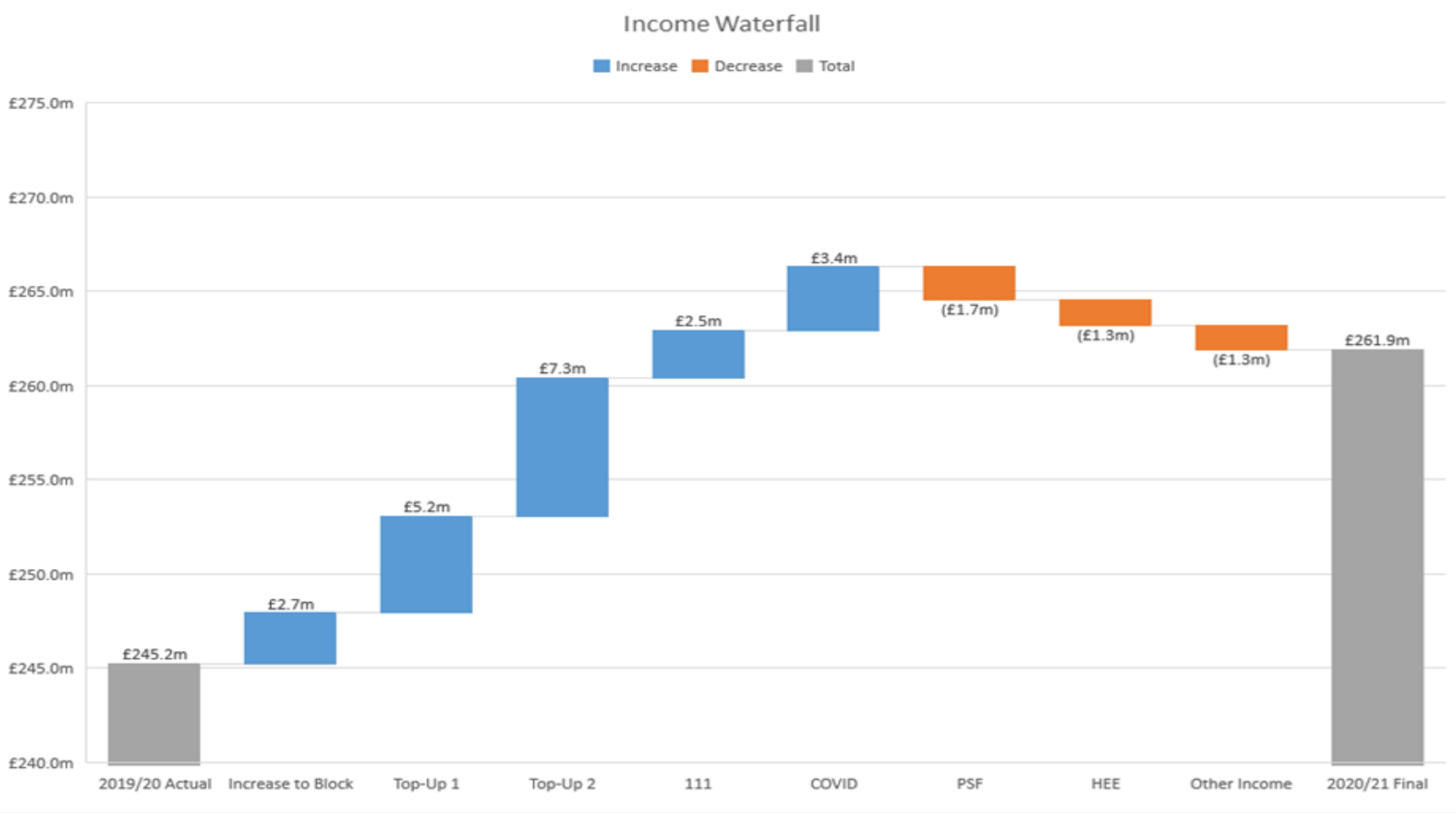
	2016/17	2017/18	2018/19	2019/20	2020/21
	£M Actual	£M Actual	£M Actual	£M Actual	£M Plan
Income	198.3	211.4	223.1	243.5	249.5
Top-up 1	0.0	0.0	0.0	0.0	5.2
Top-up 2	0.0	0.0	0.0	0.0	7.3
Income - Including Top-ups	**198.3**	**211.4**	**223.1**	**243.5**	**261.9**
Pay	147.4	143.2	158.9	180.3	193.8
Non-Pay	56.4	68.0	65.3	70.4	72.0
CIPs				(7.1)	(5.5)
Operating Expenditure	**203.8**	**211.2**	**224.2**	**243.6**	**260.3**
EBITDA	**(5.5)**	**0.2**	**(1.1)**	**(0.1)**	**1.6**
Financing Costs (excl. Imp)	1.6	1.6	1.0	1.4	1.6
Total Surplus/(Deficit) Excl. PSF/FRF	**(7.1)**	**(1.4)**	**(2.1)**	**(1.5)**	**0.0**
PSF/FRF Income	0.0	2.7	2.8	1.8	0.0
Total Surplus/(Deficit) Incl. PSF/FRF	**(7.1)**	**1.3**	**0.7**	**0.3**	**0.0**
Control Total / Trajectory		**(1.0)**	**(0.8)**	**0.1**	**0.0**

values shown subject to rounding

Plan – Income


Income Waterfall
Increase
Decrease
Total
£275.0m
£270.0m
£265.0m
£260.0m
£255.0m
£250.0m
£245.0m
£240.0m
£245.2m
£2.7m
£5.2m
£7.3m
£2.5m
£3.4m
(£1.7m)
(£1.3m)
(£1.3m)
£261.9m
2019/20 Actual
Increase to Block
Top-Up 1
Top-Up 2
111
COVID
PSF
HEE
Other Income
2020/21 Final

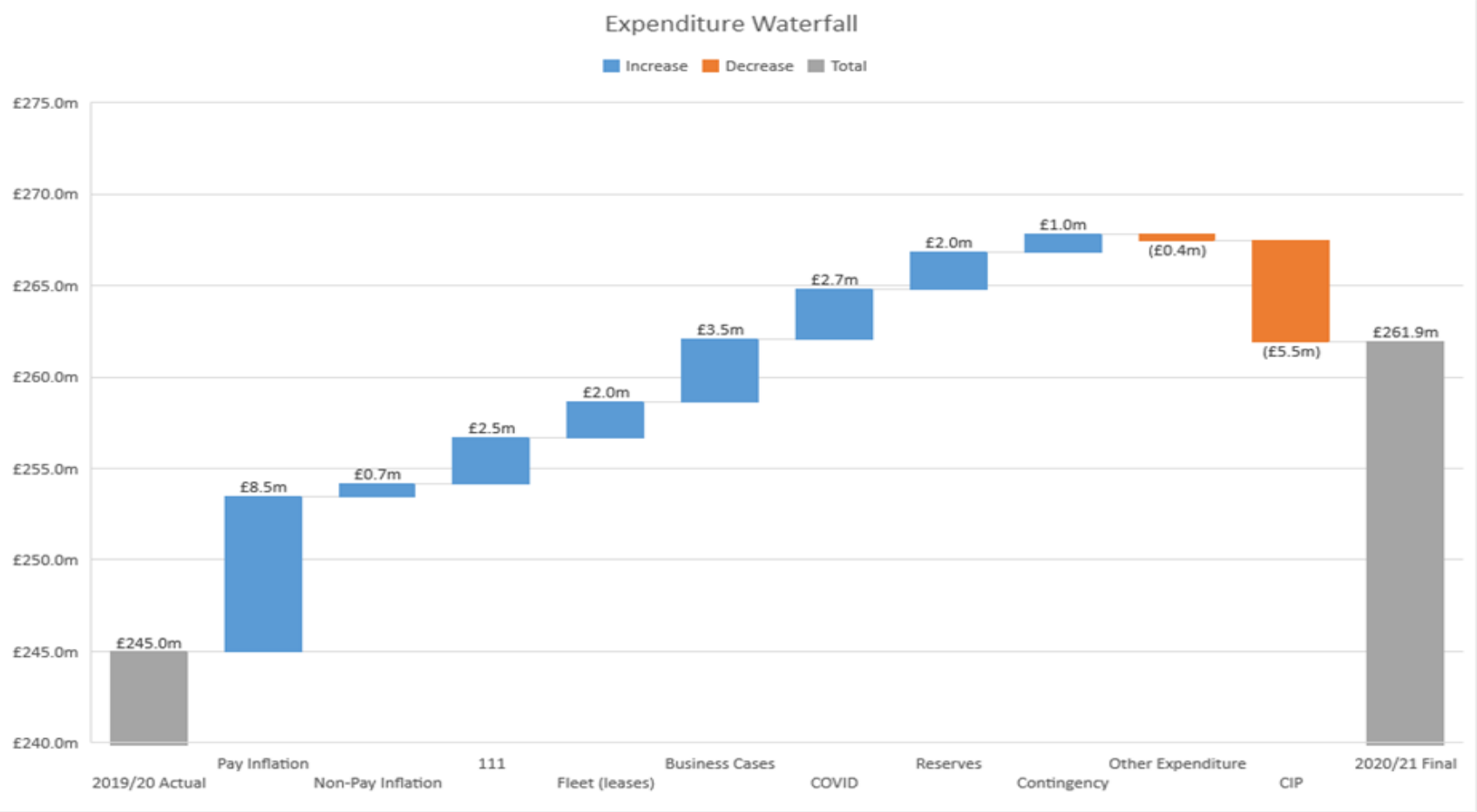
Income breakdown

	2019/20	2020/21
	£M Actual	£M Plan
999 - Block	222.6	225.2
Top Up 1	-	5.2
Top Up 2	-	7.3
111	13.4	15.9
NEONATAL	0.4	0.4
RTA	0.6	0.7
NARU	0.4	0.4
HEE	3.3	2.0
COVID	1.0	4.4
PSF	1.8	-
Other	1.8	0.4
Total Income	**245.2**	**261.9**

values shown subject to rounding

Plan - Expenditure

South East Coast Ambulance Service
NHS Foundation Trust



Expenditure by Directorate

South East Coast Ambulance Service NHS Foundation Trust

	2019/20	2020/21	2020/21	2020/21
	£M Actual	£M Plan Pre CIP	£M Plan CIP	£M Plan Post CIP
Chief Executive	3.2	3.5	(0.1)	3.4
Finance & Corporate Services	26.9	28.0	(0.7)	27.3
Human Resources	4.7	4.7	(0.1)	4.6
Medical	10.8	12.6	(0.3)	12.3
Operations	180.5	197.4	(4.3)	193.2
Quality and Safety	2.5	2.5	(0.1)	2.5
Strategy & Business Development	2.7	3.5	(0.0)	3.4
Reserves	0.0	3.0	0.0	3.0
Depreciation	12.1	10.6	0.0	10.6
Total Operating Expenditure	**243.6**	**265.8**	**(5.5)**	**260.3**
Financing Costs (excl. Imp)	1.4	1.6	0.0	1.6
Total Expenditure	**245.0**	**267.4**	**(5.5)**	**261.9**

values shown subject to rounding

Frontline Operations Costs per Unit hour

NHS
South East Coast Ambulance Service
NHS Foundation Trust

	Unit Hours	Pay Cost £	Cost per Productive Hour £
2020/21 Budget			
Staff in Post	2,938,575	90,389,944	*30.76*
Overtime	254,972	6,412,809	*25.15*
PAPS	174,939	6,810,367	*38.93*
Total 2020/21 Budget	3,368,485	103,613,120	*30.76*
2019/20 Actual			
Staff in Post	2,627,270	82,306,326	*31.33*
Overtime	251,809	6,729,204	*26.72*
PAPS	314,326	11,197,315	*35.62*
Total 2019/20 Actual	3,193,404	100,232,845	*31.39*

Unit hours are net of abstracted hours. Abstraction assumed in the 2020/21 budget is 28.6% (2019/20 actual: 38.3%)

Capital – Five Year Plan

	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000
BAU Estates	925	500	500	500	500
Strategic Estates	7,761	31,461	9,000	6,000	8,000
IT	2,930	5,150	800	800	2,150
Fleet	5,657	4,667	2,737	3,512	2,352
Clinical Operations	1,237	592	120	120	120
Total Purchased	**18,510**	**42,370**	**13,157**	**10,932**	**13,122**
Finance Leases	0	10,213	7,575	8,334	6,336
Total Capital Plan	**18,510**	**52,583**	**20,732**	**19,266**	**19,458**

Cash

- Cash projection based on March 2020 year-end balance of £28.3m rising to £48.7m by end of Q1 dropping back to £22.1m by March 2021.
  - Block contract income assumed for 999/111 receipts with accelerated receipts for April to July received 1 April to 15 June
  - In July no block income is received then resumes in August and monthly thereafter
  - Top Up and Covid-19 reimbursement assumed to be in the second month following submission
  - £3.0m of Wave 4 cash receipts is assumed
  - No disposal of Trust properties assumed

Risks

- There is a risk that 'Top-Up 2' will not fully cover the I&E shortfall if the Trust's governance processes and cost control measures are deemed insufficient to ensure value for money
- There is a risk that the CIP target will not be met, increasing reliance on 'Top-up 2'
- There is a risk that CIPs will not be delivered recurrently, worsening the Trust's underlying I&E deficit
- There is a risk that not all Covid-19 related costs are reimbursed

Conclusion

- Planning arrangements for 2020/21 are exceptional, driven by the Covid-19 crisis
- Some element of financial risk is removed as costs are underwritten from the Centre; there remains a requirement for the Trust to exercise strong financial governance and ensure value for money in its use of resources
- The Trust Board is asked to note the planning proposals for 2020/21 and the associated risks

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	11/20

Name of meeting	Trust Board
Date	28 May 2020
Name of paper	Learning from Deaths Report
Responsible Executive	Fionna Moore, Executive Medical Director
Author	Richard Quirk, Deputy Medical Director
Synopsis	NHS Improvement/England mandated that Ambulance NHS Trusts must start reporting learning from deaths in their care from Quarter 4 of 2019/20. The first mandated board report, reporting on the Quarter 4 period, was due to be published at the June Trust Board. 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.
Recommendations, decisions or actions sought	The Board is asked to review the information within this paper for assurance purposes

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**

1. Introduction

1.1. When deaths occur in our care, 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 (carers/relatives). This review of care should then improve future care. The intention is that if carers, relatives, staff or other organisations raise concerns about the care of a patient at the time of their death, they will be fully involved in any review.

1.2. NHS Improvement/England mandated that Ambulance NHS Trusts must start reporting learning from deaths in their care from Quarter 4 of 2019/20. The first mandated board report, reporting on the Quarter 4 period, was due to be published at the June Trust Board.

1.3. 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.

1.4. There are additional 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 in people with serious mental health conditions to their mental health trust and a requirement to report all maternity deaths to the Healthcare Safety Investigations Branch (HSIB).

2. Covid-19 Pandemic

2.1. The introduction of the electronic patient care record (ePCR) has enabled the organisation to collate and assess data on people who die in our care (defined as from the time the first call is made through to the 24 hours after the care is transferred to another provider). This data is extracted monthly.

2.2. This report was intended to review the care of those patients who had died in Jan-Mar 2020, however following the Covid-19 pandemic business continuity incident, staff were diverted to responding to the pandemic response. It has therefore only been possible to analyse the January 2020 data. Data from February and March 2020 will be reviewed retrospectively when normal corporate business resumes.

3. Overview of January 2020 mortality data

3.1. In January 2020 there were 661 recorded deaths in our Trust. 276 were female and 376 were male (sex was not recorded or unknown in 9 cases).

3.2. 10 children (<18 yrs old) died during this period.

3.3. Table 1 shows the breakdown of the number of people who died in each age bracket:

Age Range	Number of patients who died
0-18	10
18 – 29	12
30 – 39	16
40 – 49	22
40 – 59	47
60 – 69	80
70 - 79	114
80 – 89	125
90 – 99	63
100+	4
Age unknown	168

3.4. Table 2 shows the numbers of patients who had an advance plan/DNACPR in place, those who were dead on arrival and those who we attempted resuscitation:

Care Plan in place	Number of patients who died	Percentage (%)
Advance Care Plan	2	0.3
Professional Decision not to Resuscitate	24	3.6
Do Not Attempt CPR order in place	120	18
Resuscitation attempted	235	35.6
Dead on arrival	279	42.2

3.6. Table 3 shows the categorisation of the call on our Computer Aided Dispatch (CAD) system when the initial call was made to SECAmb for all those who have died:

Categorisation of Call	Number of patients who have died	Percentage (%) (approx.)
Arrest/Peri-arrest	405	63
Unconscious – noisy breathing	91	14
Unconscious – normal breathing	28	4
Breathing Problems	25	4
Medical Condition	15	2
Concern for welfare	14	2
NHS 111 referral	12	2
Stroke	11	2
Fitting	7	~
Heath Care Professional Call	7	~
Hanging/Suicide	7	~
Chest/Upper Back Pain	6	~
Death Expected – over 18	4	~
Collapse/Breathing Normal	3	~
Bleeding	2	~
Choking	1	~

4. Review Process

4.1. In accordance with the new Trust Learning from Deaths policy, 20 random cases have been selected to be reviewed. 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 20 cases.

4.2. The original intention was for local clinical governance leads in each OU to undertake a multi-disciplinary review of the randomly selected death. Phase two of the operational restructure is not yet complete and so the Deputy Medical Director undertook the reviews. Ideally in the future the reviews would be undertaken by a small group of different professionals.

5. Two cases reviewed following concerns

5.1. During this reporting period, two cases were referred to the Learning from Deaths process for a Structured Judgemental Review from the Serious Incident Group.

5.2. The first case was an 85-year-old lady who had fallen at home and was found by her carer and put back to her bed. This lady then called her care line for an ambulance to check her shoulder as it was painful. We performed a thorough assessment and she was found to have normal observations, bruising to the left of her face and lower limbs but was able to move all her limbs independently. She said she was tired and wanted to stay in bed. The crew liaised with the patient's next of kin and encouraged her to call her GP to assess her leg bruising. The crew left a comprehensively completed form explaining to the patient what they should do if they feel worse. The crew then discharged the patient at scene. The patient subsequently died of a brain haemorrhage within 48 hours of our attendance. The patient was not on any blood thinning medication. The SJR found that the care of this patient was very thorough, and the crew made the correct decisions at the time based on the information that they had. The Serious Incident Group asked for a review of whether an ECG should have been performed, but it was concluded that this would not have made a difference to the outcome.

5.3. The second case was a 76-year-old gentleman who died. A complaint was received by the medical director of a hospice in our region and the complaint was reviewed at Serious Incident Review Group. SIG asked that Learning from Deaths undertake a review of care. This gentleman had Motor Neurone Disease and was under the care of the Hospice. The patient had a 'Do Not Attempt Cardio-Pulmonary Resuscitation' completed. Unfortunately, the call handler did not check IBIS (the software system which stores patient's DNACPR forms in the control room) and so the crew were not aware of the DNACPR on arriving at scene. The SJR was completed and found that when the crew arrived, the wife explained to the crew that there was not a DNACPR in situ and that she wanted the crew to attempt resuscitation. The review found that the care provided by the crew was very good. Although the IBIS system should have been checked by control, the care of this patient was not compromised as the crew followed the information given by the wife at the time (which was that there was not a DNACPR in place). The learning from this review has been a reminder to control staff about the need to check IBIS for patients in peri/arrest.

6. Learning from the random review of 20 deaths

6.1. In all 20 reviews the care of the patient was good or better. In all 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. Any delays in attending the patient were small (compared to the target performance times) and none of the delays 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. For those patients where the crew decided not to attempt resuscitation, but there was no advance care plan or DNACPR, I believe we need to have clearer guidance on how and when crews can make these decisions. This is not because I believe that they have made the wrong decisions in the cases I have reviewed, but more to protect staff, should their decision get challenged at a later time.

6.6. More training and guidance needs to be provided on the plethora of documentation and forms which may present to a crew on arrival at an arrest/peri-arrest. It is clear from the reviews that so many different scenarios may arise ranging from relatives asking the crew not to resuscitate their relatives to Lasting Power of Attorney's giving a view on resuscitation without any paperwork to confirm that they are indeed the LPA. The End of Life Care team would be a useful resource in creating some case studies for crews to learn about these very challenging situations where they are expected to make split second decisions on whether to resuscitate or not.

6.7. 6.7 From the way that we collect the data on deaths, we need a clearer process of identifying 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, but we currently don't have an automatic recognition system in the software to advise us of these deaths.

6.8. 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.

6.9. In the majority of reviews undertaken, the death was categorised as 'unexpected' and the Police were automatically called. This, in some cases, leads to the unnecessary use of Police resources and unnecessary lengthening of on-scene time waiting for the Police. It is not clear why the term 'unexpected' death has been used in a number of the cases reviewed.

7. Conclusion

7.1. I have not identified any deaths where SECAmb have caused harm or contributed to the death. I have identified many examples of very good compassionate care.

8. Actions resulting from the review of deaths from January 2020

8.1. End of Life Care team to create learning opportunities for crews regarding DNACPR, Respect forms, Lasting Power of Attorney etc scenarios.

8.2. Learning from Deaths Group to oversee a review of procedure and policy to support crews when they make a decision not to start resuscitation.

8.3. Learning from Deaths Group to oversee a review of the definitions and procedures associated with ‘unexpected’ and ‘expected deaths’ particularly with reference to Police involvement.

Dr Richard Quirk
Deputy Medical Director
May 2020

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Health and Safety
Annual Report 2019/2020

Amjad Nazir, Head of Health & Safety

Board Commitment to Health & Safety

The organisation is governed by a Trust Board. The Board of Directors are responsible for all aspects of the performance of the Trust.

The Board is made up of both Executives and Independent Non-Executive Directors. The Independent Non-Executive Directors hold the Executives to account and are accountable to the members, through the Council of Governors**.**

Currently all our board of Directors have completed the (IOSH) Institution of Occupational Safety & Health dedicated course for Executives and Directors. The board are fully committed to Health & Safety and support on-going improvements.

Improvement Plan

In October 2018, an improvement plan was developed and implemented. The plan focused on the implementation of a robust Health & Safety management system. This is a comprehensive management system designed to manage safety elements in the workplace.

Amjad Nazir, Head of Health & Safety reported on progress for the improvement plan every 2 weeks. The monitoring group responsible for this was the Quality and Compliance Steering Group. The improvement plan was successfully completed on time and approved in July 2019 by the Quality Compliance Steering Group.

Diagram below shows each component from the improvement plan.

Amjad Nazir, Head of Health & Safety

Improvement plan objectives

- Objective 1) Recruitment of a new Health & Safety Management team.
- Objective 2) Develop & implement a new Health & Safety audit programme.
- Objective 3) Review and create all relevant Health & Safety policies and procedures.
- Objective 4) Develop and agree an organisation wide Health & Safety training programme.
- Objective 5) Create and implement a governance and communications network that actively supports health & safety compliance within the trust.
- Objective 6) Develop and agree a revised approach for health & safety risk assessments within Fleet Services.
- Objective 7) Develop and implement a suite of generic Health & Safety risk assessments.
- Objective 8) Develop and agree a revised Statutory PPM (Planned Preventative Maintenance) schedule process within Estates and Fleet Services.

The successful completion of the improvement plan has been a significant piece of work undertaken by the Health and Safety team which has improved our compliance with Health and Safety legislation and rapidly embedded a Health and Safety culture at all levels of the Trust. The improvements have created a solid foundation to continue building our Health and Safety management system. The management system is becoming an integral part of good management rather than a stand-alone system. Furthermore, this supports our longer-term goal to implement ISO 45001 for Occupational Health and Safety Management. ISO 45001 is designed to reduce work-related injuries, ill-health and to provide safe and healthy workplaces.

Fire Safety

Compliance with The Regulatory Reform (Fire Safety) Order 2005 is monitored at the Fire Safety sub-group and Health and Safety Committee. During the last financial year significant fire safety improvements were made to our sites following recommendations from fire safety risk assessments. The Trust shall continue making improvements and specifically focusing on fire evacuations at each Trust site.

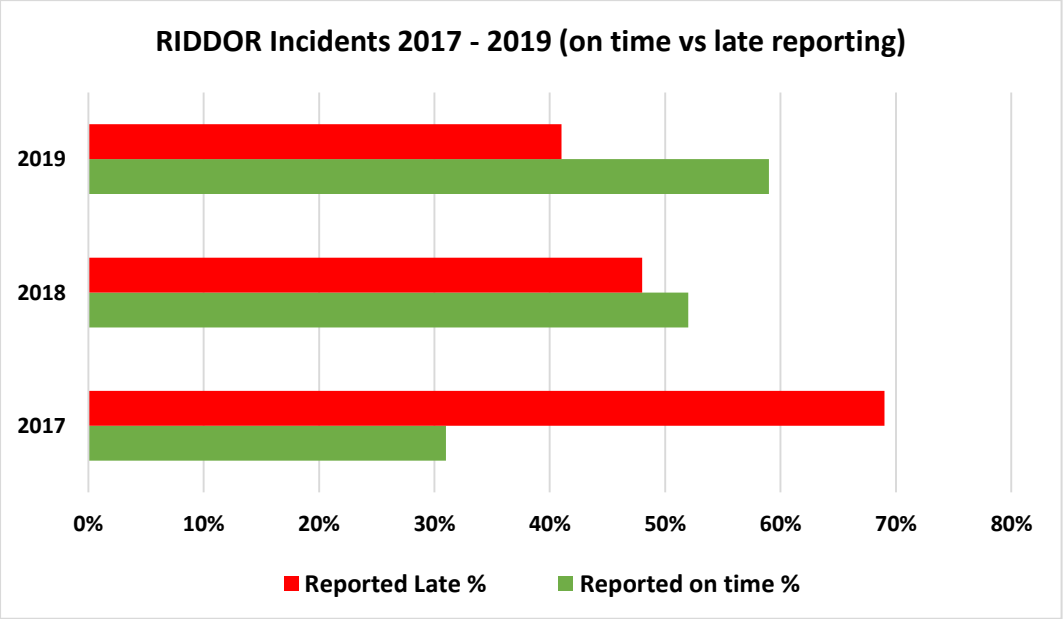
Amjad Nazir, Head of Health & Safety

RIDDOR

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. The regulation requires employers to report certain workplace accidents, occupational diseases and specified dangerous occurrences. The formal reporting is made by the employer to the Health & Safety Executive. Accidents resulting in over-seven-day incapacitation of an employee, require notification to the enforcing authority within 15 days of the incident.

During 2019/2020 the organisation reported **80** RIDDOR incidents and **59%** of these incidents were reported on-time to the Health & Safety Executive. This is a **7%** improvement in compliance when comparing to the previous year.

The data chart below highlights on-time RIDDOR reporting improvements since 2017.



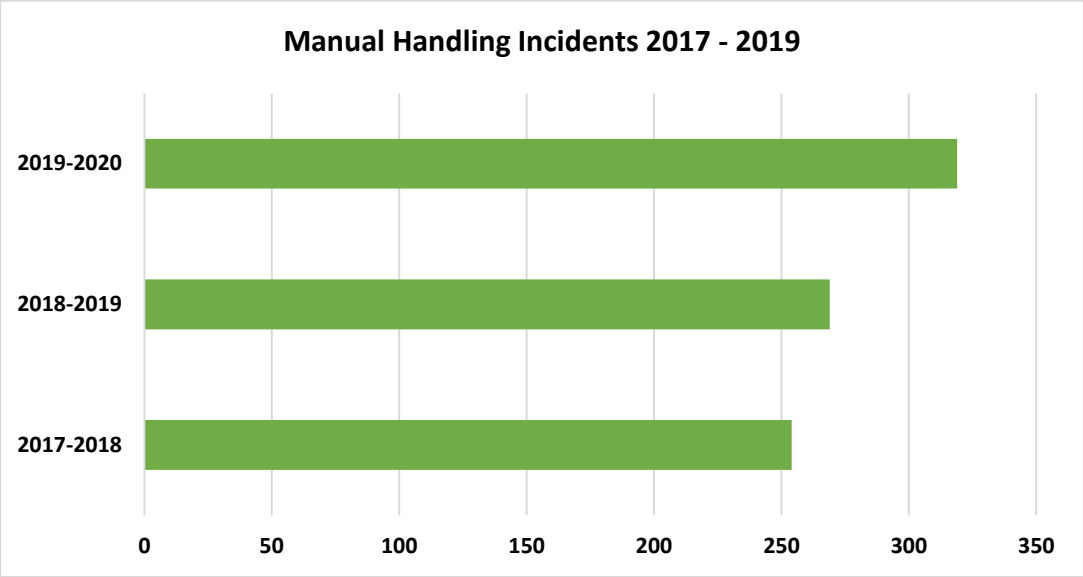
The Health & Safety team continue to raise the importance of on time RIDDOR reporting within the trust. Early trigger points have been setup within Datix (incident reporting software) for potential RIDDOR incidents which allows the Health & Safety team to screen each potential incident further.

Amjad Nazir, Head of Health & Safety

Manual Handling Incidents

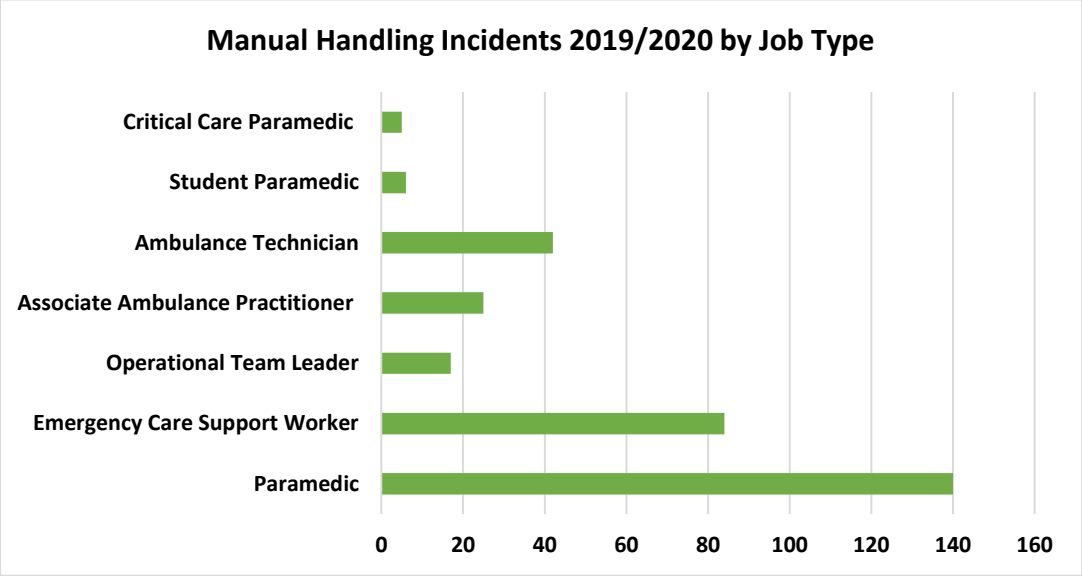
During 2019/2020 staff reported **319** manual handling incidents. This is an increase of **50** incidents when comparing to the previous year. The trust employed new staff during the 2019/2020 period. Furthermore, we are seeing improvements to our reporting culture within the trust.

The data chart below captures manual handling incidents from 2017-2019.



Paramedics reported the highest amount of manual handling incidents during the 2019/2020 period.

The data chart below captures each job type for reported manual handling incidents.

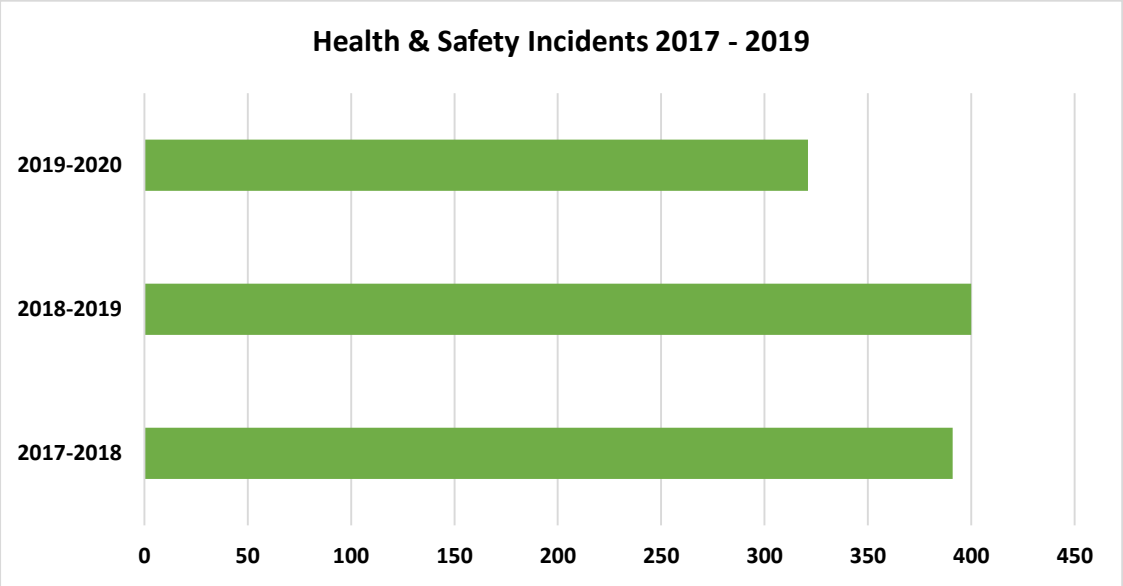


Amjad Nazir, Head of Health & Safety

Health & Safety Incidents

During 2019/2020 staff reported **321** Health & Safety Incidents. This is a decrease of **79** incidents when comparing to the previous year.

The data chart below captures Health & Safety incidents from 2017-2019.



Health & Safety Audits

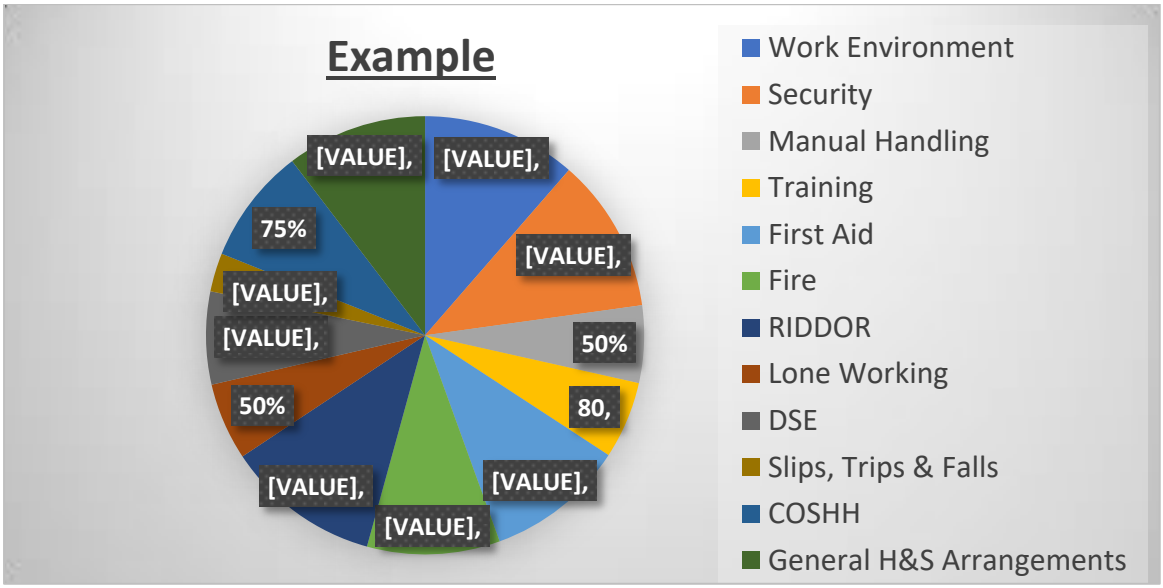
The Health and Safety Executive define safety audits as: “The collection of independent information on the efficiency, effectiveness and reliability of the total health and safety management system and drawing up plans for corrective action.” Safety audits are an essential part of a successful organisation.

Amjad Nazir, Head of Health & Safety

Amjad Nazir, Head of Health & Safety created a bespoke Health & Safety audit tool which measures compliance across 12 different categories as listed below. When an audit is completed the software generates an overall compliance score.

Audit categories

1. General Health & Safety arrangements at department level
2. Slips, Trips & Falls
3. DSE (Display Screen Equipment)
4. RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)
5. Fire Safety
6. First Aid
7. Training (Health & Safety related)
8. Manual Handling
9. Security (site related)
10. Lone Working
11. COSHH (Control of Substances Hazardous to Health)
12. Work Environment (PAT testing, condition of working environment etc.)



The annual Health and Safety audit programme was successfully implemented in January 2019. The trust Health & Safety Managers undertake the audits on a monthly basis across their regional areas of responsibility.

We expected to see a variation in year one compliance figures as our previous Health & Safety resources and management system were limited.

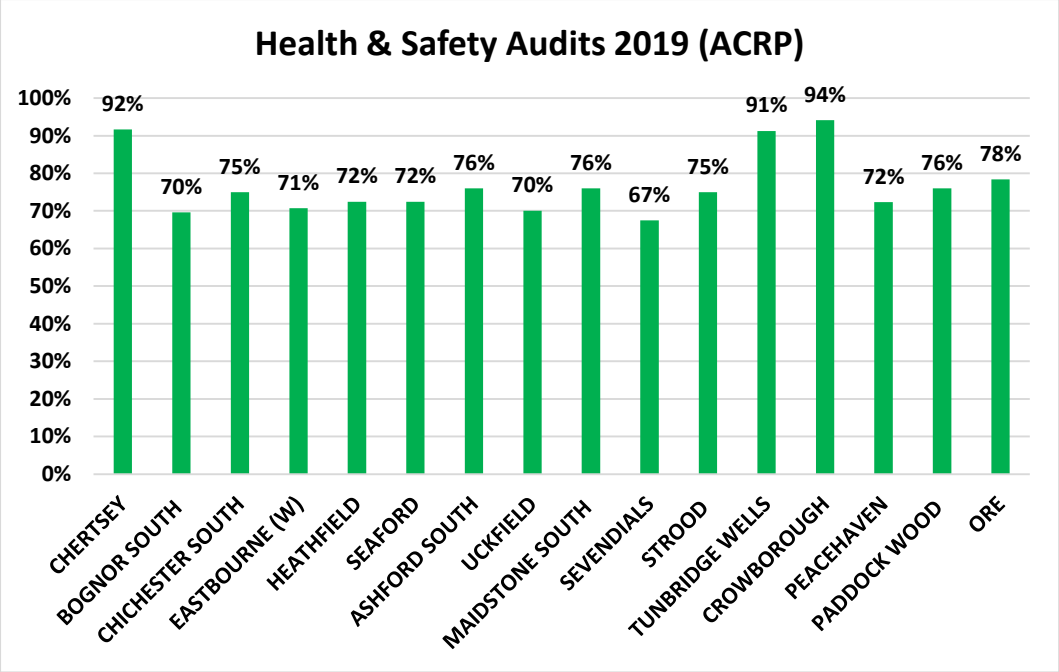
Non-compliance audit categorys are transferred onto an action plan which is monitored for progress at regional Health & Safety sub-groups. The organisation chart below is the trust Health & Safety Committee and sub-group structure.

Audit Results

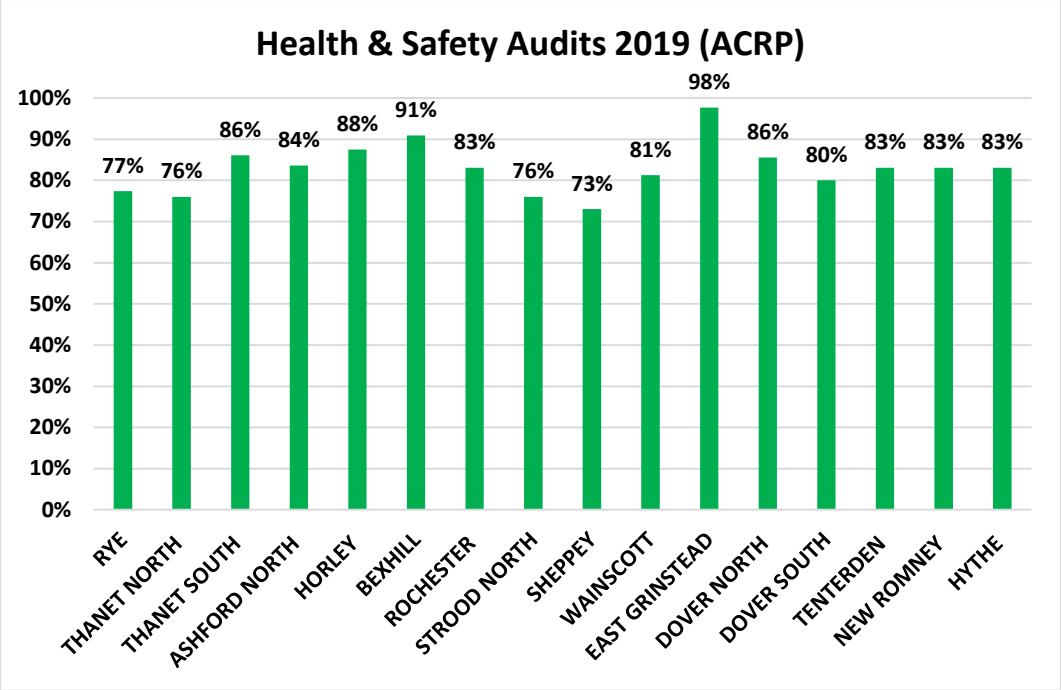
(ACRP) - Ambulance Community Response Post; a small base with facilities, where ambulance crews can wait between calls.

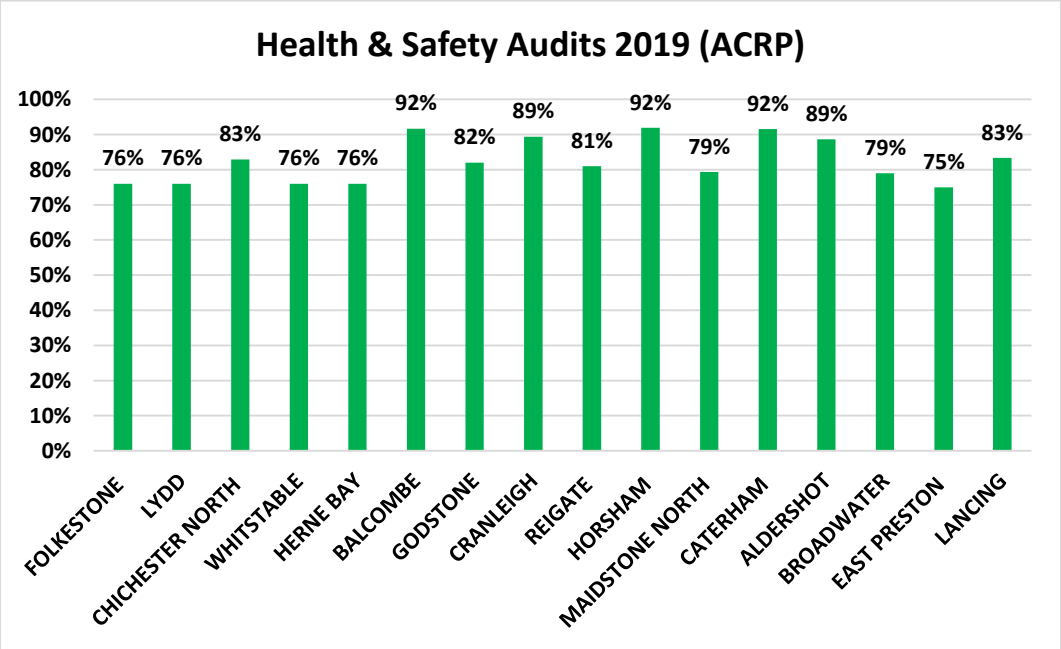
During January to December 2019 (**66**) Health & Safety audits were undertaken at ACRP sites. The overall average compliance figure for ACRP audits was **77%**. The three lowest scoring measurable categories are listed below as an average value.

- Lone Working **41%**
- Manual Handling **47%**
- Security **65%**

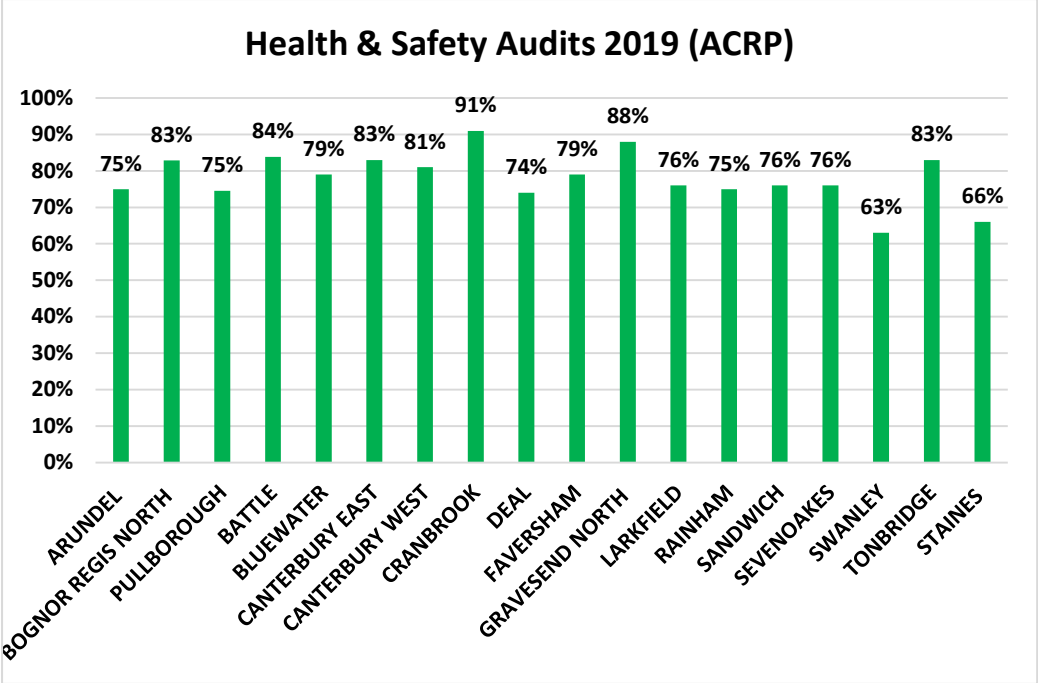


Amjad Nazir, Head of Health & Safety





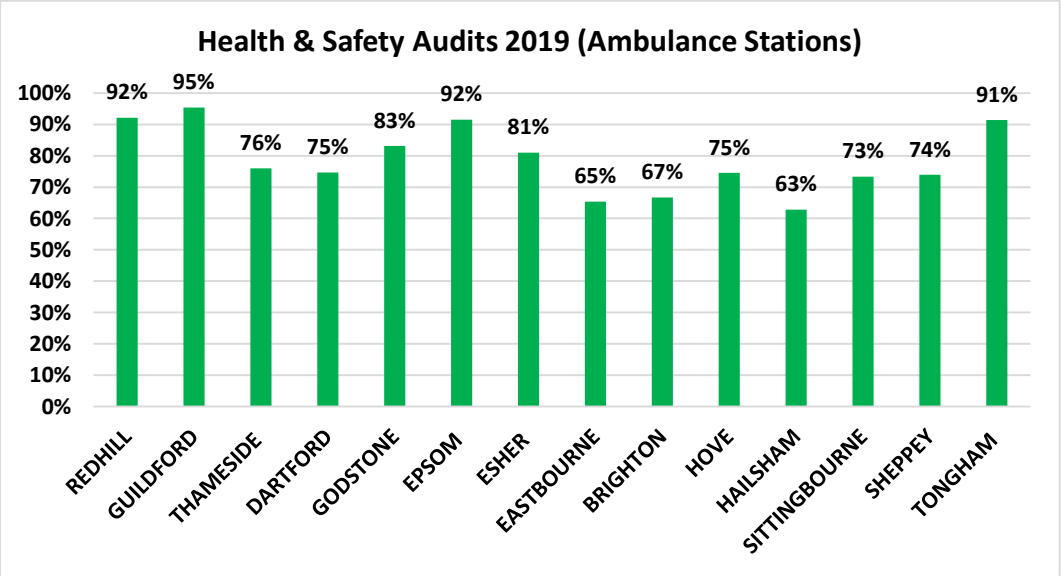
Amjad Nazir, Head of Health & Safety



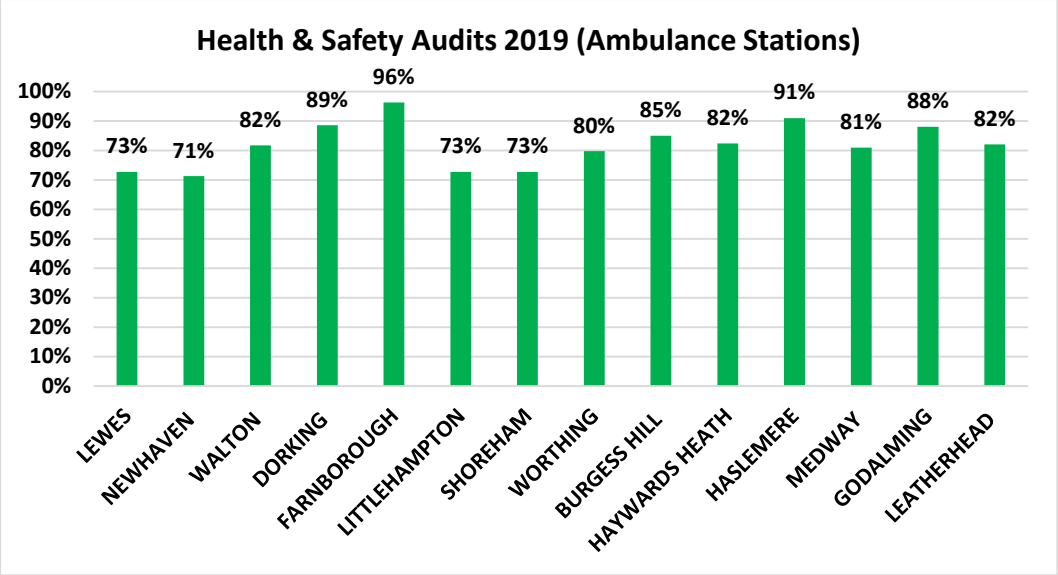
(Ambulance Stations) - Where ambulance crews begin & end shifts

During January to December 2019 (**28**) Health & Safety audits were undertaken at Ambulance Stations across the trust. The overall average compliance figure for Ambulance Station audits was **75%**. The three lowest scoring measurable categories are listed below as an average value.

- Lone Working **35%**
- Manual Handling **45%**
- Slips, Trips and Falls **58%**



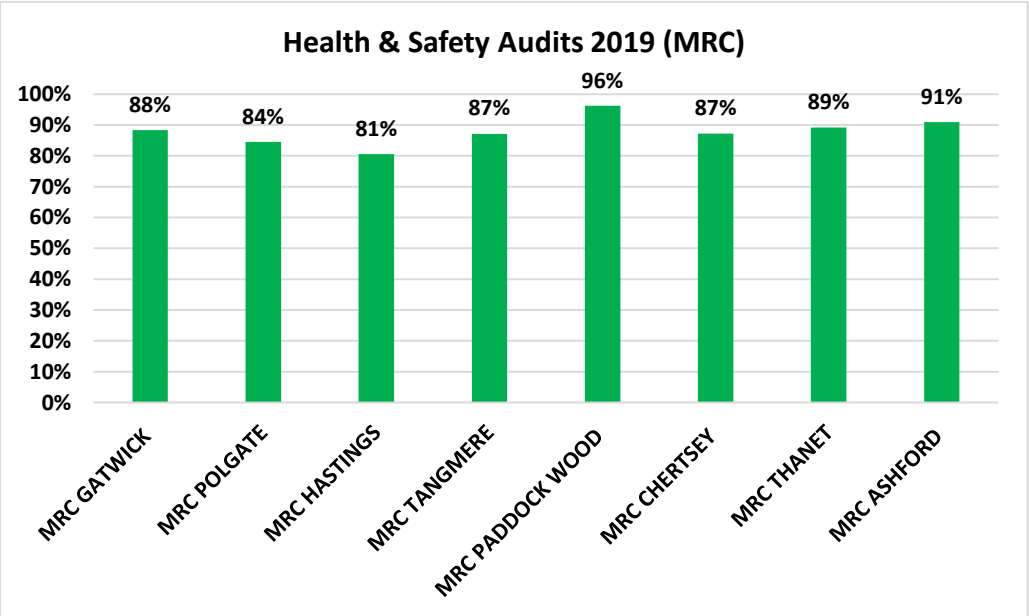
Amjad Nazir, Head of Health & Safety



(MRC) - Make Ready Centre; a large depot where ambulance crews start & end shifts & where vehicles are cleaned, maintained & re-stocked.

During January to December 2019 (**8**) Health & Safety audits were undertaken at MRC sites across the trust. The overall average compliance figure for MRC audits was **85%**. The three lowest scoring measurable categories are listed below as an average value.

- Lone Working **63%**
- Manual Handling **74%**
- Slips, Trips and Falls **75%**

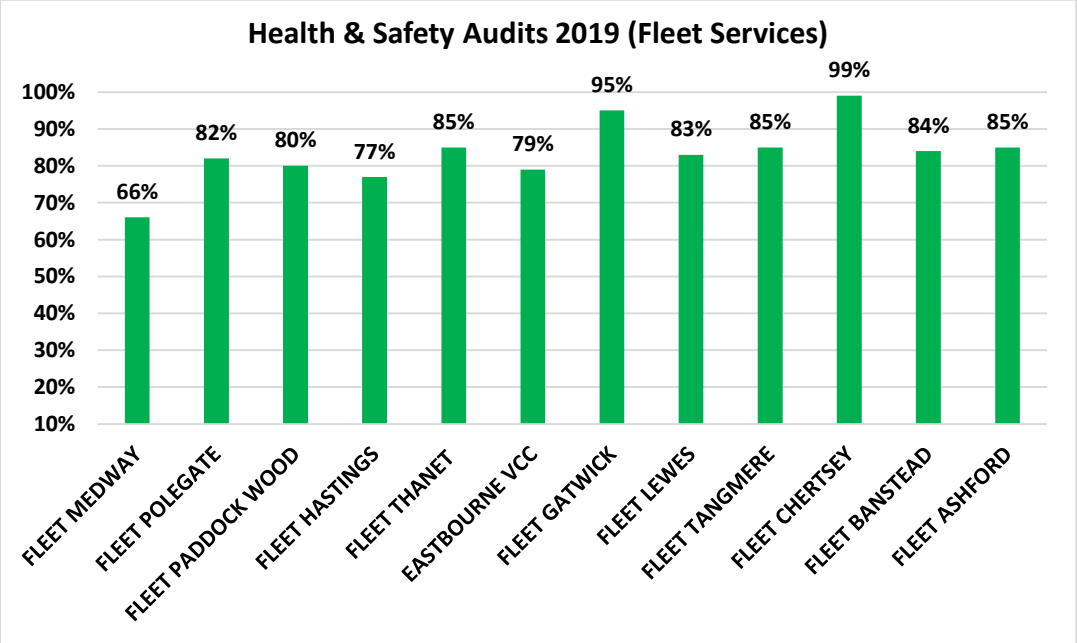


Amjad Nazir, Head of Health & Safety

Fleet Services - (Vehicle Maintenance Centre)

During January to December 2019 (**12**) Health & Safety audits were undertaken at Fleet sites across the trust. The overall average compliance figure for fleet audits was **81%**. The three lowest scoring measurable categories are listed below as an average value.

- Display Screen Equipment **47%**
- Slips, Trips and Falls **70%**
- RIDDOR Awareness **80%**



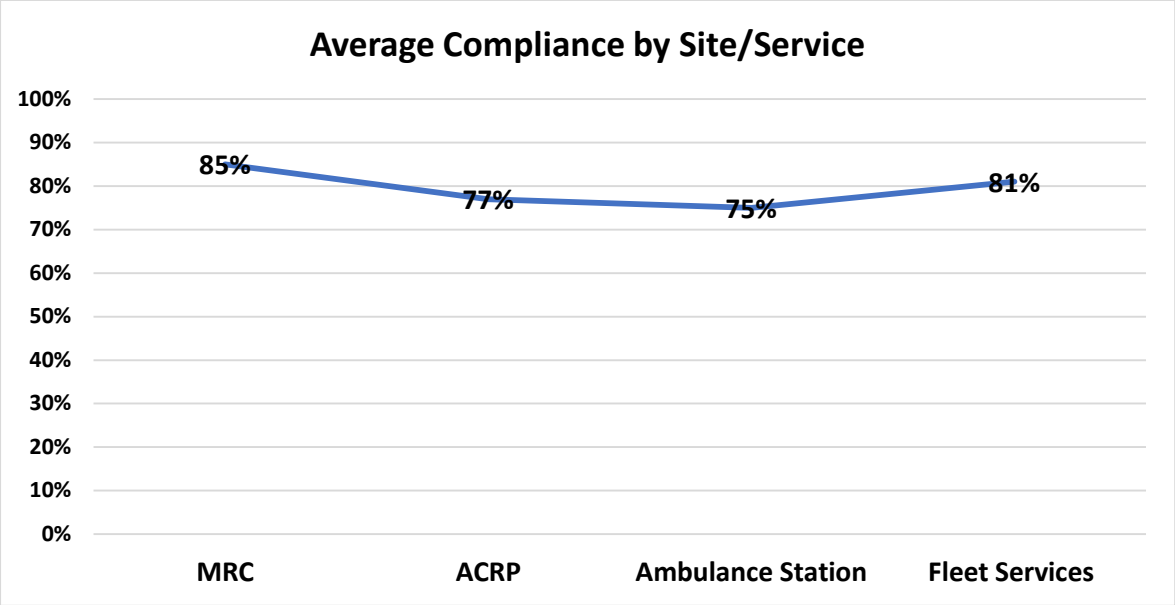
Amjad Nazir, Head of Health & Safety

Data Analysis

MRC sites achieved the highest overall average compliance figure of 85%. However, MRC sites had the lowest number of sites in comparison to the other sites and services audited. Ambulance stations achieved the lowest overall average compliance figure of 75% with 28 sites audited.

Fleet services were the second highest scoring with 12 sites audited achieving an overall average compliance figure of 81%.

ACRP sites received the highest number of audits with 66 sites audited achieving an overall average compliance of 77%.



Health and Safety priorities for 2020/2021

Additional Health & Safety Training

During 2019/2020 the Health & Safety team delivered an in-house trial course similar to the IOSH Managing Safely course. The course was delivered to Managers on a block release basis over 3 days. The feedback from the staff was positive and they felt they were given the correct training to allow them to undertake their Health & Safety duties. The Health & Safety team are undertaking a training needs analysis to identify how many staff require this advance level of training. The team will then prepare an options paper and review the merits of becoming an accredited training centre for Health & Safety.

Continue building our Health & Safety Culture

The Health & Safety team have been developing working relationships with our workforce to embed a positive safety culture and will continue to do this via our Health & Safety sub-groups.

Amjad Nazir, Head of Health & Safety

Annual Health & Safety audits

The Health & Safety team will continue with the annual audit programme. This has proven to be useful as it focuses on highlighting good practice and areas of improvement.

Generic Risk Assessments

The team will continue building our suite of generic Health & Safety risk assessments which can be used by the workforce with local adaption. The risk assessments are produced in collaboration with subject matter experts.

Networking at National Level

The trust is committed to networking with the national ambulance group for Health & Safety. This is a good forum to share good practice and ideas of innovation that will further improve the safety of our staff.

Amjad Nazir, Head of Health & Safety

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	

Name of meeting	Executive Management Board
Date	13th May 2020
Name of paper	Safeguarding Annual Report
Responsible Executive	Bethan Haskins
Author	Philip Tremewan, Nurse Consultant for Safeguarding
Synopsis	The Annual Report seeks provide assurance to patients, service users and key stakeholders that South East Coast Ambulance Service NHS Foundation Trust is discharging its Safeguarding responsibilities. The report provides evidence on how these responsibilities were discharged and highlights priority areas for Safeguarding during 2020/21.
Recommendations, decisions or actions sought	The Executive Management Board is asked to recommend approval of the report to the Quality & Patient Safety 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).	**Yes/<u>No</u>**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Safeguarding Annual Report 2019/20

Authors: Philip Tremewan, Nurse Consultant for Safeguarding

Nursing and Quality Directorate
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Contents

1. Introduction

Throughout 2019/20 South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has striven to meet its statutory responsibilities in the care and protection of patients of all ages. This report demonstrates to the Trust Board and external agencies how SECAmb discharges these statutory duties and the report offers assurance that the Trust has effective systems and processes in place to safeguard patients who access our services. We continue to deliver a high-quality credible service to patients and families, whilst reflecting continually on areas for learning and improvement.

2019/20 has been dominated by two considerable challenges that have impacted on the majority of departments across the Trust. EU Exit and Covid-19 global pandemic have significantly tested SECAmb's wider safeguarding function; the Safeguarding Team are confident however that diligent business continuity planning has ensured that vulnerable children, young people and adults at risk have been protected and supported during these challenging times.

The existing statute which continues to underpin the work of colleagues who support healthcare practitioners delivering services to children is in line with Working Together to Safeguard Children 2015 guidance and Section 11 of the 2004 Children Act. All staff have a statutory responsibility to safeguard and protect the children and families who access our care.

The legislation which frames the work of colleagues in adults' services is influenced by the introduction of the 2015 Care Act. The introduction of The Care Act put adult safeguarding on a statutory footing for the first time in addition to embracing the principle that "the person knows best". In addition our work to safeguard adults is informed by The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007.

SECAmb acknowledges that safeguarding is everyone's business and strives to support the Department of Health's six principles of Safeguarding:

- **Empowerment** – People feel safe and in control, give consent to decisions and actions about them. They should be helped to manage risk of harm either to themselves.
- **Protection** – Support and help for those adults who are vulnerable and most at risk of harm
- **Prevention** – Working on the basis that it is better to take action before harm happens
- **Proportionality** – Responding in line with the risks and the minimum necessary to protect from harm or manage risks
- **Partnership** – Working together to prevent or respond to incidents of abuse
- **Accountability** – Focusing on transparency with regard to decision making.

The Annual Report provides the readers with the following detail:

- An overview of the national and local context of safeguarding
- An overview of the areas of practice included in safeguarding within the Trust
- An update on safeguarding activity within 2019/20
- Assurance that the Trust is meeting its statutory obligations and the required national standards with regard to safeguarding

- An overview of any significant issues or risks with regard to safeguarding and the actions being taken to mitigate these
- A briefing on the challenges and work to be addressed by the safeguarding teams in 2019/20.

2. Governance and Commitment to Safeguarding

As an NHS Service provider SECAmb is required to demonstrate that they have safeguarding leadership and commitment at all levels within the organisation and that we are fully engaged in support of local accountability and assurance structures, via the Safeguarding Boards across Kent, Medway, Surrey, Sussex and NE Hampshire. Most importantly, SECAmb reinforces the principle that safeguarding is everybody's responsibility and develops a culture of continuous learning and improvement to promote the safety and welfare of adults at risk, children and young people and looked after children.

SECAmb ensures that its senior management is committed to safeguarding demonstrated at Executive and Non-Executive level at Trust Board. The non-executive director (NED) who is chair of the Trust's Quality and Patient Safety (QPS) Committee is the also the NED lead for safeguarding. Safeguarding is always included in the annual cycle of business and comes within the scope of influence and scrutiny of the QPS Committee. The Trust have robust governance structures and systems in place in line with Working Together to Safeguard Children 2015 and the Care Act 2014.

Evidence of SECAmb's commitment to safeguarding includes clear statements on the Trust's website demonstrating how our services safeguards the welfare of children, young people and adults. The Trust's Five-Year Strategic Plan for 2017-2022, refreshed in January 2019 also recognises how safeguarding and patient safety underpins its core services.

The Trust's Safeguarding function sits within the portfolio of the Nursing and Quality Directorate and is led by the Executive Director for Nursing & Quality. The work of the department is scrutinised at the Safeguarding Sub-Group (SSG) meeting jointly chaired by the Nurse Consultant for Safeguarding and Safeguarding Lead. Terms of Reference for the group highlights the required core membership and includes senior roles and individuals from a wide range of operational, educational, HR, staff partnership and commissioning colleagues.

2019/20 evidenced a continued investment by the Trust in its safeguarding function. During the year a new Safeguarding Lead was appointed to lead on operational safeguarding across the Trust and support the Nurse Consultant for Safeguarding and Director of Nursing & Quality in delivering high standards of care and experience to patients. At the time of writing the total skill mix of the Safeguarding Team at SECAmb is:

Job Role	Band	WTE
Nurse Consultant for Safeguarding	8b	1
Safeguarding Lead	8a	1
Safeguarding Practitioners	6	2
Safeguarding Coordinators	5	3.2

The total investment allows for greater focus on the Trust's internal and external safeguarding responsibilities. The focus includes improved representation at Safeguarding Adults Boards, Safeguarding Children's Partnerships and child death review panels across Kent, Surrey and Sussex. Additionally, during 2019-20 there had been continued improvement in the Trust's approach to safeguarding training, including bespoke face to face training for NHS111 and EOC staff.

Standing agenda items at each SSG meeting provide assurances to the Trust Board and Executive Team. These include a review of the Trust's Safeguarding policies and procedures, departmental workplan, safeguarding risks and monitoring progress against safeguarding action plans following Serious Case Reviews, Domestic Homicide Reviews, Safeguarding Adults Reviews or Section 11 returns.

Regular assurance evidencing how the trust is discharging its safeguarding responsibilities is provided to the Designated Professionals at the Trust's lead CCG; this includes:

- Submission to the Surrey wide CCG Designated Safeguarding team of an annual report and 6 monthly update that provides a narrative and data against each of the standards
- Submission of exceptions reporting for any areas of non - compliance with the standards as identified
- Submission to the Surrey wide CCG Designated Safeguarding team of Section 11 audits undertaken and resultant action plans for the Surrey Safeguarding Children's Partnership
- Providing evidence at Contract Quality Review Meetings (CQRM)
- Providing evidence at other contract monitoring meetings
- Named / Lead professionals meetings/supervision with Surrey wide CCG Designated Safeguarding team and use of the Annual Assurance Framework Report
- Providing information to the Surrey wide CCG Designated Safeguarding team in the twice yearly Dashboard on safeguarding activity.
- Providing evidence at Surrey Safeguarding Adults Board, Surrey Safeguarding Children Partnership meetings and sub groups
- Participating in Surrey wide CCG Designated Safeguarding team and SSCB and SSAB audits and inspections
- Demonstrating the Trust's commitment to preventing modern slavery and human trafficking by evidencing a Modern Slavery Act statement on its public facing website

Changes in new statutory requirements during 2019 resulted in Safeguarding Children Boards being replaced by Safeguarding Children Partnerships across Kent, Medway, Surrey and Sussex. The new Partnerships require three lead agencies that see commissioners, police and local authorities work together as joint and equal partners to shape bespoke arrangements which respond to local needs.

Although the Surrey Safeguarding Adults Board and Surrey Safeguarding Children Partnership remain lead Boards for SECAmb, throughout 2019/20 continued improvements have been noted in SECAmb's representation at Safeguarding Board meetings across Kent, Medway, Surrey and Sussex. The Trust has continued to invest in senior safeguarding leadership across the organisation resulting in greater capacity to contribute to the priority areas of each Board.

Safeguarding Risks

During 2019/20, a total of three safeguarding risks have been formally recorded on the Trust's Risk Register. These related to:

1) **A failure by the Trust to display on the Trust's internet page of a statement of compliance in line with the expectation of the Modern Slavery Act**
   To comply with the expectations of the Modern Slavery Act 2015 all publicly funded organisations need to ensure they have a statement of compliance regarding modern slavery on their public facing webpages. The Statement was approved at the May Trust Board meeting and the risk was subsequently closed.

2) **Non-compliance with Mental Capacity Act assessments**
   During the last financial year, the Clinical Audit team undertook an audit on the Trust's compliance on the Mental Capacity Act. The audit demonstrated some deficiencies in SECAmb's approach to the Act. As a result of the audit an action plan was developed to address these deficiencies and added the subsequent risk onto the risk register.

   The Trust's partner Safeguarding Boards and commissioners have had oversight of the audit results and SECAmb submitted quarterly assurance on progress against the action plan. One of the agreed actions was that the Trust would re-audit Mental Capacity compliance during 20/21.

   Safeguarding training for all clinical staff for 2019/20 has, through Key Skills and e-learning had a greater focus on the Mental Capacity Act. Additionally, developed within the new electronic Patient Care Record (ePCR) is an improved section that will promote improved compliance with the expectations of the Mental Capacity Act. The ePCR requires clinicians to complete mandatory fields before progressing onto the recording of any subsequent best interest decision making.

   The Safeguarding Sub-Group continues to monitor the Mental Capacity risk where it's recognised there will be little evidence indicating rapid change in until practice is re-audited.

3) **Private Ambulance Providers - Delay in making safeguarding referrals**
   There is a risk that safeguarding referrals are not being received and processed in a timely manner from PAP partners. This is as a result of;

- PAP providers being unable to access Datix
- Unclear processes around sending paper-based referrals to safeguarding team
- Points of failure resulting in lost referrals.

This may lead to a vulnerable adult or child being placed in danger through not being referred to an appropriate agency.

To provide optimal assurance that safeguards patients and effectively manages the timely processing of paper safeguarding referrals the Trust, through an operational bulletin in June 2019 ensured the following actions are adhered to:

- All individuals that complete paper safeguarding referrals must ensure that they have access to new orange safeguarding referral envelopes (all Private Providers and back-up mechanisms for internal Datix failure)
- All crews must complete the front box identified as 'Crew to Complete' and hand the sealed envelope to the Duty Operational Team Leader or placed into the Patient Care Record box on station
- All Duty Operational Team Leaders must:
    - Complete the front of the orange envelope identified as 'OTL to Complete' which identifies all required action has been taken. This identifies the process of scanning the referral to the Safeguarding Team dating the time scanned and marking whether the process followed is an internal Datix failure or not.

    - Ensure that any orange Safeguarding envelopes are processed as above and PCR boxes checked for any orange envelope

3. Policies, Procedures and Guidelines

As a commissioned NHS provider SECAmb needs to ensure that staff are aware of the Trust's Safeguarding policy and any relevant guidance and procedures.

The Safeguarding function assumes lead responsibility for several organisational policies, all of which have been ratified and are in date. The policies are:

- Managing Safeguarding Allegations – Policy and Procedure, updated and ratified January 2020
- Mental Capacity Act Policy
- Safeguarding Policy for Children, Young People and Adults – updated and ratified October 2019
- Safeguarding Referrals Procedure – updated and ratified October 2019
- Seeking Consent Policy
- Child Death Procedures
- Freedom to Speak Up: Raising Concerns Policy
- Safeguarding Supervision Policy – ratified January 2020

4. Appropriate Training, Skills and Competencies

The *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* Intercollegiate Document defines the safeguarding training expectations for all

individuals working in healthcare. The document sets out five levels of training based on roles throughout the organisation. Throughout 2019/20 there was an expectation that every member of staff would complete level 2 training as a minimum.

During 2019/20 all operational staff were expected to complete both child and adult safeguarding training at Level 2 as an e-learning element of their key-skills. E-Learning throughout the year focused on Safeguarding Children, The Mental Capacity Act and for the first time a new Basic Prevent Awareness Training (BPAT) was introduced for all non-clinical staff. Throughout 2019/20 a total of 87% of staff completed safeguarding children e-learning, 89% completed the Mental Capacity Act e-learning and 86% of staff completed the BPAT. Safeguarding commissioning expectations requires a minimum of 85% compliance with all safeguarding training.

Closer scrutiny of training figures identified that compliance within the Operating Units remained very high throughout the year with many achieving 100% across the required elements.

The 2018/19 CQC inspection report highlighted a low-level uptake of safeguarding training by only 58% of clinicians in EOC. Subsequently the Safeguarding Team worked in partnership with the senior leadership within EOC to provide Level 3 face to face training for clinicians that was in line with the requirements of the Intercollegiate Document. Figures provided by the EOC leadership highlight that as a result of the increase in face to face attendance 88% of clinicians were up to date with the required level of safeguarding training.

2019/20 has seen a number of extrinsic challenges which have had an impact on the team's ability to deliver safeguarding training across the Trust, namely EU Exit and the Covid-19 outbreak of 2020. The team had planned to deliver safeguarding training sessions for all EOC staff, focusing on the identification and escalation of safeguarding concerns in the context of telephone triage, where face to face assessments cannot be made.

Unfortunately, due to the cancellation of two of the quarterly Key Skills dates for EOC (as a result of the EU Exit preparations), this training was only able to be delivered to the West EOC staff in Q4. East EOC staff and Ashford 111 training was planned for Q1 of 2020/21, however this has now been postponed due to the Covid-19 outbreak. Likewise, a multi-disciplinary safeguarding conference hosted by the Trust that was planned for April 2020 has now been deferred to later in the year.

Impact of Training

One of the key priority areas for the Safeguarding Team during 2019/20 was to increase awareness of the signs and symptoms of domestic abuse. 2019/20 has seen a significant rise of over sixty per-cent in referrals for individuals at risk of or have suffered domestic abuse (DA) compared to the previous year. During this time the Safeguarding Team have targeted this area of work in attempt to raise the profile of DA across the organisation. Additional resources supporting EOC, 111 and front-line staff have been developed together with a greater emphasis on DA contained within Level 3 face – face safeguarding training for clinicians.

Despite the lower than anticipated level of training provided to EOC colleagues a referral completed by a member of EOC there was positive impact on those who'd received the

training. For example, evidence from a referral from an EOC colleague provided key information about what was said on the phone including vital information overheard from the child. Without this referral we would have not had the extra key information that is so helpful to MASH teams.

A referral from EOC demonstrated an EMA giving advice to a non-conveyed patient whose parents were reluctant to engage with advice provided by the EMA and clinicians. Without this referral social care may not have been highlighted to the concerns for the patient.

Wider Organisational Learning
Feedback from the CQC inspection in 2018 stated that the trust should improve on notifying staff with safeguarding alerts to develop learning. Following this feedback, the safeguarding team explored the best way in which learning can be shared with not only with front-line staff but with all staff within SECAmb on a routine basis. As there was already a communication in place within the Trust that was directed and available to all staff; the weekly bulletin, the safeguarding team thought this was the best place to be able to share safeguarding resources and knowledge.

Since October 2019, safeguarding learning has been published once a month and continues to be shared. The safeguarding information that is published is topical to the month, for example information and resources on domestic abuse in December when rates are high, and information on young carers in January in support of young carers day. The team also share information on the SECAmb community Facebook page that has over 2.5 thousand followers when appropriate.

Throughout the year the Safeguarding Team have analysed trends and themes from several sources including referrals and input into multi-agency reviews that influence wider practice. Face to face training has also sought to have a greater focus on national priority areas including risks that compromise the wellbeing of young carers.

Historical evidence from NHS England suggests that young carers have mixed experiences of the ambulance service, subsequently promoting greater recognition of these needs has seen an increase in safeguarding referrals for young carers. For example, clinicians made a referral for an individual who they recognised as a young carer. The young man disclosed to the paramedic that he had no social life, felt very isolated from his friends and that his mental health was deteriorating as a result of his caring responsibilities. The paramedic referred the young carer via the safeguarding route where subsequent feedback from the relevant local authority indicates he has been in contact with local support groups for young carers.

5. Effective Supervision and Reflective Practice

Safeguarding Supervision for the Trust's Safeguarding Lead and Nurse Consultant is undertaken by the relevant Designated Nurse for Safeguarding within clinical commissioning.

NHS Commissioning Safeguarding Standards highlighted that SECAmb should have a separate safeguarding and looked after children supervision policy. Throughout 2019/20 the Safeguarding Lead worked closely with internal and external partners to develop a stronger model of safeguarding supervision across the organisation. Subsequently SECAmb's

inaugural Safeguarding Supervision Policy was ratified in January 2020. The ratification of a Safeguarding Supervision Policy bought SECAmb in line with expectations for all NHS commissioned services.

6. Effective Multi-Agency Working

Changes in the Safeguarding Referral Form

During 2019/20 the Safeguarding Team received feedback from our partner agencies including commissioners and local authorities suggesting that the original safeguarding referral form lacks vital information that they require to be able to action upon our concerns. On closer analysis the Team recognised that the referral often lacked any reference to wider national safeguarding priority areas such as for example, patients who were also young carers or whether children at scene are subject to private fostering arrangements.

Subsequently the team working in partnership with our key stakeholders developed a more 'fit for purpose' safeguarding referral that includes elements to capture for example the safeguarding risks to our homeless population, consideration whether the child is in the care of the local authority or whether staff have concerns about the welfare of other people on scene. Although the 'think family' concept wasn't explicitly included within the updated referral form, evidence from safeguarding referrals highlighted that staff are able to recognise safeguarding concerns that might impact on other individuals at risk within the family, home or other environments.

2019/20 Safeguarding Referral Information

The Trust has continued to see a year on year increase in safeguarding referral activity. Safeguarding referrals made across EOC, NHS111 and 999 services totalled 16,353 and reflected a 19 per cent increase on the previous year. Despite the annual increases in overall referral, with the exception of referrals for domestic abuse, numbers trends and themes in safeguarding concerns have remained constant and further details are outlined below on innovations that have developed and triaged referral practices across the Trust.

Safeguarding referrals for children constitute 17% of the total number of referrals despite the under 18 population accounting for around 10 per cent of SECAmb's workload. Safeguarding training throughout 2019/20 and the updated referral form had a greater focus on risks to children. This suggests that our staff are able to recognise and escalate safeguarding concerns where there's an indication of a child is at risk of harm, abuse or neglect.

Safeguarding and the Intelligence Based Information System (IBIS)

The Safeguarding Team are frequently contacted by external agencies, predominately social care, who have vulnerable individuals with sometimes unique circumstances of complex, social and medical needs which require them to be safeguarded by other agencies such as the ambulance service. This information can originate from safeguarding referrals submitted by the Trust's Safeguarding Team on behalf of crew attending incidents highlighting safeguarding concerns.

An innovation developed this during 2019/20 allows the Safeguarding Team to create IBIS records noting relevant clinical information and safeguarding risks. This allows for closer

partnership working, effective information sharing and transparency to safeguard our patients; putting their needs first using our systems to update Safeguarding Teams and other service users with how best to accommodate the situation or an individual.

When patients who have a Safeguarding IBIS record come in contact with SECAmb, an IBIS alert is raised making the team aware and when appropriate this information can feed back to the originator.

It's important to note that the Safeguarding IBIS record is not an information collating service, but a crucial way of supporting patients who have been deemed especially vulnerable by wider professional services and are being helped by a joint information sharing approach.

Developments in Partnership Working
Despite the year-on-year increase in referrals there has been general acceptance that a significant number of these highlight individuals who, rather than safeguarding, require a wider assessment of their care and support needs. Clearly processing these increasing number of referrals in a timely way increases the pressure on the limited safeguarding resources across the health and social care economy. A priority area for the Safeguarding Team during 2019/20 was to work with commissioners, Boards and local authorities to triage referrals according to thresholds operating across Kent, Surrey & Sussex. This allowed greater focus on the quality of each referral to ensure information is shared with the appropriate service and to improve outcomes for those individuals at risk.

Commencing in August 2019 Surrey County Council (SCC) Adult Social Care (ASC) and South East Coast Ambulance (SECAmb) have been working together on improving the way all referrals are sent to ASC. The project began as Surrey ASC made a challenge to SECAmb as the numbers of safeguarding referrals SECAmb were reporting did not match the number ASC were receiving – predominantly because the Surrey Multi-Agency Safeguarding Hub (MASH) were receiving care assessment referrals that should have gone to ASC instead of the MASH.

Working in partnership with SCC and ASC SECAmb began in September 2019 labelling referrals within their internal system with levels of need that are matched to the Surrey thresholds/Levels of Need document. This involved prioritising patients with true safeguarding needs and ensuring they are receiving timely support from the Multi Agency Safeguarding Hub (MASH) workers.

The benefits of the project:

- It has enabled the MASH to spend less time processing referrals, as there is now clarity as to the purpose of the referral.
- The MASH is able to process more referrals, therefore better meeting the needs of adults; be this a response to safeguarding concerns or a request for assessment, information for advice.
- Issues of consent are also clarified within the Levels of Need document. This ensures that the adult's confidential information is protected accordingly, and information is shared appropriately, in a timely manner.

It's anticipated that during 2020/21 other partner local authorities are likely to change safeguarding threshold referral criteria. Despite this SECAmb are in a position to evidence that the Safeguarding Team are in a positive position to integrate these changes within it 'business as usual' approach.

Referrals to Local Fire & Rescue Services
Referrals to other agencies recognises the preventative role that Fire & Rescue (F&R) Services can play in supporting adults at risk. During 2019/20 SECAmb activity indicates that over 700 referrals have been made to Fire & Rescue services across Kent, Surrey and Sussex. This has seen a considerable rise in referrals to F&R compared to the previous year. Changes to the safeguarding referral form has incorporated greater opportunities for staff and crews to recognise and escalate fire risks for vulnerable people. Secondly, the safeguarding training delivered throughout the year focused on the area of self-neglect and detrimental hoarding behaviour, including the relative fire risk associated with this behaviour. The training encourages staff to consider a referral to local F&R services in the event that the hoarding reached a pre-determined threshold.

Child Death Reviews
Members of the Safeguarding Team continue to be involved in the multi-agency Child Death Review process, which now supplies information to the National Child Mortality Database.
During 2019-20, SECAmb has reported on a total of 111 cases: 22 in Surrey, 35 across Sussex including Brighton & Hove and 54 in Kent & Medway.

With the introduction of the revised Child Death Review arrangements from September 2019, SECAmb's involvement has largely moved from attendance at the Child Death Overview Panels to a more proactive role within the analysis stage of the process, Practitioners attending Joint Agency Review meetings and the Child Death Review Meetings, representing or supporting the operational staff. Child Death Overview (CDR) Panels are attended at the Chair's request to provide SECAmb specific input for certain cases.

Through the CDR process, the purpose is to identify "modifiable factors" and identify learning that may help to prevent similar child deaths in the future. Some practical learning has been brought back to SECAmb and passed to operational staff through Informatics posters and informing training and CPD events. One example is clinicians learning the importance of accurate documentation of a baby's presentation when found following a sudden death during sleep e.g. where they were found, in what position they were found, if they have any blood loss – how much and where from. Another example is for clinicians to be reminded that if a baby is born in the community, all products of that delivery, including the placenta, must be kept with the baby and passed to the midwifery team for assessment.

As the ambulance service is often the first agency on scene of an incident and has the opportunity to report its findings in cases of child deaths, it is common that SECAmb's contribution is often unique and invaluable; informing the CDR process and that information being fed into the wider actions and recommendations for Health, Education and Social Care that result from the panel as well as to the National Children's Bureau.

Throughout 2019/20 the Safeguarding Team has sought to embed safeguarding principles within other functions across the Trust. For example, the Team recognised there was a

need to have regular access to the live Computer Aided Dispatch (CAD) system. Without this access workarounds were being utilised; however these could be time consuming, use multiple systems to access this information and not conducive to effective use of time.

Utilising communication channels the team were given access to the Cleric system with relevant training. Implementing CAD access has demonstrated numerous benefits including quicker access to information held in one place. Using the live CAD supports multi-agency investigations including CDRs as the team have full view of NHS Pathway reports. Subsequently the team are able to easily see if other agencies attended an incident and input their references into our referrals, and it gives us the ability to view previous attendances for additional information along with many other benefits. We will continue to make this successful in the future as this access can enable us to monitor safeguarding concerns through live 999 calls.

Multi-Agency Safeguarding Assurance
Throughout 2019/20 SECAmb provided regular assurance about its safeguarding function to the Safeguarding Adults Boards, Safeguarding Children's Partnerships and Clinical Commissioners across Kent, Medway, Surrey, Sussex and NE Hampshire. Monthly exception reporting and quarterly dashboard returns were submitted in line with other NHS providers to NHS Guildford & Waverley CCG. The information was subsequently shared with all Safeguarding Boards across the region. Regular reporting included assurance on:

- SECAmb's policy developments in relation to Safeguarding Supervision
- Prevent activity
- Safeguarding training
- Referral activity
- Serious Incidents that had a safeguarding theme

Areas of challenge in SECAmb's safeguarding assurances and governance are discussed and agreed at the Safeguarding Sub-Group and through Safeguarding Supervision with Designated Professionals at the CCG.

Local Safeguarding Children Partnerships (SCP) seek assurance about organisational compliance under Section 11 of the Children Act 2004. The introduction of the Care Act 2015 placed Safeguarding Adult Boards (SABs) onto a statutory footing and each Board has been developing benchmarking assurance tools to identify good practice for safeguarding adults which broadly replicates the Section 11 requirements.

Multi-Agency Safeguarding Audits
Section 11 audits are received every two years; during 2019/20 SECAmb received a section 11 audit request from the Medway SCP. The audit was completed and submitted during March 2020; the audit identified four key areas of development:

- Promote the principle of establishing that the 'voice of the child' is reflected in escalating safeguarding concerns
- Ensure safer recruitment processes evidence Safeguarding statements to all job adverts where there is contact with patients
- Provide safer recruitment training for recruiting managers
- Raise the profile of private fostering arrangements within face to face safeguarding training

Challenge events are usually held by the relevant Safeguarding Partnership that allow the relevant provider the opportunity to demonstrate assurance on how risks are mitigated and improved. Due to the Covid-19 pandemic the challenge events have been placed on hold however the actions have been incorporated into the annual Safeguarding Workplan that's scrutinised at each Safeguarding Sub-Group meeting.

SECAmb's Contribution to wider Multi-Agency Enquiries
The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened.

The findings from the enquiry are used to decide whether abuse has taken place, whether the adult at risk needs a protection plan and whether any wider learning can reduce future risk.

The Trust were requested to contribute to 27 Section 42 enquiries throughout the year.
In many of these cases the Trust was asked to provide a summary of involvement as concerns had been raised on the care delivered by other providers. Areas of learning for SECAmb are recorded and monitored at the monthly Safeguarding Sub-Group. The example below highlights the outcome of a Section 42 enquiry and the subsequent learning for the Trust in relation to the patient's mental capacity.

> *Care Act - Section 42 Enquiry - case summary*
> There had been an Ambulance delay for patient living in a care home who'd trapped his arm. There was a lack of information obtained during the triage stage which could have interfered with a higher disposition being obtained, and therefore caused a delay in reaching the patient.
>
> *Areas of learning*
> The Trust's welfare call procedure does not identify after what time a registered clinician is expected to review or call back any calls with a delayed response. These call backs can be made by a Pathways trained EMA OR a clinician. In the case of this patient, the call was upgraded immediately when reviewed by a clinician due to use of their clinical judgement

Under the requirement of the Children Act (1989) a Sec. 47 investigation will involve social care receiving a referral from SECAmb or another agency that results in a social worker suspecting that the child is suffering or likely to suffer significant harm. A Strategy Discussion Meeting will be held to decide whether to initiate enquiries under Section 47 of the Children Act 1989.

Strategy Discussions/Meetings will contact SECAmb to establish if the Trust have had any information in relation to the children or family as it is acknowledged that SECAmb will often

have information that others will not due to the way our service is accessed. The Safeguarding Team supported 21 Section 47 enquiries during the reporting year.

4 Sec. 17 investigations were carried out by the team during 19/20. A S17 is a query in relation to a Child in Need assessment under the Children's Act 1989. A child is defined as being in need either through disability or poor health and they are unlikely to achieve or maintain a reasonable life or a reasonable standard of health or development, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority.

NHS England's Safeguarding *Accountability and Assurance Framework* sets out the safeguarding roles, duties and responsibilities of all organisations commissioning and delivering NHS health and social care. During 2019/20 SECAmb completed two self-assessment documents benchmarking its position in relation to twelve commissioning standards incorporated into the Framework. Any gaps or risks in the self-assessment document were included in the annual safeguarding workplan and monitored at the monthly Safeguarding Sub-Group. Monitoring of the Trust's compliance against the Accountability & Assurance Framework is undertaken via CCG exception reporting and Safeguarding Supervision.

7. Reporting Serious Incidents (SIs)

Contained within the safeguarding commissioning standards are the expectations that SECAmb will ensure that any serious incidents are reported and are investigated in line with the Serious Incident Framework. Additionally, the Trust needs to ensure that any serious incident related to safeguarding children and adults is reported to the lead commissioners. As has been highlighted elsewhere within this report regular exception reporting to the lead commissioner provides assurances on the overlap between SIs and safeguarding.

According to the Serious Incident Framework developed by NHS England in 2015, the purpose of SI investigations in the NHS is to identify learning to prevent recurrence. The Framework. SIs in the NHS also include 'actual or alleged abuse…acts of omission and organisational abuse where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring'. This includes abuse that resulted in or was identified through a SPR, SAR, Safeguarding Adults Enquiry where delivery of NHS funded care caused or contributed towards the incident.

During 2019/20 the Trust declared 20 SIs that had a safeguarding element. 3 SIs were declared following reviews carried out via multi-agency Child Death Reviews and 17 SIs were declared where neglectful care met Local Authority safeguarding thresholds. Following improvements in the Trusts' SI processes throughout the previous year this is the first time that accurate figures can provide the number of SIs with safeguarding components. The subsequent SI investigations and reports have highlighted areas of learning for the Trust in an attempt to reduce the risk of recurrence.

Examples of safeguarding concerns investigated via the safeguarding route included:

- A delay in responding to an infant in cardiac arrest
- Allegations of theft by a member of SECAmb staff from a patient's property

- A significant number of unprocessed safeguarding referrals made by Private Ambulance Providers that potentially resulted in a delayed response by the relevant local authorities

Learning from SI investigations with safeguarding concerns is reviewed at the Trust's Safeguarding Sub-Group where any subsequent assurance or risks are escalated to the Clinical Governance Meeting.

Example of Learning from a Serious Incident Investigations

SI Investigation - Case Summary

The Safeguarding Team received twenty-seven unprocessed paper safeguarding referrals from Health Records dating back over the previous six weeks.

The Trust's Contracts Manager and Nurse Consultant for Safeguarding worked collaboratively with operational and private providers to develop a new Operational Bulletin that clarifies and further strengthens the correct process for paper safeguarding referrals.

Areas of good practice

A review of each referral by the Safeguarding Team could not identify any harm to patients as a result of this failure.

Concerns escalated and recorded on the Trust's Risk Register and monitored by the Safeguarding Sub-Group

Areas of Learning

All operational staff employed by SECAmb and PAP companies have received an approved Operational Bulletin clarifying the agreed process for submitting safeguarding referrals in the absence of Datix access

All paper safeguarding referrals received by the Safeguarding Team continued to be double-checked to ensure they have been scanned and received in a timely way

Changes in practice or service delivery/reminders of practice

Development of a consistent process for paper safeguarding referrals for all PAP crews and as a back-up for IT/Datix failure

The monthly QI Hub Infographic poster to all operating units and EOC produced by the Safeguarding Team with a focus on timely safeguarding referrals

8. Engaging in SCRs/SARs/DHRs/Partnership Reviews

In line with the Local Safeguarding Children Partnerships arrangements the key guidance for Safeguarding Practice Reviews (SPRs) (formally Serious Case Reviews) is *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* (D; for Safeguarding Adult Boards (SABs) the Care Act 2015 introduced the requirement to undertake Safeguarding Adult Reviews (SARs). Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

Safeguarding activity across our key partners and local authorities continues to demonstrate year on year increase in activity. During 2019/20 SECAmb were asked to contribute to 67 Serious Case Reviews, Safeguarding Children's Reviews and Domestic Homicide Reviews. This almost doubles the number for the previous year.

Throughout April 2019 – March 2020 SECAmb were asked to contribute Summaries of Involvement to commissioning Safeguarding Boards and Community Safety Partnerships to 20 SPRs, 29 SARs and 14 DHRs across Kent & Medway, Surrey, Sussex and Hampshire. The number broken down into each local authority is:

- 4 Brighton and Hove SCR
- 1 Brighton and Hove SAR
- 3 DHR East Sussex Domestic Homicide Reviews
- 1 SCR Hampshire
- 4 DHR Surrey
- 4 SAR West Sussex
- 5 SCR West Sussex
- 7 DHR Kent
- 11 SCR Kent
- 23 SAR Kent
- 4 SCR Surrey

One Safeguarding review that the Trust were not directly involved in was an Isle of Wight review that had recommendations for Ambulance Services in reference to patients of a no fixed abode.

Areas of wider learning following these reviews have been shared across the organisation using various methods, including training examples, to cascade. Examples of learning include a recommendation that people of no fixed abode should be referred into safeguarding support as there's a risk they can be often be missed. An example of good practice includes how the Safeguarding Team liaised with Brighton & Hove Adult Services who have a high population of homeless people. It was agreed that when referrals are recorded, these are recorded with the last seen location for the person; this information will help social care support this vulnerable population as it gives support services an idea of where this patient may be.

As has been highlighted earlier in this report, 2019/20 focused on embedding a greater understanding from Domestic Homicide Reviews and how to support staff in dealing with domestic abuse in patients and colleagues.

- 2019/20 witnessed a significant increase in safeguarding referrals that have a domestic abuse component compared to previous year

- The Trust's Safeguarding Newsletter has focused on raising awareness of DA across the organisation
- Improved and updated DA resources available to staff on the Trust's intranet pages
- Draft Domestic Abuse in the Workplace Policy in process of development

9. Safer Recruitment and Retention of Staff

Highlighted within the 2019/20 Safeguarding and Looked after Children Standards for NHS Foundation Trusts is the expectation that providers can demonstrate they have safe recruitment procedures that protect and safeguard adults at risk and children in line with guidance for NHS employers.

The Trust's Recruitment and Selection Policy and Procedure confirms that all job descriptions include a statement on the roles and responsibilities to safeguard and promote the welfare of children, young people and adults at risk of abuse and neglect. The safeguarding statement in all job descriptions take into account the work of all staff and volunteers throughout the organisation. All contracted services or individuals that work in regulated activity for the Trust follow safer recruitment processes.

In line with commissioning standards for safeguarding, SECAmb has a process in place to respond to positive Disclosure and Barring Service (DBS) concerns. All cases whereby a disclosure is made or a DBS check identifies previous convictions/cautions etc. will be reviewed by the DBS panel. The panel will consist of a member of the HR recruitment team, a senior operational manager and a senior safeguarding representative. The HR representative will ensure that the decisions made, and the rationale for them, are captured, shared in a timely manner and held securely. All decisions will be made by the operational and safeguarding representatives.

10. Managing Safeguarding Allegations Involving Members of Staff

SECAmb is required to adhere to statutory guidance in Working Together to Safeguard Children 2015, the Care Act 2014 and the Safeguarding Boards' multi-agency procedures. The Trust therefore has a duty to report any incident where a member of staff has behaved in a way that has or may have harmed a child/adult at risk, acted inappropriately towards a child/adult at risk or committed a criminal offence against or related to child/adult at risk.

The Trust's Managing Safeguarding Allegations policy and procedure, updated during this reporting period, sets out how SECAmb manages any allegations against employees relating to the abuse of children and adults at risk.

This policy seeks to prevent and address abuse by those who work with both children and adults at risk, particularly children and adults who may be at increased risk and may be unable to protect themselves from harm because of their care and support needs.

This policy sets out the Trust's commitment to safeguarding children and adults from abuse and neglect and gives direction to enable the Trust to deliver an appropriate response. The procedures also clarify the actions than the Trust are expected to take in the event to the relevant external agencies including the Local Authority Designated Officer (LADO) and the Care Quality Commission if appropriate.

During the year allegations of a safeguarding nature were made against a total of 20 members of staff. Concerns included allegations of theft, inappropriate clinical intervention, perpetrating domestic abuse and allegations of controlling and coercive behaviour. All cases had been managed in line with the Managing Safeguarding Allegations policy with evidence that risk assessments were undertaken as per the Trust's Disciplinary Policy where concerns arose about the employee's behaviour occurring outside of their employment with the Trust.

Where allegations have been made either by the patient, member of the public or member of staff, in addition to discussion with police, local authority and CCG, cases have been escalated to the Serious Incident Group for consideration in line with the Managing Safeguarding Allegations policy.

Outcomes for staff where allegations had been made varied throughout the year, depending on the original allegation. Following comprehensive HR investigations outcomes were:

- Dismissed – 3
- Suspended from duty, investigation on-going – 1
- Still under investigation – 2
- Bank contract terminated – 1
- 1st written warning – 1
- Final written warning – 1
- Alternative duties while police continue to investigate – 1
- Returned to duties with further guidance regarding future conduct – 1
- No further action – 9

Assurance can be provided that Safeguarding involvement ensured wider patient safety in supporting vulnerable individuals who suffered abuse as a result of a SECAmb employee. Additionally, partnership working between Safeguarding, HR and Operational Teams ensured that referrals were made to the HCPC or relevant regulatory authority where appropriate.

11. Mental Capacity Act Policy

The Mental Capacity Act 2005 (MCA) provides a legal basis for determining an individual's capacity to make decisions at the time they need to be made.

The Trust's MCA policy is for all staff working within SECAmb who are involved in the care, treatment and support of people over the age of sixteen (living in England or Wales) who are unable to make some - or all - decisions for themselves.

The policy is designed primarily for all staff who have direct patient contact, however all staff have a duty to act in accordance with the MCA.

Following the findings of the previous year's Clinical Audit Department MCA audit, the Trust increased Mental Capacity Act classroom based Key Skills training during 2019/20. However, as has been highlighted previously in the report, 2019/20 has seen a number of extrinsic challenges which have had an impact on the Trust's ability to deliver safeguarding training across the Trust, namely EU Exit and the Covid-19 outbreak of 2020. Section 4 of

this report provides assurance on the Trust's safeguarding training position, however it's likely that MCA workstreams will be carried over to the coming year.

12. Review of the Priority Areas for 2019/20 and Look Forward to 2020/21

The priority areas for 2019/20 are highlighted as below and were included within this year's workplan. The workplan is scrutinised at the Trust's monthly Safeguarding Sub-Group meeting

- Embed changes in Serious Incidents (SI) and safeguarding incidents reporting during 2019/20
    - The Terms of Reference of the Safeguarding Sub-Group have been amended to ensure that any SI declared by the group that have a safeguarding theme are recognised and submitted to the Designated Safeguarding function at the Trust's lead commissioners
    - Any areas of safeguarding learning continue to be monitored at the Safeguarding Sub-Group
- This year the focus looked at embedding a greater understanding of domestic abuse and how to support staff in dealing with domestic abuse in patients and colleagues.
    - 2019/20 witnessed a significant increase in safeguarding referrals that have a domestic abuse component compared to previous year
    - The Trust's Safeguarding Newsletter has focused on raising awareness of DA across the organisation
    - Improved and updated DA resources available to staff on the Trust's intranet pages
    - Draft Domestic Abuse in the Workplace Policy in process of development
- Work in partnership with commissioners, local authorities and Safeguarding Boards to streamline and triage safeguarding referrals
    - Local Adult Social Care teams and SECAmb have been working together to improve the way referrals are sent to adult social care. This has involved SECAmb labelling referrals with levels of need that are matched to the local thresholds. This ensures when they reach local Safeguarding Hubs they are triaged effectively.
    - The results of a pilot with one of SECAmb's local partners was presented to the Surrey Safeguarding Adults Board in March 2020
- Develop a stronger model of safeguarding supervision across the organisation.
    - SECAmb's inaugural Safeguarding Supervision Policy was ratified in January 2020
    - The Safeguarding Supervision Policy bought SECAmb in line with expectations for all NHS commissioned services
- Training Plans for 2019/20
    - Increased Mental Capacity Act Key Skills training
    - Introduction of a new Prevent Basic Awareness e-learning training package for all staff
    - Focus on developing Level 3 Safeguarding Adults training resources consistent with the Intercollegiate Document

Priority Areas for 2020/21

- Reconfigure the Trust's publicly facing Safeguarding webpages
- Embed a safeguarding audit programme – including focus on the Trust's compliance of the Mental Capacity Act (2005)
- Promote the principle of establishing that the 'voice of the child' is reflected in escalating safeguarding concerns
- Streamline the existing referral process to allow greater focus of wider national safeguarding priority areas
- Develop a ratified Workforce Domestic Abuse Policy
- Embedding the implementation of the updated Managing Safeguarding Allegations Policy across the organisation

13. Conclusion

2019/20 saw continued developments within the safeguarding function across the Trust. Greater financial investment in the Safeguarding Team has allowed improved processing of safeguarding referrals submitted by practitioners across the Trust. Safeguarding is 'everybody's responsibility'; the year has demonstrated new and innovative practices that embedded safeguarding approaches within other vital functions of the Trust's business and directorates. Closer partnership working with the Trust's key stakeholders has demonstrated improved outcomes for vulnerable people across Kent, Medway, Surrey and Sussex.

The work of the Safeguarding Sub-Group continues to flourish and is responsible for scrutinising and gaining assurance of every aspect of the Trust's safeguarding function. 2019/20 has overseen important updates in the Trust's safeguarding policies that provide assurance that the Safeguarding Team leadership are sighted on any safeguarding allegation made against a SECAmb member of staff. A consistent focus on raising awareness of domestic abuse throughout the year has seen a considerable increase in referrals to the Safeguarding Team who in turn have contributed to fourteen Domestic Homicide Reviews across Kent, Surrey & Sussex.

Learning from incidents, complaints and safeguarding reviews have allowed the team to contribute to organisational learning and the priorities for 2020/21 will ensure that, despite the best efforts of a global pandemic, protection and learning will be central to the safeguarding function.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	15-20

Name of meeting	Trust Board
Date	28.05.2020
Name of paper	Board Assurance Framework Risk Report
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic goals and sets out the controls, assurances, and actions. This version includes some changes to the risks included in the BAF risks report, demonstrating the dynamic nature of the risk.
Recommendations, decisions or actions sought	The Board is asked to; 1. review the BAF risks and confirm its level of assurance that it is sufficiently focussed on the most relevant risk areas. 2. agree the changes recommended in section 3. 3. Agree the risk appetite statement (section 4) as recommended by the Audit & Risk Committee in March.

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. The current recommendations are listed in section 4.

2. Structure of the BAF Risk Report

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

The next version of this report will align each risk to the new strategic goals / objectives, which are due to be formally approved by the Board at the meeting in May.

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

Committee	Agenda Item	BAF Risk
Finance and Investment	Financial Performance	178
	Operational Performance 111 Mobilisation	123 966
	IT update	495
Quality and Patient Safety	EOC clinical safety	269 & 579
Workforce and Wellbeing	Personnel Files	362
	Workforce Planning	111
	H&S Annual Plan	517

Management Review & Recommendation

As set out in Appendix A, each risk has a nominated scrutinising forum, where the subject matter experts consider the risk, and update accordingly. Where the forum is not EMB, it will make recommendations to EMB about any changes to the risk. When applicable, EMB will recommend removal and / or an addition of a BAF risk(s). EMB agreed the following which was considered by the relevant committees in May 2020.

i. Risk 517 – Health & Safety
To be removed from the BAF risk report on the basis that the risk score is met; demonstrated by the positive annual report and Internal Audit review. It will remain a risk on the risk register and will continue to be closely monitored by the workforce and wellbeing committee.

ii. Risk 123 – ARP standards
Current risk score reduced from 16 to 12, on the basis that performance across Cat 1 – 4 has significantly improved and sustained since March and, despite this being in large part due to the change in activity following the COVD crisis, Cat 3 had been on an upward trajectory, in any event.

iii. Risk 178 – Financial Control Total
This risk score has been met due to the control total for 2019/20 having been met. The risk will now be revised to reflect the risk for 2020/21; as referenced in the finance committee's escalation report to the Board.

iv. Risk 269 – 999 Call Answering
Current risk score reduced from 15 to 10, given that the performance target has been consistently achieved since Q3 of 2019/20.

v. Risk 579 – 999 Call Answering
Current risk score reduced from 20 to 16, given the positive impact of improving performance resulting in fewer patients waiting.

In addition, the Board will note the inclusion of the Clinical Education risks as previously agreed. A COVID risk will be added and, in the meantime, appended to this report is the related risk paper recently received by the COVID Management Group.

4. Risk Appetite Statement

At its meeting in March the Audit & Risk Committee agreed to recommend to the Trust Board the following risk appetite statement:

In all matters SECAmb aims to provide services within the limits of practicality, efficiency, control and financial resources. As part of that overall philosophy SECAmb intends to take risks appropriately and establish effective management mechanisms expected under the terms of the National Health Service Act 2006 and in accordance with the NHS Foundation Trust Code of Governance.

By carefully balancing our objectives against the risks we are prepared to take, we aim to conduct our business in a socially responsible and sustainable manner whilst delivering the best possible care to our communities. The Trust Board is committed to ensuring that all risks are identified, recorded and managed effectively; bottom up and top down (operationally and strategically).

The Board recognises that it is impossible and not always appropriate to eliminate all risks. Systems of control must be balanced in order that innovation and the use of limited resources are supported when applied to healthcare. The Board also recognises the complexity of risk issues in decision-making and that each case requires the exercise of judgement. However, the Risk Appetite Statement can be used to inform decision-making in connection with risk and what limits may be deemed as outside their tolerance.

The Risk Appetite Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite, however these instances would usually be required to be referred to the Board.

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners.

The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives.

As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance.

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience

is not adversely affected.

The Trust has a moderate appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Similarly, the Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives.

The Board has greatest appetite in seeking strategic transformation of healthcare across the South East Coast Ambulance Services current boundaries. As well as developing wider effective partnerships, alliances and commercial ventures where positive gains can be anticipated, it is providing they are done so within the regulatory environment in which we operate.

The Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high in comparison to the potential severity of the risk and the likelihood of it occurring.

The Trust are committed to protecting the environment by providing high quality health care services in an environmentally sustainable manner when viable.

In implementing the Trust's risk appetite, target risk scores must be determined for each risk based on the appetite described.

Escalation occurs to a higher group, committee, board or level of authority, because the risk profile is sufficiently close to the risk appetite limit that additional corrective action must be considered.

The Trust Board will review annually the levels of risk the Trust is comfortable to tolerate in the pursuit of its objectives and goals, but sooner if periods of increased uncertainty or adverse changes, both internally and externally are presented.

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 Executive will continue to refine the report, so that is clearly sets out the controls, actions and sources of assurance it relies on. Before the next version is will specifically confirm the target dates for each risk. The BAF risk report will continue to be used by the Board and its committees, to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

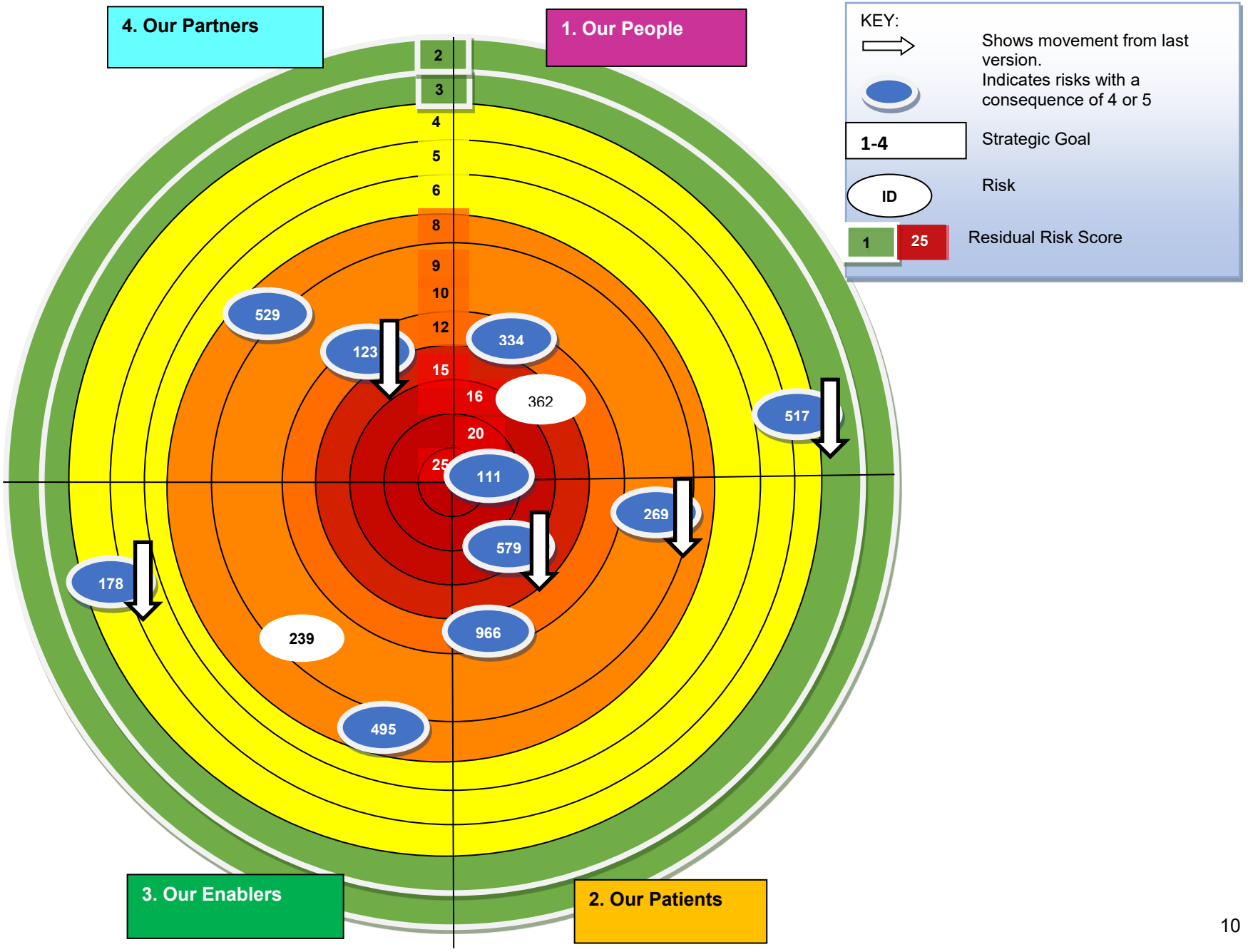
Dashboard

Links to objectives (from July 2020)	Link to Delivery Plan (from July 2020)	Risk ID / Theme	BAF Dashboard	Initial Score	Current Score	Target Score	Target Date (TBC)	Board Oversight
		Risk ID 111 Workforce	Risk that we will not deliver the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	25	20	10		WWC
		Risk ID 123 ARP	Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm. Currently, the principal risk relates to Cat 3 patients.	20	12 ⇩	08		FIC
		Risk ID 579 Care & Treatment	Risk that patients waiting for a response are not appropriately prioritised, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand,	20	16 ⇩	04		QPS

			which may lead to patient harm.						
		New Risk Risk ID Clinical Ed	Risk that we will not train and develop sufficient staff to meet the needs of our patients as a result of a historically poorly functioning Clinical Education service		20	12	04		WWC
		Risk ID 178 Control Total	Risk that the Trust fails to achieve its planned income and expenditure targets (control total), as a result of loss of financial control. This may lead to limiting or delaying key investments and the Trust being place in 'Financial Special Measures'.		16	04 ⇩	04	31.03.2020 Now met	FIC
		Risk ID 269 EOC	Risk that the Trust does not consistently answer calls within the national standards (Mean 5 seconds & 90th Centile 10 seconds) as a result of; •non-delivery of the planned workforce (see separate workforce risk) •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment		25	10 ⇩	05		QPS
		Risk ID 362 Safer Recruitment	Risk that the Trust is not able to always provide evidence of the relevant employment checks, as a result of inadequate internal controls / record keeping, which may lead to sanctions and reputational damage.		15	15	06		WWC
		Risk ID 966 111 Service	Risk that the Trust does not achieve operational standards for 111 as a result of increased pressure on the service, which may lead to patient harm.		16	12	04		FIC

		Risk ID 334 Culture	Risk of not improving the culture and behaviours within the Trust, as a result of; •not embedding the Trust's values and behaviours •poorly developed leadership and management styles This may lead to low staff morale, issues with retention, adverse impact on patient care and reputational damage.		12	12	04		WWC
		Risk ID 517 H&S	Risk that we do not comply with H&S legislation as a result of sub optimal infrastructure and governance, which may lead to harm to staff and related sanctions on the Trust and / or individual directors.		16	04 ⇩	04	01.04.2020 Now met	WWC
		Risk ID 495 IT	Risk that IT does not enable delivery of services as a result of; •system development maturity and integration not achieved at right pace •inability to respond to a major cyber crime This may lead to inability or delay to provision of care		16	08	04		FIC
		Risk ID 239 IG	Risk that the Trust does not adhere to Information Governance requirements and standards as a result of inadequate systems, resourcing and controls, which may lead to sanctions from the ICO and reputational damage.		09	09	03		AuC
		Risk ID 529 Change	Risk that the Trust is unable to substantively engage with Integrated Care Services and the service delivery		12	08	04		FIC

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


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
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16
20
25
529
123
334
362
517
111
269
579
178
239
966
495
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
ID
Risk
1
25
Residual Risk Score

Appendix A

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

Underlying Cause / Source of Risk:		
Risk that the Trust will not delivery the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff •inability to recruit to the future needs Due to; •not having optimal HR support functions •not having optimal education and training This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	**Accountable Director**	Director of HR & OD
	Scrutinising Forum	HR Working Group
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current Risk Score	**20** (Consequence 5 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**10** (Consequence 5 x Likelihood 2)

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

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

Gaps in Control

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

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Development of a retention strategy	1. In development

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Workforce & Wellbeing Committee

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

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

Controls in place (what are we doing currently to manage the risk)
Project established to review the various issues relating to personnel files; this sits under the HR Transformation programme, and includes the management actions from the Internal Audit report. DBS checks (renewals/no initial) are being regularly monitored. DBS policy has been reviewed

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

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

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Decision taken to write to all staff asking them to provide key ID documents so that every file is up to date	1. Letter to all staff being sent w/c 18.11.2019. Aim to conclude this work by 31.12.2019 – see separate Board update (28.11.2019) Due to COVID this action has been delayed. Paper coming to EMB 13.05.2020

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Workforce & Wellbeing Committee

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

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

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

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

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

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Workforce & Wellbeing Committee

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

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

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

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

Gaps in Control

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Independent Review May 2018 (-) manual handling incidents high (-) RIDDOR reporting (+) HSE inspection visit in February 2018 focussing on Muscular Skeletal Disorders (+) violence and aggression to staff showing a slow downward trend. (+) increase in H&S reporting – showing greater awareness (+) Delivery Plan showing H&S as Green (+) WWC assured with delivery of the improvement plan	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. MDT training	1. Over 200 operational managers have received classroom based H&S training

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Workforce & Wellbeing Committee

Goal 1 Our People	**BAF Risk ID** (tbc) Clinical Education	**Date risk opened: 11/02/2020**

Underlying Cause / Source of Risk:		
Risk that we will not train and develop sufficient staff to meet the needs of our patients as a result of a historically poorly functioning Clinical Education service due to:- • Insufficient leadership • Lack of clearly defined clinical education strategy • Insufficient numbers of qualified education staff • Poor facilities • Increased demand for training and development	**Accountable Director**	Executive Medical Director
	Scrutinising Forum	Transforming Clinical Education Programme Board and Working Group
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	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)
Backlog Marking – Personal Development Plans for those students who have not completed assignments; trajectory to reduce backlog to under 30 days; Emstar contracted to manage the backlog. Ofsted Compliance – Dedicated Task & Finish group to create capacity and resourcing plan for next inspection; progress confirmed by FutureQuals report 'good'. Co-delivery of apprenticeships – AAP programmes commenced; awaiting contract signature with external apprenticeship provider following legal advice. Level 6 – Paramedic Programme – Outline business case approved for University of Cumbria co-delivery. Workforce Education Development Review – 9 weeks of face to face training booked. Clinical Education Courses – 2020/21 training plan developed, aligned to current workforce planning requirements.

Gaps in Control
Insufficient qualified (educational) staff within the service to deliver all the training and development required. Lack of substantive leadership in place. Clinical Education strategy

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
Number of staff being trained in each cohort (per professional group) against plan + Quality of education provided as assessed by Ofsted and FutureQuals + Completion of coursework marking on time + Re-established Clinical Education Working Group, reporting to the Clinical Governance Group	A clear mapping of the numbers being trained/about to be trained against the workforce plan for the Trust reported to QPS/Board (this work has been carried out and is in the planner but now needs to be reported through the assurance route)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Analysis of the requirements of the team structure (including education qualifications required by clinical education staff and numbers of staff required) 2. New Consultant Paramedic appointed (start date to be confirmed) to lead the Clinical Education service. 3. Review of seconded posts to encourage more substantive posts. 4. Stakeholder engagement has commenced for the new Clinical Education Strategy.	1. Review of team undertaken by Sara Songhurst including role reviews, contract reviews, performance reviews and where necessary banding reviews. 2. Consultant appointed. 3. Review undertaken and individual career conversations are taking place currently. 4. Workshops with stakeholders has taken place. Awaiting Trust strategy to be published to ensure alignment.

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Workforce & Wellbeing Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently answer calls within the national standards (Mean 5 seconds & 90th Centile 10 seconds) as a result of; •non-delivery of the planned workforce (see separate workforce risk) •design of the processes and technology within EOC This may lead to patient harm due to delay in providing care and treatment	**Scrutinising Forum**	Teams A/B (EOC)
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current Risk Score	**10** (Consequence 5 x Likelihood 2)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**05** (Consequence 5 x Likelihood 1)

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

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

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) NHS Pathways / MT audit compliance (+) Call Answer performance – consistently within ARP. (+) EMA capacity (+) reduction on EMA turnover against trajectory	

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

Last management review	Executive Management Board	**Last committee review**	21.05.2020 Quality & Patient Safety Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Nursing & Quality
Risk that patients waiting for a response are not appropriately prioritised, as a result of lack of clinical resource; suboptimal IT systems; and an inability to respond to demand, which may lead to patient harm.	**Scrutinising Forum**	Executive Management Board
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

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

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

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

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

Last management review	Executive Management Board	**Last committee review**	21.05.2020 Quality & Patient Safety Committee

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

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

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

Gaps in Control

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) (+) clinical performance not meeting national standards but compares well to national average (-) High number of referrals to 999 (+) Impact of the additional Service Advisors and the use of Patient Safety callers (+) Maintenance of full NHS Pathways compliance with regards to audit (+) w/c 04 May 2020 Weekly service level increases despite increased call activity and additional public holiday: up from 78.9% to 84.5%. Abandonment rate reduced from 2.99% to 1.99% - achieving our 2% stretch target for the first time since mid-January.	

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

Last management review	Executive Management Board	Last committee review	14.05.2020 Finance and Investment Committee

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

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Operations
Risk that the Trust does not consistently achieve ARP standards as a result of insufficient resources, which may lead to patient harm. The principal risk relates to Cat 3 patients.	**Scrutinising Forum**	Executive Management Board
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

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

Over 100 new vehicles, include NET vehicles to ensure focus on Cat 3 / 4
EMA recruitment in the EOC (see BAF Risk 111 & 269)
Recruitment (see BAF risk 111)
External review through AACE of EOC Practice & Process completed / External review of EOC by NHS I Commissioned Project (National work)
Demand and Capacity Review agreed / additional funding provided for 2019/20
Support from NHS England Performance Team, NHSI and the Ambulance Advisor to the Department of Health
Stopped Key Skills between October 2019 - January 2020 to ensure more hours

Gaps in Control

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

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

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

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Finance and Investment Committee

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

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

Controls in place (what are we doing currently to manage the risk)
Cost improvement programme (CIP) Contracts with NHS commissioners (currently only for one year) that secure planned income subject to successful service delivery. Robust financial governance processes to support sound financial management. Approved budgets and a system of budgetary control. Promotion and increased awareness of financial governance issues across the organisation. Long term financial plan in place
Gaps in Control
Robust & recurrent CIP plans Operational performance resulting in reduced income. Identity of additional income opportunities.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Use of Resource Metric for I&E Margin 2 or better on a consistent basis (+)The Trust met its Control Total (-) shortfall in income as a result of failure to meet activity. (-) level of cost pressures (-) CIP shortfall / many schemes non-recurrent	

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

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Finance and Investment Committee

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

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

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

Gaps in Control

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

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

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Finance and Investment Committee

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

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

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

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

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

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

			Quarter 3 2019, meetings have now been scheduled for late November / December 2019
Last management review	Executive Management Board	**Last committee review**	Audit and Risk Committee 12.12.2019

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

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

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

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

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

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

Last management review	Executive Management Board	**Last committee review**	14.05.2020 Finance and Investment Committee

Appendix B

Appendix C

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

	Local media 1 day e.g. inside pages or limited report	Regulator concern	Regulator action	Local MP concern Questions in the House	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 Foundation Trust

Risk Management – Paper 2

1. Overarching Covid Risk

1.1. Risk 1249 is the overarching covid-19 risk; there is a risk that in the event of an outbreak of COVID-19 in the United Kingdom, the Trust will experience severe disruption to key elements of its service

1.2. There would be both immediate and longer-term negative impacts on Trust activity:
- Reduction in the provision of workforce across all areas of the Trust (111, Field Operations, EOC and corporate services) caused by illness / following the national self-isolation guidelines
- Access to sufficient medical consumables equipment (particularly PPE: masks, aprons, suits, goggles, hand sanitiser and fit testing fluid) caused by unusually high national demands on the NHS Supply Chain
- Ability to deliver effective and appropriate patient care caused by loss of personnel and equipment
- Additional financial burden should unbudgeted actions and controls be implemented
- Consequent inability to achieve national performance targets
- A prolonged event could have an adverse impact on staff and volunteer wellbeing
- Existing technology could be strained should large numbers of staff be asked to work from home

2. Linked risks added to the Risk Register

2.1. There are 11 linked risks on the Risk Register set out below.

Risk No.	Title / Summary	Current Risk Level
1209	Wuhan Novel Coronavirus – risk of crew coming into contact with patients who are covid positive	High
1236	Impact of COVID-19 on KMS 111 CAS Mobilisation	High
1237	Covid-19 – risk that the studies undertaken by the Research and Development will be curtailed by covid-19	High
1239	Potential for Covid-19 to impact on supplier's ability to meet KMS 111 CAS timelines	High
1244	PPE Equipment (missing / faulty items) and the impact of availability I	High
1246	Risk of not informing crews of SARS-CoV-2 infection risk – breakdown in communication between EOC and crews in dispatch	High
1250	Challenges of social distancing in 111 and contact centres	High
1251	Impact of Covid 19 on the implementation of the approved 2020/21 training programme	High

1254	Sheppey Refurb – Furniture / Equipment Delivery Delays – COVID 19	Moderate
1255	Aerosol Generating Procedures – risk of staff developing respiratory infections as a result of conducting (AGPs)	High
1257	Miscommunication of COVID-19 test results	High

3. Risks identified but not yet on the Risk Register

3.1. Two departments have identified 9 risks related to their covid-19 workstreams but have not yet added them to the Risk Register. They are set out below.

Department	Description	Rating (where provided)
Recruitment	Original ID documents being seen for staff. Being considered by the Safer Recruitment Task & Finish Group.	N/A
Recruitment	Ensuring no one is recruited to the bank who wouldn't be accepted on a substantive basis. A working group is being set up to address this.	N/A
Community Resilience	CFRs attending patients in Level 2 PPE are at risk when AGPs are used by attending crews	16
Community Resilience	Stopping of Recruitment for CFRs	16
Community Resilience	Stopping of Training for CFRs	16
Community Resilience	Reputational Damage from standing down CFRs	9
Community Resilience	Impact of not using CFRs to attend C1 calls	16
Community Resilience	Ongoing Effective Communications	9
Community Resilience	Loss of CFRs due to Covid-19 long term impacts	16

4. Work in Progress

4.1. Assurances have been received that additional Risk Register entries are being considered for capture:

4.1.1. Access to sufficient medical consumables; the NHS Supply Chain PPE push pallet implications and the measures the Trust has taken to ensure a supply of PPE for staff.

4.1.2. Bank staff; actions being taken to address the challenge of utilising this staff group.

4.1.3. The Covid Command Hub; management of confidential personal information whilst the team is located outside of the designated Command Hub room.

5. Monitoring

5.1. On behalf of the Covid Management Group, a weekly meeting is scheduled to review Covid-19 risk management. The invited attendees are the Head of Patient Safety, Business Support Manager (Operations), Interim Covid-19 Business Support Manager, Covid Operating Unit Manager and Business Performance & Delivery Manager (COVID-19 Management Team).

5.2. As the Business Continuity Incident progresses and workstreams develop and change, the weekly meeting is used to identify potential new risks which should be recorded, and to agree follow up contact with the relevant managers.

5.3. Potential risks directly related to the activity of the Regional Covid-19 Co-ordination Service are tabled and discussed during the weekly meeting.

5.4. It has been evident that during the initial flurry of covid-19 related activity risk management was not a significant priority; staff were fully engaged in 'doing the do'. However, as a new working rhythm has developed for the organisation, managers are now giving due consideration to the risks associated with their covid-19 workstreams.

6. Conclusion

6.1. The Covid Management Group is asked to note the contents of this paper.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	16-20

Name of meeting	Board of Directors
Date	28 May 2020
Name of paper	Board Committee Annual Review / TOR
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of the Board Committees' plans for 2020/21 and their Terms of Reference (Appendices 1-10). The annual plans have been considered jointly by each of the committees and will be appropriately dynamic to reflect any need to change focus. On behalf of the Board, the Audit & Risk Committee will undertake a formal review of the plans mid-year. The amendments to the terms of reference are indicated in the version control schedules at the end of each document.
Recommendations, decisions or actions sought	The Board is asked to confirm that it is satisfied with the plans for each of the four main committees and to agree the revised terms of reference / membership.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Appointments and Remuneration Committee (ARC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Appointments and Remuneration Committee (ARC).

2. Purpose

2.1. The Committee is responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

2.2. The Committee is also responsible for determining the remuneration and terms of service for any other senior employee appointed on terms outside of the Agenda for Change framework, i.e. where their remuneration exceeds Band 9.

2. Membership

3.1. The Committee shall be composed of all the independent non-executive directors. However, when appointing or removing executive directors (other than the Chief Executive) the Chief Executive will be a member, as described in Schedule 7, 17 (3) of the NHS Act 2006, as amended by the Health & Social Care Act 2012.

3.2. The Trust Chair will determine who should be Chair of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be three members.

5. Attendance

5.1. Only members of the committee have the right to attend committee meetings.

5.2. The trust secretary shall be secretary to the committee.

5.3. At the invitation of the committee, meetings shall normally be attended by the director of human resources.

5.4. Other persons may be invited by the committee to attend a meeting so as to assist in deliberations.

5.5. Any non-member, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

6. Frequency

6.1. Meetings shall be called as required, but at least twice in each financial year.

7. Authority

7.1. The Committee is constituted as a standing committee of the trust's board of directors (the board). Its constitution and terms of reference are as set out in these terms of reference, which are subject to amendment at future board meetings.

7.2. The Committee is authorised by the board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the committee

7.3. The Committee is authorised by the board to instruct professional advisors and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

7.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

8. Duties

8.1. Appointments – the committee will;

i. regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the council of governors, with regard to any changes;

ii. give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future;

iii. keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy;

iv. be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise;

v. when a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation,

prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria;

vi. ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation;

vii. ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise;

viii. ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

ix. carefully consider what compensation commitments (including pension contributions) the directors' terms of appointment would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw back provisions should be considered in case of a director returning to the NHS within the period of any putative notice;

x. consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract

8.2. Remuneration – the committee will

i. establish and keep under review a remuneration policy in respect of executive board directors [and senior managers on locally-determined pay];

ii. consult the chairperson and/or chief executive about proposals relating to the remuneration of the other executive directors.

iii. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors [and senior managers on locally-determined pay], including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars;

- allowances;
- payable expenses;
- compensation payments.

In adhering to all relevant laws, regulations and trust policies:

iv. establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

v. decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

vi. make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the foundation trust, and take as a baseline for performance any competencies required and specified within the job description for the post;

vii. consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements;

viii. use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors [and senior managers on locally-determined pay], while ensuring that increases are not made where trust or individual performance do not justify them;

ix. be sensitive to pay and employment conditions elsewhere in the trust, especially when determining annual salary increases;

x. monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

xi. monitor procedures to ensure that existing directors are and remain 'fit and proper' persons as defined in law and regulation.

8.7 In accordance with the Standing Financial Instructions, the Committee will consider and approve individual redundancy payments that fall outside of the employees' contract / standard AfC terms and conditions

8.8 The Committee will also consider and approve large scale redundancies, e.g. as a result of re-organisation.

8.9 The Committee will consider any other workforce issue referred to it by either the Chief Executive, the Chairman or a Committee member, where the nature of the discussion is considered to be sensitive and not appropriate for more general discussion at one of the other Board Committees.

9. Reporting

9.1. Formal minutes shall be taken of all committee meetings

9.2. The Chair of the Committee shall report a summary of the proceedings of each meeting to the Board and draw to the attention of the Board any significant issues that require disclosure.

10. Support

10.1. The secretary to the committee shall support the committee by:

- Agreeing meeting agendas with the Chair of the Committee;
- Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings;
- Recording formal minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Advising the Chair and the Committee about fulfilment of the Committee's Terms of Reference and related governance matters.

11. Review

11.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

11.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

11.3. These Terms of Reference shall be approved by the Board and formally reviewed at intervals not exceeding two years.

Approved by: Trust Board
Approved date:
Review Date:

ARC ANNUAL CYCLE OF BUSINESS 2020-21

Appointments & Remuneration Committee	Executive Lead	25 June 2020	24 Sept 2020	21 January 2020			
ADMINISTRATION							
Apologies	Chair	√	√	√			
Declarations of Interests	Chair	√	√	√			
Minutes	Chair	√	√	√			
Action Log	Chair	√	√	√			
Next Meeting Agenda / Forward Look	Chair	√	√	√			
APPOINTMENTS / GOVERNANCE							
Executive Succession Planning / Skills Gap Analysis / Diversity	Chief Executive	√					
Annual Review of structure, size and composition of the Board	Trust Chair	√					
Fit and Proper Persons Test Annual Review	Company Secretary	√					
Committee Annual Review / TOR	Company Secretary			√			
REMUNERATION / APPRAISALS							
Executive Director Remuneration Framework	Chief Executive		√				
Annual Review of Executive Remuneration	Chief Executive		√				
Chief Executive Appraisal / Objectives Incl. 'Earn Back' Review	Chair	√ **A**	√ **EB**				
Executive Director of HR & OD Probation Outcome	Chief Executive	√					
Executive Director Appraisals	Chief Executive	√					
*Staff Remuneration Outside of AfC / Interims & Consultants to be Approved	Chief Executive						
*Redundancy / Exit Packages to be Approved	Chief Executive						

*AS REQUIRED

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'The Committee'.

2. Purpose

2.1. The purpose of the Committee is to provide the Trust with a means of independent and objective review of internal control over the following key areas:

- Financial systems
- The information used by the Trust
- Assurance Framework systems
- Performance and Risk Management systems
- Compliance with law, guidance and codes of conduct

2.2. In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have at least three members, to include the Chairs of the other Board committees appointed by the Board from amongst the independent Non-Executive Directors of the Trust.

3.2. The Chairman of the Trust shall not be a member.

3.3. One of the members with recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.4. Current members**:**

- Michael Whitehouse, Independent Non-Executive Director (Chair)
- Al Rymer, Independent Non-Executive Director - ARC
- Howard Goodbourn, Independent Non-Executive Director - FIC
- Laurie McMahon, Independent Non-Executive Director - WWC
- Tricia McGregor, Independent Non-Executive Director - QPS

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

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance

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

- Chief Executive
- Executive Director of Finance & Corporate Services
- Executive Director of Nursing & Quality
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5.3. Officers unable to attend a meeting are required to send a fully briefed deputy or provide a written update to the Committee members at least two working days beforehand.

5.4. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

5.5. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency

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

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Telephone Conference

7.1. With leave of the Chair of the Committee, any member or attendee of the Committee may participate in a meeting of the Committee by means of a teleconference/videoconference where circumstances require it or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

8. Authority

8.1. The Committee has no executive powers. It is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

9. Duties

9.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

9.2. Governance, Risk Management and Internal Control

9.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

9.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

9.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing policy(s) so test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

9.3. Internal Audit

9.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

9.4. External Audit

9.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

9.5. Financial Reporting

9.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

9.6. Other Assurance Functions

9.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

9.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

9.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

10. Reporting

10.1. The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support

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

12. Review

12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0		March 2016	
1.1		May 2018	1. Amend to Audit and Risk 2. Included members 3. Amended attendees 4. Quorum from 3 to 2 NEDs to reflect other committees. 5. Authority section to be consistent with other committees 6. Amended the admin support arrangements 7. Included review from every 2 years to annually to be consistent with other committees
2.1		23 May 2019	Updated membership and revised wording on frequency.
2.2			Updated membership Minor revision to section 9 – to remove the specificity of who will provide administrative support.

South East Coast Ambulance Service NHS Foundation Trust

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- Compliance with law, guidance and codes of conduct

2.2. In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have at least three members, to include the Chairs of the other Board committees appointed by the Board from amongst the independent Non-Executive Directors of the Trust.

3.2. The Chairman of the Trust shall not be a member.

3.3. One of the members with recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.4. Current members**:**

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5.4. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

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8.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

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ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

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viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

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xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

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xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

9.6. Other Assurance Functions

9.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

9.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

9.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

10. Reporting

10.1. The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support

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

12. Review

12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0		March 2016	
1.1		May 2018	1. Amend to Audit and Risk 2. Included members 3. Amended attendees 4. Quorum from 3 to 2 NEDs to reflect other committees. 5. Authority section to be consistent with other committees 6. Amended the admin support arrangements 7. Included review from every 2 years to annually to be consistent with other committees
2.1		23 May 2019	Updated membership and revised wording on frequency.
2.2			Updated membership Minor revision to section 9 – to remove the specificity of who will provide administrative support.

Audit & Risk Committee	Executive Lead	21 May 2020	16 July 2020	10 Sep 2020	03 Dec 2020	11 March 2021
ADMINISTRATION						
Apologies	Chair	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√
Minutes	Chair	√	√	√	√	√
Action Log	Chair	√	√	√	√	√
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√
FINANCIAL STATEMENTS & THE ANNUAL REPORT						
Annual Report & Accounts -External Audit Report -ISA260 Report (Audit Hilights Memo) -Management Representations Letter on the financial statements -Management Representations Letter on the quality report	Exec Director of Finance KPMG	√				
Annual Governance Statement	Company Secretary	√				√Draft
Accounting Policies	Exec Director of Finance			√		
Accounting and Reporting Systems	Exec Director of Finance					
Financial statements - integrity / judgments	Exec Director of Finance				√	
Single Tender Waivers	Exec Director of Finance		√			
Losses and Special Payments [incl. baseline numbers / % as per action 164-19 04.03.2019]	Exec Director of Finance					√
INTERNAL AUDIT						
Counter Fraud Progress Report	RSM		√	√		√
Counter Fraud Work Plan	RSM					√
Counter Fraud Annual Report incl. SRT	RSM					√
Internal Audit Progress Report	RSM		√	√	√	√
Internal Audit Annual Plan	RSM					√
Annual Report to include Internal Audit Opinion	RSM	√				√Draft
EXTERNAL AUDIT						
External Audit Finding Report	KPMG	√				
Report to Governors on Quality Report	KPMG	√				
Limited Assutance opinion on Qualiry Report Indicators	KPMG	√				
Progress Report / Technical Update	KPMG					√
Audit Plan	KPMG				√	
GOVERNANCE & RISK MANAGEMENT						
Plan for the production of the Annual Report & Accounts	Chief Executive				√	
Business Continiuty	Exec Director of Operations		√			
Data Quality	Exec Director of Strategy				√	
Whistleblowing	Exec Director of Nursing			√		
Decl. of Interests	Company Secretary			√		
Policy Matrix - Annual Review	Company Secretary					√
Assurance Map - Annual Review	Company Secretary					√
Board Assurance Framework Review	Company Secretary				√	
Risk Review, incl. BAF Risk Report	Executive Director of Nursing / Company Secretary		√	√	√	√
Risk Management System / effectivess of the policy and procedure	Exec Director of Nursing			√		√
Annual Review of SO's/SFI's	Exec Director of Finance		√			√
Annual Self Certification GC6/COS 7	Company Secretary	√				
Corporate Governance Statement	Company Secretary	√				√Draft
Integrated Performance Report Annual Review	Exec Director of Strategy		√			
Information Governance (incl. *Annual Report)	Exec Director of Nursing		√*			√
Annual Review of Cycle of Business	Company Secretary					√
Annual Self-Assessment	Company Secretary					√
Review of Terms of Reference	Company Secretary					√
Review Purview / TOR of other Board Committees	Company Secretary					√
MANAGEMENT RESPONSE (delete once received)						
Internal Audit Plan 2020 21						
BAF / Risk Management					√	
GDPR / IG						√
Financial Systems / Payroll						√

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, corporate services and investments in future operational capability, are designed appropriately and operating effectively.

3. Membership

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

The members of the committee shall be:
Howard Goodbourn, Independent Non-Executive Director (Chair)
Michael Whitehouse, Independent Non-Executive Director
Lucy Bloem, Independent Non-Executive Director
Executive Director of Finance & Corp. Services (Executive Lead)
Executive Medical Director
Executive Director of Operations

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

4. Quorum

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

5. Attendance

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

- Executive Director of Strategy & Business Development
- Company Secretary
- Deputy Director of Finance
- A senior manager from operations

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

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

6. Frequency

The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively.

8. Purview

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

9. Support

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

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review

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

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	21 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. FBDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	19 October 17	23 October 17	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Update to membership
2.1	13 May 2019	23 May 2019	Update to membership Increased frequency from 4 to 6 meetings Revised section 7 leaving the detail of areas covered by the committee to the purview/annual plan.
2.2			Updated membership including moving the executive director of strategy to an attendee so there is equal membership between exec and non-exec. Minor revision to section 9 – to remove the specificity of who will provide administrative support.

Finance and Investment Committee	Executive Lead	14 May 2020	23 July 2020	10 September 2020	12 November 2020	14 January 2021	18 March 2021
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
SCRUTINY							
Use of operational resource / impact on performance 111 & 999	Executive Director of Operations	√		√		√	
999 Operational efficiencies, e.g. job cycle time / unit costs	Executive Director of Operations		√		√		√
Financial Planning - annual plan / budgets	Executive Director of Finance						√
Capital Programme Plan - development* and delivery**	Executive Director of Finance				√**		√*
Reference Costs / Patient Level Costing	Executive Director of Finance	√					
ERIC Return (Estates)	Executive Director of Finance		√				
Cost Improvement Programme / Overview of Schemes	Executive Director of Finance	√					
Winter Planning	Executive Director of Operations			√			
Utilisation of Technology	Executive Director of Finance		√				
Make Ready Process	Executive Director of Operations					√	
Fleet Strategy Implementation Plan	Executive Director of Operations			√			
Department Deep Dives - Procument Estates Fleet IT Finance	TBC	P	E	F	IT	F	
PMO	Executive Director of Strategy		√				
Monitoring Performance							
111 / CAS & 999 Operational Performance	Executive Director of Operations	√	√	√	√	√	√
Financial Performance (Pack) / Forecast	Executive Director of Finance	√	√	√	√		√
IT Dashboard/KPIs	Executive Director of Finance	√			√		
Estates Dashboard/KPIs	Executive Director of Finance		√				√
Business Cases							
Business Case Schedule / Tracker	Executive Director of Finance						
Business Cases for Recommendation	TBC						
Return on Investment / Benefits Realisation	TBC						
Strategies							
Digital Strategy	Executive Director of Finance						
Fleet Strategy	Executive Director of Operations						
Estates Strategy	Executive Director of Finance						
Governance & Risk							
BAF Risks	Company Secretary	√	√	√	√	√	√
Committee Annual Self-Assessment	Company Secretary					√	
Cycle of Business	Company Secretary						√
Terms of Reference	Company Secretary						√
Internal Audit Plan 2020 / 21							
Fleet Management				√			
IT					√		

Financial Planning						√	

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution

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

2. Purpose

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

3. Membership

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

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

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

4. Quorum

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

5. Attendance

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

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

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

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

6. Frequency

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

7. Authority

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

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

8. Purview

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

9. Support

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

10. Reporting

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

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

11. Review

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

VERSION CONTROL SCHEDULE

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

Quality & Patient Safety Committee	Executive Lead	21 May 2020	09 July 2020	17 Sept 2020	19 Nov 2020	07 Jan 2021	18 March 2021
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
SCRUTINY							
111							
111 / CAS Clinical effectiveness	Executive Director of Operations		√			√	
EOC							
EOC clinical safety	Executive Director of Operations	√		√		√	
999							
Consent to Treatment (is it being sought in line with legislation and guidance)	Executive Medical Director	√					
Surge (application of the SMP / Clinical Harm Review)	Executive Director of Operations				√		
Bariatric Care (vehicle equipment and response) Are they located correctly, Policy, equipment, analysis of performance, tasking, training	Executive Director of Operations						
Private Ambulance Providers: to include governance, policies and procedures in place, system for planning, compliance data to include complaints, risks, issues, serious incidents. Plus clinical effectiveness	Executive Director of Operations			√			
Clinical Outcomes - deep dive in to specific areas, e.g. cardiac survival	Executive Medical Director	√	√	√	√	√	√
Medical Equipment: Full review of Medical Devices IAP including all equipment, pre implementation checks	Executive Director of Operations						
Obstetrics: effective care and treatment	Executive Medical Director	√					
RTC's - Emergency, non-emergency, Collisions not involving public, and safety. Assurance of learning from incidents	Executive Director of Operations						
Co-Responders: Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning. To include recruitment & retention. To include tasking	Executive Director of Operations						
Paediatrics: effective care and treatment	Executive Medical Director		√				
Frequent Callers - Review of Strategy/Plan and resources	Executive Medical Director						
Specialist							
HART: Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning.To include recruitment & retention. To include tasking. NARU Audit readiness assessment	Executive Director of Operations				√		
Specialist Paramedics (PP & CCP) Scope of Practice - Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning. To include recruitment & retention	Executive Medical Director		√				
Clinical Governance / Standards / Compliance							

Quality & Patient Safety Committee	Executive Lead	21 May 2020	09 July 2020	17 Sept 2020	19 Nov 2020	07 Jan 2021	18 March 2021
Non Registered Clinicians - Scope of Practice - Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning. To include recruitment & retention	Executive Medical Director						
Medicines Governance Incl. QAVs	Executive Medical Director		√				
Infection Prevention and Control - internal controls / effectiveness	Executive Director of Nursing & Quality						
Learning from Serious Incidents, complaints, incidents.	Executive Director of Nursing & Quality						
Serious Incident Q Thematic Review / Learning from Deaths	Executive Director of Nursing & Quality / Executive Medical Director	√			√		√
Duty of Candour - compliance with legislation and staff impact	Executive Director of Nursing & Quality						
Patient Records / ECPR	Executive Director of Operations						
Complaints Management - design and effectiveness of controls	Executive Director of Nursing & Quality					√	
Safeguarding	Executive Director of Nursing & Quality						
Key Skills Annual Programme	Executive Medical Director						
CIP QIAs	Executive Director of Nursing & Quality	√					
QIA mid year review	Executive Director of Nursing & Quality						
CFR Governance & Effectiveness	Executive Director of Operations						
Clinical Supervision	Executive Medical Director						
CAS Alerts: Monitoring management and oversight of Trust policy and procedures	Executive Director of Nursing & Quality						
NHS Pathways Compliance 999 & 111	Executive Director of Operations						
Compliance with Modern Slavery Act	Executive Director of Nursing & Quality						
MONITORING PERFORMANCE & QUALITY							
Quality & Safety Dashboard / Report	Executive Director of Nursing & Quality	√	√	√	√	√	√
Safeguarding Mid-Year Review	Executive Director of Nursing & Quality						
Quality Account Development*/Sign Off**/Mid Year Review***	Executive Director of Nursing & Quality	√**			√***		√*
Incident / SI Annual Report	Executive Director of Nursing & Quality						
Infection Prevention and Control Annual Report	Executive Director of Nursing & Quality						
Clinical Audit Annual Report / Plan	Executive Medical Director	√					
Annual Safeguarding Report	Executive Director of Nursing & Quality						
Accountable Officer for Controlled Drugs Annual Report (Medicines Governance)	Executive Medical Director	√					
Cardiac Arrest Annual Report	Executive Medical Director		√				
Freedom to Speak Themes / *Annual Report	Executive Director of Nursing & Quality						
Quality Assurance Visits / Patient Safety Leadership Visit	Executive Director of Nursing & Quality						
ENABLING STRATEGIES							
Volunteers	Executive Director of Operations						
Freedom to Speak Up	Executive Director of Nursing & Quality						
Safeguarding	Executive Director of Nursing & Quality						
Patient Experience	Executive Director of Nursing & Quality						
Infection Prevention & Control	Executive Director of Nursing & Quality						
MANAGEMENT RESPONSES (delete once received)							
GOVERNANCE & RISK MANAGEMENT							
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√	√	√	√	√	√
Bi-Annual Review of High/Extreme Risks	Executive Director of Nursing & Quality						

Quality & Patient Safety Committee	Executive Lead	21 May 2020	09 July 2020	17 Sept 2020	19 Nov 2020	07 Jan 2021	18 March 2021
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary					√	
Mid-Year Review of Cycle of Business	Company Secretary				√		
Internal Audit Plan 2020/21							
Complaints (schedule as at the draft 18.02.2020)						√	
Medicines (schedule as at the draft 18.02.2020)			√				

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the workforce (encompassing resourcing, staff wellbeing and HR processes) are designed appropriately and operating effectively.

3. Membership

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

The members of the committee shall be:
Laurie McMahon, Independent Non-Executive Director (Chair)
Terry Parkin, Independent Non-Executive Director
Al Rymer, Independent Non-Executive Director
Executive Director of HR & OD
Executive Director of Operations
Executive Director of Nursing & Quality

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

4. Quorum

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

5. Attendance

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

- Executive Director of Strategy
- Company Secretary
- HR Business Support Manager

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

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

6. Frequency

The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview

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

9. Support

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

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure

11. Review

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

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	12 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. WDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16 Board.
1.1	20 Sept 16		Minor amendment proposed at para 5.3 see italicised changes.
2.0	04 October 2017		Change in Chair and Membership Additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
2.1		25 May 2018	Updated membership Reduced frequency to minimum 4 times a year (from 6)
2.2		23 May 2019	Updated membership Increased frequency to minimum 6 time a year (from 4)
2.3			Change to membership – Chair will change in Q1 2020/21 Small amendment to section 9 removing the specificity of the administrative support.

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021	
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	
SCRUTINY							
Programmes (overview of progress against objectives)							
HR Transformation Plan	Executive Director of HR & OD	√					
Clinical Education Plan	Executive Medical Director	√	√	√			
HR Service Centre							
Payroll Discrepancy - effectiveness of policy	Executive Director of HR & OD	√					
Payroll Contract	Executive Director of HR & OD	√					
Workforce Planning							
Workforce delivery (Demand and Capacity Review Phase 1)	Executive Director of HR & OD	√	√	√	√	√	
Workforce delivery (Demand and Capacity Review Phase 2)	Executive Director of HR & OD					√	
Student Paramedics - recruitment and support	Executive Medical Director						
Workforce Governance							
Personnel Files	Executive Director of HR & OD		√				
Pre-Employment Checks	Executive Director of HR & OD		√		√		
Clinical Education							
External Compliance (Ofsted; Fquals; ESFA)	Executive Medical Director					√	
Annual Training Plan	Executive Medical Director	√		√			
Key Skills Annual Plan* / Progress**	Executive Medical Director			√**		√*	
Workforce Education Development Review (B5>6 uplift / mentorship)	Executive Medical Director						
Continuous Professional Development - clinical staff	Executive Medical Director				√		
Driving Standards	Executive Medical Director		√				
Apprenticeship Governance	Executive Medical Director					√	
Higher Education Institution - partnerships with Universities	Executive Medical Director			√			
Employee Relations							
Bullying & Harassment	Executive Director of HR & OD						
Grievances	Executive Director of HR & OD	√					
Equality, Diversity, Inclusion & Wellbeing							
Equality Delivery System - EDS2 Goals, Delivery on the WRES, DES, Equality Objectives, Gender Pay gap.	Executive Director of HR & OD						

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021	
Learning & OD							
Management Training - Fundamentals	Executive Director of HR & OD			√			
Staff Induction Programme	Executive Director of HR & OD		√				
Health & Safety							
Health & Safety Management systems	Executive Director of Nursing & Quality				√		
MONITORING PERFORMANCE & QUALITY							
Staff Survey Results / Next Steps	Executive Director of HR & OD					√	
Committee Dashboard - Power BI, incl. H&S	Executive Director of HR & OD	√	√	√	√	√	
Annual H&S Audits	Executive Director of Nursing & Quality						
Annual Wellbeing report	Executive Director of HR & OD						
Annual Inclusion report (including an overview of stat and legislative requirements: Equality Delivery System (EDS2), Delivery on the WRES, DES, Equality Objectives, Gender Pay gap, etc)	Executive Director of HR & OD						
MANAGEMENT RESPONSES (delete once received)							
STRATEGIES							
People Strategy	Executive Director of HR & OD						
Clinical Education Strategy	Executive Medical Director						
Inclusion Strategy	Executive Director of HR & OD						
Retention Strategy	Executive Director of HR & OD						
GOVERNANCE & RISK MANAGEMENT							
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√	√	√	√	√	
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary				√		
Internal Audit Plan 2020 / 21							
Recruitment Process & Governance			√				
Workforce / Resourcing				√			
Clinical Education						√	

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021