South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

30 July 2020
10.00-13.00

Via Video Conference

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Introduction					
19/20	10.00	Welcome and Apologies for absence	-	-	Chair
20/20	10.02	Declarations of interest	-	-	Chair
21/20	10.02	Minutes of the previous meeting: 28 May 2020	**Y**	Decision	Chair
22/20	10.03	Matters arising (Action log)	**Y**	Decision	PL
23/20	10.05	Board Story	-		
24/20	10.15	Chief Executive's report	**Y**	Information	PA
COVID-19					
25/20	10.25	COVID Response Incl. IPC Assurance Framework	**Y**	Assurance	BH
Quality & Performance					
26/20	10.40	Integrated Performance Report / Committee Reports	**Y**	Information	PA
Break 11.35-11.45					
27/20	11.45	Out of Hospital Cardiac Arrest Annual Report 2019/20	**Y**	Information	FM
28/20	11.55	Clinical Audit Annual Report 2019/20	**Y**	Information	FM
29/20	12.05	Learning from Deaths Report	**Y**	Information	FM
Strategy					
30/20	12.15	Community Resilience Strategy	**Y**	Decision	JG
Governance & Risk					
31/20	12.25	Audit & Risk Committee Report Incl. IG Annual Report	**Y**	Information	MW
32/20	12.35	BAF Risk Report	**Y**	Assurance	PL
33/20	12.45	Charitable Funds Committee Report / TOR	**Y**	Decision	MW
34/20	12.55	Appointment and Remuneration Committee Report	**Y**	Information	AR
Closing					
35/20	13.00	Any other business	-	Discussion	Chair
36/20	-	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: 24 September 2020

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 28 May 2020

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

Present:

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

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Judith Ward	(JW)	Deputy Director of Nursing & Quality

Chairman's introductions

DA welcomed members and those in attendance and confirmed that the meeting is being recorded via Teams.

01/20 Apologies for absence

Steve Emerton	(SE)	Executive Director of Strategy & Business Development

02/20 Declarations of conflicts of interest

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

03/20 Minutes of the meeting held in public 30.01.2020

The minutes were approved as a true and accurate record.

04/20 Action Log

The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed. The Board reinforced the urgency needed in getting the volunteer strategy agreed.

05/20 Board Story [10.06 -10.27]
AM introduced the video, which is timely during mental health awareness week. He explained that staff have had to work in very difficult circumstances during the COVIID crisis, both in patient-facing and support roles.

The video showed the impact on ambulance staff's mental health and wellbeing. It has been shared with our own staff and used during a webinar for staff on the provision of mental health support, which has had over two and half thousand views.

DA reflected on the very powerful video. He asked directors whether we are confident in the wellbeing provision and leadership in place to ensure staff can be confident to say when they need support. JG felt we do have robust support in place; we have daily briefing calls plus weekly live webinars to communicate with staff about how it is for them, especially during this time. We then use these opportunities to remind staff to look out for each other. PA added that mental health issues affect many of us and so we will continue to make is as easy as possible to talk to each other when we are finding things difficult.

06/20 Chief Executive Report [10.27 – 10.51]
PA highlighted the following areas from his report;

- Operational performance – in 999 performance has never been better than in April and May, helped by slightly lower demand. By the end of May we have returned broadly to seasonal norm, but we are doing better as we are putting more hours. This has been possible for a combination of things, such as lower abstraction, specifically annual leave and training. In terms of 111, the service was really challenged in February and March when we were seeing five times normal volumes. As in 999 we are now back to normal demand.
- Sad passing of staff - Rhod Prosser, Rosie Hales (not COVID-related). We also lost a recently-retired colleague, Ricky Powell, and Peter Hart was lost to COVID.
- Testing – normal testing (symptomatic) is running well. A pilot is completed for asymptomatic testing of 120 staff; none were positive. The next thing is antibody testing, which is starting shortly, and staff will be involved in system wide testing. Track and trace starts today, and we will be monitoring the impact on our staff.
- COVID governance – this is on the agenda and PA commended BH and DH for their leadership of the management and learning and improvement groups.

On behalf of the Board DA offered his condolences to the friends and family of the members of staff that have recently passed away. He then opened up to questions.

MW asked whether we are more or less resilient than before COVID if we get a second wave in the winter. PA confirmed that we have increased our resilience; firstly, we have arrangements that enable social distancing and there is much greater focus on infection prevention and control. Secondly, we have a good number of people on the bank than before and are improving our ability to employ them efficiently. Plus, there is greater ability to recruit more easily in this climate. However, a concern is the lack of leave being taken and so we are encouraging staff over the next period as the second peak is modelled to be in August / September.

With regards track and trace TP asked if we are assuming that staff wearing PPE when in contact will not need to isolate. Will staff need direction to ignore the request to self-isolate? BH confirmed we are still waiting for clarity on this. JG added that with the pilot in the Isle of Wight the instruction is effectively; PPE on / App off. TP felt that we might need to provide guidance to staff if only to say to contact their line manager in the event they get a phone call. BH confirmed that we will use the 16.00 daily call and webinar tomorrow.

LM thanked PA and DA for engaging with external stakeholders and asked whether we are developing team / key messages. PA agreed to consider this with particular focus on the longer term messaging.

07/20 COVID Response Management Group [10.51 – 11.03]
BH outlined the governance arrangements that have been implemented to respond to the COVID crisis, while in the BCI as outlined in the paper. She reinforced that all trust governance remains in place, e.g. QIA / business cases etc. We have just become a little more agile, for example we have more QIA panels and a framework to allow decisions to be taken out of hours.

MW agreed there is good governance in place and asked about how we use data to make real time decisions. JG gave the example of PPE where we now have a very detailed running tally of each item of PPE and remaining stock levels, so we have advanced warning when we are due to run short.

LB asked for assurance that issues non-COVID related go through usual governance; BH confirmed this is the case and CRMG closely monitors this to ensure only COVID-related decisions are taken.

BH confirmed that the IPC assurance framework would come to July's Board meeting as wasn't quite ready for this one. It will be reviewed first at the quality and patient safety committee.

DA summarised that the Board is assured by the way we have risen to this challenge while at the same time maintained normal business.

09/20 Patient Experience Strategy (11.03 – 11.14)
JW introduced this strategy which has been considered by the quality and patient safety (QPS) committee. The next step is to develop a strategy on a page for patients/carers, which is more digestible. This has had much engagement and has good support; it is an ambitious but achievable plan.

LM felt that it is a great document. It talks about patients and carers and as we review over time and extend our reach, we might need to reflect the community beyond patients and carers.

TM confirmed that QPS supported it and reflected that as we develop our services, we should ensure a more multidisciplinary response, especially in Cat 3 and 4. But overall TM felt this is a great step forward.

TP referred to the development plan which indicates significant work is needed to get patient feedback; he wondered if this was too onerous and suggested that it could be very complicated to engage patients in staff appraisals. JW responded that there are different ways to do it, e.g. complaints and compliments. TP acknowledged this but felt this will be patchy and we won't have feedback in this way for all our staff. In other words, if we want this as a goal, he suggested we need a clear plan to make it work.

AR fed back that it seems to be missing what good looks like for the patients/carers. JW explained the plan to be developed will include this.

DA confirmed that the Board supports this strategy and QPS will oversee delivery.

[Break at 11.14-11.20]

08/20 Trust Strategy [11.20 – 11.40]
PA confirmed that he has reviewed the strategy agreed by the Board shortly before the lockdown, to see whether he thinks it is still right for what the future now looks like. He believes it has stood this test and all the elements are what we should be doing over the coming months / years. There needs to be minor amendments following discussions with some Board members in recent days, including being more

confident than before in getting to outstanding. There also needs to be a review of the way the objectives are described to make them pithy, so they better fit with other documents including the BAF. Overall, PA is very happy with the strategy developed by the Board and so commends it for approval.

LM agreed that it is an excellent strategy and the mark of a good strategy is that is survives COVID. It demonstrates that the Board has worked well together and engaged stakeholders to develop it. It reflects coherently our aspirations and the reality of the operating environment. He agreed that the objectives need a bit of refining to ensure clearer line of sight between them and the strategy. The objectives need to be strong enough to hold the weight of the subsequent delivery plan which the Board will use to hold the executive and each other to account. The next step is to agree the key messages and how we use these in our discussions with stakeholders.

MW supports the move to revise the objectives to ensure focus on the added value over and above delivering 111/999, which we must reflect in the delivery plan. Also, he emphasised the importance of the delivery plan so we can track how we are delivering and the difference we are making.

HG also felt it is excellent. He referred to improving population health of communities, which seems a big target and asked how we would do this. PA explained that this arose from the previous Board sessions and we are not saying we are responsible for public health but rather have a role to play, e.g. every contact we are advising how to maintain health and wellbeing. FM supported this and gave other examples which aligns to 'making every contact count'.

AM stated that as we develop the delivery plan we will need to engage further with staff and other stakeholders and use this opportunity to further embed the Trust values.

In terms of the ambition to being outstanding, LB felt we should have the confidence to achieve this in all we do not just in the CQC rating.

DA summarised - first of all the Board receives with enthusiasm this new strategy, which is a team effort. The way we have responded to the COVID crisis gives us a newfound confidence to be even more ambitious, while not losing sight of delivering the basics. The strategy reflects this, and the delivery plan needs to come to the Board following good engagement with Board members.

Action
Draft Strategic Delivery Plan to come to Board for consideration and feedback.

10/20 IPR / Board Escalation Report [11.40 – 12.47]
DH introduced the report, which covers March when the COVID crisis emerged. He then asked directors to update anything by exception.

Clinical safety
FM highlighted the improvement in care bundles for STEMI and stroke, explaining that the improvement is largely a result of recording via EPCR.

HG asked about clinical outcomes and what influence we have over these and what can we do to improve outcomes on cardiac arrest survival. FM explained the numbers of survivors are relatively small so taking a look across the year is more useful. There is an ongoing project with focus in EOC to gets 'hands on the chest' via bystanders as soon as possible; response times are mostly under 7 minutes.

Quality

BH firstly highlighted incident reporting and the weekly review by CRMG and QPS. Duty of candour is back up to 100%.

MW asked mental health data and the times we did not respond. BH explained this is s136 patients and so it will be where the Police have transported the individual. LB followed up asking whether we are now at a point where our data with Police and mental health trusts is in line. BH confirmed this is the case, save for with one trust where work is ongoing to understand why there appears to be a difference.

In terms of duty of candour, LB asked if the compliance rate quoted includes moderate harm. BH confirmed it does and acknowledged the wording in the report is not clear and so will ensure this is changed in the new version of the IPR.

QPS Committee Escalation Report

TM outlined the areas of focus as set out in the report. She confirmed the approach in meeting weekly to oversee the decisions at CRMG and these will now continue on a fortnightly basis.

There were no questions.

Operational Performance

JG took the Board through the performance data in the IPR, including the section giving the current picture from the past three weeks, which show good levels of compliance with ARP targets.

MW reinforced the need to test our resilience going forward, rather than only looking back. This was noted and something the executive is working on in the development of the new IPR.

TP reflected that it is quite exceptional we have been able to put out so many hours, suggesting the workforce plan is starting to deliver the capacity needed. However, he asked whether we are able to manage demand as it returns. JG responded by confirming that while 999 call volume has dropped, incidents have remained relatively stable, in part due to the significant reduction in duplicate calls. He is therefore confident we can handle 999 call activity.

LB noted that although our scorecard is green across the board and asked how our improvements compare to other ambulance trusts; in other words, how do we benchmark our utilisation of resources. JG confirmed that while we are green, we are still toward the bottom of the pack, especially for Cat 3/4. Middle to upper for Cat 2.

PA responded to TP's comment about the workforce plan delivering, explaining that this isn't quite the case; the increase in hours is more to do with lower leave and pausing training etc.

Workforce

AM confirmed that there has never been such a large volume of recruitment at the Trust. The number of bank staff has doubled from circa 300 to 600. This has caused some onboarding challenges. AM also highlighted from the report the employee relations activity, explaining that while it may look by the dashboard that cases are decreasing, this is only because cases are paused in line with national COVID guidance.

In terms of workforce compliance data, AM confirmed that the way we report appraisals and statutory and mandatory training will move to rolling data.

MW asked whether the recovery plan addresses the areas that have been paused, as this is key to our long term resilience. AM explained that it will be and confirmed that the issue of leave is mentioned on every 16.00 call. There are no defined plans to get to the normal position, but we are working on it.

Action
WWC to oversee the plan to ensure annual leave is taken given its impact / risk to operational resilience

WWC Escalation Report
LM took the Board through the report highlighting the shift in emphasis to ensure the committee gathers intelligence from staff across the trust. Work on HR processes is a key focus. In terms of workforce planning, it is important to note that we are taking more of a forward view about how our service develops and implications on skill mix going forward. As a consequence of this the committee has scheduled additional meetings through the year.

Finance
DH confirmed the year end position, which was as planned. All targets were met save for CIP, despite achieving the bottom line. As confirmed previously we removed some schemes that were more cost avoidance than cost improvement.

In terms of the budget presentation in the pack, DH took the Board through the slides which have been through the finance committee. The key part to note is that this year is unique as we have been mandated to move to a block contract from 'cost and volume'. The formal position is that this will be up to July, but it is likely to be extended to March 2021. The block is based on the month 9 position and topped up to reflect the difference between month 9 and month 12. A retrospective top up will then be applied which looks at issues not yet picked up, as the underlying principle is all trusts will deliver a breakeven position. The top up is therefore effectively the balancing process.

DH then described the way the budget comes together as per the waterfall chart in the slides, with slide 11 showing how the money is spent on front line operational hours; an increase of £3m, and slide 12 showing the five year capital plan

In summary, planning arrangements for 2020/21 are exceptional, driven by the COVID -19 crisis. Some element of financial risk is removed as the costs are underwritten from the center, but there remains a requirement for the Trust to exercise strong financial governance and ensure value for money in its use of resources. DH asked that the Trust Board approves the budget, noting the associated risks, in particular the assumptions re 'top up 2' and recovery of all COVID costs.

MW added that the audit committee is confident we are claiming COVID expenditure appropriately and are using internal audit for third line assurance.

DA congratulated the executive on the year end position, which demonstrates good financial control. The Board then formally approved the budget, noting the risks.

FIC Escalation Report
HG outlined the key areas of focus by the committee. There were no questions.

11/20 Learning from Deaths Report [12.47 – 12.52]
FM introduced the report highlighting that this is the first such report and is not the whole of Q4, but only January, due to COVID. The full quarter will come to the meeting in July.

FM confirmed that we need to look at how staff are supported in making best interest decisions. The report includes 20 structured judgmental reviews and no harm was identified; the good practice is as set out in the report.

TP asked about section 3.3 and whether there is benefit from having a breakdown of the age ranges. Also, he did not understand how 168 patients ages are unknown. FM confirmed that this is likely to be patients in a public place and will clarify this in the next report.

The Board welcomed this and will look forward to future reports.

12/20 H&S Annual Report [12.52 – 12.54]
Board noted the report, which has been reviewed by the workforce committee, and thanked Amjad Nazir, Head of H&S, his team and the whole trust for taking this seriously and making such positive improvements.

13/20 Safeguarding Annual Report [12.54-12.55]
The Board noted this positive report that has been reviewed by the quality committee.

14/20 Audit & Risk Committee Escalation Report [12.55 – 13.02]
MW provided a verbal update explaining that the focus of the meeting was reviewing on annual report and accounts, in conjunction with internal and external audit. As a going concern, the committee confirmed the financial resilience and so there is no going concern issue to escalate.

The positive message is that while KMPG are yet to complete the work, no material issues have been raised in giving a clean audit opinion. External Audit also gives view on value for money / use of resources; last year we did not get a clean opinion but this year a positive opinion will be provided so a good step forward and assurance that we are using resources appropriately.

In terms of internal audit MW explained that the positive annual opinion gives the Board assurance that we have a good control environment to manage services effectively. They also need to give opinion on approach to management of risks. Last year we had a positive opinion on risk but concern about internal controls – this year there is a positive opinion on both controls and risk; this is in keeping with the trajectory of Trust in the last 18-24 months.

In June the formal accounts will be presented, in line with the new deadline of 25 June.

On behalf of the committee MW congratulated the executive team.

DA agreed and reflected that this is a good position to be in.

15/20 BAF Risk Report [13.02 – 13.04]
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.

16/20 Board Committee TOR / Annual Plans [13.04 – 13.06]
PL explained the process for the development of the annual plans with them being reviewed in aggregation by the chairs of each committee. The Board approved the amendments to the terms of reference and supported the focus of each committee as reflected in the annual plans.

17/20 AOB
None

18/20 Review of meeting effectiveness
The meeting overran but directors felt that there was good business transacted with balanced discussion. Also 'Teams' worked well.

There being no further business, the Chair closed the meeting at 13.09

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	C	Discussed at the devcelopment session in June
24.01.2019	145/18d	Confirm to the Board the timeline and approach to developing the CFR / Volunteer strategy.	JG	30.07.2020	Board	C	On agenda 30.07.20
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	C	Included in the new IPR on agenda
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	Q2 2020	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	Q2 2020	WWC	IP	
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.	DH	Q1 2020/21	FIC	IP	Ongoing - see FIC escalation report on agenda
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.	AM	Q2 2020/21	WWC	IP	
28.05.2020	08 20	Draft Strategic Delivery Plan to come to Board for consideration and feedback.	PL	Q1 2020/21	Board	C	Reviewed at the development session in June
28.05.2020	10 20	WWC to oversee the plan to ensure annual leave is taken given its impact / risk to operational resilience	PL	TBC	WWC	IP	To be added to the COB

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	24-20

Name of meeting	Trust Board
Date	30.07.2020
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 June and July 2020 to date.

2. Local issues

2.1 Operational Performance

2.1.1 During the on-going challenge of the COVID-19 pandemic, the Trust's Senior Operational Leadership Team is continuing to closely monitor 999 and 111 performance.

2.1.2 999 call answering performance has remained consistently strong during this period, with our performance meeting the national targets and comparing very strongly to our colleagues in other services.

2.1.3 In terms of response time performance, performance during June was strong overall, however has been more challenged during July to date. As a result, we have not met the Category 1 mean target for this period, missing this by 31 seconds. We did however meet the Category 1 90th centile standard and did meet both targets for Category 2 calls.

2.1.4 Our performance against the Category 3 and 4 standards continues to be challenged and unfortunately, we are continuing to see unacceptably long waits to a small number of calls in these categories. Improving performance against these targets remains a key focus for the Operational team.

2.1.5 When analysing our operational performance, it is clear that although demand has increased from the levels seen earlier on in the pandemic, the main challenge facing us is ensuring we are providing operational hours up to the required levels. During this period, we are continuing to see higher levels of staff abstraction including those staff who are self-isolating for a range of different reasons, in addition to the expected levels of sickness and this is significantly impacting, at times, on our performance.

2.1.6 Our focus is on managing our abstractions closely and ensuring that we can safely return as many staff as possible to the workplace. The recently-introduced national requirement for us to undertake COVID risk assessments for specific staff groups (see below) has added some complexity to this process, however we are now making good progress in this area.

2.1.7 In terms of wider system performance, we have also begun to see an increasing number of requests for inter-hospital diverts – this is an indication that our regional acute trust colleagues are beginning to experience periods of increased pressure. We are continuing to monitor this closely, as having to transport patients further than necessary has a knock-on impact on the availability of our resources.

2.1.8 Our NHS 111 service has seen demand continue at close to expected levels during June and July 2020 and we have delivered largely consistent performance against our performance standards. However, demand continues to be heavily impacted at times by any national announcements made about how to access services or changes in process.

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 the pandemic, the focus of the EMB has been on the impact of COVID-19 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. Specific COVID-related issues discussed have included: PPE/Fit Testing, Testing (viral/antibody), Risk Assessments and ensuring we are doing everything possible to support our staff.

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

- Development of the new Strategic Delivery Plan and Quality Improvement Plan (coming to the Board in September)
- Clinical Education
- 111 CAS Mobilisation
- Approval of the following Business Cases:
    - CCP Education Pathway
    - 111 & 999 Accelerated HA / EMA staffing
    - C1 Driving Qualification Courses

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 Clinical Education

2.3.1 During July 2020 we received the FutureQuals audit report into our Clinical Education provision. As a reminder, FutureQuals are the awarding organisation for the Trust's vocational qualifications (ECSW and AAP, and driver training) and are regulated to undertake site visits/audits and External Quality Assurance (EQA) audits to monitor and evaluate our performance in this area.

2.3.2 As shared previously, the Trust had undergone an audit at the end of November 2019, and achieved a Level 2 outcome, which resulted in the application of a number of sanctions.

2.3.3 I am very pleased to report that the most recent audit (which was undertaken remotely due to lockdown restrictions) shows demonstrable evidence of improvement and resulted in the Trust receiving an improved Level 1 outcome. This means that FutureQuals were assured that there is 'adequate assurance', from limited assurance previously.

2.3.4 Within the audit report, the Clinical Education team were commended for the significant improvements made since the November 2019 audit. There is now a short window for the final actions to be completed and evidence provided.

2.3.5 Successful completion of this will result in the closure of the audit by FutureQuals, which will be an extremely positive step forwards in our development of Clinical Education within SECAmb.

2.4 Ambulance Leadership Forum (ALF) Award

2.4.1 One of the casualties of the pandemic was this year's Ambulance Leadership Forum, due to take place in March and which was understandably cancelled. I was especially sorry not to be able to see Operating Unit Manager Andy Rowe receive his award during the ALF Awards Dinner – a national event which recognizes outstanding service in a number of categories.

2.4.2 Andy had been successfully nominated for an award in the category of 'Paramedic Manager'. During his 12 years with the Trust, his desire to make a difference to staff and patients is self-evident and he was very deserving of this award.

2.4.3 To ensure he didn't miss out entirely, I was very pleased to present Andy with his award, albeit in the less glamorous surroundings of Crawley HQ. Well done Andy on your award.

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 and spending time at our Trust locations, although this has been more limited than usual and has obviously been carried out virtually in most cases.

2.5.2 On 18 June 2020, I was very proud to pay my respects ahead of the funeral of Peter Hart, a paramedic who worked at East Surrey Hospital and who sadly died of COVID. Peter had previously worked for SECAmb for a number of years and had continued to undertake bank shifts for us. Although obviously upsetting, it was an extremely moving occasion which I know meant a great deal to Peter's many friends and colleagues at SECAmb.

2.5.3 On 26 June 2020, I was very pleased to join the special Virtual Pride event as well as the fantastic SECAmb 'after party'. It's such a shame that Brighton Pride won't be able to take place this year in its usual format but it's great that people are still able to come together to celebrate in different ways.

2.5.4 I have continued to attend a range of system meetings during this period, including weekly CEOs meetings with my peers in Surrey and Sussex ICSs, an Exec to Exec meeting with Kent and Medway CCG on 1 July, the regional Chief and Chairs network meeting on 2 July and the virtual Surrey Heartlands ICS Equality, Diversity and Inclusion Conference on 16 July.

3. Regional Issues

3.1 NHS111/CAS contract

3.1.1 As shared in previous updates, 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 We are continuing to work hard on our mobilisation plans for the new service, together with our partners and are working towards launching the new service on the 1st October 2020. In the meantime, the current NHS 111 service continues as normal.

3.1.3 This is likely to be followed quite quickly by a contract variation to include a new project called “Think 111 First”, which aims to reduce Emergency Department (ED) demand by using 111 to triage patients who would otherwise make their own way to ED.

4. National issues

4.1 COVID-19 outbreak

4.1.1 Despite changes in the national approach and position, SECAmb continues to be 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 changing circumstances.

Governance

4.1.2 The robust governance framework established to support the Trust’s response to the pandemic remains in place, including the COVID Response Management Group (CRMG), the key group for managing the Trust’s response to the pandemic. The CRMG continues to meet regularly during the week and at weekends, ensuring that all COVID-related decisions and actions are considered appropriately, as well as focussing on key areas including safeguarding and PPE.

4.1.3 As we move into a different phase of the pandemic, focus is increasingly shifting to the COVID Recovery, Learning & Improvement Group, which is focussed on ensuring 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. The key workstreams within this group - our people, estates, IT utilisation and new ways of working – are making good progress and we are beginning to see tangible outputs from this work.

Staff Testing

4.1.4 12 July saw the conclusion of the initial COVID-19 antibody testing programme that we delivered internally, with 3,260 tests completed in total, meeting the target we had set ourselves and reported nationally.

4.1.5 The test was available to all staff, volunteers and contractors on a voluntary basis and of those tested,14% had antibodies detected, 85% had no antibodies detected and less than 1% were inconclusive.

4.1.6 We know that testing of NHS staff nationally is likely to be required for some time, so it's good to have established and tested the process during recent weeks.

Personal Protective Equipment (PPE)

4.1.4 Following some real challenges in this area earlier on in the pandemic, our Logistics Team have worked hard to establish robust processes to ensure we are able to manage and deploy PPE as needed throughout the Trust in a timely and accurate way.

4.1.5 The provision of PPE through the national deployment system has largely stabilised during recent months. However, variation in the brand of face-masks provided through the national supply chain, including the discontinuation of some particular brands, has presented some challenges with regard to ensuring that all front-line staff can be fit-tested on and have access to the correct face mask.

4.1.6 We have worked hard to ensure that our record-keeping in this area is accurate and up to date, so that we are able to easily identify those staff members for whom, due to various reasons including face shape/size, face masks do not fit and therefore cannot be successfully fit-tested.

4.1.7 To ensure the safety of these staff, a decision was taken by CMG to temporarily remove them from front-line duties, whilst we procured alternatives to the conventional face mask. Although availability of the alternatives is very limited, we are continuing to roll these out to the staff affected, who are then able to return to full, front-line duties.

Impact of COVID-19 on particular staff groups

4.1.8 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.

4.1.9 To support the safety of these staff in the NHS, all Trusts have been undertaking specific risk assessments for their BAME staff, as well as those who are shielding due to pregnancy, age or underlying health conditions.

4.10 Despite the tight national timescales required to complete these risk assessments, we have made excellent progress in completing these so far. We have also ensured that our processes are robust and would apply to any future risk assessments required.

4.2 Black Lives Matter

4.2.1 The death of George Floyd in the USA on 25 May and the subsequent Black Lives Matter movement has led to all ambulance trusts in the UK examining their individual approaches to racism and discrimination and, in many cases, challenging themselves about progress made so far.

4.2.2 I was really sorry to have missed the 'Our BME People & Communities – a Conversation' webinar on 7 July, organised by the Association of Ambulance Chief Executives (AACE) due to being on leave but was pleased to hear that lots of staff had joined it and found it to be an excellent and thought-provoking session.

4.2.3 We held a meeting of the Trust's Inclusion Working Group meeting shortly after the webinar and there was a real desire to move away from 'talk' to action that will make an actual and visible difference to improving diversity within the ambulance sector and for us within SECAmb.

4.2.4 A national programme of work in this area is being led by AACE and we will, of course, participate in this fully. However, I am also keen to ensure that we do everything we can locally to stamp out racism and see our commitment to equality and diversity for all becoming obvious and overt.

4.3 Violence and aggression towards ambulance staff

4.3.1 In recent weeks, we have seen a worrying spate of attacks on ambulance colleagues nationally, including extremely serious incidents reported by West Midlands and North East Ambulance Services.

4.3.2 The Assaults on Emergency Workers (Offences) Act was passed in November 2018 and now makes it a specific crime to commit assault or battery against an emergency worker, punishable with up to 12 months in prison - double the previous maximum sentence - a fine or both. It will be interesting to see the impact that this has nationally.

4.3.3 Locally, our Head of Health and Safety & Security, Amjad Nazir, has written to all local Police forces requesting a collaborative working pact to support our staff. The outcome of this is to raise staff awareness and understanding that being assaulted is not an occupational hazard but an offence and is vital to ensure that appropriate actions are taken by the Police and the CPS.

4.3.4 We are also continuing with work to investigate the use of body-worn cameras in the Trust. This piece of work is led nationally by NHS England/Improvement and all Ambulance Trusts have been involved in the assessment and evaluation discussions. SECAmb has been listed in phase two of the programme which is scheduled for Q4 in the current financial year.

4.4 Changes to treatment of spinal injury patients

4.4.1 On 15 July we shared externally our pioneering guidance aimed at improving the treatment of spinal injury patients. The guidance includes ending of the use of neck braces or semi-rigid collars on spinal injury patients. While collars are often seen as synonymous with spinal care, there is growing evidence that they could cause further harm, while providing little or no benefit.

4.4.2 Soon to be adopted nationally by the Joint Royal Colleges Ambulance Liaison Committee, (JRCALC), SECAmb has been assigned as an ‘early adopter’ while the national guidelines are formalised. The new approach follows a working group being established at SECAmb, headed by CCP, Alan Cowley.

4.4.3 Our external launch has generated a significant amount of positive national and international interest and a number of queries from other Trusts keen to adopt this approach.

Philip Astle, Chief Executive Officer

21 July 2020

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	25/20

Name of meeting	Trust Board
Date	30th July 2020
Name of paper	COVID-19 Response Management Group Assurance including IPC Assurance Framework
Executive sponsor	Bethan Eaton-Haskins, Executive Director of Nursing and Quality
Author name and role	Bethan Eaton-Haskins, Executive Director of Nursing and Quality David Hammond, DCEO, Executive Director of Finance and Corporate Services - (COVID Recovery, Learning and Improvement).
Synopsis (up to 120 words)	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 follows previous assurance to the Trust Board on the 28th May 2020 and details the significant actions and decisions taken by the group since this date. During May 2020, NHS England requested that each NHS Trust undertake an Infection Prevention and Control Assurance Framework which is provided with this paper in order to provide additional assurance to the board. The paper also reports the progress of the COVID-19 Recovery Learning and Improvement Group which has been set up to ensure that the Trust can exit the pandemic in a strong position.
Recommendations, decisions or actions sought	The board is asked to note the contents of this 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

Trust Board

COVID-19 Response Management Group Assurance including IPC Assurance Framework

1. Introduction

This report details the significant actions and decisions taken through the COVID-19 Response Management Group (CRMG) since the last assurance report on the 28th May 2020.

The CRMG was created in March 2020 at the request of the Executive Management Board in order to provide an overarching governance framework for issues relating to the COVID-19 pandemic and mitigate risks and challenges to the Trust.

The CRMG has continued to meet frequently and since the 28th May 2020 has met every Monday, Wednesday and Friday for a full meeting and each Saturday and Sunday for those staff on call. Every meeting to date has been quorate as required by the terms of reference for the group and since the first meeting in March, the group has taken 2488 items for discussion, has completed 964 actions and recorded 422 decisions.

Each action and decision taken is both captured on the action log and within the Trust incident management system Clio. Each decision also has a Quality Impact Assessment and Data Protection Impact Assessment as required prior to the approval of CRMG.

2. Actions and Decisions

Significant actions and decisions taken since the last assurance report on the 28th May 2020 are detailed below;

- **Staff Testing**, COVID-19 venous sample antibody tests were undertaken on staff, volunteers and contractors who requested a test as per national guidance. 3260 tests were undertaken which equated to 86% of the Trust headcount and exceeded the trajectory we had submitted in relation to our testing capacity. The presence of antibodies was identified in 14% of these samples which is in line with the national picture. 1708 COVID-19 PCR swab tests have been undertaken on asymptomatic staff since the last update to the Trust board.

- **Test and Trace / Outbreak Management,** In line with national requirements for NHS Trusts, the Covid Management Team have established an internal test and trace cell which is required to be staffed 16 hours per day, seven days per week. An Outbreak

Management Framework is in the final stages of testing and will be implemented through the COVID Management team and this cell once approved.

- **Role of Volunteers**, The CRMG approved the reinstatement of Community First Responders (CFR's) to category one incidents initially and in July 2020 approved the reinstatement to category two and three incidents in addition to this. The CRMG also approved the reinstatement of Chaplain visits to Trust sites (subject to risk assessments as required) in July 2020.

- **REAP (Resource Escalation Action Plan) level reviews**, A REAP level review is undertaken at each CRMG, with a full in-depth review on a weekly basis. On Friday 16th June 2020, the Trust moved to REAP level 3 based on the recommendation from CRMG. We remain at REAP level 3 currently.

- **Tactical and Strategic COVID-19 Plans,** Both the tactical and strategic plans relating to COVID-19 have been reviewed regularly in line with the changing nature of the pandemic and amendments made accordingly.

- **Staff Risk Assessments,** In line with national requirements, risk assessments have been undertaken for staff who identify as Black, Asian and Minority Ethnic (BAME). As of the 27th July 2020, 97% of the risk assessments were complete with plans in place to ensure the completion of the remaining 3%. Risk assessments are also required for those staff classed as clinically vulnerable, the process of undertaking these in underway and progress is being closely monitored through the CRMG.

- **IPC Guidance,** Constant vigilance continues in relation to IPC guidance including PPE (Personal Protective Equipment) and social distancing measures and mitigations. Numerous actions have been taken in relation to PPE and ensuring as many staff as possible are able to be adequately protected and working in a front-line capacity.

3. IPC Assurance Framework

The completed IPC Assurance Framework (attached to this paper) provides assurance in relation to the significant IPC measures and practices in place specifically relating to COVID-19. This framework has been approved by the CRMG and the Executive Management Board. There are no significant areas to escalate to the Trust Board.

4. Covid-19 Recovery Learning and Improvement Group (CRLIG)

This update follows on from the presentation shared with the Trust Board in May. The CRLIG has continued to meet bi-weekly and has reviewed the progress of all ten work streams. The group is supported

by the Trusts PMO and has established a framework, rationale and format for each of the workstreams to report against.

In line with the terms of reference, the group has reviewed the decisions of the CMG and has allocated them to the appropriate CRLIG workstream using an Adopt, Adapt, Abandon approach.

In addition, using the learning from the Trusts COVID response, each workstream has presented a series of outline project plans for new initiatives which will be explored over the coming months. It should be noted that the speed at which different workstreams will able to deliver varies hugely due to the complexity of the subject area.

The CRLIG also now has a regular slot on the weekly Trust webinar, with Operations featuring on the 6th August and New Ways of Working on the 20th August.

5. Summary

The Board is asked to note this report.

Infection Prevention and Control Board Assurance Framework – Covid-19

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	The Covid-19 SECAmb Guidance promotes an individual risk assessment for scene approach and on scene clinical precautions. Risks, when identified, are recorded on the patient notes and captured on the CAD via pathways assessment..	No gaps at present time.	Follow PHE guidance on the donning of level 2 PPE for all patient contacts and level 3 when undertaking AGP or where there is a risk that AGP may be required. Incidents of non-compliance raised via the Trusts reporting system (DATIX).	Medical / Operations
• patients with possible or confirmed COVID-19 are not moved unless this is	Assessment of COVID by clinicians bulletin provides a flowchart that identifies	No gaps at present	Any incidents are reported using the Trusts reporting	Medical

appropriate for their care or reduces the risk of transmission	patients that can be left at home and those that need to be transported. It is based on guidance published by BMA, RCGP and a review published in the BMJ		system	
• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	Not Applicable to ambulance services			
• patients and staff are protected with PPE, as per the PHE national guidance	The Trust provides PPE to staff in accordance with the PHE national guidelines. A daily dashboard of PPE status is issued, and the National Ambulance Co-ordination Centre given 72 hours' notice of shortages.	The Trust is still reliant on national stock, but the situation is improving with levels and type of stock being provided.	Stock is counted every three days and managed centrally now. FFP3 masks are still counted daily due to risk of running low.	Operations
• national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The IPC Team have two dedicated staff to manage this and the Head of IPC sits on the National Ambulance Services IPC Group which hold two calls every week.	No gaps at present time	Able to move team members into this role if required	Nursing & Quality

	Staff have access to the latest guidance on the ZONE and a Covid-19 APP on their iPad as well as regular bulletin articles			
• changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	The Head of IPC is a member of the Covid-19 Management Group and provides all updates via the group	None currently	IPC Lead can pick up the work if the Head of IPC is absent for any reason	Nursing & Quality
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	All risks associated with Covid-19 are on the Trust risk register and reviewed by the relevant Risk Lead	None currently	Monthly review of all related risks	Nursing & Quality
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	The IPC Team have three staff that are tasked with the day to day IPC processes and practices which includes audits and risk assessments	No gaps at present time	Able to move team members into this role if required	Nursing & Quality

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in place to ensure: • teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas	All staff in frontline roles are trained to use Personal Protective Equipment and a detailed IPC training package is part of the annual mandatory training.	No gaps at present	Formal Contracts in place with KPIs to measure compliance and provide assurance.	Medical
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	A bulletin and poster has been circulated highlighting the PPE that must be worn when treating suspected COVID patients, including when there is a need for Level 2 and Level 3 PPE, what is an aerosol generating procedure and colour flag system to indicate when additional risks should be considered.	No gaps present	Contractor has training records for staff involved in deep clean of vehicles and office areas Minutes of meetings	Finance
• decontamination and terminal decontamination of	Not Applicable to ambulance services.			

isolation rooms or cohort areas is carried out in line with PHE national guidance				
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	Our cleaning contractors for both vehicles and the environment have been provided with all Trust guidance for Covid-19 related cleaning requirements and they have trained their staff appropriately. Weekly meetings with the contractor are held to discuss any issues	No gaps present	Increased cleaning hours and enhance cleaning of high touch points has been introduced in Call Centres and Make Ready	Finance
• linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	Decontamination of vehicles are managed by the Make Ready Teams at a local level and adhere to PHE national guidance. Weekly meetings are in place to discuss and manage any issues	No gaps in assurance	Minutes of meetings and training records	Finance
• single use items are used where possible and according to Single Use Policy	Environmental cleaning has been increased on sites classed as high risk (EOC's, 111 and Make Ready	No gaps in assurance	The Trusts Standard Load List provides the evidence	Medical

• reusable equipment is appropriately decontaminated in line with local and PHE national policy	Centers) in line with PHE national guidance The Trust have procedures in place for all linen and contracts with local hospitals to support a one for one exchange process Single use items are used and described in the Trust IPC Manual for Procedures Guidance for cleaning re-usable equipment is described in the IPC Manual and Procedures	No gaps in assurance	SLA's in place with Acute Hospitals laundry's Incidents of non-compliance raised via the Trusts reporting system (DATIX)	Nursing and Quality / Operations

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and process are in place to ensure:				

• arrangements around antimicrobial stewardship are maintained	Doxycycline has been added as an agent for pneumonia in the community but otherwise no PGDs have been changed in response to COVID	None currently	Reviewed at the PGD Working Group	Medical
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	The DIPC (Director for Nursing and Quality) is a full member of the Board and reports on any IPC requirements	None currently	The Head of IPC is the designated Deputy DIPC	Nursing and Quality

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible being	Not Applicable to ambulance services. Not Applicable to ambulance services.			

treated in areas marked with appropriate signage and where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Dedicated section on the ZONE and an APP on all staff iPads Full handover procedure with hospital staff is in place and EPCR linked to every patient (or paper version)	No gaps at present No gaps at present	All Covid-19 related guidance is reviewed at the CMG Non compliance to be taken up by line managers	Chief Executive Operations

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people - Not Applicable to ambulance services				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in place to ensure: • front door areas have appropriate triaging	Not Applicable to ambulance services.			

arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Not Applicable to ambulance services. Not Applicable to ambulance services. Not Applicable to ambulance services.			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in place to ensure:				

• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	All clinical staff do level 2 IPC training yearly and all non-clinical staff have been encouraged to complete the level 1 IPC workbook again this year (requirement is for it to be completed by these staff every three years)	New starters and those who did not complete Level 1 IPC last year will need to complete this year.	Any non compliance of training would be taken up by line manager	Human Resources
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	Level 2 IPC workbook for this year provides staff with training for PPE including donning and doffing. Covid-19 guidance also provides staff with further detailed guidance	No gaps at present	Non compliance to be taken up by line managers	Human Resources
• a record of staff training is maintained	Monthly reports on staff training are managed by the HR Team and sent out to all mangers	No gaps at present	Non compliance to be taken up by line managers	Human Resources
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Full guidance is in place for goggles and visors that can be re-used. All other PPE is single use.	None currently	Documents prepared should there be a need to re-use PPE	Nursing & Quality
• any incidents relating to the	The Trust reporting system		Documents prepared	Nursing &

re-use of PPE are monitored and appropriate action taken	(DATIX) is used for any incidents relating to PPE	None currently	should there be a need to re-use PPE	Quality
• adherence to PHE national guidance on the use of PPE is regularly audited	Constant review as described earlier by the IPC Team staff	None currently	IPC Team working with the National Team on a draft guidance if required	Nursing &Quality
• staff regularly undertake hand hygiene and observe standard infection control precautions	IPC audits continue to be carried out locally and the IPC Team monitor compliance and report monthly figures via the IPR	None currently	IPC Team monitoring the situation	Nursing and Quality
• staff understand the requirements for uniform laundering where this is not provided for on site	Guidance is provided in the Trust Uniform Procedure and IPC Manual and Procedures. An Infographic has also been produced as guidance for staff returning home and how to 'Keep the Home Safe'.	None currently	Non compliance to be taken up by line managers	Operations
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their	Action Cards for a range of Covid-19 related concerns have been produced and updated at the CMG following PHE national guidance	None currently	IPC Team monitoring the situation Any updates required go through the CMG for approval	Nursing and Quality

household display any of the symptoms.				

7. Provide or secure adequate isolation facilities – Not Applicable to ambulance services				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC	Not Applicable to ambulance services. Not Applicable to ambulance services. Not Applicable to ambulance services.			

guidance, including ensuring appropriate patient placement				

8. Secure adequate access to laboratory support as appropriate				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	Healthcare Service Providers provide and coordinate a rota of appropriately trained healthcare practitioners to carry out community testing via the swabulances. PCR testing of SECAmb staff is on a self-swab basis. Antibody venous blood testing of staff is completed by a qualified phlebotomist or paramedic (or above) grade member of staff who has completed the online internal venepuncture training.	An Asymptomatic Staff Testing Strategy is being developed to outline provision post the interim arrangement currently underway. The Trust plans to offer testing to all staff by 10 July 2020.	SECAmb is currently undertaking PCR swab and antibody venous blood testing of asymptomatic staff for an interim period 04/06/20 – 14/06/20.	Operations

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance	PHE national guidance forms the basis of the Memorandum of Understanding for the Regional Covid-19 Co-ordination Service, which sets out the role of the Trust in patient testing for Covid-19. Provision exists for symptomatic staff to be tested.	None currently	Testing is offered to all staff and contractors in line with PHE guidelines including support services and non-patient facing roles.	Operations
• screening for other potential infections takes place	. This is not part of our remit at this time.	Not applicable at this time	Not applicable at this time	Operations

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Systems and processes are in				

place to ensure that:				
• staff are supported in adhering to all IPC policies, including those for other alert organisms	The IPC Team have support from local IPC Champions across the Trust to promote all IPC policies and procedures along with the local Operational Team Leaders	No gaps in assurance	IPC Team would investigate any incidents	Nursing & Quality
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	As described earlier the IPC Team continue to review daily guidance and updates for all IPC related issues and report into the CMG	No gaps in assurance	Head of IPC to move team members into roles as required	Nursing & Quality
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance	The Trust has a Clinical Waste Procedure described in the IPC Manual and Procedures that all staff adhere to. The guidance is in line with PHE national guidance and staff are asked to dispose of clinical waste for individual patient episodes at the receiving hospital	No gaps in assurance	A formal contract is on place with SUEZ for any waste returned to sites	Finance
• PPE stock is appropriately	PPE is available on every	No gaps at present	PPE Working Group	Operations

stored and accessible to staff who require it	Trust vehicle in specified cupboards and a separate IPC Bag. EOC's and 111 also have supplies of relevant PPE for the environment		has now been set up and meets weekly to monitor all PPE stocks	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Directorate
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff are being identified and managed through the Action Cards. Wellbeing Hub working with staff on any support required due to psychological and physical concerns	No gaps at present	Any issues to be addressed by line manager	Human Resources

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	HART developed train the trainer sessions for OTL's for fit testing. Recent discussion on staff that have failed fit testing is ongoing and the newly formed PPE Group are leading n this.	Some staff have been unsuccessful with fit testing	Work is ongoing to provide an alternative mask for these staff	Operations
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Full support form Line Manager for staff absence and self-isolation. GRS recording all records	No gaps at present	Any issues to be addressed by line manager	Human Resources
• staff that test positive have adequate information and support to aid their recovery and return to work.	Action Cards provide information for staff and support from Line Managers for return to work as and when fully recovered	No gaps at present	Any issues to be addressed by line manager	Human Resources

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	26-20

Name of meeting	Trust Board
Date	30 July 2020
Name of paper	Integrated Performance Report
Responsible Executive	Philip Astle, CEO
Author	Izzy Allen, Asst Company Secretary
Synopsis	*The IPR has been revised, in discussion with Board members, to deliver a more rounded picture of Trust-wide performance against metrics that 'get under the skin' of the organisation – not simply those that we report nationally. It is set out under CQC domains.* *This IPR is a work in progress and over the coming year will include additional datasets to achieve this aim. The version you have includes 'aspirational' metrics, and the data the Board usually receives, up to and including May 2020. We aim to include data a single month in arrears from September (August data), wherever possible.*
Recommendations, decisions or actions sought	*Feedback from the Board will help us improve this as we continue to work on it.*

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).	NA

Introduction

This month's IPR is in a new format. The aim is to present a more holistic overview of Trust performance, under CQC domains, which brings together the most helpful indicators to allow the Board to better understand performance across the Trust.

Development

The Trust's Senior Leadership Team has led the development of this new IPR for the Executive, with considerable help from Sharon Gasson in Strategy and Tanisha Perry-Warner in the Business Intelligence Team. Non-Executives were consulted early on about the aims of the development and that feedback helped us define the specification, and the wider SLT (30+ senior colleagues) have reviewed and commented on progress.

A work in progress

A single dataset for the Trust

Our vision is that the IPR is only the 'top' layer of a considerably more detailed cake that can be sliced into as appropriate to service the information needs of teams, management groups and oversight committees.

The growing dataset is now accessible on the Power BI platform and work is ongoing to enable automated data capture, drill down by e.g. OU or Directorate, and easy selection of metrics to export in paperwork, e.g. for WWC, the SI Group or an OU meeting. The Board won't be overwhelmed by too much detail – however we will have the ability to select specific data on occasion where it helps us paint the full picture of Trust performance.

Data/metrics

One of the most important areas we have reviewed and are beginning to evolve is the selection of which datasets/metrics to present to the Board.

We strongly believe that while 'hard' data such as our national performance indicators, financial data and figures about sickness absence are vital for the Board to see, they don't tell the full story of the Trust.

We have developed an extensive set of new metrics to supplement the metrics usually presented. These will seek to get under the skin of, for example, how the Trust performs for patients with dementia, whether we have the right number and level of clinicians available for our patients, whether staff absences are related to mental health, and the proportion of staff shifts that end in overruns. In some cases, such as dementia care, we haven't even defined the metric, let alone begun to collate the data. In other cases, such as absences related to mental health, we have the data but haven't reported it regularly to the Board before. As you can imagine, having the above for the Board, and also the ability, where this does not enable any inappropriate identification of individuals e.g. around sickness, to look at it by OU or Team, will bring great benefits.

In coming months, this suite of 'aspirational' metrics will be populated (the IPR before you includes a small number to give a flavour of the type of indicators we are working to include - currently left blank but indicated by a blue square icon throughout). We will also seek to use the data to tell a story and demonstrate improvement so, while there will be core data you will see every month, some additional data may change: where there is a story to tell

that helps explain the service our patients are receiving, we can include more detail in certain areas to help show that to the Board.

You will note in particular that there is no data in the 'caring' domain. This is because when we broke down the current reported data into CQC domains, none fitted squarely into 'caring'. You'll see we are developing a number of new indicators to tell our 'caring' story – for this certainly doesn't mean we aren't caring – indeed our CQC reports show the exact opposite – however we weren't including any indicators to demonstrate that in your IPR. We will in future.

Horizon-scanning and system partnership pages
Pages 5 & 6 present an overview of major challenges and opportunities and changes and developments in relation to system working, respectively. This is something the Board won't get from data. The information presented this month is current at July 2020 (it seems odd to 'horizon-scan' in July from a May perspective) and contains only information that is confirmed or in the public domain. The team would like to develop a more 'cutting-edge' supplementary paper for presentation at the Part Two Board whenever there are things on the horizon or in relation to system working that the Board should be aware of. This happens now, but this way of reporting might bring more rigour to it. We would retain a public-facing version to ensure we are open and accountable.

Reporting – highlights and escalations/exceptions
For the previous IPR, data owners were asked to comment on all data they provided. This meant a lot of repetition and text on areas of the Trust where there was little to report. The new approach is to provide data owners with the ability to:

- Note any highlights that they wish the Board to be aware of – this could be really positive performance or anything else about the data they would want the Board to understand;
- Note any exceptions/escalations to the Board where performance is outside of normal parameters and an ongoing cause for concern;
- Note any additions to the 'horizon scanning' section so as to advise the Board of anything important coming around the corner; and
- Add anything to the system partnership and engagement section.

It is intended that this builds a more rounded report, prevent unnecessary commentary (both for those reading it and those providing it) and focus the text within the report on the areas that matter most.

May was not a usual month for the Trust (due to Covid) and data owners are getting used to the new format for reporting. As such, we received a number of 'highlights' from data owners – included in the report – and initially no notable 'exceptions'. Exception reporting presented here has been completed by the Executive Team.

Our view is that, as much as anything, this demonstrates that the existing/current metrics used do not tell the full picture about what is going on and only makes it more important to start reporting data that will help the Board (and Trust management) understand the real drivers of successes and issues, where staff morale, patient experience, and those softer areas of intelligence are considered alongside our job cycle time.

Making sense of the data

Rag-rating/symbols
There is a key on each page. Throughout, red and green shading in boxes has been used to show whether performance is above or below target and symbols are used to show the direction of travel compared to the previous month. National average performance has been included where available, and whether we are above or below that, as well as targets for performance.

Graphs
We intend that graphs will include trend lines, where it will help the viewer understand the data better, and where possible targets too. The latter has been possible in some cases for this month but not all. We aspire to include forecasting and performance versus forecast wherever possible in future.

National benchmarking
At the end of the report we set out SECAmb's performance in 999 and 111 compared to other providers of those services. The 111 data is still to be added at the time of writing and we hope this will be included.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
July 2020

Data up to and including May 2020

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

Contents

CQC Rating and Oversight Framework

Use of Resources Metric (Financial Risk Rating) *	3
NHS Oversight Framework**	3
CQC Rating ***	**GOOD**
Information Governance Toolkit Assessment ****	Level 2 Satisfactory
REAP Level *****	2

*	A measure of how effectively we are managing our financial resources to deliver high quality, sustainable services for patients.
**	NHSI segments Trusts (1-4) according to the level of support each Trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability, with level 4 requiring the most support (Trusts in special measures).
***	Our rating following the most recent CQC inspection. These can help patients to compare services and make choices about care. There are four ratings that are given to health and social care services: outstanding, good, requires improvement and inadequate. **GOOD:** We are performing well and meeting CQC expectations.
****	The Information Governance Toolkit is a system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit Assessments. Levels range from 0 to 3; 3 being the highest.
*****	Resourcing Escalatory Action Plan (REAP) is a framework designed to maintain an effective and safe operational and clinical response for patients and is the highest escalation alert level for ambulance trusts. Level 2: Moderate pressure (May 2020)

How to use this report

A New Format & Reporting Aspirations

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

Performance Dashboards

- The Board is presented this month with the data set it is used to seeing, albeit in the new format. As an indication of the types of metrics we will seek to report on in the coming months, 'aspirational' metrics are included (with no data attached). Where there is no data this does not mean the Trust does not monitor these areas of performance, merely that those metrics are not routinely presented to the Board and work is still to be done to provide them in this format
- The vision for the IPR is that it is dynamically generated, with RAG ratings and performance direction automatically populated, giving us the ability to maintain a core set of metrics but also to select those most relevant for the Board in order to tell our story more fully
- More work is to be done to include all targets and to distinguish internal targets from national ones

Performance Charts

- In the future, we intend to include trend lines on charts, where it will help the viewer understand the data better, and where possible targets too. The latter has been possible in some cases for this month but not all. We also aspire to include forecasting and performance versus forecast wherever possible

A Focus on CQC Domains

- You will note that there are currently no metrics under the Caring domain – which may seem odd given we were "Outstanding" in this area in our most recent CQC report
- When we reviewed the metrics regularly reported to the Board in your IPR, none fell into the Caring domain
- Our suite of 'aspirational' metrics includes numerous across all domains, including Caring, and when populated will provide a far more rounded snapshot of performance to the Board

Reporting Performance Highlights & Exceptions

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

Chief Executive Overview

I am very pleased to present this month's IPR in its new format. The IPR has been revised, in discussion with Board members and Senior Managers, to allow the readers to gain a better understanding of Trust-wide performance. One of the most noticeable changes is that the report is set out using the CQC domains.

This IPR is a work in progress and over the coming year will include additional datasets, metrics and targets which are still to be defined. (You will note in particular that there is no data in the 'caring' domain as we are developing a number of new indicators to tell our 'caring' story).

The data in this report covers the period of May 2020 and is therefore a-typical when compared to previous years due to the Covid-19 pandemic. The report shows that despite the difficulties that Covid-19 has placed on the health system, the Trust has continued to perform well.

The month saw a fall in activity due to lockdown measures and in available staff resources due to shielding and isolation. We put out 99.10% of our targeted front line hours and continued to enhanced our EOC and 111 capacity utilising furloughed staff particularly in the Gatwick area.

This allowed us to achieve all of our Ambulance Response Programme targets for the month. 111 performance also increased as activity levels started to reduce to the level we would expect to see at this time of year.

Our clinical performance also continues to improve. The deployment of the Electronic Patient Care Record via the iPads allows real time data collection and reporting which in turn allows feedback and learning. In addition to this our quality and risk teams have been looking at our SIs, complaints and duty of candour compliance to ensure that these remain as expected.

Our workforce indicators for the month, show a reduction in attrition rates which is to be expected and further recruitment particularly to our bank as part of our Covid-19 plans. A key component of our Covid-19 response has been to ensure our staff are safe. This has meant a continued adherence to infection control measures and fit testing.

Lastly, due to the changes in the financial architecture for this year as a result of the pandemic, all providers have moved to a block contract and top up arrangement with a view to being breakeven at the end of the financial year. Further updates from NHSE/I will be forthcoming over future months as to how this will develop.

Philip A Astle
Chief Executive

Trust Overview:
Strategy, Values & Ambition

Our Purpose

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

Our Strategy

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

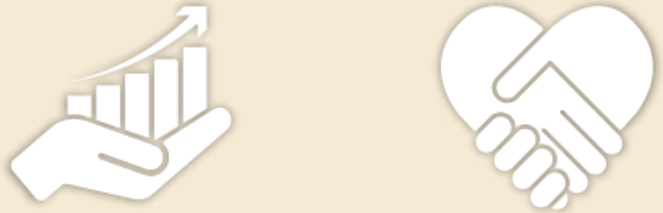
Our Priorities

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

Our Values

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

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



Trust Overview:
Horizon Scanning – July 2020

Finance

- There is uncertainty surrounding funding levels for the current year once we have moved beyond the known short-term interim arrangements
- Known challenges in meeting the resourcing plans for 999 and 111 services and the potential premium costs to ensure delivery of the agreed performance trajectories
- The challenging level of cost improvement that needs to be delivered to ensure financial balance. There will be a requirement for substantial and sustainable productivity improvements to release cash for investment in the Trust's services and to make more effective use of limited resources
- The impact of Covid-19 may require additional resources that are not fully funded as the scale of the Covid-19 crisis presents logistical and resourcing challenges during the return to business as usual period
- The macroeconomic cost of the Covid-19 response will put considerable pressure on public sector finances in future years. In order to ensure the sustainability of the organisation going forward, it is vital that all resources are used as efficiently as possible

Business Development

- In consultation with Commissioners, our new CAS/111 service launch was delayed from April until the Autumn due to the Covid-19 pandemic
- Sussex PTS procurement expected in early Spring 2021

Workforce

- The Employee Journey Task & Finish Group are looking at what processes have positively and negatively affected colleagues throughout Covid-19 and what working practices we would like to take forward and improve further. The outputs of this working group are expected to impact retention positive
- The new appraisal and pay progression process (utilising full ESR functionality) is progressing at pace and we expect to be able to launch this in December. The new appraisal process will integrate appraisals and pay progression with better reporting functionality and ease of use than our current external system
- Some preliminary reporting on exit interview data pre- and during Covid-19 has revealed some interesting findings, such as the switch from a pre-Covid female leaver ratio of 77% to 50% during the pandemic, a 9% reduction in under 35s leaving SECAmb (our largest age demographic), and a 12% reduction in disabled staff leaving SECAmb during Covid-19. This reporting is being expanded on as part of the recovery work to help us better understand how our management of the pandemic has impacted on attrition
- NHS England have introduced a focus on conducting risk assessments for clinically vulnerable, BAME and other 'at risk' staff members as shielding and lockdown restrictions are lifted. This requires a substantial input from managers and their team members in a relatively short space of time but it is essential that we continue to minimise risk to staff

Trust Overview:
System Partnership & Engagement – July 2020

Reducing avoidable conveyances to ED

- We remain focussed on how we can safely reduce avoidable conveyances to ED by working with system partners to optimise community pathways and where there is a need to convey to hospitals, we agree direct conveyances to non-ED destinations reducing congestion in ED. This will be particularly important as space will be restricted in ED with the need for social distancing
- We continue to encourage crews to use Service Finder and access care plans including ReSPECT and DNACPR plans where they are available
- Paramedic Practitioner Hubs, currently OU based, are in operation across the Trust, operating 24/7. Averaging 3 hubs a day, they undertake an average of 100 Emergency Crew Advice Line Calls (ECALs) a day. Call back times and outcomes are monitored on a daily basis

Future commissioning arrangements

- The way in which future 999 commissioning will be undertaken is uncertain. This will present both risk and opportunity to the organisation
- We continue to work with Commissioners to ensure effective implementation of changes in the 111 service

Deep dive into Mental Health conveyances

- Commissioners are planning to undertake a deep dive into mental health primary conveyances in the coming months

Service Transformation & Reconfiguration

- From 1st July until further notice, there will be an operational divert for suspected stroke and TIA patients from Medway Maritime Hospital (MMH) to Darent Valley Hospital (DVH) and Maidstone General Hospital (MGH). The stroke ward at MMH recently received several resignations from its Specialist Stroke Nurses, resulting in unsafe staffing levels. The inability to recruit to these positions has been exacerbated following the announcement that Darent Valley, Maidstone General and William Harvey Hospitals are to be the future Hyper Acute Stroke Units across Kent and Medway.
- NHS Kent and Medway Clinical Commissioning Group (CCG) is working with the health and care organisations, which provide services to the people living in East Kent to design high quality, sustainable health services. We are fully engaged and contributing to these discussions
- East Sussex - Primary Percutaneous Coronary Intervention (pPCI) emergency move planned for July 2020, which will consolidate services on one site. East Sussex Health Trust (ESHT) plan to recommence consultation for a one-site option longer term once their return to business as usual. The alternating of sites receiving pPCI patients was for ‘out of hours’ only as ‘in hours’ both sites accepted patients (low numbers of activity out of hours). The site chosen for this emergency move is Eastbourne, which means that patients east of Hastings could now be conveyed to Ashford as the nearest pPCI site and not Eastbourne
- There are 92 Primary Care Networks (PCNs) across our region. These PCNs - part of the NHS England future workforce plan - are being provided with funding for additional workforce to support primary care provision within the community. One of the roles identified is that of Paramedic and/or Paramedic Practitioner. Initial discussions with system/ICS leaders as well as SECAmb’s Lead Commissioner have indicated that all partners will continue to work with the Trust to find a shared solution that reflects local need whilst not destabilising ambulance service workforce

Trust Overview:
Domain Overview Dashboard (May 2020)

Key indicators at a glance for May 2020 (unless otherwise indicated)

Safe

Metric	May-20	PD
999 Frontline Hours Provided %	99.10%	▲
Number of Incidents Reported as SIs	7	–
Hand Hygiene Compliance %	95.00%	●
**Physical Assaults (Number of Victims - Staff)	3	▲
Medicines Management % of Audits Completed	100.00%	▲
Registered Clinicians Against Plan %		■
Number of RIDDOR Reports	8	▼
DBS Compliance %		■

Effective

Metric	May-20	PD
**Cardiac ROSC Utstein %	33.00%	▼
**Stroke - Assessed F2F Diagnostic Bundle %	98.00%	▲
**Sepsis Care Bundle %	88.00%	▲
**Acute STEMI Care Bundle Outcome %	71.00%	▼
ECAL Mean Response Time	00:23:51	▼
Statutory & Mandatory Training Compliance %	70.80%	▲
Clinical Education		■

Caring

Metric	May-20	PD
Dementia Performance		■
End of Life Care Performance		■
Falls Performance		■
Proportion of Complaints Relating to Dignity and Respect %		■
Proportion of Complaints Relating to Crew Attitude %		■

Responsive

Metric	May-20	PD
Cat 1 Mean	00:07:00	▲
Cat 1 90th Centile	00:12:10	▲
Cat 2 Mean	00:14:28	▲
Cat 2 90th Centile	00:26:58	▲
Cat 3 90th Centile	01:40:20	▲
Cat 4 90th Centile	02:14:44	▲
999 Call Answer Mean	00:00:01	●
111 Calls Answered in 60 Seconds %	87.90%	▲
111 Calls Abandoned - (Offered) %	1.40%	▲
111 to 999 Referrals (Answered Calls) %	13.00%	▼
Complaints Reporting Timeliness %	86.00%	▼

Well-Led

Metric	May-20	PD
Cost Improvement Plan (CIP) (£000s)	£0.00	●
Surplus/Deficit (£000s)	£0.00	●
Disciplinary Cases	4	▲
Collective Grievances	0	▲
Bullying & Harrassment Internal	1	▲
Annual Rolling Turnover Rate	14.80%	▲
Annual Rolling Sickness Absence	6.00%	▲
*Staff Successfully FIT-Tested %	93.9%	–
Absence Relating to Mental Health %		■
Absence Relating to MSK %		■
Workforce Diversity		■
999 Frontline Late Finishes/Over-Runs %		■

*Latest data – July 2020
**Latest data – April 2020

Symbol Key

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

Trust Overview:
Summary of Performance Highlights

Domain	ID	Performance Highlight
Safe	Number of SIs reported	7 SIs were reported in May 2020: 3 x treatment/care, 2 x delayed dispatch/attendance, 2 x staff conduct. In the month of May, 8 SIs have been closed with a further 4 de-escalated from SI status
Safe	Number of RIDDOR reports	100% compliance of reporting within statutory 15-day timescale
Effective	STEMI care bundle	The Trust has seen a continuous improvement in performance against the STEMI care bundle since changes were made to ePCR to prompt the documentation of best practice
Effective	Sepsis care bundle	The sepsis care bundle continues to exceed the national average and SECAmb's historical performance after changes were made to ePCR to encourage documentation of best practice
Effective	Stroke care bundle	The stroke care bundle continues to exceed SECAmb's historical performance after changes were made to ePCR to encourage documentation of best practice
Responsive	999 Call Answer (Mean & 90th centile)	999 call answer time - mean and 90th centile - continues to be strong at 1-second. SECAmb ranked 3rd in the national tables for both metrics in May 2020. The Trust achieved 99.7% against a target of 95%. Call volume fell slightly during the month
Responsive	Cat 1 performance (Mean & 90th centile)	In May 2020, Cat 1 mean actual was 00:07:00 representing an improvement of 5-seconds on April 2020. Nationally, the Trust ranked 8th. Since January 2020 the 90th centile actual has been slowly improving. Nationally, all Trusts are achieving this target and SECAmb ranks 10th out of 11 Trusts
Responsive	Cat 2 performance (Mean & 90th centile)	April 2020's strong Cat 2 mean and 90th centile performance continued into May 2020. The Trust's Cat 2 mean was 00:14:25.; 90th centile performance was 00:26:58 an improvement on the preceding month's achievement, which was 00:27:32. Nationally, other Trusts continued to improve in these metrics and SECAmb fell 3 places in the national table, from 3rd to 6th. Cat 2 mean resources arriving remained steady at 01:06:00
Responsive	Cat 3 & Cat 4 performance (90th centile)	SECAmb achieved its best ever Cat 3 performance in May 2020. This was 01:40:20. Although the Trust ranked 11th in the national table, the impact on patient care is more significant. At 02:14:44 the Trust achieved the metric for Cat 4 performance
Responsive	Total hours lost at hospital	Improved performance in total number of operational hours lost over 30-minutes turnaround compared with previous month and a 24% decrease in hours lost compared with May 2019. However, overall number of conveyances is 10% lower than May 2019. 87% decrease in number of hospital handovers >60-minutes and 53% decrease in number of hospital handovers >30-minutes compared with May 2019

Trust Overview:
Summary of Performance Highlights

Domain	ID	Performance Highlight
Well-Led	Net surplus / deficit	The Trust's position is break-even, as planned. The main income source is a block contract with Commissioners, supplemented by a national 'top-up' arrangement to bring the Trust's financial position to a break-even. This arrangement is in place until 31 July 2020 when new guidance will be issued
Well-Led	Capital Expenditure	Capital expenditure in the month was £0.3m, £0.7m lower than planned. Year to date expenditure was £1.5m, £0.3m lower than planned due to delays in the Sheppey redevelopment. The Trust continues to draw down the agreed funding from the Department of Health & Social Care (DHSC) for the Brighton Make Ready Centre Scheme to match expenditure
Well-Led	Cash Position	Cash at the end of May was £44.7m, £2.0m lower than planned and a decrease of £3.5m from April. The main movements in the month were the payments for annual insurances of £1.6m and annual IT licences of £0.8m. Performance for the year to date against 'Better Payment Practice Code', measured by payment of suppliers within their payment terms, was 92.8% by value against a target of £95% in the month. The Trust is in line with the national procurement notice and is paying suppliers at the earliest opportunity
Well-Led	Income	Total income in the month of £22.8m was £0.7m above plan, year to date income is £44.7m, £0.1m lower than plan. The monthly variance is due to additional top-up income totalling £2.1m. For the year to date £3.4m of top-up income has been claimed from NHSE/I, as planned, and the variance in the month is mainly due to timing of spend
Well-Led	Expenditure	Total expenditure in the month of £22.8m was £0.7m above plan, year to date expenditure is £44.7m, £0.1m lower than plan. The monthly variance is due to an additional £1.4m of pay costs relating to Covid-19 backfill of staff who are in isolation, offset by lower fuel and consumable costs directly related to reduced activity. Year to date also benefits from the sale of Knaphill Ambulance Station in April 2020
Well-Led	Agency Spend	Agency expenditure (included in pay) was £0.3m lower than plan in the month and £0.5m lower than year to date. This reduction reflects the steps taken by the Trust to reduce its reliance on agency staff

Trust Overview:
Summary of Exceptions

Domain	ID	Exception
Safe		None to report
Effective		None to report
Caring		None to report – all metrics are in development
Responsive		None to report
Well-Led	Cost Improvement Plan (CIP)	Although the Trust has met it's £1m CIP target in Q1, validated schemes only amount to £1.7m, leaving a potential £3.8m gap for the year
Well-Led	Cost pressures	The level of cost pressures identified at budget setting has the potential to significantly exceed available reserves

Performance by Domain
Safe: Performance Dashboard

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-1	Number of Datix Incidents	858	929	1040	1057	947	868	1024	1042	1019	1043	1028	834	973	-	-	-	-	-
QS-2	Number of Incidents Reported as SIs	10	16	14	10	9	8	9	12	7	9	2	5	7	-	-	-	-	-
WF-15	Registered Clinicians Against Plan %	-	-	-	-	-	-	-	-	-	-	-	-	-	■	■	■	■	■
999-12	999 Frontline Hours Provided %	90.90%	88.20%	87.80%	85.80%	83.50%	86.80%	89.20%	92.70%	94.80%	90.70%	87.50%	97.30%	99.10%	100.00%	-	-	-	▲
QS-3	Duty of Candour Compliance %	100.00%	100.00%	95.00%	100.00%	90.00%	100.00%	90.00%	91.00%	100.00%	90.00%	100.00%	75.00%	100.00%	100.00%	-	=	-	▲
QS-7	Hand Hygiene Compliance %	83.00%	91.00%	93.00%	94.00%	98.00%	89.00%	89.00%	92.00%	90.00%	93.00%	92.00%	95.00%	95.00%	95.00%	-	=	-	●
QS-8	Safeguarding Training Completed (Children) Level 2 %	21.50%	32.80%	40.80%	48.00%	53.50%	62.20%	65.80%	66.30%	69.80%	72.30%	86.90%	12.30%	35.60%	95.00%	-	-	-	▲
QS-13	**Physical Assaults (Number of Victims - Staff)	4	5	4	9	2	2	2	4	10	3	5	3		-	-	-	-	-
MM-1	Number of Medicines Incidents	192	169	128	194	132	111	162	139	149	165	135	112	168	-	-	-	-	▼
MM-3	Single Witness Signature Use CDs Omnicell	7	12	20	3	8	4	9	4	6	4	5	4	2	-	-	-	-	▲
MM-4	Single Witness Signature Use CDs Non-Omnicell	2	1	0	2	7	0	3	3	3	3	4	0	1	-	-	-	-	▼
MM-5	Number of CD Breakages	13	10	15	15	8	14	18	19	21	21	11	20	17	-	-	-	-	▲
MM-7	Medicines Management % of Audits Completed	100.00%	99.00%	99.00%	99.00%	100.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	100.00%	-	-	-	-	▲
WF-1	Number of Staff WTE (Excl bank and agency)	3517	3529	3541	3564	3602	3624	3710	3689	3685	3667	3667	3734	3768	-	-	-	-	▲
WF-2	Number of Staff Headcount (Exc bank and agency)	3811	3836	3897	3879	3918	3940	4034	4016	4020	4001	4005	4075	4120	-	-	-	-	▲
WF-3	Finance Establishment (WTE)	3837	3724	3768	3791	3803	3811	3860	3940	3920	3924	3905	3905	3905	-	-	-	-	●
WF-4	Vacancy Rate %	8.30%	5.20%	6.00%	6.00%	5.30%	4.90%	3.90%	6.40%	6.00%	6.50%	6.10%	4.40%	3.50%	-	-	-	-	▲
QS-9	Number of RIDDOR Reports	2	10	9	8	10	8	5	4	2	6	12	2	8	-	-	-	-	▼
WF-16	DBS Compliance %	-	-	-	-	-	-	-	-	-	-	-	-	-	■	■	■	■	■

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

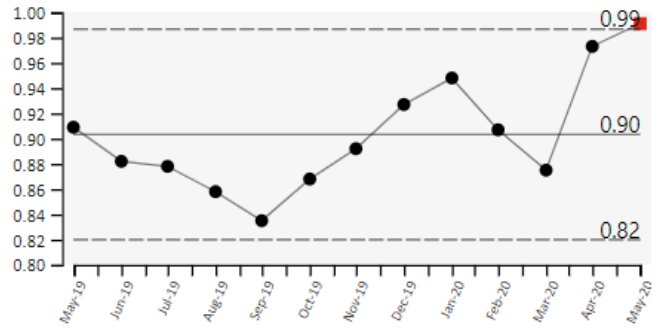
\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

999-12

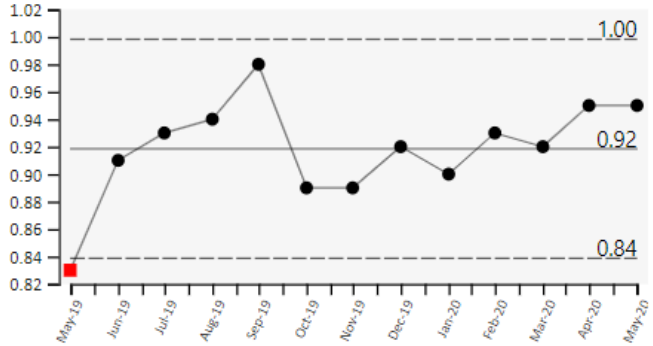
999 Frontline Hours Provided %



May 2020	Target
99.10%	100.00%

QS-7

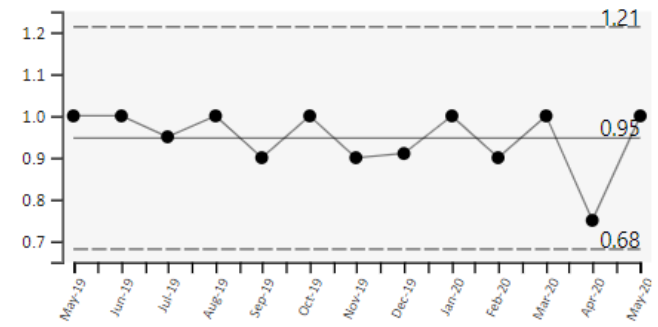
Hand Hygiene Compliance %



May 2020	Target
95.00%	95.00%

QS-3

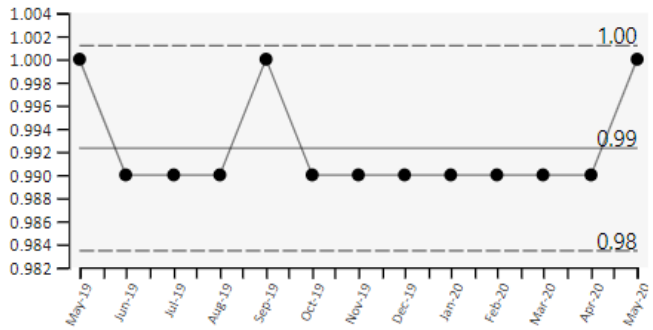
Duty of Candour Compliance %



May 2020	Target
100.00%	100.00%

MM-7

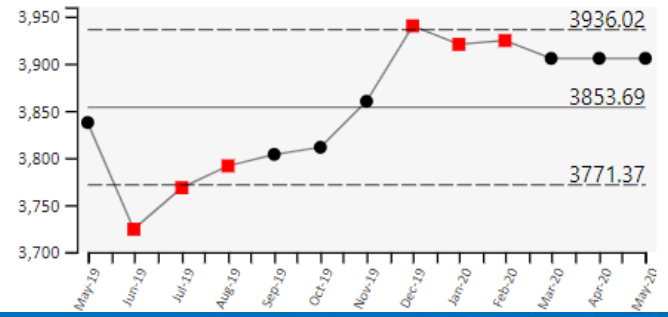
Medicines Management % of Audits Completed



May 2020	Target
100.00%	N/A

WF-3

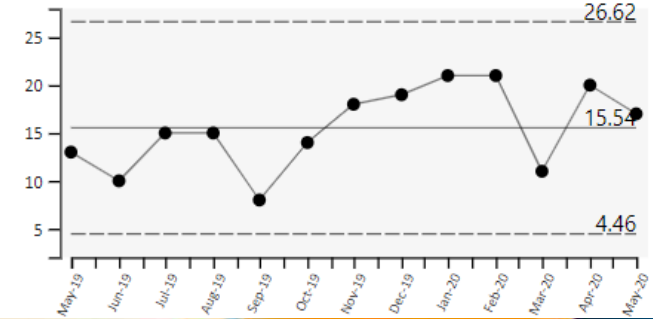
Finance Establishment (WTE)



May 2020	Target
3905	N/A

MM-5

Number of CD Breakages



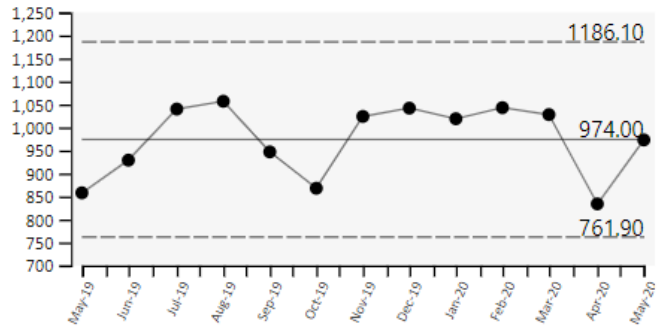
May 2020	Target
17	N/A

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

QS-1

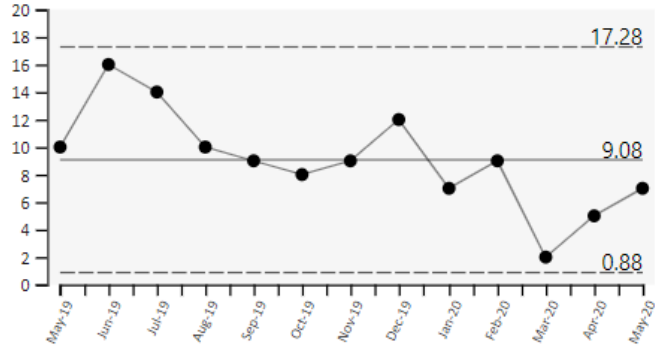
Number of Datix Incidents



May 2020	Target
973	N/A

QS-2

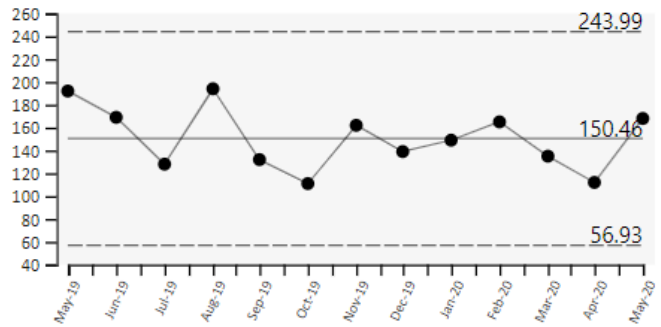
Number of Incidents Reported as SIs



May 2020	Target
7	N/A

MM-1

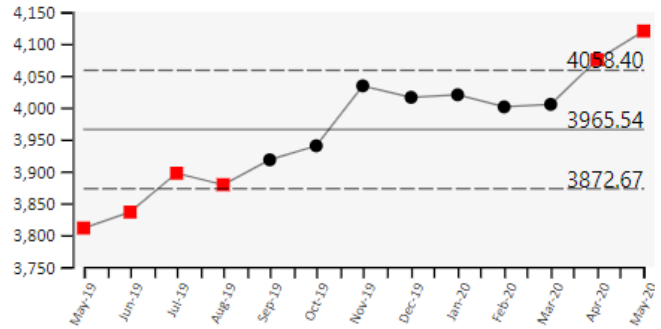
Number of Medicines Incidents



May 2020	Target
168	N/A

WF-2

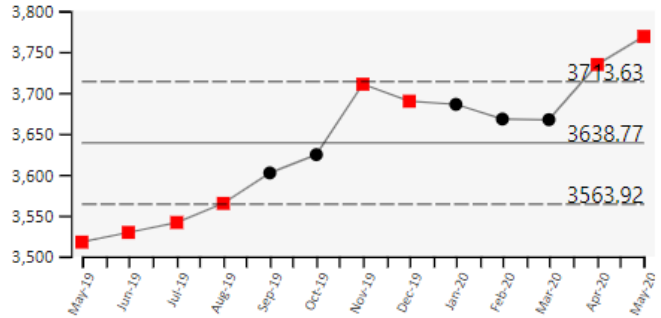
Number of Staff Headcount (Excl bank and agency)



May 2020	Target
4120	N/A

WF-1

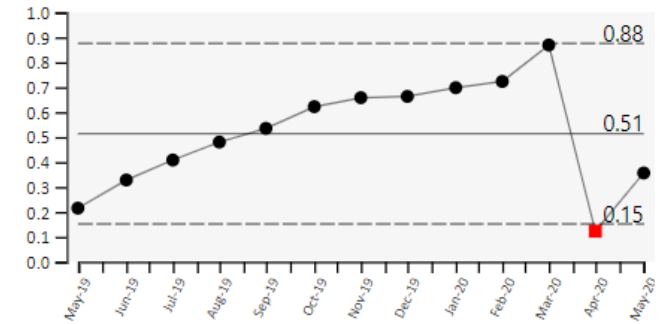
Number of Staff WTE (Excl bank and agency)



May 2020	Target
3768	N/A

QS-8

Safeguarding Training Completed (Children) Level 2 %



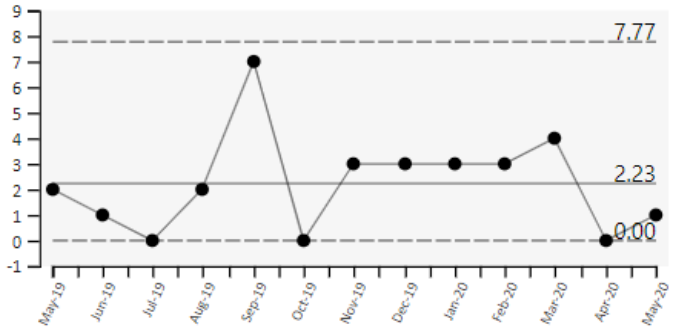
May 2020	Target
35.60%	95.00%

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

MM-4

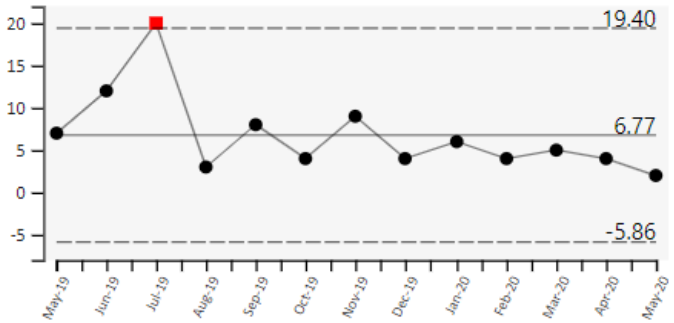
Single Witness Signature Use CDs Non-Omnicell



May 2020	1
Target	N/A

MM-3

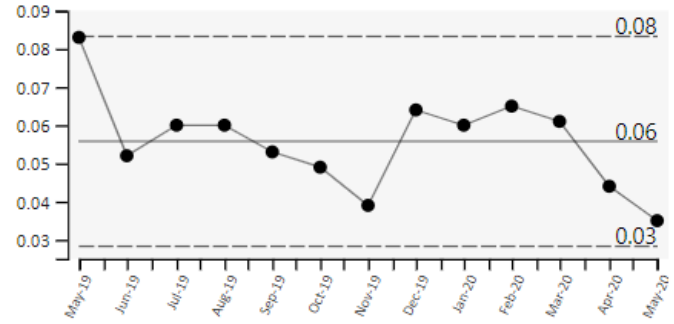
Single Witness Signature Use CDs Omnicell



May 2020	2
Target	N/A

WF-4

Vacancy Rate %



May 2020	3.50%
Target	N/A

Performance by Domain
Effective: Performance Dashboard

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

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-11	JCT Allocation to Clear at Scene Mean	01:15:30	01:15:27	01:14:03	01:14:47	01:15:21	01:16:58	01:18:03	01:14:23	01:15:07	01:15:55	01:19:00	01:22:33	01:19:55	-	-	-	-	▲
999-11	JCT Allocation to Clear at Hospital Mean	01:47:21	01:48:00	01:47:46	01:47:34	01:48:04	01:49:14	01:50:19	01:50:13	01:50:34	01:50:08	01:51:21	01:50:08	01:47:51	-	-	-	-	▲
M-1	**Cardiac ROSC Utstein %	58.00%	31.00%	64.00%	72.00%	57.00%	54.00%	52.00%	50.00%	55.00%	22.00%	42.00%	33.00%		-	-	-	-	▼
M-2	Cardiac ROSC ALL %	24.00%	23.00%	31.00%	36.00%	33.00%	25.00%	27.00%	23.00%	28.00%	25.00%	18.00%	24.00%		-	-	-	-	▲
M-3	Cardiac Survival Utstein %	32.00%	24.00%	33.00%	18.00%	37.00%	31.00%	22.00%	29.00%	33.00%	9.00%	31.00%			-	-	-	-	-
M-4	Cardiac Survival ALL %	7.00%	9.00%	11.00%	7.00%	12.00%	11.00%	5.00%	8.00%	10.00%	7.00%	7.00%			-	-	-	-	-
M-11	Cardiac Arrest - Post ROSC %	83.00%	77.00%	77.00%	85.00%	82.00%	78.00%	82.00%	75.00%	80.00%	77.00%	78.00%	81.00%		-	-	-	-	▲
M-5	**Acute STEMI Care Bundle Outcome %	59.00%	66.00%	51.00%	47.00%	58.00%	56.00%	63.00%	65.00%	71.00%	69.00%	73.00%	71.00%		-	-	-	-	▼
M-6	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	02:10:00	02:22:00	02:12:00	02:03:00	02:16:00	02:07:00	02:14:00							-	-	-	-	-
M-7	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	02:48:00	03:08:00	03:03:00	02:33:00	03:03:00	02:37:00	03:09:00							-	-	-	-	-
M-8	Stroke - Call to Hospital Arrival Mean	01:17:00	01:25:00	01:16:00	01:17:00	01:22:00	01:26:00	01:30:00							-	-	-	-	-
M-9	Stroke - Call to Hospital Arrival 90th Centile	01:58:00	02:17:00	02:02:00	02:00:00	02:06:00	02:25:00	02:24:00							-	-	-	-	-
M-10	**Stroke - Assessed F2F Diagnostic Bundle %	96.00%	97.00%	96.00%	94.00%	95.00%	92.00%	94.00%	96.00%	97.00%	99.00%	97.00%	98.00%		-	-	-	-	▲
M-12	**Sepsis Care Bundle %	79.00%	82.00%	80.00%	76.00%	72.00%	61.00%	86.00%	87.00%	87.00%	87.00%	87.00%	88.00%		-	-	-	-	▲
M-13	Sensitivity of Cardiac Arrest Detection During Telephone Triage %	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	■	■	■
M-14	Proportion of Witnessed Cardiac Arrests Receiving Bystander CPR %	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	■	■	■
M-15	Time to Commence Telephone-Guided CPR Mean	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	■	■	■
M-16	Percentage of Resuscitation Attempts with PAD Applied to Patient %	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	■	■	■

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

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

Performance by Domain
Effective: Performance Dashboard

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

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-13	ECAL Mean Response Time	00:33:20	00:33:04	00:28:38	00:26:44	00:31:37	00:28:27	00:27:42	00:25:55	00:27:03	00:27:49	00:26:21	00:23:15	00:23:51			-	-	▼
WF-6	Statutory & Mandatory Training Compliance %	60.20%	60.80%	60.70%	63.50%	65.20%	68.80%	70.20%	70.60%	73.60%	76.60%	83.70%	68.60%	70.80%	95.00%		-	-	▲
WF-22	Clinical Education																■	■	■

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

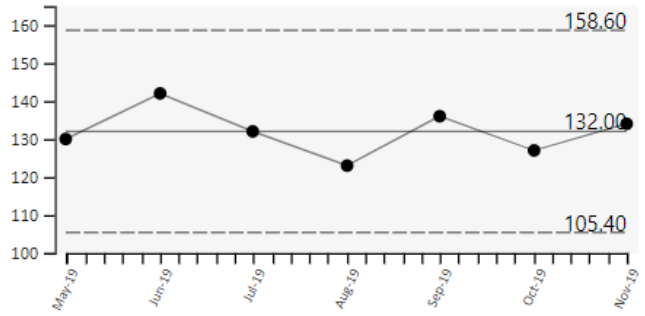
\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Effective: Performance Charts

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

M-6

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



Nov-19

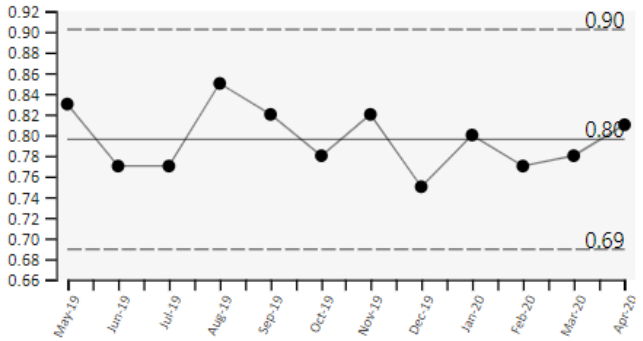
02:14:00

Target

N/A

M-11

Cardiac Arrest - Post ROSC %



Apr-20

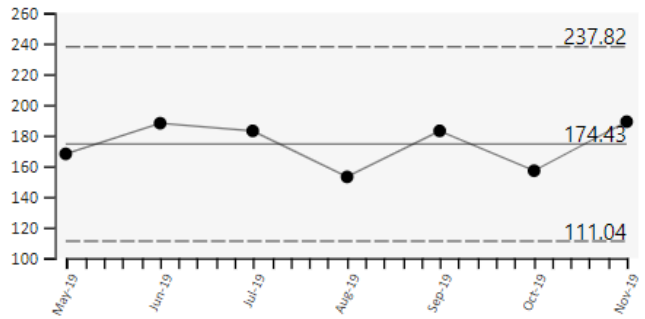
81.00%

Target

N/A

M-7

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



Nov-19

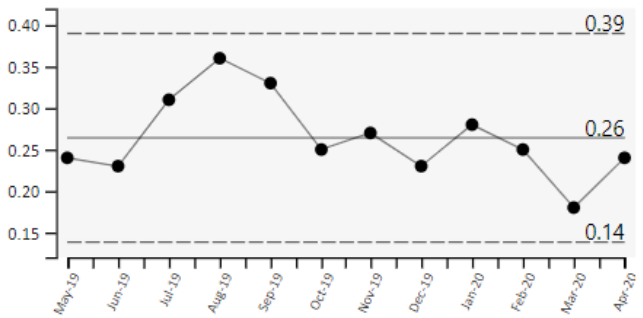
03:09:00

Target

N/A

M-2

Cardiac ROSC ALL %



Apr-20

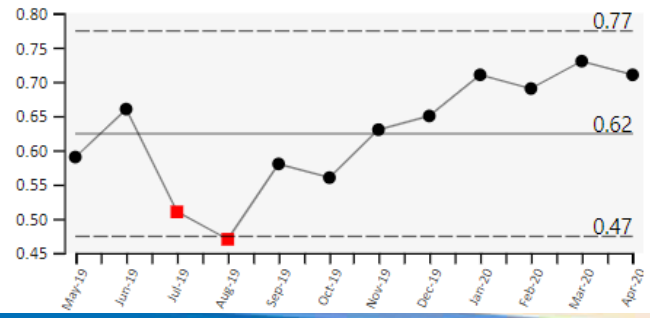
24.00%

Target

N/A

M-5

**Acute STEMI Care Bundle Outcome %



Apr-20

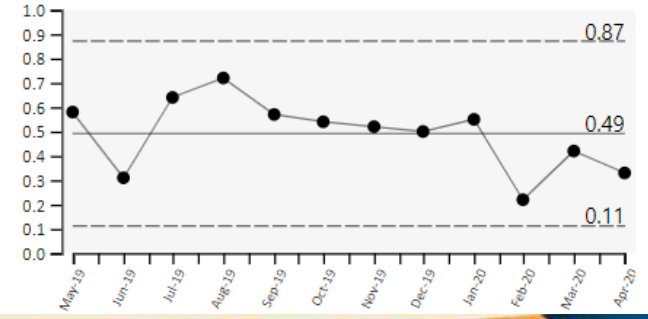
71.00%

Target

N/A

M-1

**Cardiac ROSC Utstein %



Apr-20

33.00%

Target

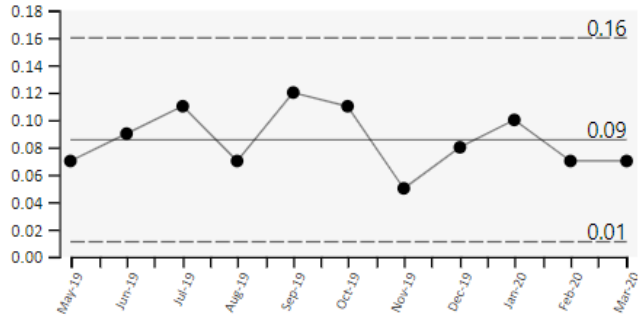
N/A

Performance by Domain
Effective: Performance Charts

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

M-4

Cardiac Survival ALL %



Mar-20

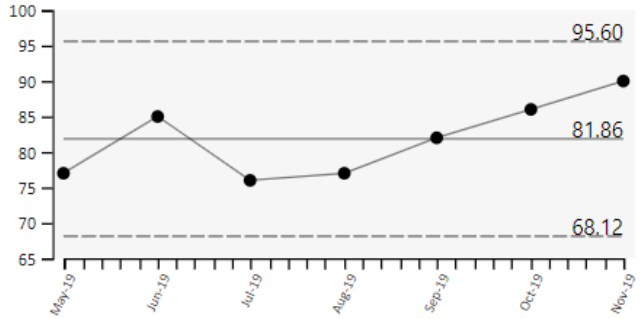
5.00%

Target

N/A

M-8

Stroke - Call to Hospital Arrival Mean



Nov-19

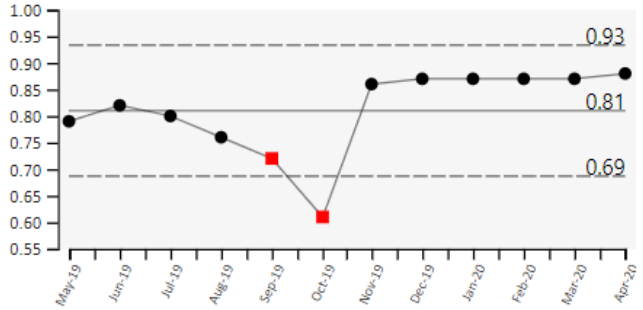
01:30:00

Target

N/A

M-12

**Sepsis Care Bundle %



Apr-20

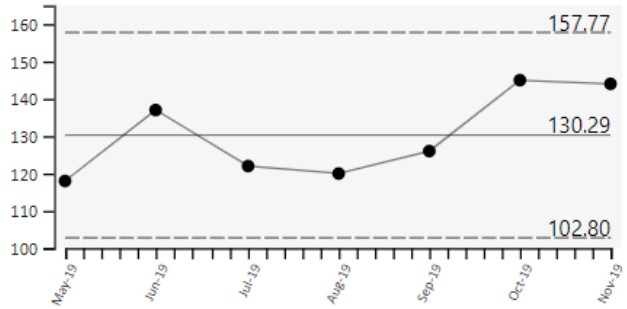
88.00%

Target

N/A

M-9

Stroke - Call to Hospital Arrival 90th Centile



Nov-19

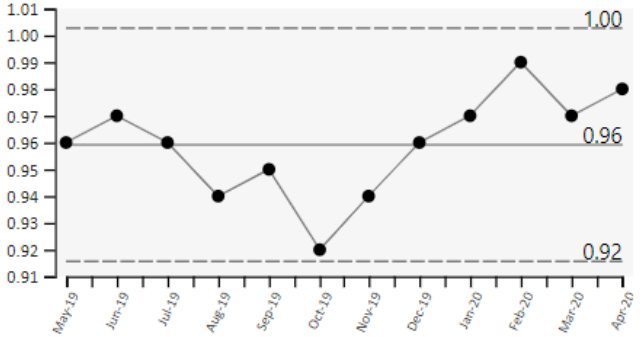
02:24:00

Target

N/A

M-10

**Stroke - Assessed F2F Diagnostic Bundle %



Apr-20

98.00%

Target

N/A

Performance by Domain
Caring: Performance Dashboard

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

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-12	Proportion of Complaints Relating to Dignity and Respect %																■	■	■
M-17	Dementia Performance																■	■	■
M-18	End of Life Care Performance																■	■	■
M-19	Falls Performance																■	■	■
111-6	111 SMS Feedback																■	■	■
QS-10	Proportion of Complaints Relating to Crew Attitude %																■	■	■
QS-11	Patient Experience																■	■	■

Note:

- You will note that there are currently no metrics under the Caring domain – which may seem odd given we were “Outstanding” in this area in our most recent CQC report
- When we reviewed the metrics regularly reported to the Board in your IPR, none fell into the Caring domain
- Our suite of 'aspirational' metrics includes numerous across all domains, including Caring, and when populated will provide a far more rounded snapshot of performance to the Board

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

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

Performance by Domain
Responsive: Performance Dashboard

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

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
111-1	111 Calls Offered	74311	70989	73544	74832	68451	72487	78017	92173	75904	85080	162194	89757	81333			-	-	▼
111-2	111 Calls Answered in 60 Seconds %	68.50%	75.40%	71.80%	80.80%	78.50%	78.30%	77.50%	78.20%	86.30%	61.50%	16.50%	48.70%	87.90%	95.00%		-	-	▲
111-3	111 Calls Abandoned - (Offered) %	7.70%	7.70%	6.20%	3.60%	3.60%	3.80%	3.60%	3.00%	1.90%	8.00%	50.20%	18.60%	1.40%	5.00%		+	-	▲
111-4	111 to 999 Referrals (Answered Calls) %	15.50%	15.40%	16.10%	15.50%	16.10%	16.90%	15.80%	15.10%	14.50%	12.70%	9.80%	11.90%	13.00%		12.00%	-	-	▼
111-4	999 Referrals	8649	8378	8791	8961	8514	9454	9638	10672	8726	7960	5443	6734	8768			-	-	▼
111-5	A&E Dispositions %	9.20%	10.00%	10.40%	10.10%	10.30%	10.20%	9.70%	9.50%	10.70%	9.70%	6.00%	9.20%	11.60%		10.50%	-	-	▼
111-5	A&E Dispositions	5135	5424	5674	5808	5460	5697	5903	6676	6443	6047	3316	5235	7795			-	-	▼
999-1	999 Call Answer Mean	00:00:05	00:00:07	00:00:09	00:00:06	00:00:05	00:00:06	00:00:03	00:00:03	00:00:02	00:00:02	00:00:07	00:00:01	00:00:01	00:00:05	00:00:02	+	+	●
999-1	999 Call Answer 90th Centile	00:00:02	00:00:16	00:00:26	00:00:10	00:00:04	00:00:11	00:00:01	00:00:01	00:00:01	00:00:01	00:00:12	00:00:01	00:00:01	00:00:10	00:00:02	+	+	●
999-2	Cat 1 Mean	00:07:18	00:07:30	00:07:21	00:07:15	00:07:35	00:07:43	00:07:39	00:07:55	00:07:36	00:07:43	00:07:52	00:07:05	00:07:00	00:07:00	00:06:34	=	-	▲
999-2	Cat 1 90th Centile	00:13:37	00:13:52	00:13:52	00:13:44	00:13:56	00:14:37	00:14:39	00:14:46	00:13:59	00:14:30	00:14:55	00:13:32	00:12:10	00:15:00	00:11:27	+	-	▲
999-3	Cat 1T Mean	00:09:27	00:11:15	00:09:33	00:09:04	00:09:25	00:09:31	00:09:26	00:09:49	00:09:22	00:09:26	00:09:25	00:08:28	00:07:59	00:19:00	00:08:15	+	+	▲
999-3	Cat 1T 90th Centile	00:17:23	00:18:48	00:18:23	00:17:52	00:17:36	00:17:59	00:18:09	00:18:19	00:17:14	00:17:44	00:17:32	00:15:38	00:14:31	00:30:00	00:08:15	+	-	▲
999-4	Cat 2 Mean	00:20:54	00:21:31	00:20:01	00:18:21	00:18:51	00:20:06	00:20:54	00:21:42	00:18:06	00:19:15	00:21:26	00:14:50	00:14:28	00:18:00	00:13:28	+	-	▲
999-4	Cat 2 90th Centile	00:40:16	00:41:14	00:38:34	00:34:23	00:35:49	00:38:01	00:39:48	00:41:32	00:34:10	00:36:29	00:41:02	00:27:32	00:26:58	00:40:00	00:25:14	+	-	▲
999-5	Cat 3 90th Centile	03:56:04	04:17:58	03:33:52	03:09:59	03:17:42	03:52:51	04:03:22	04:11:54	02:50:33	03:25:09	04:00:52	01:54:57	01:40:20	02:00:00	01:03:07	+	-	▲
999-6	Cat 4 90th Centile	04:52:54	05:29:06	04:41:02	04:25:38	04:34:31	05:34:12	04:46:20	05:21:05	03:33:38	04:46:32	04:56:30	02:42:46	02:14:44	03:00:00	01:45:42	+	-	▲
999-7	HCP 3 Mean						02:20:25	02:05:07	02:25:37	01:50:21	02:00:42	02:18:26	01:11:25	01:11:14		00:40:18	-	-	▲
999-7	HCP 3 90th Centile						05:03:44	04:46:42	05:34:57	03:53:48	04:09:57	04:59:29	02:43:28	02:40:50		01:22:58	-	-	▲
999-7	HCP 4 Mean						03:25:25	03:17:34	02:59:04	02:32:29	02:49:16	03:08:44	01:32:09	01:34:23		00:57:39	-	-	▼
999-7	HCP 4 90th Centile						06:51:36	06:43:46	05:43:16	05:44:15	05:44:04	07:17:56	03:50:42	04:00:58		01:59:40	-	-	▼
999-9	Hear & Treat %	5.60%	6.20%	5.70%	5.90%	5.80%	5.80%	6.20%	6.70%	5.60%	6.50%	8.40%	6.70%	5.90%		7.50%	-	-	▼
999-9	See & Treat %	32.10%	31.60%	32.60%	32.40%	31.90%	31.30%	30.80%	31.70%	31.50%	31.80%	37.10%	42.40%	37.10%		36.40%	-	+	▼
999-9	See & Convey %	62.30%	62.20%	61.70%	61.70%	62.30%	62.90%	63.00%	61.60%	62.90%	61.70%	54.40%	50.90%	57.00%		56.00%	-	-	▼
999-10	999 Calls Answered	65410	67514	70863	67178	64525	69301	68437	73898	65125	63620	77690	56319	54224			-	-	-
999-10	Incidents	60075	59601	64052	63107	60410	64407	64620	68798	65363	61110	64209	58064	60484			-	-	-

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

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

Performance by Domain
Responsive: Performance Dashboard

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

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-10	CFR Attendances	995	948	1024	1105	997	1340	1242	1321	1185	1051	785	0	0			-	-	●
999-10	FFR Attendances	425	349	358	341	266	221	338	398	427	261	243	144	180			-	-	▲
QS-4	Complaints Reporting Timeliness %	55.00%	61.00%	75.00%	77.00%	59.00%	55.00%	55.00%	73.00%	72.00%	78.00%	90.00%	92.00%	86.00%	95.00%		-	-	▼
QS-5	Number of Complaints	64	80	91	78	59	111	91	68	79	66	56	43	48			-	-	▼
QS-6	Number of Compliments	47	61	144	220	147	147	231	148	213	187	197	169	168			-	-	▼

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

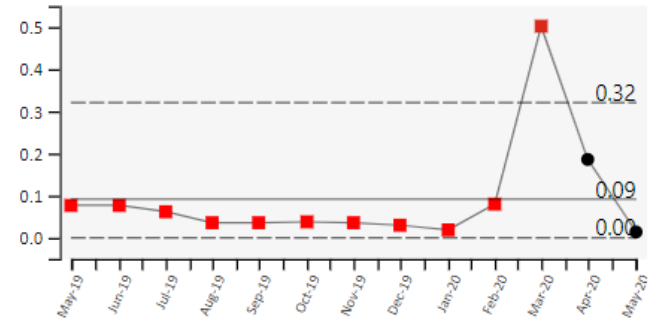
\+ Outperformed target
\- Underperformed target
= On target
\- Data not provided

Performance by Domain
Responsive: Performance Charts

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

111-3

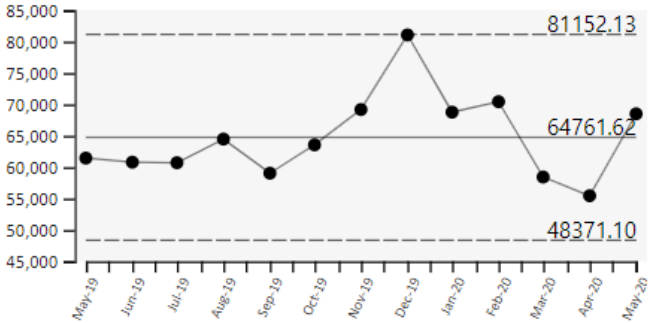
111 Calls Abandoned - (Offered) After 30 Seconds %



May-20 | 1.40% | Target | 5.00%

111-2

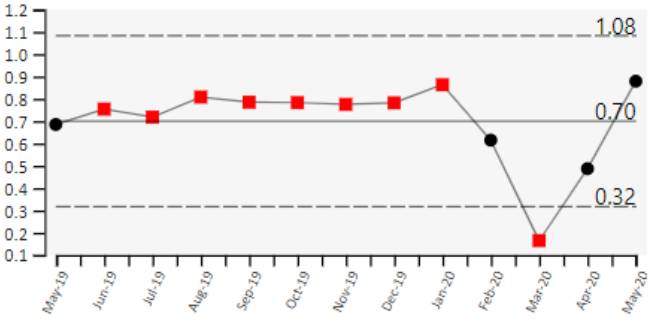
111 Calls Answered



May-20 | 68503 | Target | N/A

111-1

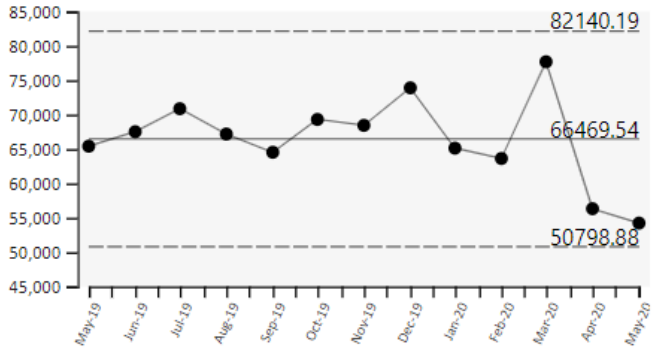
111 Calls Answered in 60 Seconds %



May-20 | 87.90% | Target | 95.00%

999-10

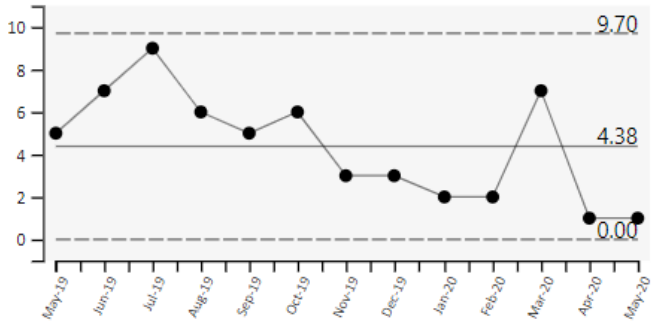
999 Calls Answered



May-20 | 54224 | Target | N/A

999-1

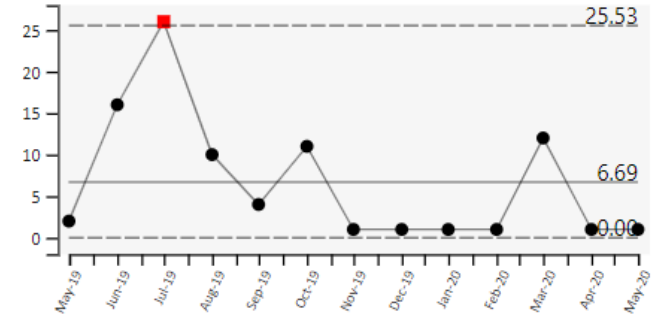
999 Call Answer Mean



May-20 | 00:00:01 | Target | 00:00:05

999-1

999 Call Answer 90th Centile



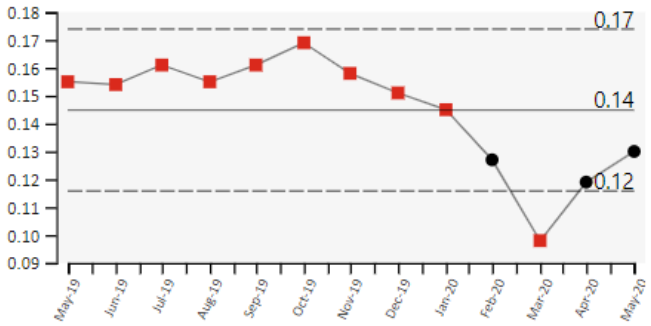
May-20 | 00:00:01 | Target | 00:00:10

Performance by Domain
Responsive: Performance Charts

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

111-4

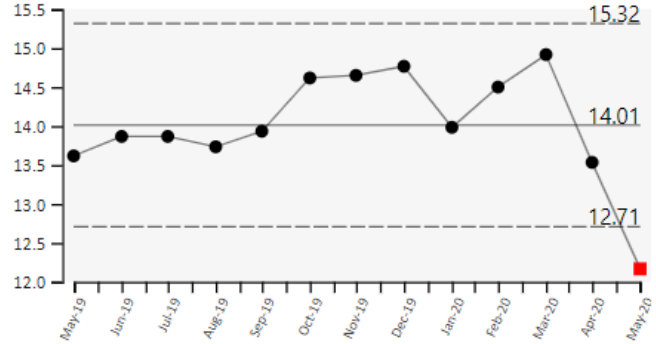
999 Referrals (Answered Calls) %



May-20
13.00%
Target
N/A

999-2

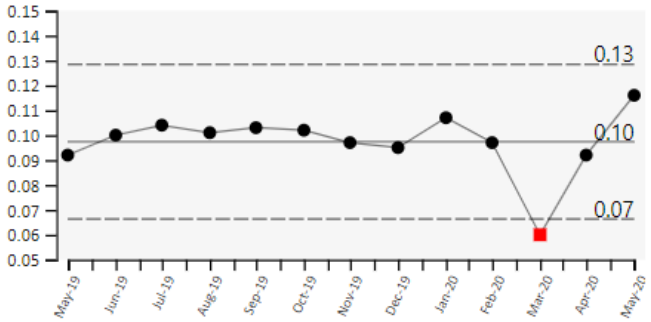
Cat 1 90th Centile



May-20
00:12:10
Target
00:15:00

111-5

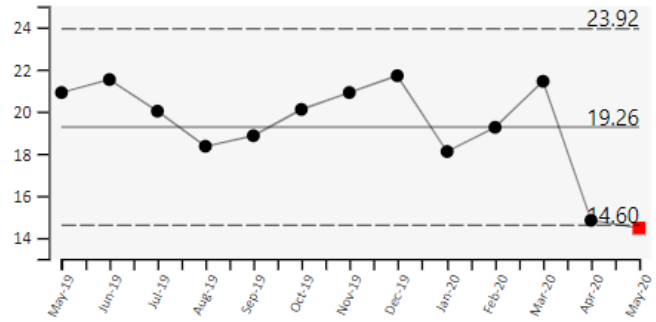
A&E Dispositions %



May-20
11.60%
Target
N/A

999-4

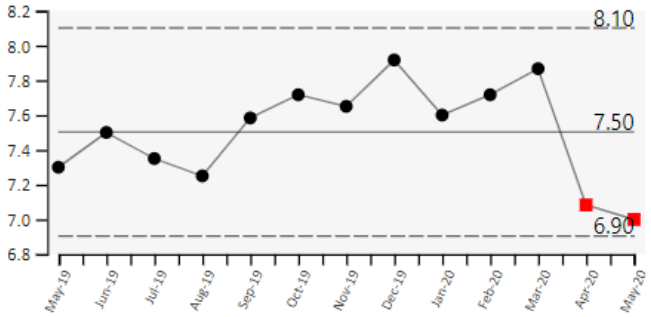
Cat 2 Mean



May-20
00:14:28
Target
00:18:00

999-2

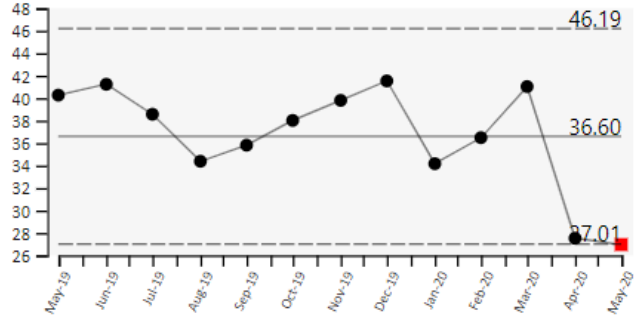
Cat 1 Mean



May-20
00:07:00
Target
00:07:00

999-4

Cat 2 90th Centile



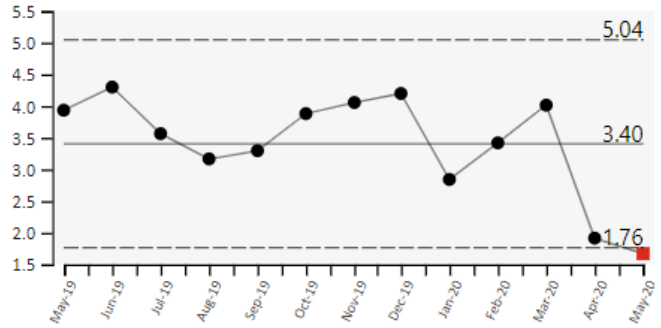
May-20
00:26:58
Target
00:40:00

Performance by Domain
Responsive: Performance Charts

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

999-5

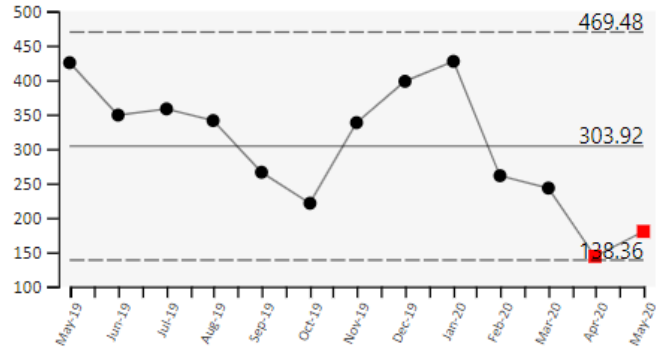
Cat 3 90th Centile



May-20	Target
01:40:20	02:00:00

999-10

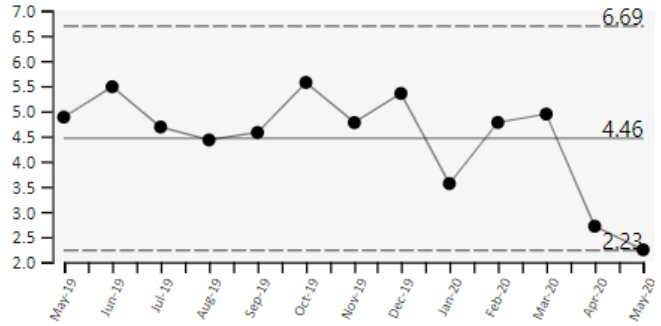
Fire First Responder Attendances



May-20	Target
180	N/A

999-6

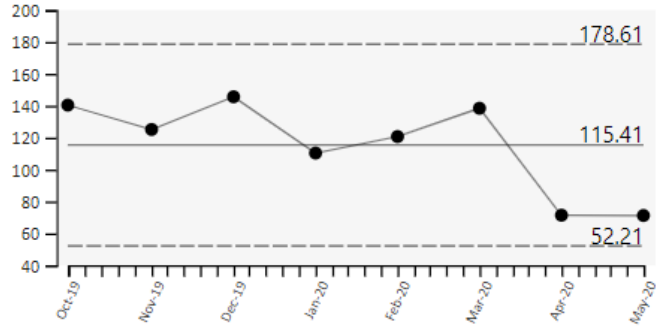
Cat 4 90th Centile



May-20	Target
02:14:44	02:14:44

999-7

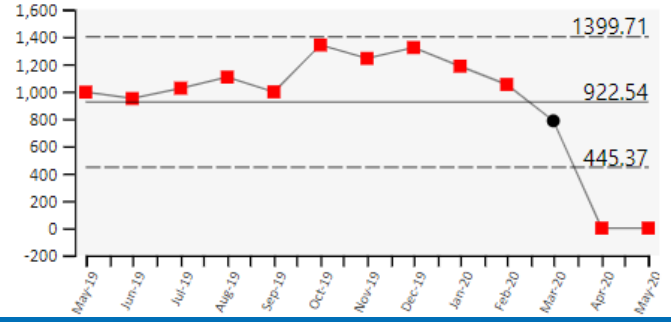
HCP 3 Mean



May-20	Target
01:11:14	N/A

999-10

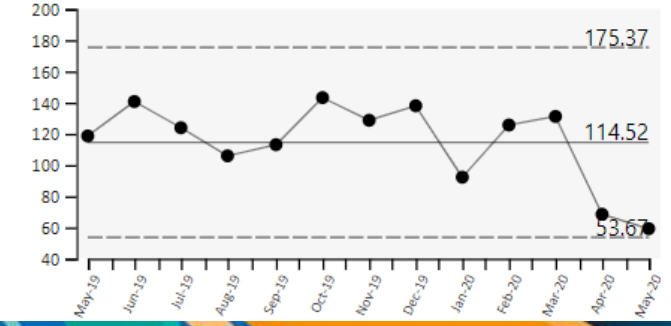
Community First Responder Attendances



May-20	Target
0	N/A

999-7

HCP 4 Mean



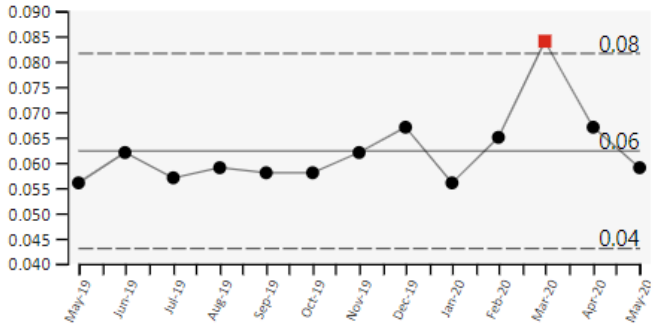
May-20	Target
01:34:23	N/A

Performance by Domain
Responsive: Performance Charts

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

999-9

Incident Outcome Hear & Treat %

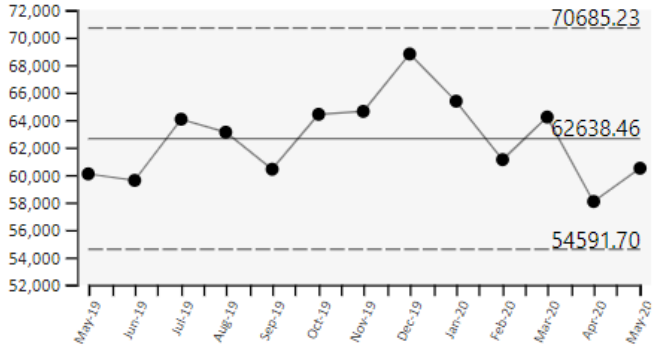


May-20 5.90%

Target N/A

999-10

Incidents A7

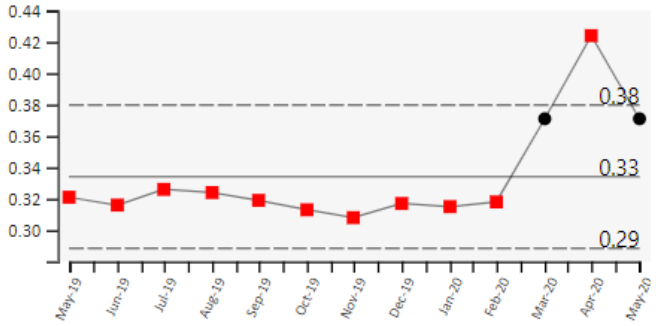


May-20 60484

Target N/A

999-9

Incident Outcome See & Treat %

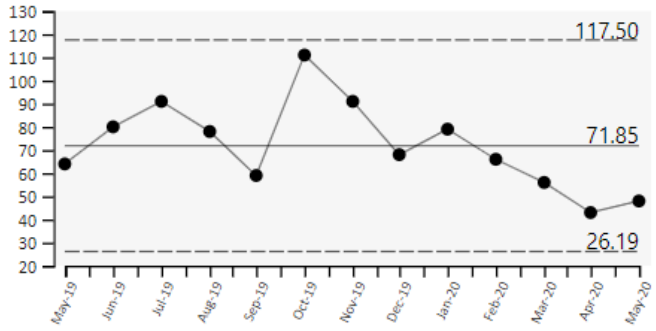


May-20 37.10%

Target N/A

QS-5

Number of Complaints

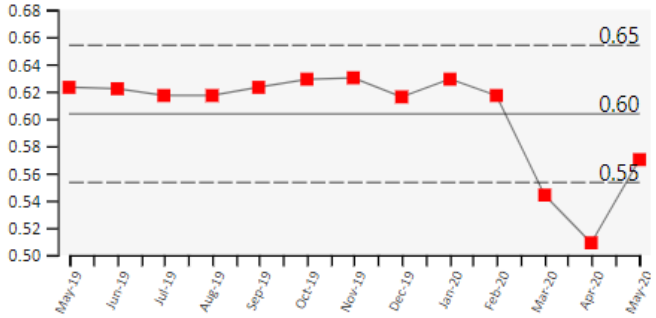


May-20 48

Target N/A

999-9

Incident Outcome See & Convey %

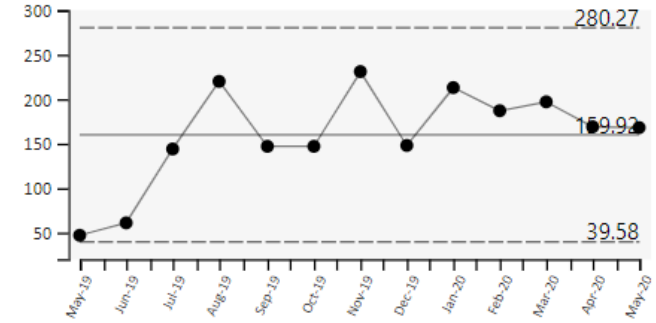


May-20 57.00%

Target N/A

QS-6

Number of Compliments



May-20 168

Target N/A

Performance by Domain
Well-Led: Performance Dashboard

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

ID	Metric	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
F-1	Income (£000s)	£20102.70	£19142.90	£20801.40	£19995.30	£19553.00	£19927.00	£20390.10	£22455.50	£21049.40	£19410.00	£23188.60	£21877.40	£22787.20	£22066.70		+	-	▲
F-2	Expenditure (£000s)	£20586.40	£19457.70	£20863.50	£20271.20	£20094.80	£20177.80	£20023.50	£20877.00	£20227.40	£19428.00	£22280.80	£21877.40	£22787.20	£22066.70		-	-	▼
F-3	Capital Expenditure (£000s)	£1021.07	£1032.93	£1790.03	£1269.97	£989.00	£1781.00	£845.00	£1022.00	£851.01	£1012.00	£1859.99	£1262.00	£254.00	£985.00		+	-	▲
F-4	Cost Improvement Plan (CIP) (£000s)	£585.37	£739.00	£580.40	£1078.31	£533.75	£467.79	£336.74	£627.15	£574.85	£700.00	£776.00	£0.00	£0.00	£217.00		-	-	●
F-6	Surplus/Deficit (£000s)	£-483.70	£-314.80	£-62.10	£-275.90	£-541.80	£-250.80	£366.60	£1578.50	£822.00	£-18.00	£907.80	£0.00	£0.00	£0.00		=	-	●
F-7	Cash Position (£000s)	£17271.00	£15668.00	£22780.00	£24597.00	£24561.00	£26496.00	£24966.00	£26136.00	£25758.00	£26577.00	£28326.00	£48150.00	£44676.00	£46696.64		-	-	▼
F-8	Agency Spend (£000s)	£525.75	£678.49	£625.29	£151.54	£242.64	£-31.85	£364.44	£431.82	£356.12	£-145.00	£145.97	£231.94	£69.41	£385.00		+	-	▲
WF-5	Objectives & Career Conversation	13.30%	20.20%	28.70%	33.20%	38.60%	42.60%	45.60%	49.60%	56.20%	61.30%	71.70%	5.40%	16.50%	80.00%		-	-	▲
WF-7	Annual Rolling Turnover Rate	14.70%	15.00%	15.00%	15.60%	15.50%	15.90%	15.40%	14.90%	15.60%	15.90%	15.80%	15.60%	14.80%			-	-	▲
WF-8	Annual Rolling Sickness Absence	5.20%	5.30%	5.40%	5.50%	5.40%	5.40%	5.60%	6.00%	5.70%	5.70%	5.80%	6.10%	6.00%	5.00%		-	-	▲
WF-18	Absence Relating to Mental Health %																■	■	■
WF-19	Absence Relating to MSK %																■	■	■
WF-9	Disciplinary Cases	4	6	8	0	0	1	4	8	6	5	2	6	4			-	-	▲
WF-10	Individual Grievances	7	4	12	0	2	7	10	7	8	8	6	4	4			-	-	●
WF-11	Collective Grievances	0	0	1	0	1	5	1	0	1	2	1	1	0			-	-	▲
WF-12	Bullying & Harrassment Internal	1	4	2	0	1	5	0	4	2	1	2	2	1			-	-	▲
WF-13	Whistleblowing	0	1	0	0	0	0	0	0	0	0	0	0	0			-	-	-
999-15	999 Frontline Late Finishes/Over-Runs %																■	■	■
WF-17	Workforce Diversity																■	■	■
999-16	*Staff Successfully FIT-Tested %													* 93.9%			-	-	-

*Latest data: July-20

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

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

Performance by Domain
Well-Led: Exception Report

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

ID	Standard	Background
CIP	Standard: Cost Improvement Plan (CIP) £'s delivery against target Definition: A target is set as part of the budget setting process in £'s	Although the Trust has met it's £1m CIP target in Q1, validated schemes only amount to £1.7m, leaving a potential £3.8m gap for the year

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The Senior Management Team have formed a Productivity Group lead by the Deputy Directors of Operations and Finance to ensure appropriate focus is given to this issue	Named person: Entire Executive Management Team Executive Director of Finance & Corporate Services will report progress back to EMB and Trust Board. Complete by date: Ongoing

Performance by Domain
Well-Led: Exception Report

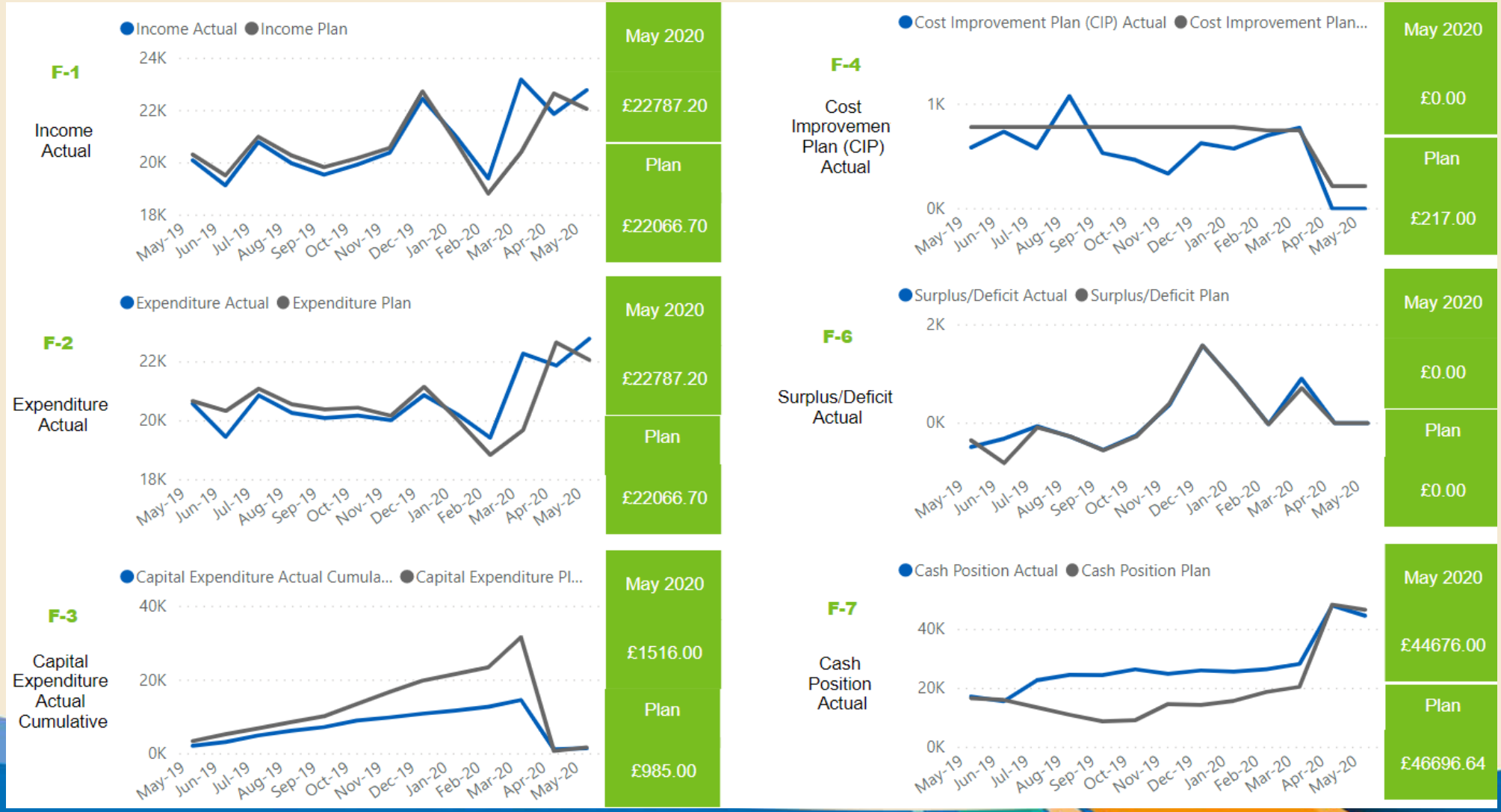
Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
Cost Pressures	Standard: There is up to £3m of reserves available to fund cost pressures assuming bottom line is on target Definition: Financial value of cost pressures against budgeted reserves	The level of cost pressures identified at budget setting has the potential to significantly exceed available reserves

Action Plan	Accountable Executive
Actions being taken to mitigate issues: The SMT review and approve all cost pressures using a standardised process. Investment decisions are undertaken using a defined BC approval process through the Business Case Group, EMB and Trust Board depending on the level of investment. Affordability both against the current financial position and in future years a key consideration	Named person: Executive Director of Finance & Corporate Services Complete by date: Ongoing

Performance by Domain
Well-Led: Performance Charts

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

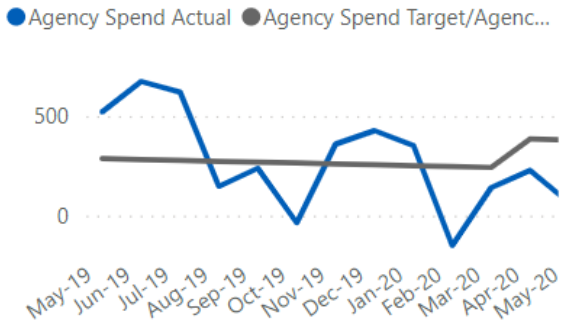


Performance by Domain
Well-Led: Performance Charts

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

F-8

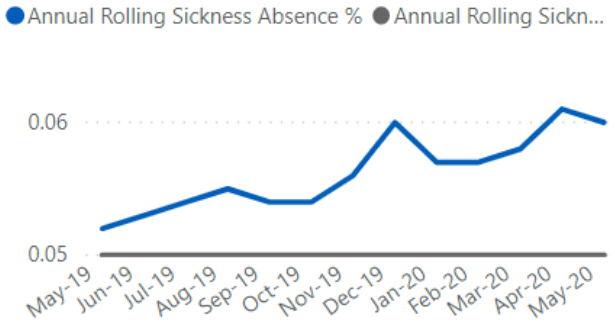
Agency Spend (£000s)



May 2020	£69.41
Plan	£0.00

WF-8

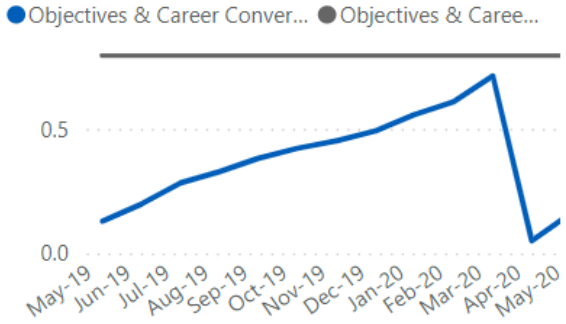
Annual Rolling Sickness Absence %



May 2020	6.00%
Target	5.00%

WF-5

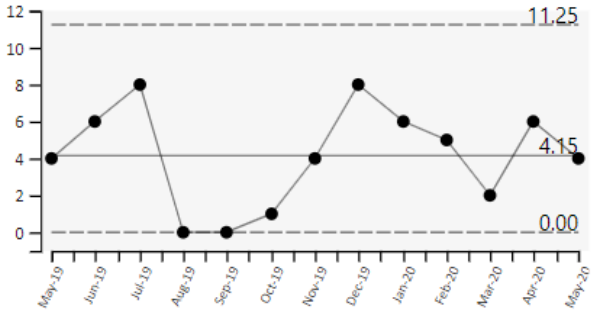
Objectives & Career Conversations



May 2020	16.50%
Target	80.00%

WF-9

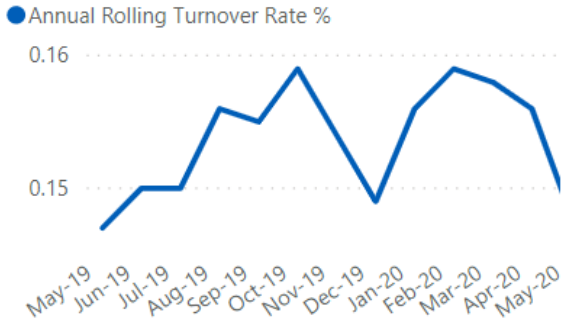
Disciplinary Cases



May 2020	4
Target	N/A

WF-7

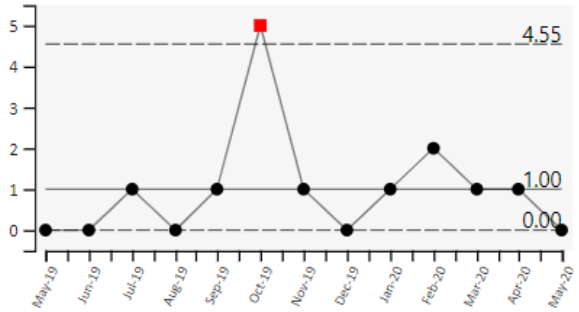
Annual Rolling Turnover Rate %



May 2020	14.80%
Target	N/A

WF-11

Collective Grievances



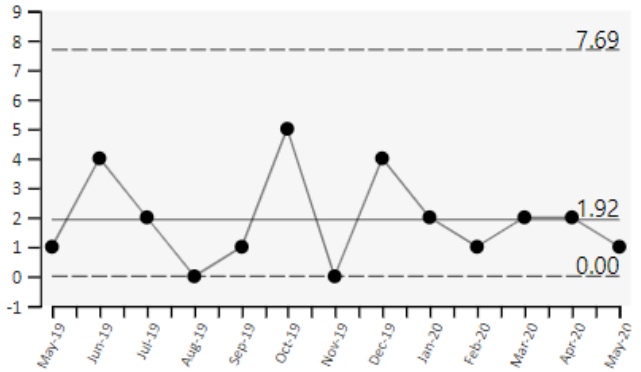
May 2020	0
Target	N/A

Performance by Domain
Well-Led: Performance Charts

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

WF-12

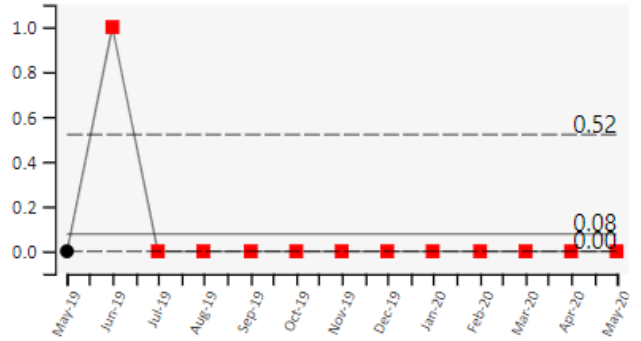
Bullying & Harrassment Internal



May 2020
1
Target
(Blank)

WF-13

Whistleblowing



May 2020
0
Target
N/A

National Benchmarking
999 Emergency Ambulance Service (May 2020)

Key indicators at a glance for May 2020

Primary Triage Software	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SECAmb	SWAS	WMAS	YAS
	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	NHS Pathways	AMPDS	NHS Pathways	AMPDS
999 Call Answer	**EEAS**	**EMAS**	**IOW**	**LAS**	**NEAS**	**NWAS**	**SCAS**	**SECAmb**	**SWAS**	**WMAS**	**YAS**
90th Centile Call Answer Time	00:00:04	00:00:02	00:00:07	00:00:00	00:00:04	00:00:01	00:00:04	00:00:01	00:00:03	00:00:01	00:00:01
Calls Answered	57067	55025	970	94433	25798	83256	34308	54224	62191	65913	40190
Mean Call Answer Time	00:00:02	00:00:02	00:00:08	00:00:00	00:00:03	00:00:01	00:00:04	00:00:01	00:00:02	00:00:01	00:00:02
Incident Proportions (Over All Incidents)	**EEAS**	**EMAS**	**IOW**	**LAS**	**NEAS**	**NWAS**	**SCAS**	**SECAmb**	**SWAS**	**WMAS**	**YAS**
All Incidents	72232	61881	1912	93014	35461	91736	45999	60484	68570	87276	63679
C1 Incidents %	7.65%	7.70%	4.76%	6.98%	6.05%	7.00%	5.41%	5.52%	5.75%	5.75%	6.65%
C2 Incidents %	49.57%	50.06%	39.59%	51.51%	50.26%	47.89%	42.24%	44.08%	48.07%	41.03%	49.20%
C3 Incidents %	22.45%	28.07%	37.50%	23.44%	27.48%	19.49%	35.73%	39.19%	26.74%	38.99%	25.20%
C4 Incidents %	0.93%	0.48%	4.18%	1.41%	1.61%	5.22%	2.71%	0.92%	1.07%	2.54%	1.51%
Incident Outcomes	**EEAS**	**EMAS**	**IOW**	**LAS**	**NEAS**	**NWAS**	**SCAS**	**SECAmb**	**SWAS**	**WMAS**	**YAS**
Hear & Treat %	7.32%	6.61%	6.49%	10.77%	6.43%	11.14%	7.64%	5.88%	5.27%	3.64%	7.92%
See & Convey %	50.28%	52.18%	53.66%	50.99%	51.85%	51.94%	47.84%	55.50%	48.20%	47.10%	50.59%
See & Treat %	38.05%	35.30%	37.87%	33.66%	33.63%	31.16%	38.94%	37.09%	41.68%	41.75%	33.68%
Response Performance	**EEAS**	**EMAS**	**IOW**	**LAS**	**NEAS**	**NWAS**	**SCAS**	**SECAmb**	**SWAS**	**WMAS**	**YAS**
90th Centile Response Time: C1	00:11:25	00:11:01	00:16:11	00:09:53	00:10:18	00:11:21	00:11:16	00:13:10	00:12:10	00:12:06	00:12:17
90th Centile Response Time: C2	00:28:48	00:26:40	00:29:23	00:15:06	00:36:17	00:28:36	00:21:39	00:26:58	00:34:08	00:19:04	00:22:35
90th Centile Response Time: C3	01:08:37	00:58:20	01:14:34	00:47:32	01:27:37	01:25:46	01:03:29	01:40:20	01:11:56	00:31:02	00:45:53
90th Centile Response Time: C4	02:06:46	01:25:20	01:49:50	01:31:13	01:45:35	02:10:27	01:47:29	02:14:44	01:53:10	00:50:17	01:36:45
Mean Response Time: C1	00:06:17	00:06:17	00:08:35	00:05:52	00:06:11	00:06:50	00:06:18	00:07:00	00:06:46	00:07:00	00:07:11
Mean Response Time: C2	00:14:51	00:13:54	00:15:54	00:08:54	00:18:10	00:15:11	00:11:31	00:14:28	00:17:24	00:10:57	00:12:23

National Benchmarking
999 Emergency Ambulance Service (May 2020)

Key indicators at a glance for May 2020

Cardiac Arrest	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SECAmb	SWAS	WMAS	YAS
Proportion of cardiac arrests discharged alive %	6.65%	5.86%	7.69%	7.85%	5.95%	6.76%	6.42%	5.12%	11.63%	11.89%	7.29%
Proportion of cardiac arrests discharged alive utstein %	26.00%	30.43%	50.00%	28.57%	20.00%	20.59%	29.17%	21.74%	25.86%	31.43%	30.43%
Proportion who had ROSC on arrival at hospital %	24.46%	23.28%	7.69%	34.34%	28.98%	27.23%	27.27%	26.58%	29.93%	33.68%	30.36%
Proportion who had ROSC on arrival at hospital utstein %	47.06%	44.44%	50.00%	76.60%	47.06%	43.59%	58.33%	52.00%	37.93%	58.33%	75.00%

National Benchmarking
NHS 111 Service (May 2020)

Key indicators at a glance for May 2020

MetricName	Care UK	Devon Doctors	DHC	DHU	HUC	IC24	IOW	Kernow Health	LAS	LCW	Medvivo	NEAS	NWAS	SCAS	SECAmb	Vocare	WMAS	YAS
Calls Answered in 60 secs %	75.22%	58.42%	59.48%	76.67%	73.69 %	75.62%	79.14%	78.70%	96.96%	92.12%	78.26%	64.06%	48.79%	74.05%	74.02%	74.89%	92.09%	81.02%
Abandoned Calls %	3.10%	10.08%	5.69%	0.87%	1.50%	2.04%	6.63%	4.43%	0.14%	0.82%	3.62%	7.08%	10.11%	3.38%	1.44%	3.52%	0.05%	1.39%
111 to A&E Transfer %	10.19%	8.24%	9.53%	7.27%	5.60%	9.65%	12.40%	3.89%	5.52%	8.02%	8.33%	10.66%	9.50%	8.58%	11.38%	9.70%	11.04%	14.24%
111 to 999 Transfer %	12.31%	10.73%	11.60%	10.79%	7.51%	11.63%	13.51%	9.02%	5.40%	6.65%	10.40%	14.39%	11.86%	8.99%	12.80%	10.97%	13.59%	10.60%

Appendix 1

Glossary

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

Appendix 2

Symbol Key

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

Chart Key

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

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	23 July 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 reviewed the key performance metrics and, while it acknowledged the improvement against the ambulance response programme (ARP) standards in Q1, it explored the measures being taken to ensure this can be sustained; in the context of the significantly worsening position during July. The focus is currently on maximising the available resources. The deterioration is due to the reduction in hours and holidays which are being encouraged after the COVID 19 peak, which links to issues with fit testing and PPE. The committee reinforced the need for an effective and resilient solution to fit testing and for clarity on the run rate for lost hours and the cost of fit testing. Longer term sustainability was then discussed, and the committee challenged the executive to ensure it is clear about the structural issues so that the Trust is best placed to meet future demand. The committee is satisfied that the executive is giving this the right level of focus. **111 / CAS Mobilisation Assured** The committee has been closely monitoring progress of the mobilisation for this new service and will schedule extraordinary meetings to check at each key milestone. The quality and patient safety committee will also review at each key clinical milestone. There is currently good confidence in being able to mobilise from 1 October 2020, based on the revised simplified IT solution of only using the Cleric system (including IC24). **Estates Assured** A good paper was received setting out where we are both with our strategic estate (capital projects) and the day to day use and maintenance. The refreshed estates strategy is scheduled for Q3 and in the context of SECamb having a high number of operational sites compared with many other ambulance trusts, the committee asked that this confirms our target estates model, linking with the workforce strategy. The committee also received reports under its section on *Monitoring Performance*, including: **Financial Performance M3/Forecast** The Trust is on plan but there are some issues, including a high average cost per hour and shortfall against the cost improvement programme (see below).

	The committee explored the complexities in being able to allocate all COVID costs, concluding that there is likely to be some gaps, which could account for some of the reasons for a high average cost per hour. It noted that we are at the lower end of COVID costs, when compared to other ambulance trusts. **CIP/Overview of Schemes for 2019/20** The Q1 target was achieved, but there is a significant shortfall in schemes for the remainder of the year. The committee noted the steps being taken to identify how we can be more efficient, including some of the benchmarking with other trusts. We need to identify more transformational efficiencies given the local and national financial pressures. The committee suggest that there is a strategic discussion at Board about this, to help establish what is needed. **COVID – Update on Spend** An update was received on COVID-related expenditure. As stated above, the Trust has one of the lowest levels of COVID expenditure compared with other ambulance trusts and management is seeking to ensure that all relevant spend is identified and claimed. In 2020/21 the projected spend is £6.5m which is £0.6m below the approved business case value available of £7.1m, although this is achieved mainly from PPE being FOC which had not been assumed. The business cases are otherwise mainly overspent having gone through or are going through due governance. Costs have been fully recovered up to May 2020. **Fleet Business Case** This business case arises from the strategy/delivery plan previously approved by the Board. The committee explored a number of things to clarify the pros and cons relating to the two different options. It also challenged the executive to reduce the vehicle relief rate, which links to the estates strategy. Given the value, this business case requires Board approval (due to commercial sensitivity it is to be considered in private) and the committee recommends option 1.
Any other matters the Committee wishes to escalate to the Board	The COVID Recovery, Learning and Improvement Group continues to run fortnightly; there are ten workstreams, with plans under development. The committee suggests that the Board use some of the time at its development session in August to review what needs to be done to ensure more transformational efficiencies are achieved, given the local and national financial pressures.

SECAmb Board

QPS Committee Escalation Report to the Board

Date of meeting	09 July 2020
Overview of key issues/areas covered at the meeting:	There were no ***Management Responses*** presented to this meeting, as the one update due, relating to vehicle strategy and decision making, was deferred until September's QPS 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; **EOC Clinical Safety Showcase Assured** (on progress made) - subject to a management response addressing queries around welfare calls, tail audits (long waits) and timeliness of ongoing reviews. The committee received a detailed paper setting out the progress of the EOC Clinical Safety Project in areas including staffing, recruitment, safe staffing, procedures, clinical tail audit, and welfare compliance. The roles of GPs, dental nurses, paediatric consultants and midwives in the quality and diversity of service provision were discussed. Full assurance was given that GPs working in EOC had gone through full due-diligence processes and reviewed by the SECAmb legal team. NHSE are funding the paediatric consultants during the Covid-19 pandemic so the Trust needs to think about service provision post-Covid, however learning from this role is already being identified by EOC/NHSE to build into future ways of working. During discussion on welfare calls and tail audits (long waits); it was explained that long waits were non-compliant, and timeframes need to be applied for achievement of the welfare call-back work plan. A management response was requested for the September QPS. NHS Pathways (NHSP); compliant in 111, non-compliant in 999. Debate was had regarding the Clinical Safety Navigator (CSN) role and the scope, demands and banding of the job. It was agreed that the Trust will monitor effectiveness of the cohort due in Sept/Oct which will bring EOC to 90% establishment; a review of effectiveness will also look at staff turnover rates of the new cohort. International recruitment of Clinical Supervisors was deemed to have been very successful. Consideration will also be given to recruiting from England but outside of the SECAmb region, as agile working has also proved to be very effective. **Current 111/CAS Clinical Effectiveness - Assured** The committee acknowledged this work is in its early stages and noted that the update provided good clarity. Further work is being done to create a clinical framework for dental nurse recruitment. Starline is a hotline for nursing homes and being trialled in Medway. **Consent to Care and Treatment - Assured** This was a very thorough paper demonstrating that ePCR has helped moved the Trust forward significantly. An update will be presented to QPS in six months' time.

Clinical Outcomes throughout Covid-19 - Assured
Highlights from the presentation document were:

- Reduction in proportion of resuscitation attempts (e.g. unnecessary attempts, unnecessary dispatches)
- Moderate reduction in STEMI/STROKE incidents
- Reduction in Sepsis incidents in line with seasonal trends

Assurance taken from SECAmb trendlines being comparable to all other ambulance Trusts, and international services.

Work to be done includes adding benchmarking data on the outcome charts and adding a summary sheet (cover sheet) to future updates.

Paediatrics: Effective Care and Treatment - Assured
A thorough review of paediatrics was presented outlining a good level of care being delivered and significant changes implemented to develop the quality of the care available. There are opportunities to develop further areas of good and best practice including improving education, delivery of analgesia and access for staff condition specific guidelines.

Discussion was had around the impact of Covid-19 on the usual operating procedure to convey all children under 2yrs. Awareness was raised around the increased number of DNACPRs, consent and non-conveyance forms completed for children during Covid-19 which could prove stressful to ambulance crews arriving on scene. Pain relief in children was discussed and cautions raised around lessons learned.

The committee complimented this excellent paper.

Obstetrics: Effective Care and Treatment – Assured

This exemplary paper outlined the significant progress made in this area and the impact of the recruitment of consultant midwife and covered areas including incidents, audit, equipment, education, preterm pathway.

Discussion was held around the increasing number of transfers to birthing units and requested a management response will be presented to QPS in September.

The committee noted the recommendation for face-to-face training to recommence when it is safe to do so to that crews are adequately prepared. This would support the move for out of hospital deliveries, which is a reversal of previous practice which brings new and heightened risks to patients and ambulance crews. It was proposed that the Trust should seek advice around this, and the issues relating to communication barriers considering the diversity of the Trust's demographic.

Cost Improvement Programme – Quality Impact Assessments - Assured
Assurance was given that all CIP plans undergo a good level of scrutiny; the list showed approved plans but did not detail the challenges/rejections prior to final approval by the QIA panel. This will be revised for future reports.

Many of the CIPs were non-recurrent savings.

Assurances provided that CIPs would not impact on WTE posts.

	Clinical Audit Annual Report / Plan - Assured This paper highlighted the positive impact that technological advances have had in making it easier for clinical audit to do its job, with scope for further improvements. Currently internal audits are uploaded to the Intranet and general updates are shared with Commissioners. Clinical Audit team to consider a forum based around 'Raising Standards' where other teams can showcase their own audit findings. The Committee acknowledged that clinical audit has never been in such a good place and took great assurance from the work detailed in the reports. Assurance was given that the 98% of all health record reconciliations includes PAP and Bank staff, and electronic and paper submissions. Improvements were evidenced e.g. clinical audit impact on improved use of the sepsis care bundle, up from 60% in October 2019 to an average 86% from November 2019-March 2020. Safety of Discharge was noted as an area for improvement and will be presented to QPS in September as an item for scrutiny. The clinical audit team will consider how Covid-19 will impact its annual audit plan. **Cardiac Arrest Annual Report - Assured** 2019/20 was the first full year that SECAmb collected comprehensive outcome and epidemiological data in its registry, which was exciting for the team! This year will focus on delivery of the recommendations within the report. Recommendations need to be prioritised, have timeframes set and be measured against a trajectory; this plan will be presented to QPS as a management response in September. QPS will then review the programme of work in six months' time. LifePak15 and the next generation of these were discussed. The Committee noted a very thorough report and thanked the team for its work.
	There were no items for review under *Monitoring Performance*.
	Governance and Risk Management: **Bi-Annual Review of High/Extreme Risks** Nothing to escalate. Charts show QPS has highest number of assigned risks, as expected. Other high risks relate to Covid and PPE, also as expected. The QPS will undertake a review of all its aligned risks in September, led by the Trust's Risk Lead.
Any other matters the Committee wishes to escalate to the Board	The spinal immobilisation paper went to Board, has been signed off by JRCALC and NASMED and the Bulletin has been issued to staff. Feedback from the trial will be shared with other ambulance trusts. The 111 CAS Clinical testing has been undertaken as planned and a number of issues identified during this process, which are being addressed as part of the mobilisation plan.

SECAmb Board

QPS Committee Escalation Report to the Board

Date of meeting	24 June 2020
Overview of key issues/areas covered at the meeting:	This extraordinary meeting was called at the request of the Trust Board to seek assurance that we were adequately managing the balance of risk between staff and patients, relating to the provision of PPE. The Chair of the workforce and wellbeing committee joined this meeting. There was a minutes' silence in memory of Tricia McGregor who very sadly passed away. The committee first spent time reviewing the following; **Staff Testing** A paper was received setting out the approach and outcome of staff asymptomatic and antibody testing. Work is ongoing to develop the longer-term asymptomatic staff testing strategy for the Trust and the COVID Management Group is to determine the required frequency of testing, in line with anticipated government and NHSE/I guidance. This strategy will outline the required resourcing and structure of the revised Trust Test and Trace service and the operating hours as outlined by NHSE/I. It will also include an outline of the ways in which we will work with system partners such as lead CCGs throughout the Trust operational footprint in continuing to access laboratory capacity and serology test results. The committee explored the governance in place to manage the data protection risks, specifically in relation to providing test results. **NHS Test & Trace** The committee reviewed how Test and Trace will work; the Trust's response to date; the risks; and then the onward management. The aim is to evolve this over time in the context of flu vaccination, to ensure it is more sustainable. **Working Safely during Covid-19 (Inc. Red Bulletin 632)** The committee supported the approach being taken to follow the recent guidance provided by Government, relating to who should be at work; social distancing; managing visitors; and PPE and face covering. There was a specific discussion about face covering and the emphasis on this being a moral and social responsibility to prevent the transmission of the virus. The committee then considered the assurance paper requested by the Trust Board related to **Staff and Patient Safety Risk Review - FFP3 FIT Testing.** This very detailed paper covered a number of aspects relating to the programme of fit testing within SECAmb, focusing specifically on level 3 masks used to protect staff against aerosol generating procedures (AGP). The paper covered; • The background to the current position

	• The issues that have arisen • The balance of risk between patient and staff safety • Mitigations identified over time and how they have been implemented • Lessons learned The committee explored how we could reduce the range of masks given the consequence of fit testing different models; we are currently using four different types of mask, which is a reduction. The committee acknowledged the future challenges with this given the uncertainty and issues with procurement in light of the international constraints. The committee also explored the mitigation in place for the staff that persistently fail fit testing; a number of which have since been taken off the road until solutions are found, e.g. procurement of hoods and smaller masks. The committee was assured by the rationale for taking the staff off the road, and the timing of this decision, which balanced the risk to the staff against the impact on patients. This decision is under constant review. The committee reinforced the need to undertake work to put in place a future strategy for PPE, and acknowledged the very complex range of issues that have arisen following the COVID pandemic. The executive have been open about the lessons, particularly in relation to the function of logistics and the management of fit testing. Overall, management were able to provide a coherent picture, demonstrating the thoughtful decision-making processes in these exceptional circumstances.
Any other matters the Committee wishes to escalate to the Board	None.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**2 July 2020**
Overview of issues/areas covered at the meeting:	The meeting 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** **E-timesheets** The Committee heard there had been significant progress, with a Procedure underway that would go to JPPF in August for approval with implementation planned in October, with broad Union support. A live trial for 2 months was starting on 7 sites imminently and a task and finish group with relevant representation had been set up. Internal audit would review the pilot after the first phase of roll out to provide independent scrutiny. Their report would be used as a gateway for go live; which was crucial as this affected people's pay. **E-expenses** A Travel and Subsistence Policy was near sign-off and the project group had been re-established. WWC wants to draw the Board's attention to the outstanding risk around car insurance which was not yet resolved, but the Team's engagement with the key stakeholders seemed a positive move. **P-files** A new project approach was being taken with positive engagement from the Unions, and aiming for a realistic completion date of December 2020. The Team would now focus on obtaining documents for those who had not already provided them – rather than taking the previous blanket approach, and would be working to support OTLs and providing HR colleagues to scan ID at different locations. WWC received reassurance provided that staff recruited since March had up to date P-files, though with COVID the speeded-up recruitment process had been managed slightly differently. WWC would maintain scrutiny as this work progressed and had asked for a full report on historic and current P-files to come to December's WWC.

Clinical Education Review Partially Assured
The Committee received a comprehensive report outlining real progress. The Team anticipated 'limited assurance' from FutureQuals once the report had been through accuracy checking and finalised. The outcomes of the ClinEd SI would also be shared with WWC for assurance that actions were on track. A consultant remained with us part-time until later in the year to close off audit actions.

Strategically, WWC discussed the need for a decision around whether to have our own training premises or work with partners with existing training facilities available. The Committee welcomed the information that a business case was going through for a short-term solution while a strategic decision was made, which included looking at shared premises.

WWC asked to understand more around the Trust's strategy related to apprenticeships. This would come back to WWC. The Committee also considered the strategic value of contracting university education to gain more control of our higher education pipeline. WWC were interested to understand the Trust's approach to this.

Driving standards Not assured
The Committee welcomed the report, as it brought together the key risks around driving very clearly and showed the Trust was now more aware of the risks.

More scrutiny was required as the work moved forward, as the paper had described several risks and, in some cases, plans to address them:

- Resourcing of driving instructors to levels to deliver Section 19 refresher course requirements (every five years);
- Inability to check the non-UK driving licences held by 4 staff members (further assurance on this was requested);
- RTC costs and lack of staff members' inclination to report, or failure to report in timely ways (further assurance requested);
- Idling costs but particularly the rationale staff gave that they preferred to idle outside standby/response posts rather than go in. Management committed to reviewing the provision of ACRPs at a suitable time (further assurance requested).

Local and SECAmb induction
WWC were pleased to see the adaptations made to restart SECAmb's induction safely and work through the backlog caused by the pause due to COVID. WWC were concerned to ensure equality of access to an online induction programme, in terms of access to IT. The team were asked to consider including more about the fundamental aims of the Trust within the SECAmb induction programme.

Further report requested to explain new joiners' access to IT and provide assurance around inclusion of the purpose and strategic direction of the Trust within the induction programme.

	HR and OD Development Programme WWC really welcomed this well-thought-out approach to reviewing training needs and supporting professional development throughout the HR and OD directorate. The Committee asked the Executive to consider messaging carefully to ensure that the Directorate was not seen as somehow exceptional or an outlier in terms of what was being offered to its staff. The Team confirmed that the aim was to roll professional development out across the Trust, and to clearly link this with the appraisal cycle and personal development plans. The Committee also highlighted the need for training to address specific as well as generic skills, such as report writing and investigations. **BAME Risk Assessments** WWC were concerned to hear only 7 ½% of BAME staff had so far received risk assessments – these had been voluntary but were now mandatory for all BAME staff and the Committee received verbal assurance that there was a plan in place and we would report to NHSE by the deadline of 23rd July. **Diversity and Inclusion Report** The Committee welcomed this comprehensive and impressive report. Time would be built into a Board development day to think about how Board members could champion areas to take forward, so this was owned by senior leadership rather than seen as the province of the Inclusion Team. The Committee supported this approach and noted that the work was of such quality that it should be recognised nationally. The committee also received reports under its section on Monitoring Performance, including: **Employee relations and workforce data** The Committee was pleased to see positive developments in modelling our workforce movements internally and externally, and in recruitment pipeline figures. WWC requested benchmarking data to give a sense of comparators, to include exemplars and not solely ambulance services, so we were aiming higher than the best in sector. Further work would be done to ensure the relevant information was presented at Committee. The Committee wanted assurance that we were addressing ER and workforce issues locally now we had intelligence at a local level. Verbal assurance was provided that there were plans to do this.

Any other matters the Committee wishes to escalate to the Board	The **BAF risks** linked to the committee were reviewed and the Committee noted: All BAF risks would be reviewed to align the BAF to the new strategy in the coming weeks. The workforce risk (risk 111) remained the highest Trust risk. Safe recruitment (risk 362) had seen improvement that should be reflected in a reduced current risk score and the controls and assurance updated. The Clinical Education risk should be revised to reflect the current relatively minor risk around securing premises for delivering training and to appropriately reduce the current risk presented by the quality of our education, once the FutureQuals report had been received (assuming it said what we expected it to). Risk 334 about improving the Trust's culture was felt not to be fit for purpose and to require rewording. It was hard to know what success looked like and should be revised to incorporate risks around the roll out of the Trust strategy and values being effective. Driving standards risk(s) should be added to the Trust's risk register and properly graded. The lack of personal development plans across the Trust would also be considered for addition to the Trust risk register.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	27-20

Name of meeting	Trust Board
Date	30 July 2020
Name of paper	Out of Hospital Cardiac Arrest Annual Report 2019/20
Responsible Executive	Dr Fionna Moore – Executive Medical Director
Synopsis	This report presents an overview of the steps taking in the past year to improve outcomes from cardiac arrest. It has been considered by the quality and patient safety committee, which will monitor progress against the priorities.
Recommendations, decisions or actions sought	For information

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**

Out of Hospital Cardiac Arrest Annual Report 2019/20

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Executive Summary

Introduction

All SECAmb staff along the patient journey can play a vital link in the chain of action that is required to save a life following out of hospital cardiac arrest (OHCA). Cardiac arrest occurs when the heart suddenly stops circulating blood around the body. It is different from a heart attack where there is a blockage in the supply of blood to the heart muscle. Cardiac arrest should not be confused with ordinary dying.

Patients suffering OHCA need rapid CPR, and defibrillation if required. This report is intended to drive prevention strategies and plans to improve outcomes from cardiac arrest.

Methodology

Records coded as a cardiac arrest are manually reviewed by the Trust's Cardiac Arrest Analyst. Data is collected from paper and electronic records and entered into a database via a digital data collection tool. Data is analysed in Microsoft Excel spreadsheets and the Trust is working towards live reporting of data through Microsoft PowerBI dashboards. 2019/20 was the first full year that SECAmb collected comprehensive outcome and epidemiological data in its registry.

Early Recognition and Call for Help

In 2019/20 SECAmb attended 7025 out of hospital cardiac arrests and resuscitation was commenced or continued on 2567 (37%) of these patients. Most cardiac arrests attended by SECAmb are those that are strongly suspected or presumed to be cardiac in origin (88%). This is followed by asphyxia (4%) and trauma (4%). Arrests following asphyxia commonly include choking and hanging.

In order to save more lives and prevent cardiac arrest, prevention strategies should continue to focus on the primary prevention of cardiovascular disease. Focus should also be given to the promotion of mental wellbeing, suicide prevention and accident prevention. SECAmb clinicians should be given the tools required to facilitate prevention in every patient contact.

If features suggestive of cardiac arrest are present or the patient is critically unwell and there is a high risk of cardiac arrest, a category 1 ambulance will be arranged. Data shows that SECAmb classifies more than 90% of non-EMS witnessed cardiac arrests as category 1. This exceeds the 75% target set by the Global Resuscitation Alliance.

Early CPR

A key skill of the Emergency Medical Adviser is to rapidly coach the caller to commence telephone CPR (tCPR). Approximately 75% of non-EMS witnessed resuscitation attempts received bystander CPR before the arrival of EMS. This exceeds the 50% target set by the Global Resuscitation Alliance.

The mean and 90th centile time to commence tCPR in 999-calls categorised as cardiac arrest in SECAmb shows that tCPR is generally commenced more quickly in SECAmb when compared to the national average, but that the Trust is 3-minutes slower than the Global Resuscitation Alliance 2-minute target.

Early Defibrillation

The quicker defibrillation takes place, the greater the patient's chance of survival. The most effective way to improve the time to first shock is through the placement of public access defibrillators in locations based on the statistical probability of a cardiac arrest occurring nearby. Currently a PAD is used in 6% of SECAmb resuscitation attempts before the arrival of clinicians.

The mean time from call to first shock for non-EMS witnessed resuscitation attempts is 13 minutes. This shows that there are opportunities throughout the chain of survival that will impact on the time to first shock, such as improving recognition to ensure correct categorisation.

Post-Resuscitation Care

The Trust currently completes the post-ROSC care bundle in 80% of cases. This is a slight reduction in annual average from 2018/19, however SECAmb continues to perform above the national average.

In 2019/20 8.5% of patients who suffered an out of hospital cardiac arrest subsequently survive to be discharged from hospital. SECAmb is currently 1% below the national annual average for survival to discharge.

Recommendations

In order to improve outcomes from cardiac arrest, the Trust should implement the recommendations listed in this report, which align to the Global Resuscitation Alliance's 10-step plan to improve outcomes from out of hospital cardiac arrest.

Introduction

South East Coast Ambulance Service (SECAmb) NHS Foundation Trust (the Trust) responds to 999 calls from the public, urgent calls from healthcare professionals and provides NHS 111 services across the region. SECAmb covers a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, West Sussex, Kent, Surrey and North East Hampshire) and a population of roughly 5.1m. The Trust operates across a diverse geographical area, which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country.

SECAmb has over 4,000 staff members working across 110 sites. Almost 90 percent of our workforce is made up of operational staff. This includes those working in the pre-dispatch phase, caring for patients remotely at our emergency operations centres where we receive 999 calls and our integrated urgent care centres where we receive NHS 111 calls. It also includes those working in the post-dispatch phase, who provide face to face care for patients ranging from the critically ill and injured in need of specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.

All these staff can play a vital link in the chain of action that is required to save a life following out of hospital cardiac arrest (OHCA). Cardiac arrest occurs when the heart suddenly stops circulating blood around the body. It is different from a heart attack where there is a blockage in the supply of blood to the heart muscle. Cardiac arrest should not be confused with ordinary dying. In a cardiac arrest, the heart is often the first organ to stop working. In ordinary dying, the vital organs fail, and the heart is the last to stop.[i]

Out of hospital cardiac arrest is a significant public health issue in the UK. Every year there are nearly 40,000 OHCAs where resuscitation is commenced or continued by ambulance clinicians and less than one in ten of these patients survive.[ii] An individual's chances of survival double if they receive immediate cardiopulmonary resuscitation (CPR - chest compressions and rescue breathing) and defibrillation (a high energy electric shock through the heart muscle)[iii]. This relies not only on the effectiveness of emergency medical services (EMS) but the preparedness of the community to respond rapidly to cardiac arrest, before the arrival of EMS.

Figure 1 - Chain of Survival

As alluded to above, an individual's chances of survival are increased if there is a strong 'chain of survival' that runs through the community and into emergency medical services. This chain includes:

- Early recognition and call for help – this means either recognition of a condition that might lead to cardiac arrest, for example severe chest pain arising from a heart attack, or rapid call for help when cardiac arrest is witnessed.
- Early CPR – this helps to buy time until the arrival of emergency medical services. For every minute that chest compressions are delayed, an individual's chances of survival reduce by 10%.[iv]
- Early defibrillation – this temporarily 'stuns' the heart with the intention that it will restart in a normal life-sustaining rhythm. A shock is more effective the earlier it is delivered.
- Post-resuscitation care – to restore quality of life and prevent recurrence of cardiac arrest.

Improving the speed of response to out of hospital cardiac arrest and outcomes for patients is highlighted in the NHS Long Term Plan. In order to improve, it is essential that the Trust monitors performance and uses data to help make decisions that will save more lives following cardiac arrest. The first step in this improvement process for SECAmb was the creation of a formal cardiac arrest registry. 2019/20 was the first full year that SECAmb collected comprehensive outcome and epidemiological data in its registry. This is also the first time that SECAmb has produced a detailed OHCA report. Previously, the Trust has relied on outcome data alone in order to improve quality. This year has been unusual and epidemiological data has been particularly useful during the height of the COVID-19 pandemic.

This report examines SECAmb's performance through the year and the epidemiological data that will drive decision making in future improvement plans. It is structured to examine the strength of each link in the chain of survival and identify opportunities for improvement. The Trust is able to benchmark its performance in some of these measures against other English ambulance services and targets set by the Global Resuscitation Alliance.[v]

This report will include family experiences of cardiac arrest in blue.

And Newly Qualified Paramedics' experiences of managing their first cardiac arrest in green.

Methodology

Case Identification

Out of hospital cardiac arrest cases are identified for inclusion in the SECAmb cardiac arrest registry using a search for the cardiac arrest 'condition code' that is applied to a patient clinical record by the clinician completing it. In order to identify cases where a condition code may have been omitted from paper records, cases are also included where there is a value recorded in the 'CPR Start Time' field.

"Maintaining organisation throughout the situation made writing up the notes a lot easier."

A limitation of this approach is that cases that are thought to be a cardiac arrest at the time of the 999 or NHS 111 call are not included and as such it is not possible to determine the sensitivity and specificity of cardiac arrest detection at the time of call for help. These cases should be included in the registry in future so that these metrics can be monitored.

Data Collection

Each case is manually reviewed by the Trust's Cardiac Arrest Analyst. Data is collected from paper and electronic records and entered into a database via a digital data collection tool. Where information contained on paper or electronic clinical records is not enough, additional information is taken from reports downloaded from the Trust's monitor/defibrillators, from Helicopter Emergency Medical Service (HEMS) records or from critical care paramedic records. The approach ensures data quality but is labour intensive. The Trust should work towards integrating these systems and automating data collection processes.

Where the information contained in patient records is complex or conflicting, cases are escalated to one of the Trust's senior clinicians to support in decision making.

Data Analysis

For the purposes of reporting, data is analysed in Microsoft Excel spreadsheets. The Trust is working towards live reporting of data through Microsoft PowerBI dashboards. This will ensure lessons are learned and changes in practice are made more quickly than they ever have been.

Early Recognition and Call for Help

‘Early recognition and call for help’ starts in the community. It means that the public can recognise the conditions that may lead to cardiac arrest and know how to respond when they arise. It also means that members of the public can recognise cardiac arrest and respond effectively to deliver the next two links in the chain; ‘early CPR’ and ‘early defibrillation’. There are the most important two elements of the chain. Early recognition could extend backwards to include primary prevention of disease. It could also extend further forward to telephone triage in EMS to include rapid recognition of cardiac arrest or disease that could lead to cardiac arrest and rapid dispatch of clinicians to the patient.

Figure 2 - Early Recognition

Epidemiology of Cardiac Arrest in SECAmb

SECAmb collects epidemiological data on the characteristics of those who suffer out of hospital cardiac arrest, the aetiology of the arrest, the location of the incident and patient outcomes. This information is intended to drive primary prevention strategies and plan community, health system and Trust response to cardiac arrest.

> “Thank you for the huge efforts to revive my father-in-law. You treated him with respect and kept family distress to a minimum. You’re a credit to the service.”

In 2019/20 SECAmb attended 7025 out of hospital cardiac arrests and resuscitation was commenced or continued on 2567 (37%) of these patients. During the peak of the COVID-19 pandemic (final week of March and first week of April 2020) the Trust saw an increase in the count of cardiac arrests attended and a significant reduction in the proportion of resuscitation attempts, to 30%. The data showed that this could be attributed to an increased proportion of patients with some sort of advance decision to refuse resuscitation and an increased proportion of patients where the attending clinicians deemed resuscitation to be futile and an inappropriate treatment.

A sample of cases during this period was reviewed and it was determined that all decisions taken were safe and appropriate. Resuscitation should not be a treatment for ordinary dying. An increased number of patients in the community with a clear plan detailing the care they do and do not wish to receive has led to more dignified and peaceful deaths for many. The Trust should continue to work with the wider health system to ensure patients receive an appropriate care plan to continue this trend.

> “Getting into level 3 PPE is hot, stressful and can feel like a long time for your colleague.
>
> Communication is also harder with reduced body language and facial expressions. I think this may have influenced teamwork and fluidity during this incident.”

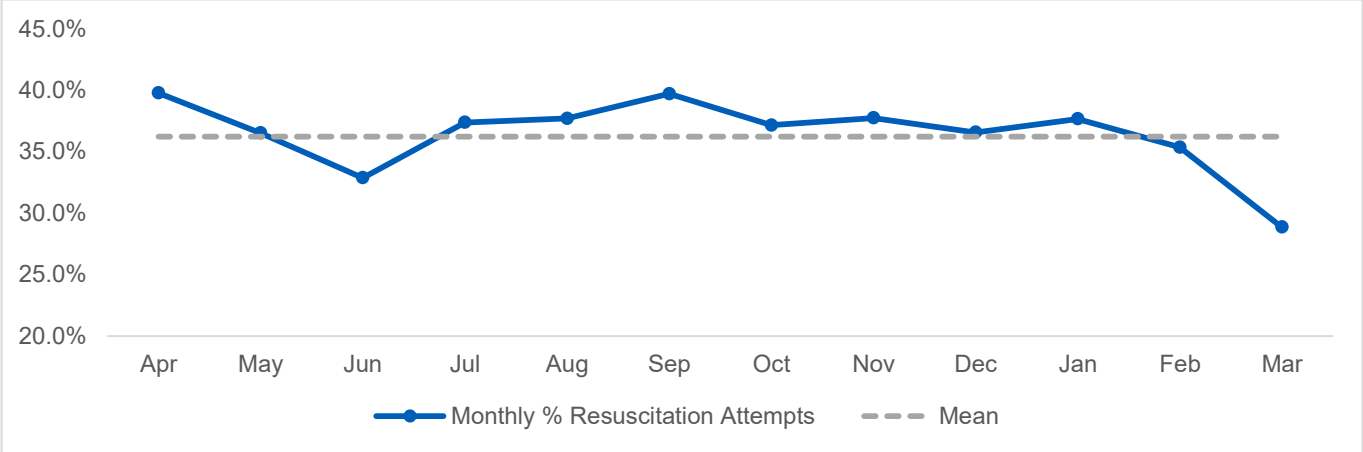

Figure 3 - Percentage of 2019/20 Cardiac Arrests with Resuscitation Commenced or Continued in SECAmb

The reasons that resuscitation was not commenced in 2019/20 cardiac arrests in SECAmb are shown in table 1 below.

Table 1 - Reasons for Resuscitation Not Commenced in 2019/20 Cardiac Arrests in SECAmb

Reason	Count	Percentage
Deceased	3086	43.9
Advance Patient Decision	1158	16.5
Ordinary Dying	214	3.0

There is a strong gender bias in the incidence of out of hospital cardiac arrest, with 66% being male and 34% being female. This may relate to differences in the incidence of disease.

Table 2 - Gender of 2019/20 Resuscitation Attempts in SECAmb

Gender	Count	Percentage
Male	1688	65.8
Female	868	33.8
Unknown	11	0.4

The mean age of patients presenting to SECAmb in cardiac arrest is 67 years. Again, this is likely to relate to the incidence of disease in older adults.

Table 3 - Age of 2019/20 Resuscitation Attempts in SECAmb

Age Group	Count	Percentage
Under 18	54	2.1
18-39	170	6.7
40-65	776	30.5
Over 65	1536	60.5

Most cardiac arrests attended by SECAmb continue to be those that are strongly suspected or presumed to be cardiac in origin (88%). This is followed by asphyxia (4%) and trauma (4%). It should be noted that when the origin of the cardiac arrest is not clear or no other category applies, the arrest is presumed to be cardiac. Arrests following asphyxia commonly include choking and hanging.

In order to save more lives and prevent cardiac arrest, prevention strategies should continue to focus on the primary prevention of cardiovascular disease. Focus should also be given to the promotion of mental wellbeing, suicide prevention and accident prevention. SECAmb clinicians should be given the tools required to facilitate prevention in every patient contact.

Table 4 - Aetiology of 2019/20 Resuscitation Attempts in SECAmb

Aetiology	Count	Percentage
Cardiac	2252	87.7
Asphyxia	108	4.2
Trauma	101	3.9
Drug Overdose	50	1.9
Exsanguination	22	0.9
Submersion	17	0.7
Other (Non-Cardiac)	10	0.4
Not Recorded	6	0.3
Electrocution	1	0.0

The Trust also monitors the proportion of patients presenting in shockable and non-shockable rhythms. Generally, patients who present in a shockable rhythm have a stronger chance of survival. In 2019/20, 29% of patients in shockable heart rhythms survived to hospital discharge, compared to 2% in non-shockable rhythms.

Table 5 - Initial Rhythm of 2019/20 Resuscitation Attempts in SECAmb

Initial Rhythm	Count	Percentage
Asystole	1282	49.9
Pulseless Electrical Activity	600	23.4
Ventricular Fibrillation/Tachycardia	585	22.8
Not Recorded	63	2.5
Non-Shockable (AED Used)	33	1.3
Other	4	0.2

The Trust began to collect data on the location of cardiac arrests. Most of these cardiac arrests were in the home (74%), followed by public buildings (8%), streets/highways (8%) and assisted living/nursing homes (4%). This suggests that public access defibrillator (PAD) programmes should continue efforts to establish PAD sites and volunteer responder programmes in locations throughout residential and public spaces. (This data was not available for all incidents.)

Table 6 - Location of 2019/20 Resuscitation Attempts in SECAmb (where data available)

Location	Count	Percentage
Home/Residence	1049	73.8
Public Building	119	8.4
Street/Highway	112	7.9
Assisted Living/Nursing Home	60	4.2
Other	43	3.0
Sport/Recreational Event	17	1.2
Industrial/Workplace	16	1.1
Unknown/Not Recorded	4	0.3
Educational Institution	2	0.1

As suggested above, the most survivable cardiac arrests are those that are witnessed, recognised rapidly and receive early CPR. 52% of SECAmb's resuscitation attempts in 2019/20 were witnessed by a bystander.

Table 7 - Arrest Witness for 2019/20 Resuscitation Attempts in SECAmb

Arrest Witnessed By	Count	Percentage
Bystander	1347	52.5
None	828	32.3
EMS	328	12.8
Unknown/Not Recorded	64	2.4

Telephone Triage of Cardiac Arrest

"Thank you to the emergency medical adviser who saved my husband's life after he had a cardiac arrest."

As described above, early recognition extends into telephone triage by emergency medical services. Highly trained Emergency Medical Advisers (EMAs), using an effective clinical decision support system (CDSS) and appropriate technology helps to ensure disease that might lead to cardiac arrest and cardiac arrest itself is recognised quickly, so that help is rapidly dispatched to the patient. The first question asked at the start of each 999 call is whether the patient is breathing, so that help can be immediately dispatched to patients who are clearly in cardiac arrest.

A summary of the problem natures described at the time of the 999 call in cases where the patient was later confirmed to be in cardiac arrest is shown in table 6 below. It shows the categories of call for which EMAs should have the highest index of suspicion of possible cardiac arrest.

Table 8 - Problem Nature at Time of 999 Call for 2019/20 Cardiac Arrests in SECAmb

Problem Nature	Count	Percentage
Arrest / Peri Arrest	4182	59.0
Unco - Noisy / Abnormal Breathing	1029	14.5
Unco - Normal Breathing	360	5.1
Breathing Problems	312	4.4
NHS111	212	3.0
Medical	171	2.4
Stroke / Neurological	152	2.1
Concern for Welfare	117	1.7
Chest / Upper Back Pain / Cardiac	112	1.6
HCP	86	1.2
Trauma	66	0.9
Fall	54	0.8
Fitting	54	0.8
Death Expected - All Ages	40	0.6
Not Recorded	29	0.4
Other	29	0.4
Information Only	28	0.4
Choking	14	0.2
Bleeding	13	0.2

Abdominal / Flank Pain	12	0.2
Drowning / Water Incident	11	0.2

One of the inherent risks of telephone triage is that it is not possible to visualise the patient or carry out a physical assessment. This means that it is possible an EMA might not detect cardiac arrest if there are features present such as seizures or agonal breathing (an irregular breathing pattern that occurs in the early stages of cardiac arrest). SECAmb EMAs use the 'no, no, go' tool to detect cardiac arrest. If the patient is not breathing and not conscious, they should 'go' ahead and commence CPR.

After the nature of call has been established and it has been determined whether the patient is conscious and breathing, the EMA captures incident location details and commences a more detailed triage. If a patient is unconscious there will be further probing to determine whether breathing is abnormal or noisy. If features suggestive of cardiac arrest are present or the patient is critically unwell and there is a high risk of cardiac arrest, a category 1 ambulance will be arranged. This is the highest priority response targeted to have clinicians with the patient within 7 minutes.

Figure 4 below shows the monthly proportion of non-EMS witnessed resuscitation attempts where cardiac arrest or the risk of cardiac arrest was recognised at the time of the 999-call. It shows that generally SECAmb classifies more than 90% of non-EMS witnessed cardiac arrests as category 1. This exceeds the target of 75% set by the Global Resuscitation Alliance. The Trust should review all cases where cardiac arrest was not identified at the time of 999-call each month to identify opportunities for learning and improvement.

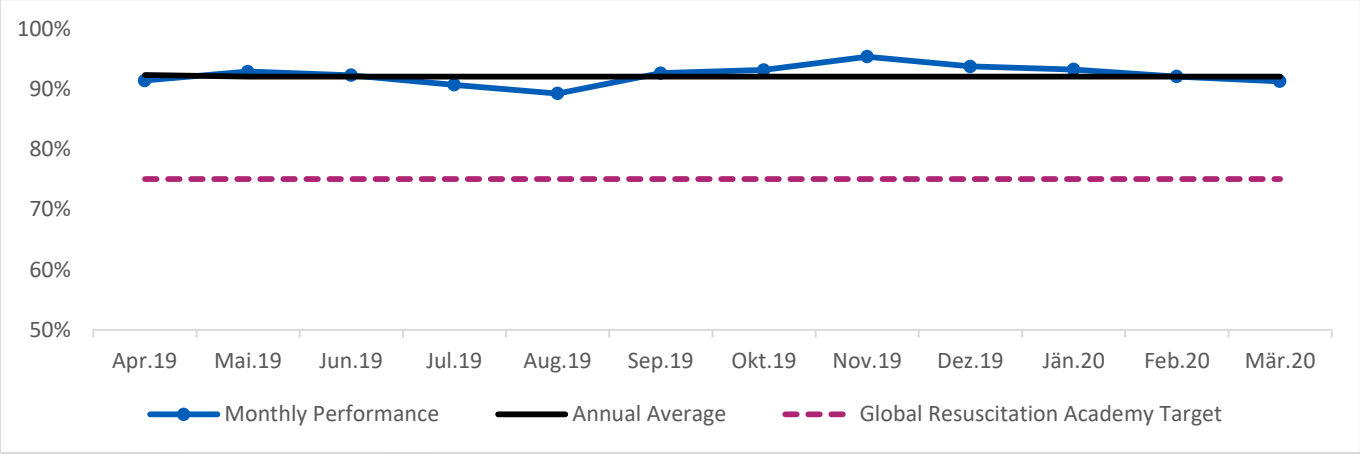

Figure 4 - Recognition of Cardiac Arrest or Risk of Cardiac Arrest at Time of 999 Call for 2019/20 Non-EMS Witnessed Resuscitation Attempts in SECAmb

Early CPR

Early CPR means that chest compressions and rescue breaths start as quickly as possible after recognition of cardiac arrest. It delivers an ongoing supply of oxygen to the vital organs. The patient's chances of survival are reduced by 10% for every minute that CPR is delayed.

Figure 5 - Early CPR

Telephone CPR

A key skill of the Emergency Medical Adviser is to rapidly coach the caller to commence telephone CPR (tCPR). This requires empathy, assertiveness and confidence to control the call and provide effective instructions.

Figure 6 shows the proportion of non-EMS witnessed resuscitation attempts that received bystander CPR before the arrival of EMS. This exceeds the target of 50% set by the Global Resuscitation Alliance. The Trust should continue to audit a proportion of 999 calls for resuscitation attempts each month to support EMAs delivering effective tCPR.

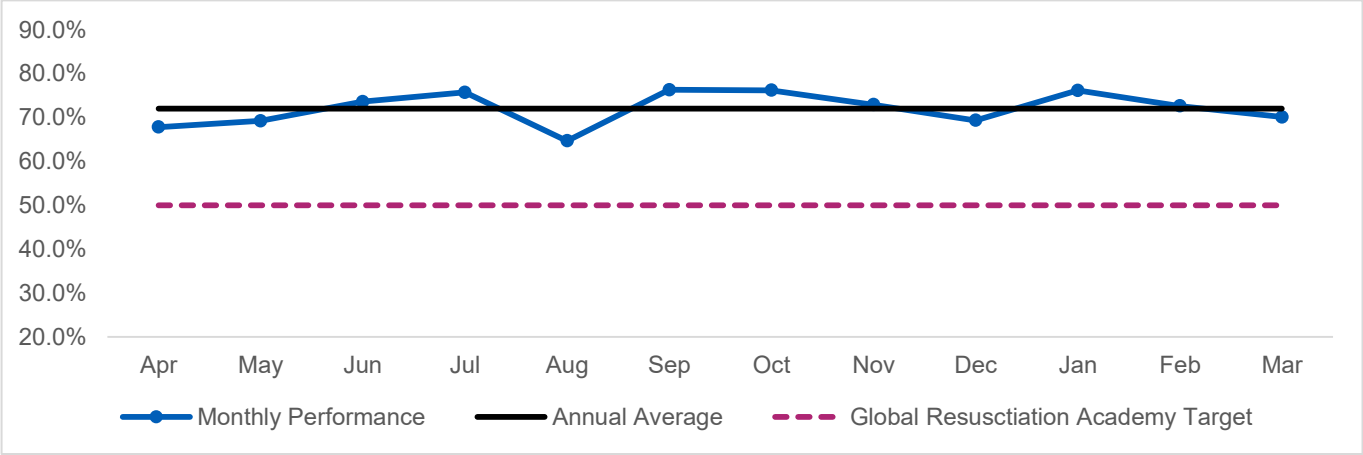

Figure 6 - Percentage of Patients to Receive Bystander CPR for 2019/20 Non-EMS Witnessed Resuscitation Attempts in SECAmb

"The call handler was so calm and reassuring, informing me the ambulance was on its way and what to do when they arrived."

Figures 7 and 8 show the mean and 90th centile time to commence tCPR in 999 calls categorised as cardiac arrest in SECAmb. It shows that tCPR is generally commenced more quickly in SECAmb when compared to the national average, but that the Trust is 3-minutes slower than the Global Resuscitation Alliance 2-minute target.

The ability of an EMA to commence rapid tCPR relies on empathy, assertiveness and confidence as described above, but also relies on the organisation's attitude to risk. Evidence suggests that CPR on a patient who is not in cardiac arrest is unlikely to do harm, but failure to deliver CPR for a patient who is in cardiac arrest is likely to have serious consequences. All clinicians and leaders who are involved in the management of cardiac arrest must recognise this and support EMAs to reduce their threshold for commencement of tCPR. There are also opportunities to embrace the use of technology to improve the time to tCPR, for example the use of artificial intelligence (AI) to

recognise cardiac arrest. The Trust should explore the use of AI to improve time to tCPR and assess the attitude towards commencing tCPR.

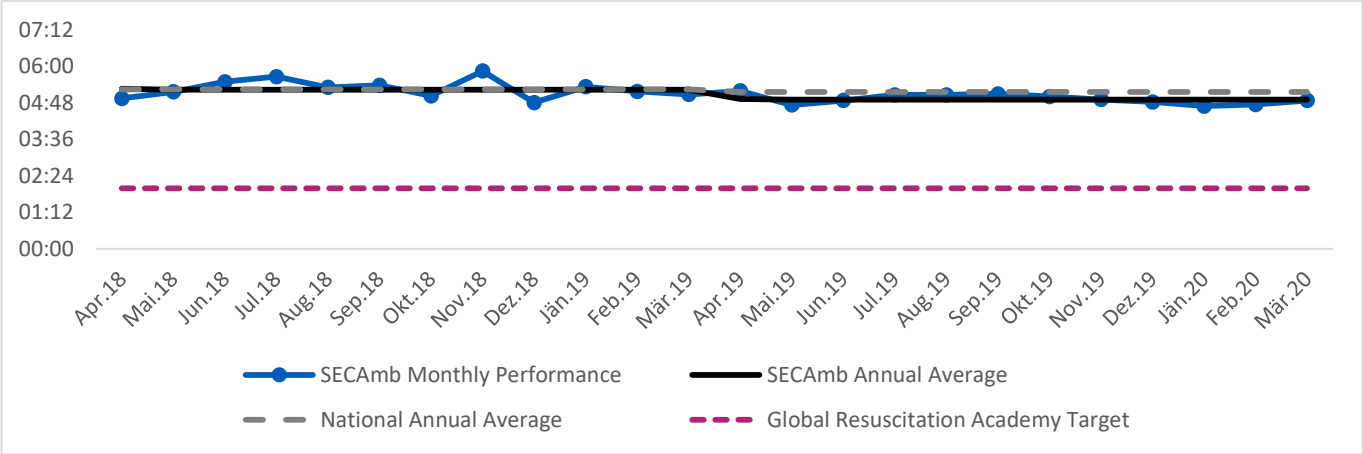

Figure 7 - Mean Time (mm:ss) to Commence tCPR in 999 Calls Categorised as Cardiac Arrest in SECAmb

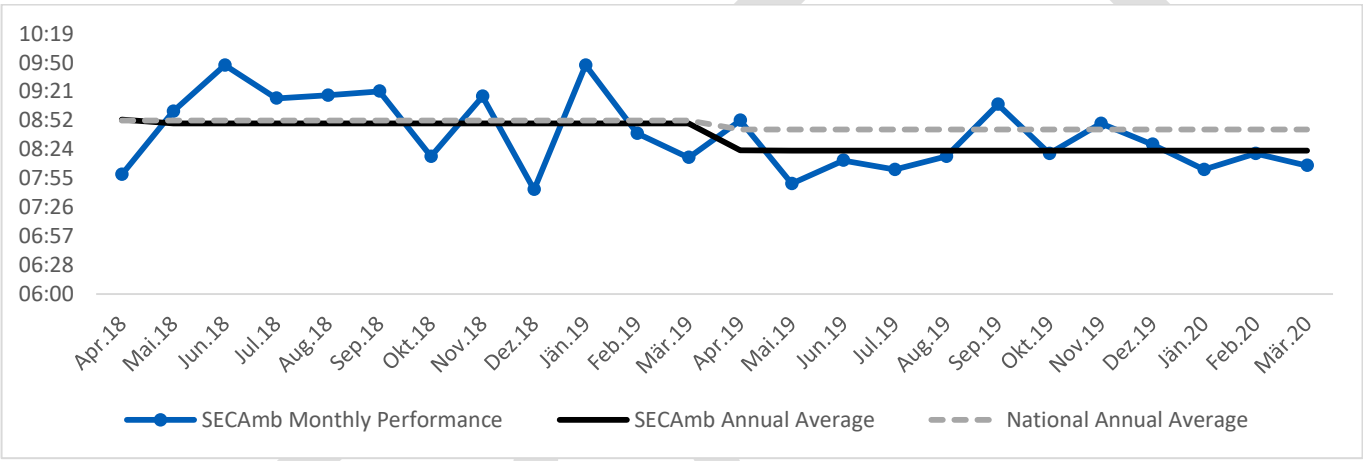

Figure 8 - 90th Centile Time (mm:ss) to Commence tCPR in 999 Calls Categorised as Cardiac Arrest in SECAmb

EMS CPR

Evidence shows that high quality CPR improves a patient's chance of survival. In order to adequately perfuse the vital organs, chest compressions should be continuous, of adequate depth, have adequate recoil, have minimal interruptions and be delivered at a rate of 100-120/minute. SECAmb measures the effectiveness of chest compressions delivered through downloads from monitor/defibrillators.

There are approximately 1.6 pauses >10 seconds per case audited. These can generally be attributed to rhythm checks, shocks, AED analysis periods, and some pauses that can't be accounted for through retrospective analysis. The mean compression rate ranges from 102-104/minute and typically 1-5% of cases per month have a compression rate below 100/minute or above 120. A metronome is used to ensure the correct rate of chest compressions in most resuscitation attempts. Currently, the medical devices in use by the Trust do not allow compression depth and recoil to be measured.

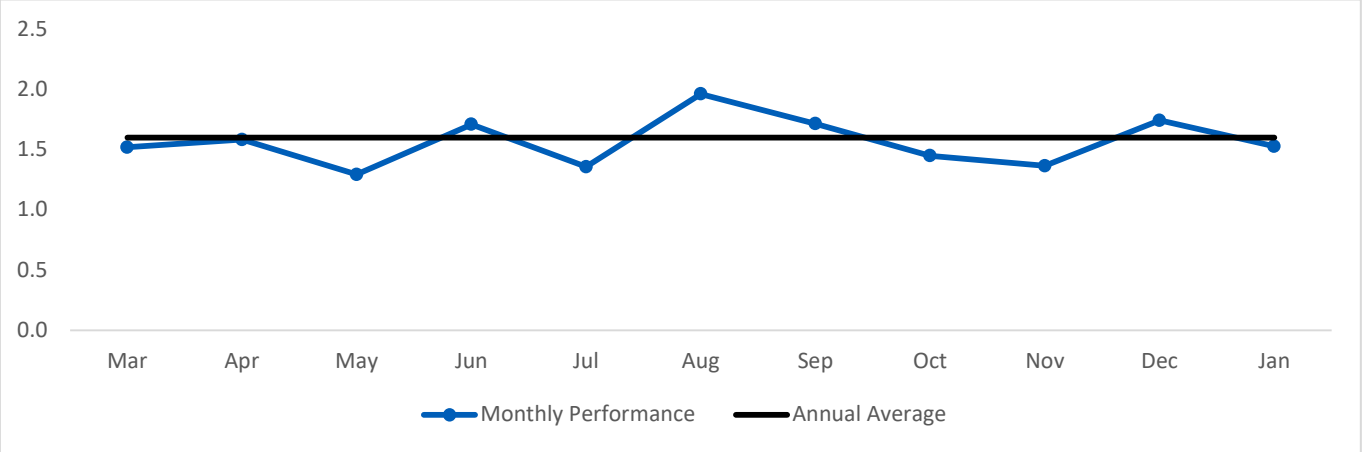

Figure 9 - Mean Number of Pauses >10 Seconds Per Resuscitation Audited

Early Defibrillation

Defibrillation involves a high energy shock through the heart muscle to temporarily stun the heart rhythm with the expectation that it will restart in a normal, life-sustaining rhythm. The quicker defibrillation takes place, the greater the patient's chance of survival. Defibrillation within 3-5 minutes of collapse can produce survival rates as high as 50-70%.[vi]

Figure 10 - Early Defibrillation

Although the Trust's intention is to respond to its sickest patients as quickly as possible, the most effective way to improve the time to first shock is through the placement of public access defibrillators in locations based on the statistical probability of a cardiac arrest occurring nearby. This should be combined with ongoing development of volunteer responder programmes and smartphone applications that alert individuals trained in CPR of the need for their help in a cardiac arrest near to them.

The Trust has a database of PADs that is linked to the computer aided dispatch system (CAD – used to take 999 calls) and the GoodSam App (a smartphone app used in the Trust to alert individuals of a cardiac arrest where CPR is required in their vicinity).

Time to Defibrillation

Figure 11 shows the proportion of non-EMS witnessed resuscitation attempts where a PAD was used before the arrival of SECAmb clinicians. This figure only includes patients where resuscitation was commenced or continued by SECAmb clinicians. It does not include cases where it was suspected that the patient was in cardiac arrest and had been successfully resuscitated before the arrival of EMS. In 2019/20 there were 49 such cases and 24 of these had been defibrillated. Nationally, 'post-resuscitation' cases are not included in cardiac arrest registries, this does mean that patients who benefit from PAD sites created by EMS are not accounted for. The Trust should recommend the inclusion of these cases in cardiac arrest registries to other EMS providers and NHS England.

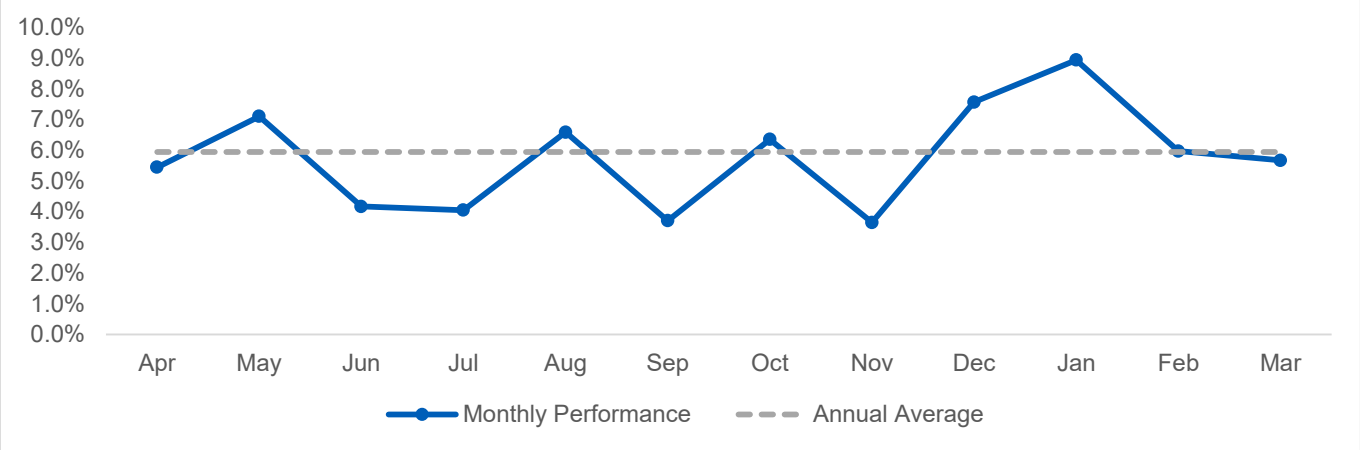

Figure 11 - Percentage of Patients with Public Access Defibrillator Used for 2019/20 Non-EMS Witnessed Resuscitation Attempts in SECAmb

"Thank you to the crew for their professional skill and unremitting determination to save my neighbour."

Figures 12 and 13 show the mean and 90th centile time from call to first shock for non-EMS witnessed resuscitation attempts. 83% of resuscitation attempts where the initial rhythm was recorded as being shockable were categorised as category 1. This shows that there are opportunities throughout the chain of survival, such as improving recognition, that will impact on the time to 1st shock.

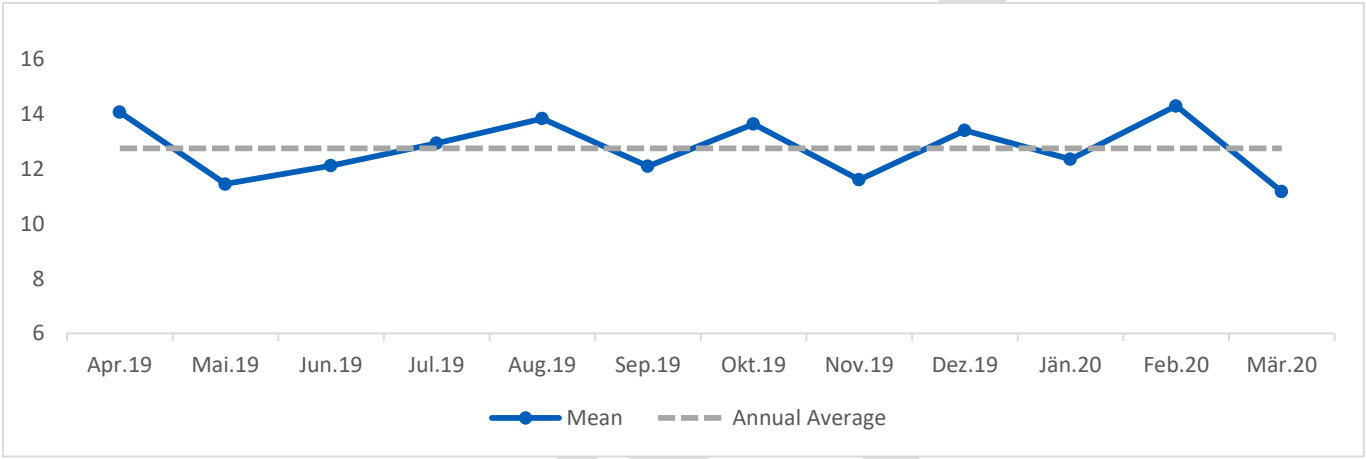

Figure 12 – Mean Time (Mins) From 999 Call to Delivery of First Shock in 2019/20 Non-EMS Witnessed Resuscitation Attempts in SECAmb

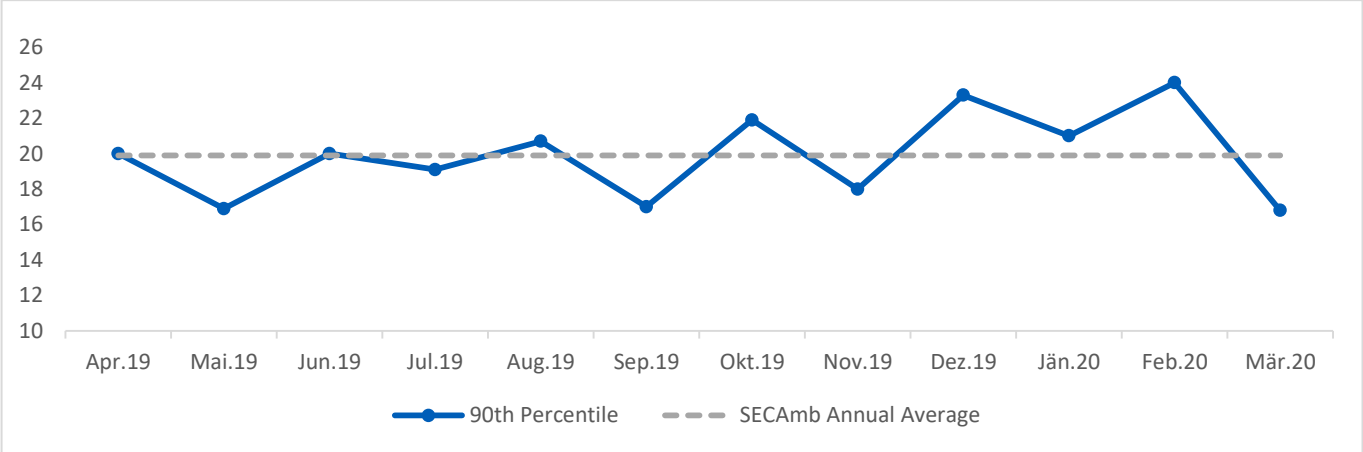

Figure 13 – 90th Centile Time (Mins) From 999 Call to Delivery of First Shock in 2019/20 Non-EMS Witnessed Resuscitation Attempts in SECAmb

Table 9 shows the mean, median, 90th centile and maximum number of shocks delivered during resuscitation attempts.

Table 9 - Number of Shocks Given to Resuscitation Attempts and Survivors in 2019/20 Cardiac Arrests in SECAmb

	All Resuscitations	Survivors
Mean	4.1	3.3
Median	3	2
90th Centile	9	7
Maximum	28	21

Post Resuscitation Care

The Trust measures performance against a nationally agreed EMS Post-ROSC Care Bundle. Along with all of the earlier links in the chain of survival this influences patient outcomes following cardiac arrest. The Trust measures outcomes from cardiac arrest on a monthly basis. This is carried out in two ways; by measuring the number of patients who have a return of spontaneous circulation (ROSC - heartbeat has returned) when they arrive at the hopsital and by measuring the number of people who survive to be discharged from hospital.

Figure 14 - Post-Resuscitation Care

These measures are split into two groups. The first group contains all cardiac arrests where resuscitation was attempted. The second, 'Utstein', group contains all cardiac arrests where resuscitation was attempted, the arrest was witnessed by a bystander, the arrest was cardiac in origin, and where the initial heart rhythm was ventricular fibrillation or ventricular tachycardia (a cardiac arrest rhythm that can be shocked with a defibrillator).

Unless there is a clear reversible cause that cannot be addressed out of hospital, clinicians will continue resuscitation on scene. This ensures that the patient receives continuous, high-quality CPR. The Trust's CCPs and Operational Team Leaders (OTLs) have access to mechanical chest compression devices to ensure that high quality CPR can be given in transit. The Trust does not currently collect data on cases where mechanical chest compressions were delivered. Table 10 below shows the proportion of resuscitation attempts transported to hospital as % of resuscitation attempts.

Table 10 - Transport for Patients in 2019/20 Cardiac Arrests in SECAmb

Transport	Count	Percentage
Recognition of Life Extinct on Scene	1755	68.5
ROSC at Hospital	664	25.9
Transported in Arrest	142	5.6

"Feedback from colleagues, especially CCPs, really helps for future jobs. I think the CCP should be the one to lead on asking how colleagues are after the incident.

In this case debriefing happened outside of the patient's door, I was less able to speak freely as the patient's wife could possibly overhear conversations.

I appreciate it when control ask: 'are you ok?' – I feel this should always be asked after a C1."

Post-ROSC Care Bundle

Following successful resuscitation, many patients will suffer post-cardiac arrest syndrome. Depending on the cause of the cardiac arrest and the severity of post-cardiac arrest syndrome, many patients will require multiple organ support, and the treatment they receive during the post-resuscitation period will significantly influence the overall outcome for the patient.

The post-ROSC care bundle in EMS includes obtaining a 12-lead electrocardiogram (ECG), measuring blood glucose, administration of oxygen as required, measuring

blood pressure, administration of intravenous fluids if required and measurement of end-tidal carbon dioxide if an advanced airway device has been used.

In 2019/20 an i-gel was successfully placed in 78% of resuscitations attempts. An endotracheal tube (ETT) was successfully placed in 40% of resuscitation attempts. (Both airway devices were placed in some resuscitation attempts.

Figure 15 shows the percentage of resuscitation attempts with ROSC achieved on-scene where a full care bundle was delivered. There is a slight reduction in annual average from 2018/19, however SECAmb continues to perform above the national average. It is suspected that this performance is due to the presence of a critical care paramedic (CCP) programme in SECAmb. A CCP was on scene for 70% of all resuscitation attempts. The Trust currently has 70 CCPs.

The most omitted elements of the post ROSC care bundle are shown in figure 16. Table 11 shows the breakdown by SECAmb Operational Unit. The Trust should continue to improve performance against the post-ROSC care bundle.

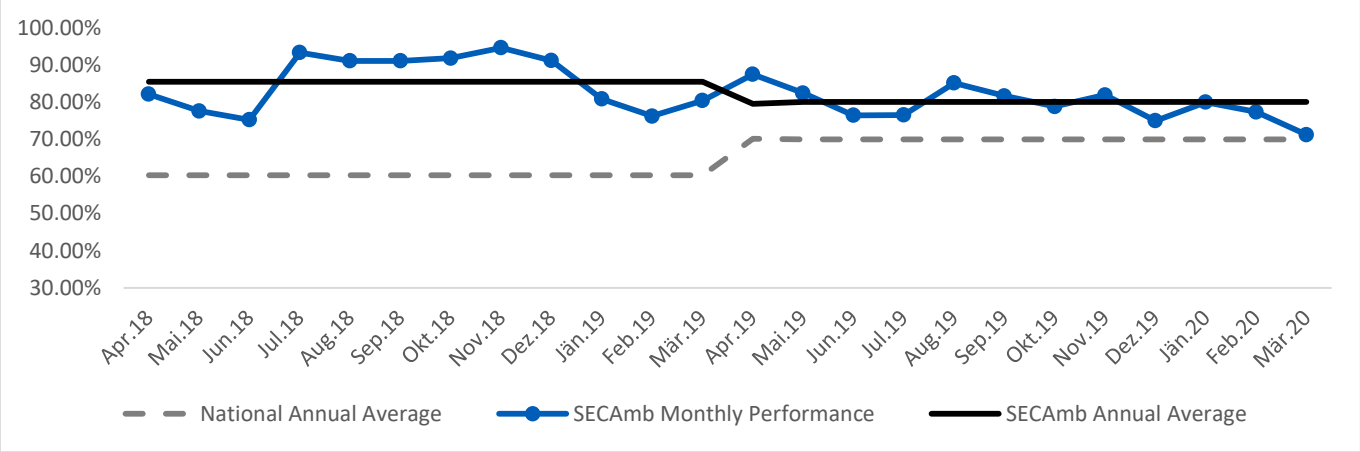

Figure 15 - Percentage Completion of Post-ROSC Care Bundle in Resuscitation Attempts with ROSC Achieved On-Scene in SECAmb

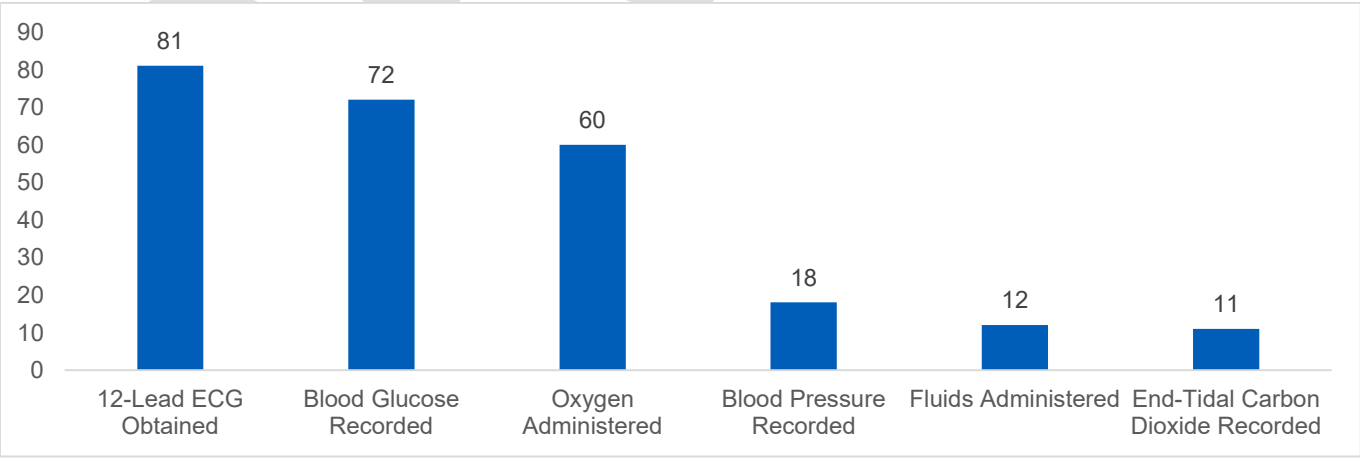

Figure 16 - Count of Elements of Post-ROSC Care Bundle Omitted in 2019/20 Resuscitation Attempts with ROSC Achieved On-Scene in SECAmb

Table 11 - Completion of Post-ROSC Care Bundle by Operational Unit in 2019/20 Resuscitation Attempts with ROSC Achieved On-Scene in SECAmb

Operational Unit	Care Bundle Required	Care Bundle Completed	Percentage Compliance

Ashford	63	52	82.5
Brighton	103	77	74.8
Chertsey	74	62	83.8
Dartford & Medway	145	123	84.8
Gatwick & Redhill	107	93	86.9
Guildford	88	71	80.7
Paddock Wood	81	73	90.1
Polegate & Hastings	105	80	76.2
Tangmere & Worthing	81	56	69.1
Thanet	80	59	73.8
Unknown	2	0	0.0
Other	7	4	57.1

Outcomes of Cardiac Arrest

> "It is emotionally difficult when dealing with distressed families, and it can feel harsh when taking control and being direct to get the information that is needed in an emergency situation (e.g. where the patient is located)."

Figure 17 shows SECAmb's improvements in the proportion of patients who have suffered an out of hospital cardiac arrest and subsequently survive to be discharged from hospital. Patients where it has not been possible to determine an outcome are not included in the calculation for these proportions. Figures 19-21 show monthly performance over the last four years. There are no clear seasonal or any other patterns apparent in the data.

SECAmb is currently 1% below the national annual average for survival to discharge in all patients. There is an opportunity to improve outcomes from cardiac arrest if the recommendations within this report are enacted. The Trust is 5% below the national Utstein average, the Utstein measure is regarded as a strong indicator of a high-performing emergency medical service.

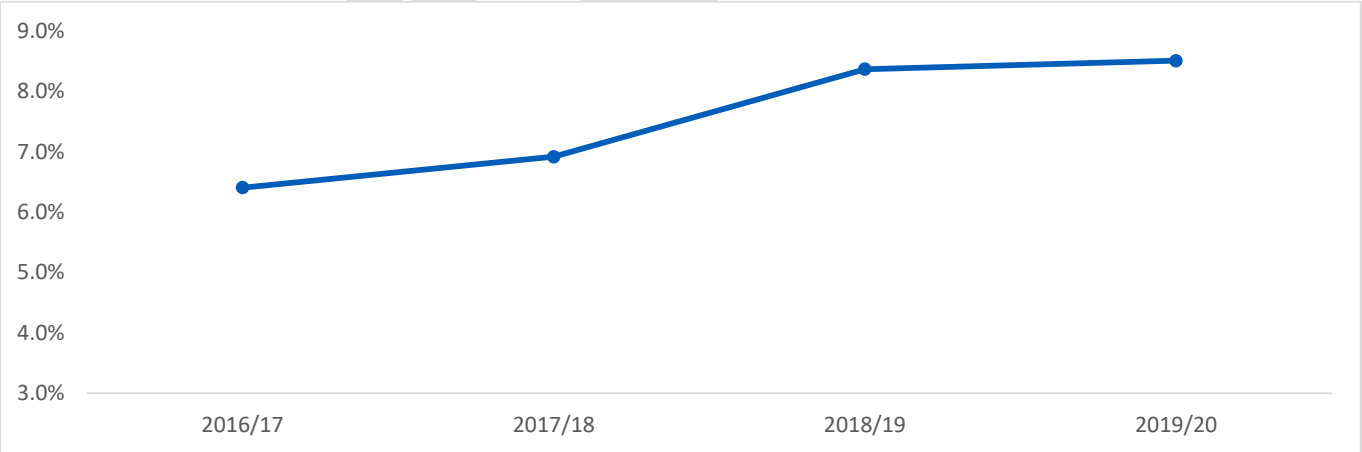

Figure 17 - Percentage of All Resuscitation Attempts with Known Outcomes Surviving to Discharge Annually in SECAmb

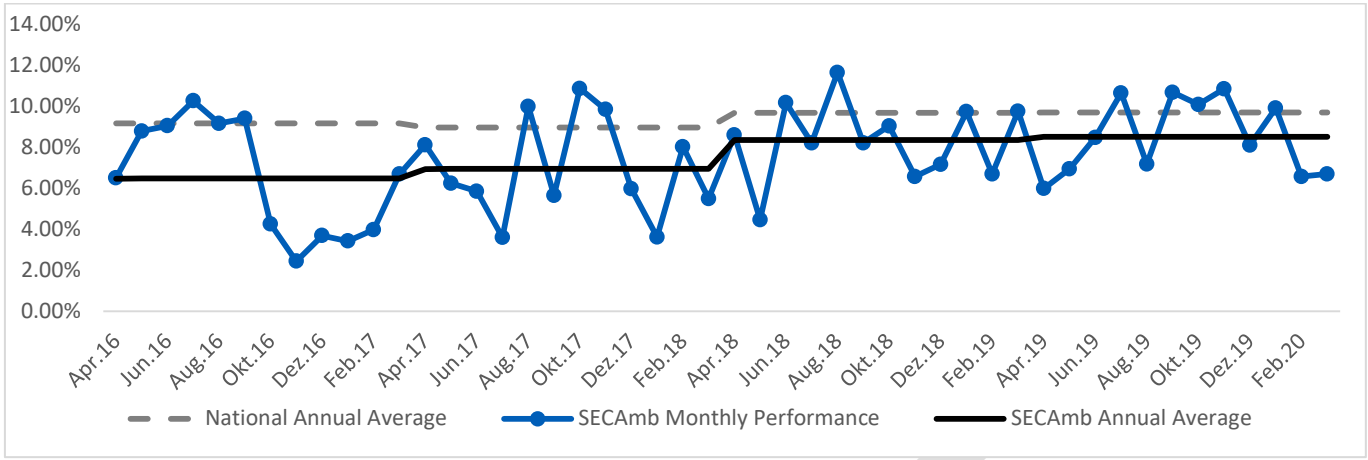

Figure 18 - Percentage of All Resuscitation Attempts with Known Outcomes Surviving to Discharge in SECAmb

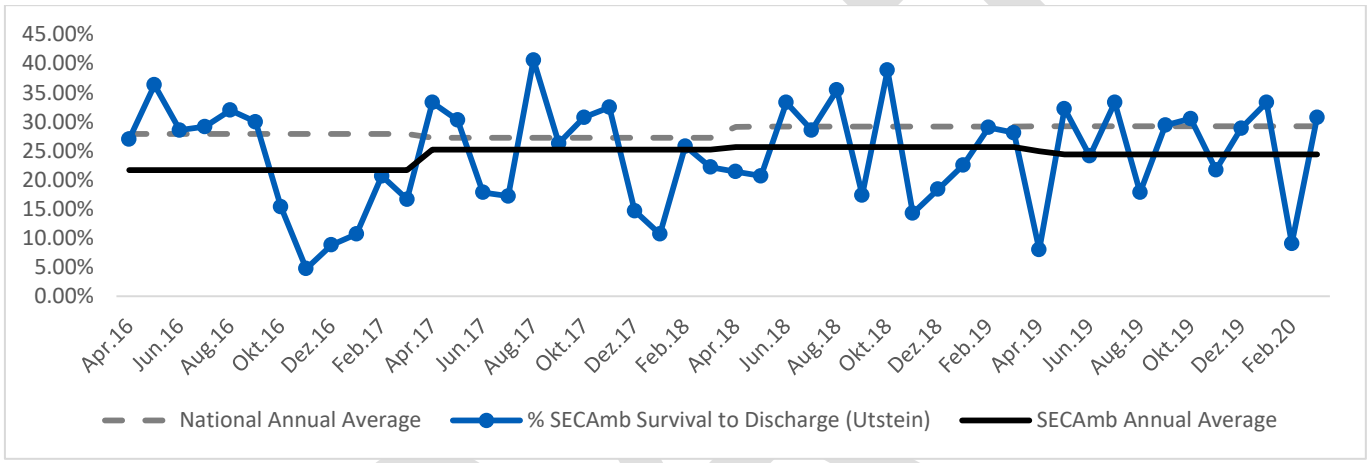

Figure 19 - Percentage of Utstein Resuscitation Attempts with Known Outcomes Surviving to Discharge in SECAmb

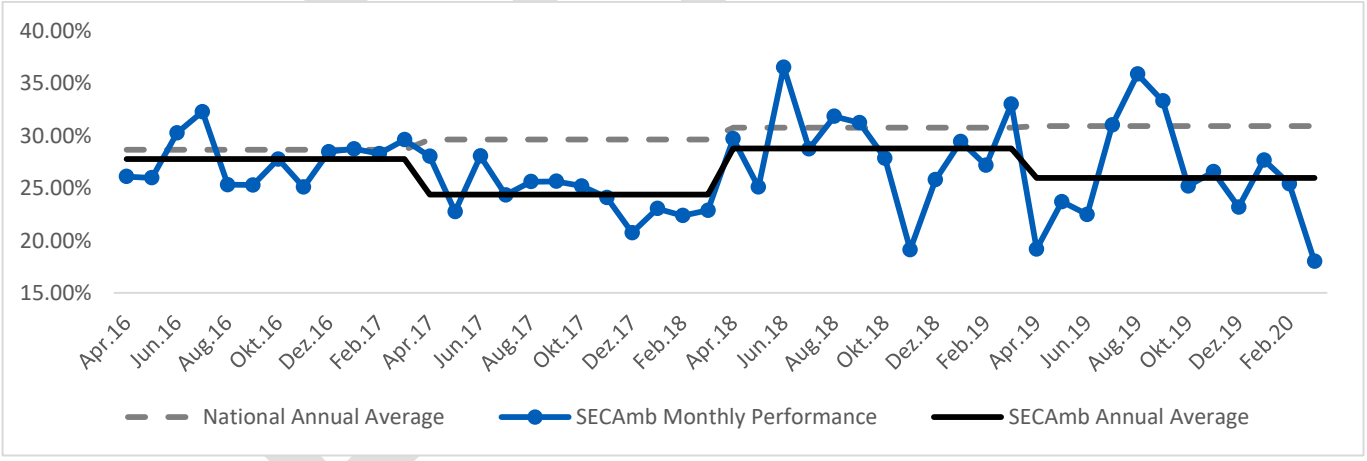

Figure 20 - Percentage of All Resuscitation Attempts with ROSC on Arrival at Hospital in SECAmb

Recommendations

The Global Resuscitation Alliance has produced a ten-step plan for emergency medical services to improve outcomes from out of hospital cardiac arrest. Based on the information contained within this report, the table below shows the Trust's progress against each step and recommendations for further improvement. These recommendations should be translated into a clear, measurable, achievable, realistic and time-bound (SMART) action plan with the appropriate accountable owner for each action.

Step	Progress	Achievements	Recommendations
1. Establish a cardiac arrest registry	Partially Achieved	• Digital registry in place, including all cardiac arrests attended by SECAmb.	• Expand data collection to include 999/111 calls classified as cardiac arrest, include data collected during measurement of resuscitation quality and cases where mechanical resuscitation was used.
2. Begin tCPR with continuous training and improvement	Partially Achieved	• CDSS system in place and EMAs trained to give tCPR. Audit programme in place. • All new EMAs received BLS and AED training to improve confidence in delivering t-CPR.	• Include explicit focus on audit of cardiac arrest calls each month. • Review all cases where cardiac arrest was not identified at the time of the 999/111 call. • Provide continuous coaching and training to EMAs.
3. Begin high performance EMS CPR with continuous training and improvement	Partially Achieved	• Roll-out of 'i-gel' supraglottic airway device to reduce task focus and improve CPR quality. • Full day of resuscitation training delivered to all patient facing staff. • New Trust guidance for resuscitation introduced. • Commenced monitor/defibrillator replacement programme listing CPR feedback technology as an essential criterion.	• Investigate the introduction of clinical devices to measure compression depth and chest recoil. • Continue to improve delivery of the post-ROSC care bundle. • Complete monitor/defibrillator replacement programme.
4. Begin rapid dispatch	Fully Achieved	• Auto-dispatch to category 1 calls in place.	• Extend auto-dispatch to include volunteers and other professional responders.
5. Measure quality of	Partially	• Download programme in place and	• Resume as soon as practically

professional resuscitation using defibrillator downloads	Achieved	clinicians given feedback on rate, rhythm and ratio of chest compressions. Temporarily paused during COVID-19 pandemic.	possible. • Expand programme, including further data to be fed back to clinicians and increase awareness of programme. • Investigate the introduction of clinical devices to measure compression depth and chest recoil.
6. Begin an AED programme for responders	Partially Achieved	• Responder programme in place with some fire and rescue services. • Commenced a collaborative piece of work with the British Heart Foundation on a National Defibrillator Network, which improves identification and management of PADs.	• Investigate the opportunities to equip police officers with AEDs to respond to OHCA. • Expand the Community First Responder programme. • Recommend to other EMS and NHS England that 'post resuscitation cases' are included in national registries. • Complete development of National Defibrillator Network.
7. Use smart technologies to extend CPR and public access defibrillation	Partially Achieved	• 'GoodSam' App in use in EOCs for staff and volunteer responders. Temporarily paused during COVID-19 pandemic.	• Resume as soon as practically possible. • Extend use of the app to include any individual with a clinical or first-aid qualification.
8. Make CPR and AEDs mandatory in schools and the community	Partially Achieved	• The Trust participates in 'Restart a Heart Day'. • Commenced work with Trust community resilience team to develop a strategy for improved community engagement and public awareness of CPR.	• Increase the scale and reach of 'Restart a Heart Day' to include all schools and a variety of public places. • Complete community engagement and awareness strategy.
9. Work towards accountability – submit annual reports to the community	Fully Achieved	• The Trust produces an Annual Report and 'Quality Account'. • This is the first Annual OHCA Report.	• The Trust should continue to produce an Annual OHCA Report.
10. Work towards a culture of excellence	Partially Achieved		• Achievement of steps 1-9 required. • Work with community health services and public services to improve

			disease prevention and integrate EMS into primary prevention strategies. • Carry out statistical analysis, based on registry data, to determine the best location of PAD sites and volunteer responder programmes. • Work with community health services to ensure patients approaching the end of their life have an appropriate care plan in place. • Explore the use of AI to reduce time to tCPR.

Appendix A – Abbreviations & Glossary

AED	Automated External Defibrillator	A portable electronic device that diagnoses life-threatening cardiac arrhythmias and is able to treat them through defibrillation
AI	Artificial Intelligence	Machines (or computers) that mimic "cognitive" functions that humans associate with the human mind.
CAD	Computer Aided Dispatch	The IT system used to collect incident location details, patient demographics, host the CDSS and dispatch ambulances.
CCP	Critical Care Paramedic	A paramedic with advanced training to care for patients with severe illness or injury.
CDSS	Clinical Decision Support System	A tool used to remotely triage patients and provide initial care advice.
COVID-19	Novel Coronavirus Disease	An infection that mainly affects the respiratory system that can be very serious for some.
CPR	Cardiopulmonary Resuscitation	A treatment to maintain circulation for patients in cardiac arrest.
ECG	Electrocardiogram	A reading of the electrical signals in the heart that allow clinicians to diagnose certain conditions.
EOC	Emergency Operations Centre/Control	Where 999 calls are answered and a response is organised.
EMA	Emergency Medical Adviser	An individual trained to answer 999 calls, assess the patient and provide initial care until an ambulance arrives.
EMS	Emergency Medical Services	The treatment/transport of people in crisis health situations
OHCA	Out of Hospital Cardiac Arrest	
PAD	Public Access Defibrillator	An AED placed in a public location to be used by a bystander on a patient in cardiac arrest.
PCR	Patient Clinical Record	The written record of the care delivered to a patient.
PPE	Personal Protective Equipment	Garments to prevent cross-infection; including mask, gloves, goggles and coveralls.
ROSC	Return of Spontaneous Circulation	Return of a pulse after cardiac arrest.
SECAmb	South East Coast Ambulance Service	The Trust.
tCPR	Telephone Cardiopulmonary Resuscitation	CPR delivered by a bystander on the guidance of an EMA.

Appendix B – Survival by Hospital and Operational Unit

Survival to Discharge by Hospital

The following table shows the proportion of patients where resuscitation was attempted by SECAmb conveyed to each hospital that subsequently survived to discharge. For data quality and information governance purposes, hospitals that received less than 10 patients are not included.

In order to allow a fair comparison, the table shows all resuscitation attempts versus resuscitation attempts that were bystander witnessed. This is to account for any skew in the data that might be caused by conveyance to a primary percutaneous coronary intervention centre.

Table 12 - Survival to Discharge by Hospital

Receiving Hospital	Total Conveyed	Survived to Discharge - All	Survival to Discharge - All	Survival to Discharge Bystander Witnessed	Survival to Discharge for Bystander Witnessed
Conquest	42	12	28.6%	8	33.3%
Darent Valley	29	2	7.1%	0	0.0%
East Surrey	33	2	6.3%	1	6.3%
Eastbourne	41	10	27.0%	5	33.3%
Frimley Park	59	17	29.3%	6	15.8%
King's College	24	7	43.8%	5	38.5%
Maidstone	21	2	10.5%	1	8.3%
Medway Maritime	56	6	11.5%	6	22.2%
QEQM	38	7	18.4%	5	27.8%
Royal Surrey County	12	3	25.0%	3	30.0%
Royal Sussex County	120	35	36.1%	18	34.6%
St George's	33	14	48.3%	13	52.0%
St Peter's	63	16	28.1%	12	32.4%
St Richard's	23	4	19.0%	4	36.4%
Tunbridge Wells (Pembury)	31	8	27.6%	4	23.5%
William Harvey	132	55	44.4%	25	41.0%
Worthing	23	2	9.1%	0	0.0%

Survival to Discharge by Operational Unit

Table 13 - Survival to Discharge by Operational Unit

Operational Unit	Count of Resuscitation Attempts	Count of Patients Survived to Discharge	Survival to Discharge %
Ashford	178	9	5.1%
Brighton	243	18	8.0%
Chertsey	196	16	8.5%
Dartford & Medway	382	38	10.2%
Gatwick & Redhill	312	26	8.7%
Guildford	230	20	8.7%
Paddock Wood	246	22	9.2%
Polegate & Hastings	285	22	7.9%
Tangmere & Worthing	225	15	6.9%
Thanet	231	16	7.0%
Unknown	5	1	20.0%
Other	*34*	*2*	*6.3%*

Appendix C - Resuscitation Attempts in Special Circumstances

Patients Under 18 Years of Age

In 2019/20 there were 54 resuscitation attempts of patients under 18 years of age. The characteristics of these cases is shown below:

Table 14 - Aetiology of 2019/20 Resuscitation Attempts Under 18 Years of Age in SECAmb

Aetiology	Percentage
Cardiac	69%
Asphyxia	11%
Trauma	10%
Other/Not Recorded	6%
Drug Overdose	2%
Submersion	2%

A public access defibrillator was used in 3 cases, all of which had a presumed cardiac aetiology.

There is not sufficient data on the location of the cardiac arrest to provide this information for this group. 13% of these patients survived to discharge.

Resuscitation Following Submersion

In 2019/20, there were 17 resuscitation attempts following submersion. 76% presented in asystole and 24% presented in ventricular fibrillation or tachycardia. None of these patients survived to discharge.

Appendix D - Characteristics of Survivors

The following table shows a list of the characteristics that might apply to a survivor and foe each characteristic columns for:

- Count of Resuscitation Attempts – the number of cases where this characteristic applies
- Characteristics as a Proportion of Total Resuscitation attempts – the proportion of resuscitation where this characteristic applies
- Total Patients Survived to Discharge – the count of patients where this characteristic applied that survived to discharge
- Survival to Discharge as a Proportion of Known Outcomes – the proportion of patients in this characteristic group that survived to discharge
- Characteristics as a Proportion of Total Survival to Discharge – the proportion of those who survived to discharge where this characteristic applied.

Table 15 - Characteristics of 2019/20 Survivors Following Resuscitation Attempt in SECAmb

	Count of Resuscitation Attempts	Characteristic as Proportion of Total Resuscitation Attempts	Count of Patients Survived to Discharge	Survival to Discharge as Proportion of Known Outcomes	Characteristic as Proportion of Total Survival to Discharge
Overall					
	2567	-	205	**8.5%**	-
Aetiology					
Cardiac	2252	87.7%	193	**8.8%**	**94.1%**
Asphyxia	108	4.2%	3	**2.9%**	**1.5%**
Drug overdose	50	1.9%	6	**13.3%**	**2.9%**
Electrocution	1	0.0%	1	**100.0%**	**0.5%**
Exsanguination	22	0.9%	1	**4.5%**	**0.5%**
Other (non-cardiac)	10	0.4%	0	**0.0%**	**0.0%**
Trauma	101	3.9%	1	**1.1%**	**0.5%**
Submersion	17	0.7%	0	**0.0%**	**0.0%**
Unknown	6	0.3%	0	**0.0%**	**0.0%**

Initial rhythm					
Asystole	1282	49.9%	11	**0.9%**	**5.4%**
PEA	600	23.4%	22	**3.8%**	**10.7%**
VF/VT	585	22.8%	162	**29.2%**	**79.0%**
Other	4	0.2%	0	**0.0%**	**0.0%**
AED recorded non-shockable	33	1.3%	1	**3.1%**	**0.5%**
Unknown	63	2.5%	9	**17.0%**	**4.4%**
Non-shockable (all rhythms)		*74.6%*	*34*	***1.8%***	***16.6%***

Witnessed by					
EMS	328	12.8%	60	**19.2%**	**29.3%**
Bystander	1347	52.5%	119	**9.1%**	**58.0%**
None	828	32.3%	21	**2.6%**	**10.2%**
Unknown	64	2.5%	5	**8.1%**	**2.4%**

Gender					
M	1688	65.8%	152	**9.3%**	**74.1%**
F	868	33.8%	52	**6.2%**	**25.4%**

Public AED used					
	133	5.2%	17	**13.5%**	**8.3%**

Appendix E – Staff Experiences

Three SECAmb colleagues volunteered to describe their early experiences of attending cardiac arrest patients as Newly Qualified Paramedics. Comments taken from each of their experiences, which were not included in the main report, are categorized below.

Clinician 1

Initial thoughts prior to attending their first cardiac arrest patient:

- **Fearful** that it would be a nightmare situation and I would be the only qualified paramedic on scene.

Reflections on what went well:

- Lucky to be working with a more experienced colleague who I felt **comfortable** with.
- The family were happy that crew were **on scene quickly**.
- I was given '**on the job training**'/shown how I could accurately measure what fluids were given.
- The team **kept the family informed** throughout and **discussed options**, such as whether the wife wished to be in the room or not.
- Even though the **CCP** was from a different OU, they **contacted every crew member** from this incident to provide an **update** and **feedback** after the event.

Reflections on what could have improved the experience:

- **Pre-alert** required a few communications with the hospital as there appeared to be some issues with the patient being accepted, but this was resolved.
- The only thing that could have improved this experience, would have been if I had had the **opportunity to be responsible for the airway**.

Clinician 2

Reflections on what went well:

- Gave the patient the **best possible outcome** we could.
- **Learning from external colleagues** – the anaesthetist explained that the locked jaw was likely due to previous cancer treatment.
- **CCP feedback** – they were happy with how the situation was handled. (Especially considering we were at the end of a night shift and were exhausted.)
- My crew mate was good at **discussing** the situation **after the event.**
- We were **well supported** by our **Police** colleague**.**

Reflections on what could have improved the experience:

- **May not have commenced CPR** if the bigger picture was realised when we arrived on scene.

Other thoughts:

- The **ambulance set-up**/layout isn't ideal.
- I used **reflection models** a lot in university. I tend to reflect during the resus and after when we debrief.
- Writing the **incident history** on the back of the ambulance was helpful – all could see it and everyone had clear/full information for ASHICE.
- **Learning from this situation** – I now look at rigor mortis in limbs, not just in the jaw.
- Lack of communication with the family due to a language barrier made my role easier in this particular situation.

Clinician 3

Reflections on what went well:

- Crew mate spoke with the wife and **explained** what was going on. The wife requested to be with her husband during CPR, which the crew allowed. The wife remained very **calm.**
- Ensured the wife had a **family member on way** to be with her.
- We **discussed on route** who would go in first and who would get into L3 PPE. We quickly **adapted the plan** when we discovered that patient's positioning was compromising the ability to deliver effective treatment.
- We maintained 'dirty' and 'clean' areas outside of the house (due to COVID-19).
- We asked the wife's **permission** to move her husband to the bed (after stopping CPR).
- My crew mate and I **discussed** how we both felt the situation went.
- We **arrived** at the scene very **quickly.**
- It was clear who was **leading**, even when the roles change.
- I have OTLs and other crew mates to speak with and **reflect.**

Reflections on what could have improved the experience:

- Not all crew members on scene took the debrief as a necessary component of continued learning.
- Initially I had trouble securing the I-gel due to the patient's anatomy. I attempted several manoeuvres, however once another crew member assisted with lifting the patient's shoulders the blanket was repositioned, enabling the accurate securing of the I-gel.
- The **feel of the situation and fluidity** changed when additional crew arrived. (This improved when the CCP arrived.)

Other thoughts:

- Being a paramedic is an emotional job!
- Before this particular job, I would not have given family members the option to be present during CPR, but seeing how well it worked on this occasion, I would consider allowing family members the option on a case by case basis.
- Staff need to be open with how they receive feedback (positive and negative).
- I need to reconsider how I request information from family members as this request can be perceived as a critique of care provided in the lead up to the current incident.

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NHS
South East Coast Ambulance Service
NHS Foundation Trust

Clinical Audit
Annual Report 2019/20

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

Contents

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Executive Summary

Overall Activity

The 2019/20 Clinical Audit programme was developed following:

- Engagement with internal and external stakeholders, who were invited to suggest specific conditions or care pathways they would like the Trust to include in the programme.
- A review of all Serious Incidents (SIs) submitted to the Trust's Quality and Safety Committee in 2018/19 to identify any potential clinical care concerns or trends of specific incidents.
- A review of the National Institute for Health and Care Excellence (NICE) guidance database to identify new or amended guidelines, which the Trust should consider including in its programme.
- A review of historical audits that require re-audit after implementation of recommendations.
- A review of the National Clinical Audits that are mandated for English ambulance services.

National Clinical Outcome Indicators (COIs) are reported to NHS England each month and measure the quality of services provided. They allow ambulance services to benchmark themselves against one another and improve quality where necessary. During 2019/20 data was collected for over 12,000 patients. The national COIs are:

- Cardiac Arrest – Return of Spontaneous Circulation (All Cases)
- Cardiac Arrest – Return of Spontaneous Circulation (Utstein Group)
- Cardiac Arrest - Survival to Discharge (All Cases)
- Cardiac Arrest – Survival to Discharge (Utstein Group)
- Post ROSC Care – Delivery of Care Bundle
- ST Elevation Myocardial Infarction (STEMI) – Delivery of Care Bundle
- Stroke – Delivery of Diagnostic Bundle
- Sepsis – Delivery of Care Bundle

The Trust also participated in a National Clinical Audit related to cardiac arrest:

- Out of Hospital Cardiac Arrest Outcomes (OHCAO) – Warwick Clinical Trials Unit.

In addition to these monthly clinical audits, thirteen local clinical audits were completed and approved by the Trust's Clinical Audit and Quality Sub Group (CAQSG). These audits were:

- Management of Maternity Emergencies – data provision only
- Salbutamol Administration
- Safety of Discharge Decisions
- Administration of Tranexamic Acid

- Supply of Codeine
- Airway Management
- Pain Management
- Supply of COPD Exacerbation Medicines
- Management of Head Injury in Anti-Coagulated Patients
- Care of Patients Under the Mental Health Act
- Assessment and Management of Croup
- Assessment and Management of Acute Behavioural Disturbance
- Paramedic Practitioner Anti-Microbial Supply

No Level 3 (low organisational risk) audits were completed.

Clinical Audit Summaries

- STEMI call to angiography time mean is equal to the national average.
- STEMI call to angiography mean time 90th centile is equal to the national average.
- STEMI care bundle performance has improved but remains below the national average.
- Stroke call to door time mean and median are currently below national levels.
- Stroke care bundle compliance has improved and now exceeds national levels.
- Sepsis care bundle compliance continues to exceed national levels.

Action plans have been developed for each of the local clinical audits undertaken and are monitored by the Clinical Audit and Quality Sub-Group.

Health Records

The Trust's Health Records Team saw a drastic transformation in 2019/20. In the previous year, we set out a plan to introduce a new patient record validation and clinical audit system (Doc-Works) and electronic patient clinical record (ePCR) solution. Both systems had a great impact on the way that the Health Records team works and the outputs of this team.

Reconciliation of health records with CAD (computer aided dispatch) incidents improved from around 85 to 89% in 2018/19 and improved further to 98% in 2019/20. These changes were enabled by the CAD matching process that Doc-Works facilitates and the automatic 'CAD push' of incident details to clinician's iPads with ePCR.

In 2020/21 the Trust will continue to monitor these processes and redistribute the capacity that has been released within the Health Records team following the introduction of ePCR.

Next Steps

The Clinical Audit Team have set a vision for what they would like to achieve through the work that they lead:

"Saving lives and facilitating the best care, by sharing knowledge and experience from across the Trust."

This vision drives the team's mission:

> "With our fingers on the pulse of the Trust, we promote learning by sharing knowledge, experience and evidence with staff and our public; so that we can deliver the best care and save more lives."

The team's vision and mission statements drive the clinical audit agenda and help us to make decisions on the direction of work.

The development of the Trusts 2020/21 Clinical Audit Plan has relied on the knowledge and insights held by SECAmb's other clinical governance teams. In quarter four 2019/20 these teams were engaged to collect, triangulate, assess and prioritise the topics to be used in the development of the new annual plan. Please refer to the SECAmb 2020/21 Clinical Audit Plan for more information.

The most transformative change in 2019/20 has been the clinical audit function's use of technology to deliver core processes and drive improvements in patient care and performance. The Trust has invested in a new electronic patient care record that prompts completion of mandatory fields by operational staff to evidence compliance with key performance measures.

Installation of a new digital Health Records and Clinical Audit system has meant that much of the audit data traditionally collected manually is now automatically processed. All of this data is now stored securely on Trust servers, rather than being saved locally on Excel spreadsheets. This allows the Trust to use data much more intelligently and share outcomes through the PowerBI system to enable continuous improvement.

Introduction

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to delivering outstanding clinical care that delivers the best possible patient outcomes. This report presents an overview of Clinical Audit activities within the Trust between 01 April 2019 and 31 March 2020. It provides the Trust Board, our commissioners and, most importantly, our public with an overview of the safety and effectiveness of clinical care.

The Clinical Audit Team is committed to raising the profile of clinical audit within the Trust and is dedicated in its aim that the annual Clinical Audit Plan should be a valuable resource in the Trust's aim to improve patient outcomes and experience.

Clinical Audit forms an integral part of the clinical governance framework through which the Trust is accountable for continually improving the quality of the services and safeguarding high standards of care, by creating an environment in which clinical care excellence will flourish. Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes, through systematic measurement against explicit criteria and the implementation of any necessary change.

The Clinical Audit Department has made significant strides in its performance during 2019/20, embracing technology to automate processes and enable continuous quality improvement and commencing a journey to implement a Trust-wide quality improvement strategy that joins up all of our quality management processes for the benefit of our people and our patients.

Fionna Moore, Executive Medical Director

Overall Activity

Oversight

The Trust Board is accountable for Clinical Audit, with the Executive Medical Director maintaining overall responsibility for the Clinical Audit function of the Trust. Throughout 2019/20, progress in achieving the Clinical Audit Plan (CAP) was monitored through various groups including the Clinical Audit and Quality Sub-Group and Clinical Governance Group, reporting to the Trust Board via the Quality and Patient Safety Committee. Clinical audit was coordinated by a team comprising of seven whole time equivalent substantive roles: a Head of Clinical Audit, a Quality Improvement Lead, a Clinical Audit Supervisor, two Clinical Audit Coordinators, a Cardiac Arrest Analyst and a Clinical Audit Administrator.

Devising the Clinical Audit Programme

The Clinical Audit Team was responsible for delivering the Trust's Clinical Audit Plan for 2019/20, together with agreeing an annual rolling audit programme. The 2019/20 programme was developed following:

- Engagement with internal and external stakeholders, who were invited to suggest specific conditions or care pathways they would like the Trust to include in the plan;
- A review of all Serious Incidents (SIs) submitted to the Trust's Quality and Safety Committee in 2018/19 to identify any potential clinical care concerns or trends of specific incidents.
- A review of the National Institute for Health and Care Excellence (NICE) guidance database to identify new or amended guidelines which the Trust should consider including in its plan;
- A review of historical audits that require re-audit subsequent to implementation of recommendations;
- A review of the National Clinical Audits that are mandated for English ambulance services.

Types of Clinical Audit

Several types of Clinical Audit were undertaken in 2019/20:

- Continuous Clinical Quality Monitoring – these involve collecting monthly data relating to a specific condition or treatment option. Using this type of audit activity, the Clinical Audit Team produces local and Trust-wide benchmark reports, highlighting aspects of operational performance and clinical care, informing future treatment options, and demonstrating the effectiveness of care packages specific to these patient groups.
- Comprehensive Clinical Audits – these examine, in detail, patient care and adherence to guidelines across the Trust. Compehensive audits may involve the collection of data for a period of one year or more. These audits examine numerous aspects of care and can involve tracking patient outcomes and measuring patient satisfaction.

- Collaborative Clinical Audits - The Trust recognises and value and importance of working collaboratively with other NHS Trusts and benchmarking clinical care and performance with other ambulance services. As such, the Trust continues to participate in national ambulance clinical audit initiatives including the Ambulance Service's National Clinical Performance Indicators (CPI) and NHS England Ambulance Clinical Quality Indicators (ACQI) along with continued participation in National Confidential Enquiries and other national clinical audit projects as required.

Delivering the Clinical Audit Programme

Each audit is classified into one of three levels:

- Level 1, external 'must-do' audits, are required by external agencies. They may form part of our contractual arrangements with NHS England, our commissioners or other external parties. Level 1 audits typically involve continuously assessing and improving the quality of care provided in some of our highest risk areas.

- Level 2, internal 'must-do' audits, seek to examine and improve our greatest organisational risks. These risks might have emerged through incidents, near misses or evidence of poor quality. Some of our Level 2 audits will involve continuous measurement in order to provide continuous assurance and improvement.

- Level 3, best practice or local interest audits, seek to examine and improve organisational issues that are low risk. Scoring indicated that these topics were a lower priority. Level 3 audits are completed if there is a voluntary offer of resource or if the Clinical Audit Team has spare resource.

Level 1 Audits

Level 1 clinical audits all have data collected on a monthly basis; all of our Level 1 audits are National Clinical Outcome Indicators (COIs). These are reported to NHS England each month and measure the quality of services provided. They allow ambulance services to benchmark themselves against one another and improve quality where necessary. The national clinical indicators are comprised of patients who present with ST elevation myocardial infarction (STEMI; a type of heart attack), a stroke or cardiac arrest. During 2019/20 data was collected for over 12,000 patients that met the COI criteria. The national COIs are:

- Cardiac Arrest – Return of Spontaneous Circulation (All Cases)
- Cardiac Arrest – Return of Spontaneous Circulation (Utstein Group)
- Cardiac Arrest - Survival to Discharge (All Cases)
- Cardiac Arrest – Survival to Discharge (Utstein Group)
- ST Elevation Myocardial Infarction (STEMI) – Delivery of Care Bundle
- ST Elevation Myocardial Infarction (STEMI) – Timeliness Measure

- Stroke – Delivery of Diagnostic Bundle
- Stroke – Timeliness Measure
- Sepsis – Delivery of Care Bundle
- Cardiac Arrest, Post-ROSC – Delivery of Care Bundle

The national clinical audits the Trust participated in are listed below:

- Out of Hospital Cardiac Arrest Outcomes (OHCAO) – Warwick Clinical Trials Unit

Level 2 Audits

In addition to these Level 1 clinical audits, thirteen Level 2, local clinical audits were completed and approved by the Trust's Clinical Audit and Quality Sub Group (CAQSG). These audits were:

- Management of Maternity Emergencies
- Community First Responder Salbutamol Administration
- Safety of Discharge Decisions
- Administration of Tranexamic Acid
- Supply of Codeine
- Airway Management
- Pain Management
- Supply of COPD Exacerbation Medicines
- Management of Head Injury in Anti-Coagulated Patients
- Care of Patients Under the Mental Health Act
- Assessment and Management of Croup
- Assessment and Management of Acute Behavioural Disturbance
- Paramedic Practitioner Anti-Microbial Supply

Level 3 Audits

No level 3 audits were completed in 2019/20.

Staff Engagement

The Trust is committed to providing opportunities for all its staff that are directly responsible for delivering patient care to participate in clinical audit. Staff have been invited to submit clinical audit topics for inclusion in the annual plan and lead clinical audits with support from the Clinical Audit Team. All clinical audits undertaken had participation from an identified clinical member of staff.

Quality Improvement

In 2019/20 the Trust has taken various approaches to quality improvement, these have included:

- Inclusion of key issues in annual mandatory training, for example cardiac arrest, good documentation and care bundle delivery.
- Communicating with staff through email, the weekly bulletin, infographic posters and Trust issued iPads.
- Development of reference materials designed specifically for iPad use, for example the Trust's 'Urgent Care Handbook', the 'Clinical Record Quick Reference Guide' and the 'JRCALC Plus' app which holds Trust specific clinical management plans.
- Providing focussed support to areas of the Trust who were outliers in performance.
- Introduction of new equipment and procedures to improve care and outcomes for patients. For example, the introduction of further mechanical CPR devices and the redesign of the suite of Patient Group Directions (PGDs) and other policies and procedures.
- Development of paper and electronic clinical records to improve documentation and better evidence delivery of high quality care.

A governance system remains in place to ensure that actions and recommendations from clinical audits are:

- relevant at the time of creation
- focussed on changing safety and effectiveness systems
- entered onto a tracker, reviewed regularly and that evidence is gathered when a recommendation is complete
- monitored and reviewed regularly
- escalated through Trust governance structures if failing to progress.

A summary of the status of actions arising from clinical audit is shown in the table below. Some actions are overdue and this is reflective of the high volume of improvement actions produced through the 2018/19 Clinical Audit Plan. All actions are progressing, and escalation has not been required.

Table 1: Summary of improvement action progress

Year	Actions Complete	Actions in Progress & On Track	Actions Overdue	Actions Overdue & Escalated	Total
2016/17	27	-	-	-	27
2017/18	17	-	-	-	17
2018/19	76	-	-	1	76
2019/20	18	14	1	-	33

Links with Other Organisations

The Trust has continued to participate in the National Ambulance Service Clinical Quality Group and its supporting Technical Sub-Group. Members of the Clinical Audit Team have attended a national benchmarking days aimed at sharing data and learning.

The Trust is sharing information regarding patient outcomes for survival to discharge and patient transport times for STEMI reperfusion (MINAP) with our acute hospitals across Kent, Surrey and Sussex.

Level 1 Audit Reports

Cardiac Arrest

This year, information on cardiac arrest is presented in the Trust's first Out of Hospital Cardiac Arrest Annual Report. Please see this report for further information.

STEMI

The Trust aims to identify and measure its performance in 100% of the ST-elevation myocardial infarctions (STEMI) cases that we attend. The Trust measures the quality of care provided to patients who are suffering an STEMI by the proportion of patients who receive a bundle of care that is shown to improve outcomes for patients who are suffering a STEMI. The care bundle includes administration of aspirin, glyceryl trinitrate (GTN), analgesia (pain relief) and recording two pain scores. The most common area of non-compliance is administration/documentation of analgesia and documentation of two pain scores. The Trust also record the call to angiography time for patients presenting with a STEMI, this is compared as the mean and the 90th centile against other Trusts.

Trust performance for these measures are shown below.

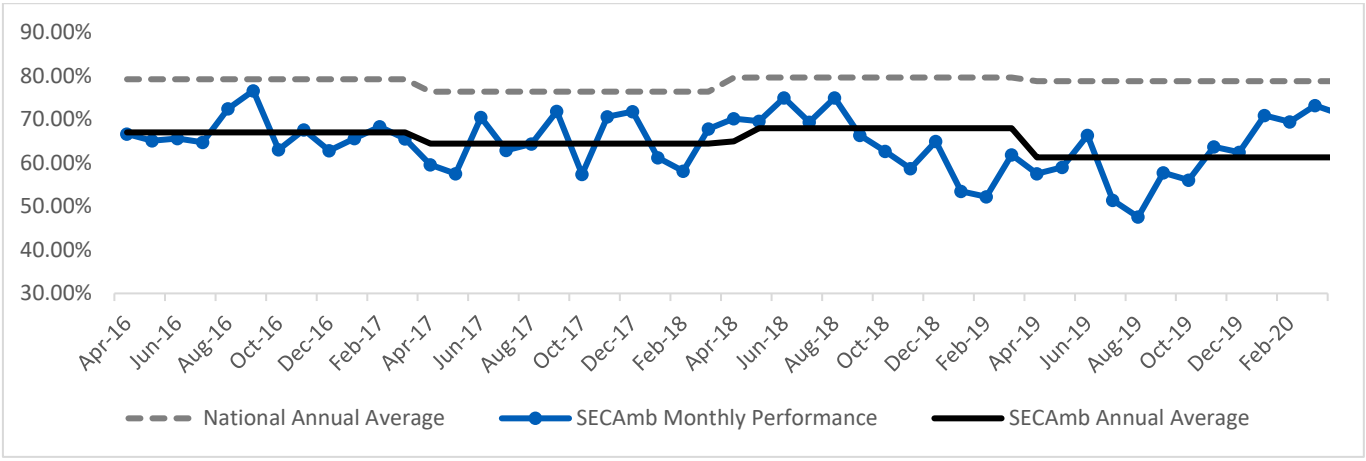

Figure 1 - Proportion of Suspected STEMI Patients Receiving Full Care Bundle

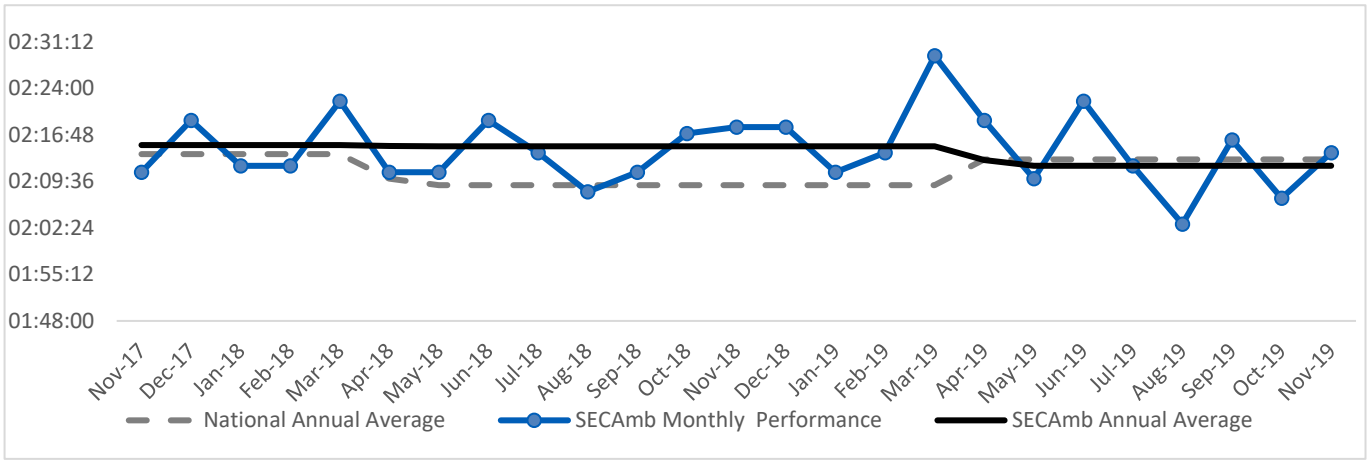

Figure 2 - Mean Call to Angiography Time for Confirmed STEMI

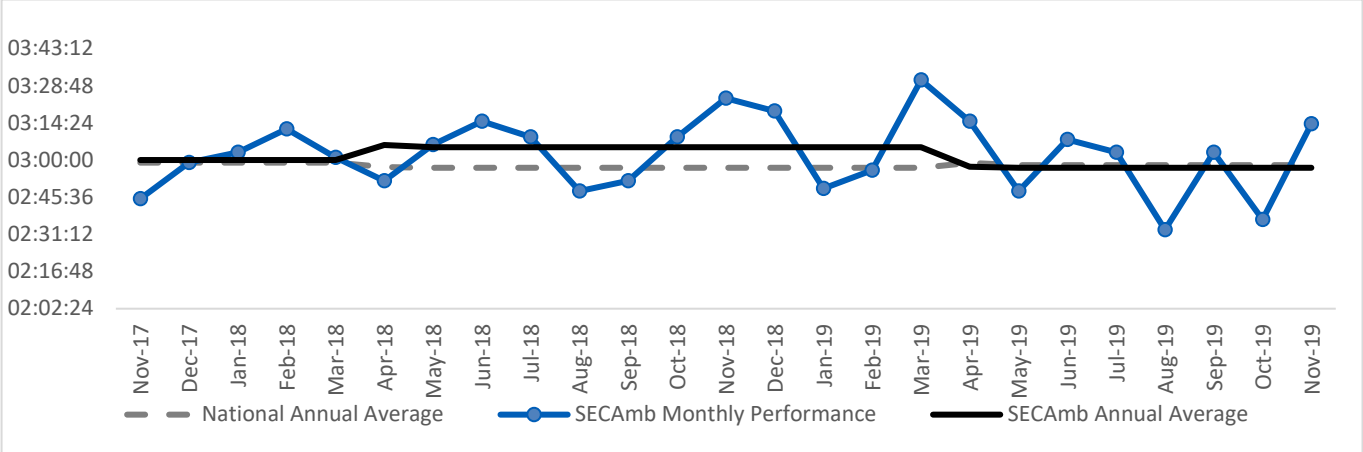

Figure 3 - 90th Centile Call to Angiography Time for Confirmed STEMI

The proportion of patients who received the STEMI Care Bundle was below average and showed normal patterns of variation until August 2019, when the Trust introduced ePCR. Based on early testing of ePCR the clinical audit team recgnised the necessity for ePCR to include forcing functions for the adequate documentation of clinical care. This led to a statistically significant improvement in performance.

STEMI call to angio mean and 90th centile was in line with national average. The latest available data is from November 2019. NHS England paused this data collection due to the COVID-19 pandemic.

The Trust undertook various actions in 2019/20 to improve outcomes for patients suffering a STEMI, these included:

- Planned additional ECG training in the Trust's annual mandatory training programme for clinical staff, to increase the accuracy and timeliness of STEMI diagnosis.
- Trust-wide communications to clinical staff to stress the importance of and the evidence base for completion of the STEMI care bundle.
- Individual feedback to clinicians on the delivery and documentation of STEMI care.
- A programme of work to improve ambulance response times aims to improve the timeliness of arrival at definitive care for patients who are suffering a STEMI.
- Improved design of paper and electronic records to improve documentation of essential care elements.
- A programme of work to promote good record keeping, to increase the evidence of high quality care in this area.

Stroke

The Trust aims to identify and meaure its performance in 100% of the stroke cases that it attends. The Trust measures the quality of care provided to patients who are suffering a stroke by the proportion of patients who receive a diagnostic bundle that is shown to improve outcomes for patients who are suffering a stroke. The diagnostic bundle includes completing a full face, arm and

speech test, testing the patient's blood pressure, testing the patient's blood glucose and recording the time that stroke symptoms started. The most common area of non-compliance is measurement/documentation of blood glucose. The Trust also record the call to door time for patients presenting with a stroke, this is compared as the mean, median and the 90th centile against other Trusts. Trust performance in these measures is shown in below.

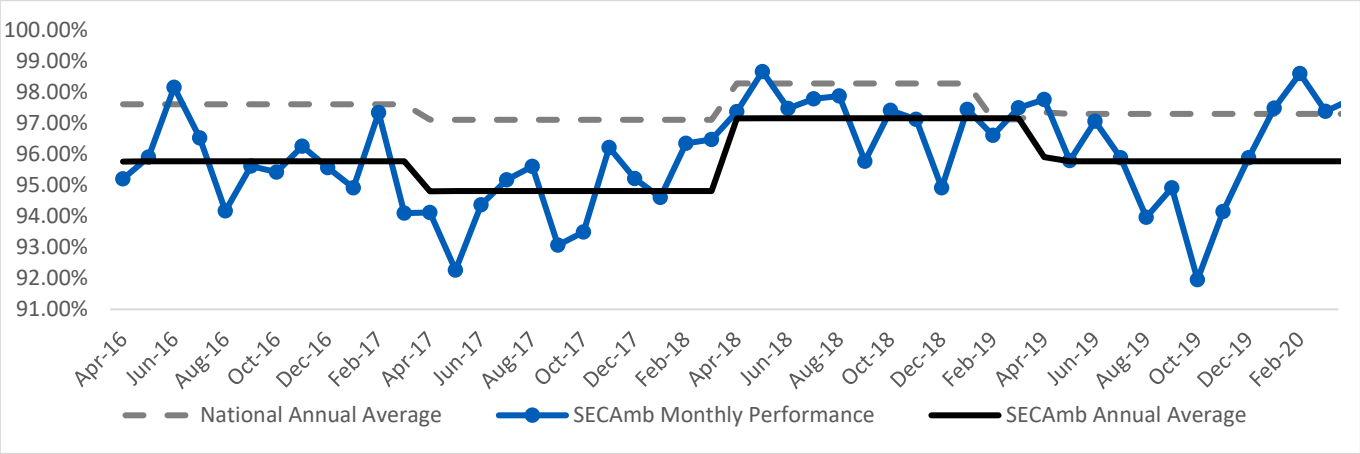

Figure 4 - Proportion of Suspected Stroke Patients Receiving Full Diagnostic Bundle

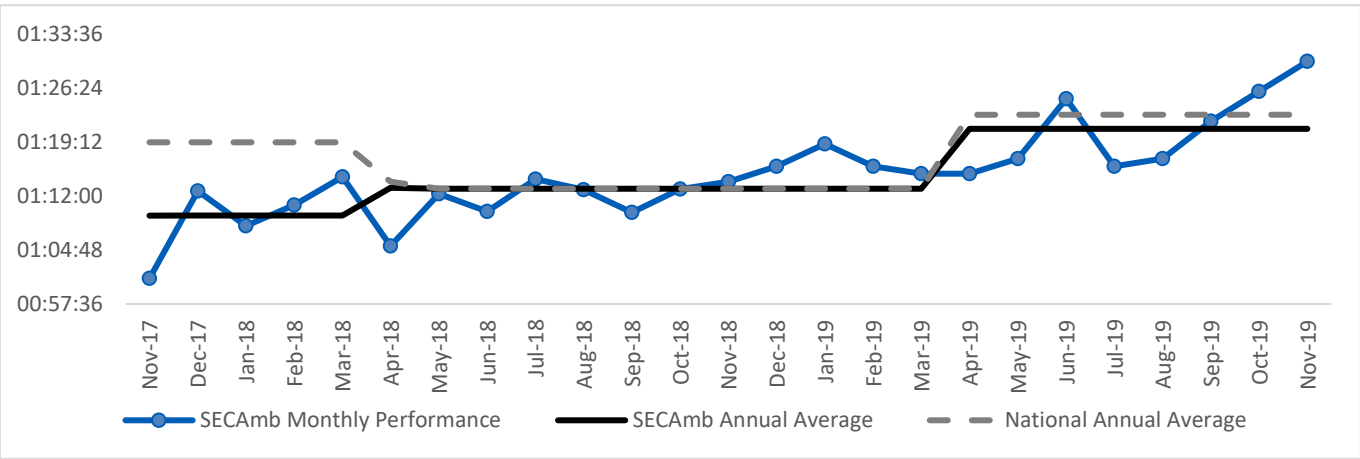

Figure 5 - Mean Call to Door Time for Confirmed Stroke

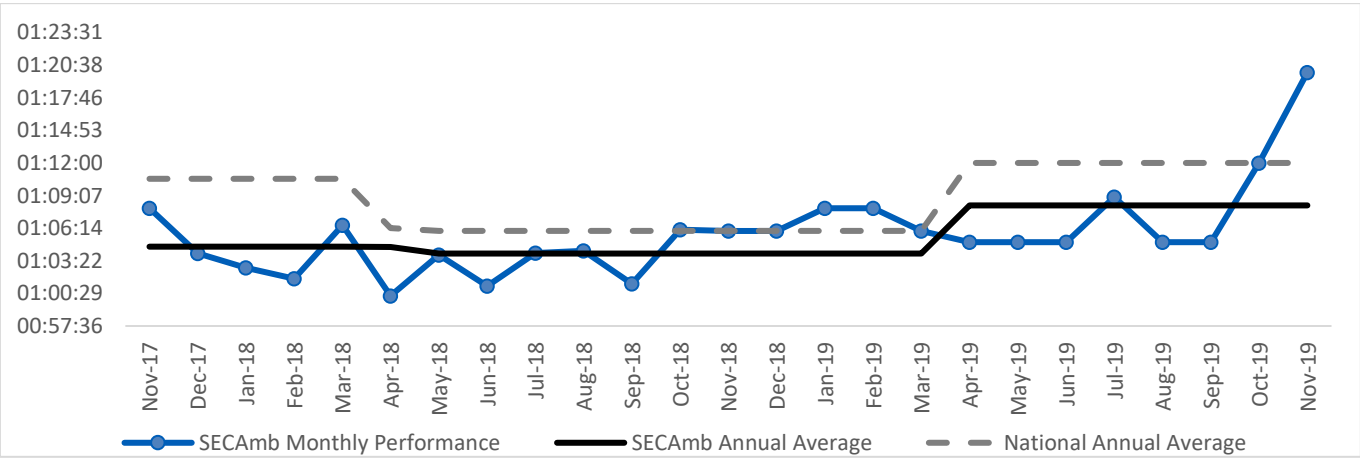

Figure 6 - Median Call to Door Time for Confirmed Stroke

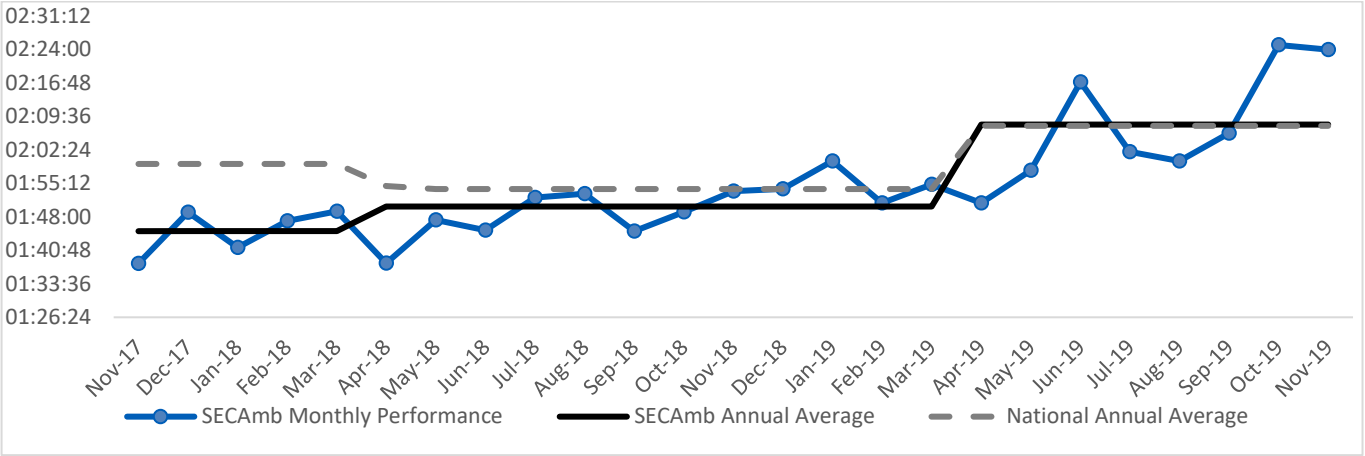

Figure 7 - 90th Centile Call to Door Time for Confirmed Stroke

In the first half of 2019/20 the Trust saw a reduction in compliance against the stroke diagnostic budle. This wasn't due to a degradation in care, but a degradation in documentation as ePCR was introduced. The clinical audit team recognised this trend and recommended the change to the system implemented in October 2019, which improved documentation to levels above the Trust and the national average.

In November 2017 the method for measuring the timeliness of care delivered to stroke patients changed nationally to a measure of mean, median and 90th centile call to arrival at a hyper-acute stroke centre. The latest available data is from November 2019. NHS England paused this data collection due to the COVID-19 pandemic. The Trust has seen a general increase in the call to door time for suspected stroke. In 2020/21 these measures will be split into the time to respond to suspected stroke and the time on scene with suspected stroke patients to identify the appropriate improvement opportunities.

The Trust undertook various actions in 2019/20 to improve outcomes for patients suffering a stroke, these included:

- Communications to clinical staff to stress the importance of and the evidence base for completion of the stroke care bundle.
- Improved design of paper and electronic records to improve documentation of essential care elements.
- A programme of work to improve ambulance response times aims to improve the timeliness of arrival at definitive care for patients who are suffering a stroke.
- A programme of work to promote good record keeping is expected to improve evidence of high quality care in this area.
- Improving the feedback of clinical audit results to local leadership teams and in turn improving the feedback to individual clinicians.

Sepsis

The Trust aims to identify and meaure its performance in 100% of the sepsis cases that it attends. The Trust measures the quality of care provided to patients who are diagnosed with sepsis by the

proportion of patients who receive the Sepsis Care Bundle. This includes patients with an infection with a NEWS (National Early Warning Score) of 7 or above. The patient must have a respiratory rate, level of consciousness, blood pressure and oxygen saturations documented. High flow oxygen and fluids must be administered where appropriate, and a hopsital pre alert call must be placed. The most common area of non-compliance is failure to make/document a pre-alert call. Trust performance in this measures is shown below.

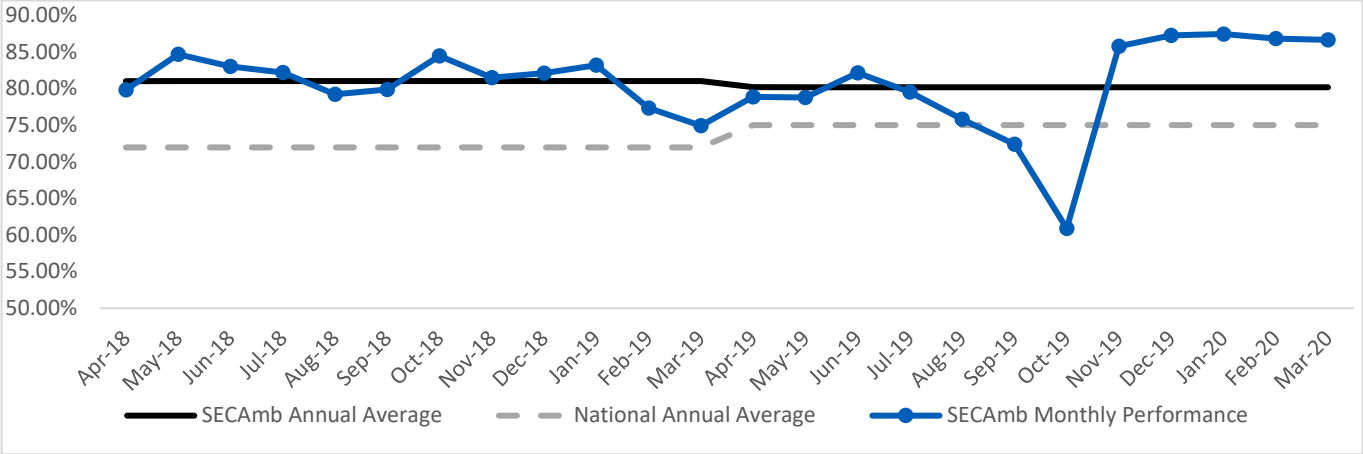

Figure 8 - Proportion of Suspected Sepsis Patients Receiving Full Care Bundle

The Trust undertook various actions in 2018/19 to improve outcomes for patients presenting with Sepsis, these included:

- Communications to clinical staff to stress the importance of and the evidence base for completion of the sepsis care bundle.
- Improved design of paper and electronic records to improve documentation of essential care elements.
- A programme of work to promote good record keeping is expected to improve evidence of high-quality care in this area.
- Addition of NEWS2 to the Trust's minimum data set.

Level 2 Audit Reports

Administration of Salbutamol

A retrospective audit of 119 incidents where Salbutamol had been administered by non-registered clinicians, between the dates of 1st April 2019 and 30th April 2019. This audit looked at the administration of salbutamol as per JRCALC guidance. This audit examined whether the medication was given in accordance to the guidance, and that the administration was adequately documented.

Observations:

- There was a high level of compliance with the indications for administering this medicine.
- Documentation of consent of the patient or their representative to administer the medication was poor.
- Administration of the correct initial dosage was not always in line with guidelines. (Some patients received a lower dose than required.)
- Some patients with COPD received nebulisation for longer than the recommended 6-minute timeframe.

As a result of this audit:

- Re-audit planned in 2020/21
- A clinical instruction was circulated reminding colleagues of the need to document consent and administer nebulisation in line with clinical guidelines.

Safety of Discharge

A retrospective audit of all 341 incidents where patients were discharged on scene by a non-registered clinician or newly qualified paramedic. This audit examined whether a conversation was held with a senior clinician before discharge (shared discharge) and whether the patient received a full set of clinical observations.

Observations:

- The audit identified that shared decision making only took place for 53% of discharges, this represents a clinical risk.
- There were high-levels of compliance with recording a full set of observations.

As a result of this audit:

- Content on the importance of shared decision making was included in the Trust's 2020/21 key skills programme.
- Amendments to the Trust's Scope of Practice and Clinical Standards Policy have been recommended.
- Changes to ePCR to better record shared decision making have been made.

Administration of Tranexamic Acid

A retrospective clinical audit was undertaken where 99 cases where Tranexamic Acid (TXA) administered between 1st January and 8th May 2019 were examined. The audit examined whether the administration was safe and in line with the patient group direction (PGD).

Observations:

- A high proportion of patients 28% received the drug for presentations that are not in-line with the PGD guidance.
- A high level of compliance was noted with documenting drug dosage, route and time of administration.
- Poor compliance with documentation of consent, allergy status, batch number and expiry date were noted.

As a result of this audit:

- The Medicines Governance Group agreed to produce a publication relating to the rationale behind changes to the TXA PGD.
- The Trust introduced specific fields for consent, catch number and expiry date on its clinical records.
- Changes were made to ePCR to display drug dose and concentration when selecting the drug.

Supply of Codeine

A retrospective audit of 45 incidents between 1st October 2019 and 31st January 2020 where codeine was supplied by a paramedic practitioner. The audit examined whether supply of codeine was safe and in line with the PGD for the medication.

Observations:

- High levels of compliance with documentation of the clinician's ID number, grade, indication for administration, allergy status and time of administration were noted.
- Improvement is required in the documentation of consent, duration and frequency of medication, batch number and expiry date.

As a result of this audit:

- Communications regarding the importance of documenting consent were planned.
- A re-audit has been planned.
- A request has been made to make batch number and expiry date of ePCR a mandatory field.

Assessment and Management of Pain

A retrospective audit of 383 incidents where the patient had a pain score of 1-10. This audit examined whether patients receive appropriate analgesia, that analgesia is administered in line with guidance and that assessment and treatment is documented adequately.

Observations:

- Only 52.5% of patients recorded as being in pain were documented to have been offered analgesia.
- Only 86% of patients who received analgesia had a second pain score recorded.

As a result of this audit:

- The Trust is considering expanding its drug formulary to include Penthrox and Codeine for all registered clinicians.
- Communication of the importance of effective documentation is planned.
- Changes to ePCR to prompt secondary pain scores and documentation of analgesia offered are being explored.

Supply of COPD Medications

A retrospective audit dated between 1st April and 30th April 2019, examining the care of patients who received a course of CPD medication. A sample of 12 cases were reviewed to determine whether care was safe and in line with the associated PGD.

Observations:

- High levels of compliance were noted with standards to document clinician grade, indication, allergy status, route and frequency were noted.
- Improved compliance is required with standards to document worsening care advice, safety netting, duration of medication course, time of supply, dosage, consent, batch number and expiry date.

As a result of this audit:

- A communication has been sent to all paramedic practitioners offering praise for the areas of high compliance.
- A re-audit has been planned for 2020/21.

Assessment and Management of Head Injured Patients on Anti-Coagulants

A retrospective audit dated between 1st March and 31st May 2019 examining any incident where the patient was documented to have suffered a head injury and was taking anticoagulant therapy. 185 incidents were examined to determine whether the assessment and management of these patients was safe and effective.

Observations:

- There were high levels of compliance with the documentation of levels of consciousness and the appropriate management of patients who presented with features described in NICE as requiring assessment in the emergency department.
- There were lower levels of compliance with the documentation of patient's medication history and completion of a full set of clinical observations.

As a result of this audit:

- The Trust has issued guidance on the importance of documenting a full set of clinical observations.

Assessment and Management of Patient's Sectioned Under the Mental Health Act

A retrospective audit of 187 incidents between 1st January and 30th May 2019 where the patient was sectioned under the mental health act. This audit examined whether the patient was adequately assessed and whether the clinician treated the patient appropriately based on those observations.

Observations:

- This audit showed very low levels of compliance with the documentation of a full set of observations (31%).
- The patient was treated appropriately in 100% of cases based on those observations.

As a result of this audit:

- The Trust plans to build findings into a case study for clinicians.
- The Trust plans to produce a podcast for clinicians.

Assessment and Management of Croup

A retrospective audit dated between 1st December 2018 and 31st March 2019 was undertaken, examining 240 incidents where the patient was suspected to have croup. The audit examined whether the patient was adequately assessed and whether the correct treatment was given.

Observations:

- There were high levels of compliance with the appropriate conveyance or referral of patients in the sample.
- 37% of eligible patients received dexamethasone.

As a result of this audit:

- A podcast for clinicians has been planned.
- A re-audit in 2020/21 is planned.

Assessment and Management of Acute Behavioural Disturbance

A retrospective audit dated 1st January 2019 to 1st January 2020 was undertaken. After extensive review, two patients with suspected acute behavioural disturbance (ABD) were identified. The audit examined whether the patients were adequately assessed.

Observations:

- Many patients were coded as having ABD, when in fact their presentation was more typical of other acute mental health presentations.
- Both patients were adequately assessed.

As a result of this audit:

- A mandatory learning module on ABD has been added to the Trust's Key Skills programme.

- A re-audit of ABD has been planned.

Supply of Anti-Microbial Medications

A retrospective audit of 58 incidents dated 1st January 2019 to 30th April 2019. The audit examined whether the medication had been supplied within the indications of the PGD and whether the supply of the medication was adequately documented.

Observations:

- High compliance with standards for administration be correct grade, indication for administration, correct dosage, correct route, and frequency of administration was noted.

As a result of this audit:

- Education as part of the Trust's Key Skills programme around appropriate airway management is planned.

Health Records

The Trust's Health Records Team saw a drastic transformation in 2019/20. In the previous year, we set out a plan to introduce a new patient record validation and clinical audit system (Doc-Works) and electronic patient clinical record (ePCR) solution. Both systems had a great impact on the way that the Health Records team works and the outputs of this team.

Reconciliation of health records with CAD (computer aided dispatch) incidents improved from around 85 to 89% in 2018/19 and improved further to 98% in 2019/20. These changes were enabled by the CAD matching process that Doc-Works facilitates and the automatic 'CAD push' of incident details to clinician's iPads with ePCR.

In 202021 the Trust will continue to monitor these processes and redistribute the capacity that has been released within the Health Records team following the introduction of ePCR.

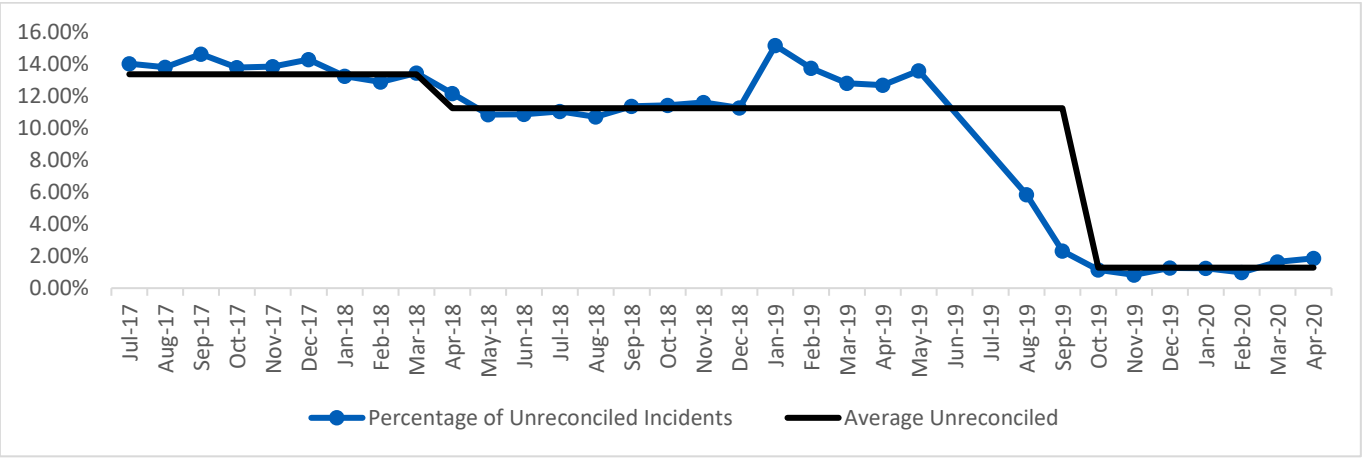

Figure 9 - Proportion of Incidents Without Associated Clinical Record

Next Steps

The Clinical Audit Team have set a vision for what they would like to achieve through the work that they lead:

> "Saving lives and facilitating the best care, by sharing knowledge and experience from across the Trust."

This vision drives our mission:

> "With our fingers on the pulse of the Trust, we promote learning by sharing knowledge, experience and evidence with staff and our public; so that we can deliver the best care and save more lives."

The vision and mission statements will drive the Clinical Audit agenda; help us to make decisions on the direction of work and remind us of the purpose and gains of clinical audit.

The Clinical Audit Team hold data and insight on all that our Trust does well, the quality challenges and the opportunities for improvement. In 2020/21 the department will continue to build upon this insight, deepen the understanding of key areas of care, and ensure the sharing of knowledge and experience across the Trust for the benefit of those who access our services.

The most transformative change in 2020/21 will be the clinical audit function's use of technology to share information for improvement.

2020/21 Clinical Audit Programme

In 2001, the US Institute of Medicine set out six domains that contribute towards creating high quality care. These domains have been adopted by health and social care organisations across the world as a framework to understand quality measures and to drive quality improvement.

These are the six domains that the Clinical Audit Team have been guided by in the development of the Trusts 2019/20 Clinical Audit Programme. An organisation that excels in each of these domains will provide care that is safer, more reliable, more responsive, more integrated, and available when required.

In order to develop the 2020/21 Clinical Audit Programme, the knowledge and insights held by the Trusts other clinical governance teams has been embraced. In quarter four of 2019/20 these teams were engaged with to collect, triangulate, assess and prioritise the topics to be used in the development of the new annual programme.

This process involved the use of a data collection form, with an integrated scoring system that enabled the prioritisation of audit topics. Data in the form was also cross-referenced with identifiers from the Trust's clinical incident reporting and risk management system to evidence the requirement for each audit topic. A thematic analysis of incidents in 2019/20 that have caused severe or moderate harm to patients was also conducted and these themes were developed into audit topics and added to the data collection form.

Each audit topic has been classified into one of three levels, as per national guidance:

- Level 1, external 'must-do' audits, are required by external agencies. They may form part of the Trusts contractual arrangements with NHS England, commissioners or other external party.
- Level 2, internal 'must-do' audits, seek to examine and improve the greatest organisational risks. These risks might have emerged through incidents, near misses or evidence of poor quality. Some of the Level 2 audits will involve continuous measurement in order to provide continuous assurance and improvement.

- Level 3, best practice or local interest audits, seek to examine and improve organisational issues that are low risk. Scoring indicates that these topics are a lower priority. The Trust must focus resource on Level 1 and 2 audits. Level 3 audits will be completed if there is a voluntary offer of resource or if the Clinical Audit Team has spare resource during the programme.

Please refer to the SECAmb 2020/21 Clinical Audit Programme for more information.

Appendix A – Abbreviations & Glossary

ACQI	Ambulance Clinical Quality Indicator	A national measure of quality for ambulance services.
AED	Automated External Defibrillator	A portable electronic device that diagnoses life-threatening cardiac arrhythmias and is able to treat them through defibrillation
CAD	Computer Aided Dispatch	A method of dispatching resources aided by a computer tool
CAP	Clinical Audit Programme	The programme of clinical audits carried out in the Trust.
CAQSG	Clinical Audit and Quality Sub Group	The Trusts clinical audit review group
CCP	Critical Care Paramedic	A paramedic with advanced training to care for patients with severe illness or injury.
COI	Clinical Outcome Indicator	A national measure of patient outcomes for ambulance services.
CPD	Continuing Professional Development	A process of tracking/documenting skills/knowledge and experience beyond initial training
CPI	Clinical Performance Indicator	A quality measure for a particular condition/treatment.
CPR	Cardiopulmonary Resuscitation	A treatment to maintain circulation for patients in cardiac arrest.
CQC	Care Quality Commission	The regulator for health and social care organisations.
EOC	Emergency Operations Centre	Where 999 calls are answered and a response is organised.
EMS	Emergency Medical Services	The treatment/transport of people in crisis health situations
ETT	Endotracheal Tube	A tube inserted into the patient's airway to manage breathing.
ePCR	Electronic Patient Care Record	An electronic record of the care delivered to a patient.
FAST	Face, Arm and Speech Test	A test used to identify stroke.
GP	General Practitioner	A family doctor in the community.
GTN	Glyceryl Trinitrate	A medication to reduce strain on the heart and improve blood supply to heart muscle.
HCP	Healthcare Professional	A person working in a clinical profession
JRCALC	Joint Royal College Ambulance Liaison Committee	Consensus group that sets ambulance clinical guidelines.
KLOE	Key Lines of Enquiry	Standards of inspection undertaken by the Care Quality Commission
MINAP	Myocardial Infarction National Audit Programme	National audit of care for patients suffering a heart attack.
IPAP	Intent, Plan, Action, Protection	A risk assessment tool for patients with thoughts of self-harm.
MARS	Medication Administration Record Sheet	A record of medications administered to a patient.
NEWS	National Early Warning Score	A system used to score severity of a patient's illness.

NICE	National Institute for Care Excellence	National organisation that sets the standards for care.
OHCAO	Out of Hospital Cardiac Arrest Outcomes	A national registry of all out of hospital cardiac arrests.
PGD	Patient Group Direction	An instruction that allows clinicians to administer medication without the authorisation of a prescriber.
PCR	Patient Clinical Record	The written record of the care delivered to a patient.
QI	Quality Improvement	A systematic approach using specific techniques to improve quality
ROSC	Return of Spontaneous Circulation	Return of a pulse after cardiac arrest.
SAD	Supraglottic Airway Device	A device that sits at the top of a patient's airway to manage breathing.
SECAmb	South East Coast Ambulance Service	The Trust.
SI	Serious Incident	An incident that has caused moderate or severe harm to a patient.
STEMI	ST Elevation Myocardial Infarction	A certain type of heart attack

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	28-20

Name of meeting	Trust Board
Date	30 July 2020
Name of paper	Annual Clinical Audit Report
Responsible Executive	Dr Fionna Moore – Executive Medical Director
Author	Dean Rigg – Head of Clinical Audit
Synopsis	This report presents an overview of Clinical Audit activities within the Trust between 01 April 2019 and 31 March 2020. It provides the Trust Board with an overview of the safety and effectiveness of clinical care.
Recommendations, decisions or actions sought	The Trust Board is asked to note this report

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
NHS Foundation Trust

Agenda No	29-20

Name of meeting	Trust Board
Date	30.07.2020
Name of paper	Learning from Deaths Report – Quarter 4 2019/2020
Responsible Executive	Dr Fionna Moore
Author	Dr Richard Quirk, Deputy Medical Director
Synopsis	A review of 20 randomly selected deaths in January 2020 was undertaken using the Structured Judgemental Review. A report was presented to Trust Board, explaining that the February and March reviews were not able to be undertaken due to Covid-19 pandemic use of resources. This further report completes the work from Quarter 4 2019/20 and is presented to the Board with additional information from February and March 2020, together with a further analysis of the results of the Structured Judgemental Reviews of Deaths. Good care or better was identified in the majority of the reviews. Additional training for staff on DNACPRs, Respect forms and Lasting Power of Attorney scenarios would be useful. Clearer guidance on the use of the term expected and unexpected deaths may result in a reduction in the inappropriate use of Police resources and reduce on scene time waiting for Police.
Recommendations, decisions or actions sought	The Trust Board is asked to receive assurance that the Trust is complying with our duty to undertake random reviews of the care that patients receive and that the Trust will identify ways to improve care in the future.

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**

Learning from Deaths Report – Quarter 4 – 2019/20

1.0 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 (the care of the carers/relatives). This review of care should then improve future care. If carers, relatives, staff or other organisations raise concerns to Secamb, about the care of a patient at the time of their death, they will be fully involved in any review of the death.

1.2 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, is presented to the July 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 of 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).

2.0 Overview of Quarter 4 (19/20) mortality data

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

Table 1

Month (2020)	Female Deaths	Male Deaths	Unknown Sex	Total Deaths
January	277	377	7	661
February	265	369	4	638
March	285	413	9	707

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

Table 2

Age Range (Yrs)	No. of patients who died – January 2020	No. of patients who died – February 2020	No. of patients who died – March 2020
Under 1 year	3	2	2
1-2			
2-3			1
3-4			
4-5			1
5-6			1
6-7			
7-8		2	1
8-9	1		
9-10			
10-11			
11-12			
12-13	1		
13-14			
14-15	2		
15-16		1	
16-17	2	1	
17-18	1	1	
18 – 29	13	14	12
30 – 39	19	14	24
40 – 49	27	25	32
50 – 59	58	70	67
60 – 69	103	89	106
70 - 79	138	137	162
80 – 89	156	162	188
90 – 99	91	109	97
100+	15	5	10
Age unknown	31	6	3

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

Table 3

Care Plan in place	No. of patients who died – Jan 2020	(%)	No. of patients who died – Feb 2020	(%)	No. of patients who died – Mar 2020	(%)
Advance Care Plan	2	0.3	3	0.4	0	0
Professional Decision not to Resuscitate	24	3.6	14	2.2	33	4.7
Do Not Attempt CPR order in place	120	18	117	18.5	150	21.2
Resuscitation attempted	235	35.6	218	34.3	193	27.3
Dead on arrival	279	42.2	282	44.5	332	46.9

2.4 Table 4 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:-

Table 4

Categorisation of Call	No. of patients who have died – Jan 2020	(%) (aprox.)	No. of patients who have died – Feb 2020	(%) (aprox.)	No. of patients who have died – Mar 2020	(%) (aprox.)
Arrest/Peri-arrest	405	63	396	65.6	451	68.3
Unconscious – noisy breathing	91	14	80	13.2	102	15.5
Unconscious – normal breathing	28	4	32	5.3	23	3.5
Breathing Problems	25	4	23	3.8	19	2.9
Medical Condition	15	2	19	3.1	16	2.4
Concern for welfare	14	2	11	1.8	16	2.4
NHS 111 referral	12	2	18	3	11	1.7
Stroke	11	2	8	1.3	6	0.9
Fitting	7	~	-	-	-	-
Heath Care Professional Call	7	~	-	-	9	1.4
Hanging/Suicide	7	~	5	~	2	~
Chest/Upper Back Pain	6	~	9	~	5	~
Death Expected –	4	~	2	~	9	~

over 18						
Collapse/Breathing Normal	3	~	1	~	3	~
Bleeding	2	~	-	-	-	-
Choking	1	~	-	-	1	~
Drowning	0		1	~	2	~

3.0 Review process

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

3.2 The 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 Executive Medical Director, Deputy Medical Director and Assistant Medical Director (Critical Care) undertook the reviews.

3.3 Table 5 shows the outcomes of the Structured Judgemental Reviews of the 60 randomly selected deaths in Quarter 4 19/20.

Table 5

	Excellent Care	**Good Care**	**Adequate Care**	**Poor Care**	**Very Poor Care**	**N/A**
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	31 (52%)	16 (27%)	6 (10%)	7 (12%)	0	-
On scene handling (Care)	42 (70%)	16 (27%)	2 (3%)	0	0	-
Transfer and Handover (Including discharge and worsening care advice)	14 (23%)	11 (18%)	1	0	0	34 (57%)
Other Aspects of Care (quality	18 (30%)	33 (55%)	5 (8%)	4 (7%)	0	-

and legibility of records)						
Overall Assessment of Care	17 (28%)	40 (67%)	3 (5%)	0	0	-

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

3.4.1 Initial Management

In the few cases where care was seen to be 'adequate' or 'poor', there was a delay in reaching the scene. The majority of calls are classed as Category 1 and should receive a response within 7 minutes. The delay was due to a range of reasons including road closures, diverts, long journey time for the nearest resource, rural locations and travelling in rush hour. The reviews did not identify any harm or a poorer outcome for these patients due to the delay.

3.4.2 On Scene Handling

The care of a patient who had fallen over before death was reviewed and found that the patient had been on a 'blood thinner' medication. There is a risk that those people on blood thinners who hit their head can have a bleed in the brain and so crews should consider conveying patients. In this case, the crew advised admission but the patient declined admission to hospital and subsequently died. The care was good but the crew were non-registered clinicians and should have had a discussion with a senior clinician when they identified that the patient was declining admission.

3.4.3 Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying. There were no identified concerns in the reviews.

3.4.4 Other aspects of care (including documentation)

The most common issue identified during the reviews was the inadequate documentation about how decisions were reached during and after resuscitation attempts. Whilst no harm or serious concerns have been identified, some records are challenging to identify the rationale for a crew ceasing the resuscitation attempt.

3.4.5 Overall Care

One review identified that there was a 13 minute response to a Category 1 patient who was in cardiac arrest. When the crew arrived there, the patient was in Ventricular Fibrillation

(VF) which is a heart rhythm which can be shocked with a defibrillator. The patient subsequently died. There is a small possibility, that if the crew had arrived earlier, the shock could have been given earlier and the patient's chance of survival may have been better.

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

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

Table 6

	No of reviews
Definitely Avoidable	0
Strong possibility of avoidability	0
Probably avoidable (more than 50:50)	0
Probably avoidable but not very likely (less than 50:50)	5
Slight evidence of avoidability	0
Definitely not avoidable	55

In the 5 reviews were the panel judged the death to be 'probably avoidable but not very likely (less than 15:50)' – 1 of the cases is referred to in 3.4.5 above and the other 4 cases identified that if the patients/carers had called 999 sooner, there may have been a possibility of early bystander CPR and/or a faster ambulance response. There is little that Secamb could have done to improve the care in those 4 cases.

4.0 Two cases reviewed following concerns

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

4.2 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.

4.3 The second case was an 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.

5.0 Learning from the random review of 60 deaths

5.1 In the majority of the 60 reviews undertaken, 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.

5.2 In a small number of reviews there was a delay in attending the patient. In one of the cases reviewed, the delay may have had an impact on the outcome for the patient as the patient was in VF arrest and could have received a defibrillation shock earlier. It has been assessed that there is only a very small chance that this would have changed the outcome for the patient.

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

5.4 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.

5.5 For those patients where the crew decided not to attempt resuscitation, but there was no advance care plan or DNACPR, there is a need to have clearer guidance on how and when crews can make these decisions. This is not because the crews are currently making the wrong decisions, but more to protect staff, should their decision get challenged at a later time.

5.6 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.

5.7 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.

5.8 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.

5.9 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 whilst waiting for the Police to arrive. It is not clear why the term 'unexpected' death has been used in a number of the cases reviewed.

6.0 Conclusion

The panel have not identified any deaths where Secamb have caused harm or contributed to the death. The panel have identified many examples of very good compassionate care.

7.0 Actions resulting from the review of deaths from Quarter 4 19/20

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

COMPLETE (Webinar to all staff completed)

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

PARTIALLY COMPLETE (Discussion with coroner (Kent) about flow charts and contact made with Police to review processes). Other work on going.

7.3 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.

WORK ONGOING – Timescales TBA – LfD workplan 2020/21

7.4 Reminder to crews to clearly document their rationale for ceasing resuscitation.

WORK ONGOING – Timescales TBA – LfD workplan 2020/21

Dr Richard Quirk
Deputy Medical Director
July 2020

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South East Coast Ambulance Service
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Community Resilience Strategy 2020-2024

Contents

Introduction from the Chief Executive

I am very pleased to introduce this strategy, which covers the work of our volunteer Community First Responders (CFRs) who play such a key role within SECAmb.

The commitment that our volunteers make to the Trust is something that I am personally very proud of. They make a very real difference to the service we provide to our local communities and to our patients on a daily basis.

Evidence from countries such as Sweden and Denmark demonstrate that, by providing communities with the right skills and equipment, we can improve the health outcomes for many more people. Our CFRs are uniquely placed within their communities to do this and have an excellent opportunity to offer life-saving interventions and appropriate care in a timely way.

As a Trust, we are keen to build on the excellent work already underway. This strategy sets out how we will go about delivering this, through initiatives which will ensure that our communities (in particular our rural communities) are better served and, equally, by ensuring that our dedicated teams of volunteers are well supported in the important work that they do for us.

This is an exciting time to be launching a new strategy. We are seeing the introduction of innovation and new technology in this area, such as the GoodSAM app and the National Defibrillator Network, which will allow our volunteers to make an even greater contribution to the lives of many people within our region.

I would like to thank everyone who has contributed to the development of this strategy and to everyone who will be involved in its implementation.

Philip Astle
Chief Executive Officer

Introduction

South East Coast Ambulance Service (SECAmb) NHS Trust serves the communities and individuals within the geographical area of South East England, providing pre-hospital health and care in conjunction with partner agencies and organisations.

The development of community resilience is both a national and local priority requiring significant engagement between statutory, non-statutory, professional and voluntary partners.

This strategy should be read in conjunction with the SECAmb Trust Strategy, and with reference to other reference material published by governmental agencies and expert advisory groups. A reference list for such documents is available in Appendix A. It is recognised that this strategy will not cover all aspects of community resilience, as it requires a multi-agency approach, where other partner agencies will take the lead in specific areas – this strategy will address those in which SECAmb has a lead role.

What is Community Resilience?

Community Resilience is the ability of a community to retain basic function and structure in the face of disruption or disturbance, including a focus on growing the capacity to 'bounce back' after such incidents or episodes. Most commonly used descriptions and definitions of community resilience include the observation that this '…is enabled when the public are empowered to harness local resources and expertise to help themselves and their communities.[1] It is also recognised that every community is different and therefore approaches to local resilience must be specific and nuanced to the particular needs of that population, each with its own unique capabilities and challenges.

There is widespread recognition that communities have a vital role in improving health and wellbeing through the mobilising of the multitude of community assets such as skills and knowledge.

The mobilisation of volunteers is a key component of community resilience. Volunteering

[1] HM Government Cabinet Office, 2019. 'Community Resilience Development Framework.' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/828813/20190902-Community_Resilience_Development_Framework_Final.pdf >

programmes strengthen the reach, accessibility and responsiveness of health services, improving patient experience and outcome.[2] In addition, volunteering is proven to be beneficial for health and wellbeing, reducing social isolation and loneliness. Communities have great insight on what is needed from health services, and on what works in improving health. As such, volunteers do not only bring practical skills – collectively they offer a valuable and diverse perspective on community issues which can benefit service design and improvement. The NHS Long Term Plan highlights the benefits that volunteers bring to staff and patients and recommends that Trusts continue to grow and develop volunteer programmes.[3]

This Community Resilience Strategy sets out an ambitious agenda to improve the accessibility, responsiveness and quality of SECAmb's service through a truly community focussed approach that meets the needs of everyone we serve.

Context

The Community Resilience Strategy is aligned with the four themes of SECAmb's Five Year Strategic Plan:

- **Our People** – Most of our people live in the communities we serve. By engaging better with our communities, including under-represented groups, we will be able to recruit staff and volunteers from a more diverse background and build a workforce that is representative of the whole community.

- **Our Patients** – By engaging with communities, and working with them to build community resilience, we will make them better prepared for emergencies. More people will have the confidence to act in a crisis and be able to provide lifesaving first aid before an ambulance arrives. Additionally, by continuing to develop our Community First Responder schemes we will provide a better response to patients experiencing both life-threatening and less serious emergencies, improving patient experience and outcome.

- **Our Enablers** – Our volunteers are enablers for the Trust. They offer us increased capability to reach patients in a timely manner, as well as a diverse range of skills and experience and a knowledge of their communities. Our strategy will include the introduction of an operational model for Community First Responders, to ensure that we better cater for the needs of our communities.

- **Our Partners** – We will work with our partners in the NHS and outside of it to develop Community Resilience. We will explore opportunities for joint working and continue to develop existing Co-Responder partnerships. We will engage with Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) to embrace system wide community programmes.

[2] David Boyle, Tessa Crilly, Prof Becky Malby, 2017. 'Can volunteering help create better health and care.'. The Helpforce Fund. <https://helpforce.community/wp-content/uploads/Helpforce-Can-volunteering-help-create-better-health-and-care.pdf>
[3] National Health Service, 2019. 'The NHS Long Term Plan.'. <www.longtermplan.nhs.uk>

Benefits of a strong approach to community resilience

A sustainable, strong and well embedded approach to community resilience will provide the following benefits to:

Our patients, by:

- Improving bystander intervention
- Providing a quicker response to critical patients
- Improving patient outcome and experience

For members of the community, by:

- Improving community understanding of the ambulance service
- Improving the visibility and approachability of the ambulance service

The Trust, by:

- Improving understanding of patient need, through closer working with the community
- Improving availability of resources to respond to patients, through an enhanced community capability
- Being visible and approachable within the community
- Reducing response time to critical patients

For volunteers, by:

- Acknowledging their motivation
- Empowering them to support their communities
- Providing them with the skills and equipment they need to carry out their role effectively
- Formalising the role of volunteers within the community
- Improving volunteer wellbeing and social interaction[4]

[4] Rachel Casiday, 2008. 'Volunteering and health: what impact does it really have?' University of Wales Lampeter. <www.scribd.com/document/352350841/Volunteering-and-Health-What-impact-does-it-really-have>

How will we build Community Resilience?

The three stages of community resilience

The Community Resilience Strategy aims to strengthen and complement healthcare provision across SECAmb. It focusses on 3 stages – aligned to the government's Community Resilience Development Framework; **Prepare**, **Respond** **and** **Recover**.

Prepare

We will give people the skills they need to act in an emergency

Every year, 30,000 people in the UK suffer an Out of Hospital Cardiac Arrest, yet just 1 in 20 of these patients survive to go home.[5] When someone has a cardiac arrest, every minute that passes without effective treatment reduces the chance of survival by 10%. The current ambulance response time target for patients in cardiac arrest is 7 minutes,[6] although this can vary depending on demand, availability of resources and geography, with rural areas particularly likely to experience longer waits.[7] For this reason, **early intervention by the community is essential**. The Chain of Survival (pictured below) describes the lifesaving actions that help to promote recovery in cardiac arrest.

Source: Resuscitation Council (UK)

The first three of these actions (early recognition, early cardiopulmonary resuscitation (CPR) and early defibrillation) are simple and can be performed by almost any member of the public. Despite this, just 5% of the UK population feel confident to act in an emergency.[8] Consequently, the UK's survival rate for out of hospital cardiac arrest is considerably poorer than other developed countries.[9]

[5] British Heart Foundation, 2019. 'Facts and Figures.' <https://www.bhf.org.uk/for-professionals/press-centre/facts-and-figures>
[6] NHS England, 2017. 'Ambulance Response Programme.' <https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/>
[7] British Broadcasting Corporation, 2018. 'Critically injured? The longest waits for 999 help. <https://www.bbc.co.uk/news/health-47362797>
[8] British Red Cross, 2018. 'New research on adults and first aid' <https://www.redcross.org.uk/about-us/news-and-media/media-centre/press-releases/press-release-new-research-on-adults-and-first-aid>
[9] Gavin Perkins, 2015. 'The UK Out of Hospital Cardiac Arrest Outcome Project.' British Medical Journal. < https://bmjopen.bmj.com/content/5/10/e008736.full>

To promote early intervention in an emergency, we will:

- Encourage and support staff and volunteers to engage with their local communities
- Develop a community resilience toolkit that can be utilised by staff and volunteers to teach lifesaving skills
- Improve the accessibility of community education, through proactive engagement with a diverse range of community groups
- Generate community interest in lifesaving skills, through targeted communications campaigns
- Deliver year-round community education, alongside continued participation in the International Restart a Heart Day, doubling the number of people trained annually by 2024.

> *Cardiac arrest is a community issue. It requires the whole community to take responsibility for providing early intervention when someone has a cardiac arrest*
>
> **David Wells, Head of Community Resilience**

We will increase the availability and utilisation of Public Access Defibrillators

The prompt use of Public Access Defibrillators (PADs) is proven to significantly improve survival.[10] A study in 2017 found that bystander use of a Public Access Defibrillator in cardiac arrest increased survival to 32%.[11] However, the utilisation of PADs within Europe is low, with studies suggesting that only 0-4% of out of hospital cardiac arrests are treated with a PAD prior to the arrival of an ambulance.[12]

To improve utilisation of Public Access Defibrillators, we will:

- Work in partnership with the British Heart Foundation to enrol SECAmb in the National Defibrillator Network. This will provide defibrillator owners with a single portal to register their defibrillator and ensure that all known PADs within the region

[10] Resuscitation Academy, 2019. '10 Steps for Improving Survival from Cardiac Arrest.' <https://www.resuscitationacademy.org/ebook/>
[11] Josefine Bækgaard, Søren Viereck, Thea Palsgaard Møller, Freddy Lippert and Fredrik Folke, 2017. 'The effects of public access defibrillation on survival after out-of-hospital cardiac arrest: a systematic review of observational studies.' Circulation. <https://ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.117.029067>
[12] Christopher M. Smith, Sarah Lim Choi Keung, Mohammed Khan, Theodoros Arvanitis, Rachael Fothergill, Christopher Hartley-Sharpe, Mark Wilson, Gavin Perkins, 2017. 'Barriers and facilitators to public access defibrillation in out-of-hospital cardiac arrest: a systematic review.' European Health Journal. Available at <https://academic.oup.com/ehjqcco/article/3/4/264/3977882>

are listed on a national database, with an assigned volunteer guardian to oversee maintenance.
- Work in partnership with the British Heart Foundation to promote the registration of PADs within the community, through community engagement and the media
- Use mapping of PAD locations to identify areas with poor coverage
- Work with colleagues from the Emergency Operations Centre and Medical Directorate to better understand the utilisation and effectiveness of PADs

We will develop a strong, capable and motivated volunteer network that complements and enhances the Trust's existing capability

Our volunteers come from a range of backgrounds and bring with them a wide range of skills and experience. This improves the diversity of our workforce and gives us valuable access to a range of skillsets. Making better use of a volunteer's skills to benefit the Trust and the community makes them feel valued and appreciated and increases their motivation and productivity. If we fully embrace and nurture their passion and willingness to support, our volunteers can deliver excellent outcomes.

> *Volunteers bring two main benefits - true passion driven by personal values and motivations, and local engagement as the volunteers tend to live within the communities they serve, so have a real vested interest in making things better for the populations in which they live.*
>
> **Emma Williams, North East Hampshire and Farnham CCG**

We will grow and develop our volunteer network by:
- Developing a brand toolkit, offering a unique, consistent and highly visible identity for Community Resilience and volunteers
- Using evidence (e.g. demand and performance data) to ensure we recruit volunteers in the areas that need them the most
- Exploring the feasibility of alternative, non-traditional roles that support the Trust's resilience – this may include support to administrative functions, EOC or frontline operations – offering an alternative role for CFRs who are no longer able to volunteer in a frontline capacity, and for members of the community who have a desire to help in a non-clinical role
- Training and empowering senior volunteers to effectively lead teams or projects
- Streamlining the volunteer recruitment process to ensure applicants gain a positive first impression of the Trust

We will support and motivate our volunteers by:

- Developing a volunteer engagement schedule, to provide greater opportunities for face to face conversations between management and volunteers
- Implementing a volunteer representation network, whereby volunteer views and suggestions can be shared with management teams
- Involving volunteers in key departmental projects
- Striving for a 'one team' culture where staff and volunteers feel valued and appreciated
- Offering volunteers development opportunities so that they can gain new skills and experience
- Introducing a new, purpose-built, volunteer platform, to improve efficiency, information sharing and engagement.

We will develop a safe, confident and well-governed volunteer network by:

- Developing a new, externally accredited CFR Education Programme which reflects clinical and educational best practice
- Providing volunteers with regular continued professional development and assessment
- Introducing high-performance CPR to Community First Responders, through enhanced training, simulation, assessment and feedback
- Implementing a robust method for sharing of clinical bulletins and updates
- Reviewing the CFR scope of practice to ensure it meets patient and Trust need
- Standardising the Trust approach to fundraising and corporate identity
- Increasing the number of Community Resilience Leads (volunteer line managers) to improve local knowledge and relations, provide greater accountability and ownership of local community resilience, strengthen volunteer oversight and governance, facilitate regular face to face education and engagement, and allow greater capacity for local and regional projects, partnerships and innovations.

We will engage with all parts of the community to build community resilience

Key to engagement is the growth and diversification of our volunteer network, which will help us to engage with all parts of the community, including under-represented groups. Most volunteers are motivated by the desire to give something back to their community, which in turn improves their morale, motivation and self-esteem.

Increases in demand for health care places considerable pressure on all health care providers, SECAmb being no exception. Pressure at any point in the system can have a knock-on effect on other services. As such, this is not for one single agency to address. An innovative, collaborative approach from all agencies will help to find ways of managing demand and maintaining service delivery in times of pressure.

We will:

- Explore ways for SECAmb volunteers to support wider health promotion initiatives
- Maintain and develop partnerships with other organisations that assist in either the *prepare, response* or *recovery* phase. This includes the continued growth of Co-Responder schemes.

Respond

We will implement an operational model that reflects the needs of the community

The needs of each community are different, and influenced by many factors – including population, infrastructure, demographic and economy. Despite this, Community First Responder schemes within SECAmb currently operate in largely the same way, with little recognition of local need. We will develop and embed an operational model for Community Resilience that complements the wider Trust operational model. A proposed operational model is included below:

	Urban	Semi-Rural	Rural
Demographic	Large towns/cities with an A&E/MRC	Small to medium sized towns	Villages/hamlets
Demand	High	Medium	Low
Average C1 response time	Good	Variable	Poor
	Urban	**Semi-Rural**	**Rural**
Response Type			
PAD sites[13]	✓	✓	✓
GoodSAM[14]			
Community Engagement [15]	✓	✓	✓
CFR team			According to demand
CFR cover	Targeted to peak hours	24/7	According to demand
Community Hub[16]			
Dynamic Response Vehicle[17]	✓	According to hours provided and demand	

Rural areas

These areas have a small population and low demand. In many cases, they are a considerable distance from built up areas and ambulance stations/hospitals, resulting in delayed ambulance responses. CFR schemes will be targeted to rural areas where there is sufficient local demand to ensure regular utilisation and exposure. This may mean that

[13] Public Access Defibrillator site
[14] Smartphone application to deploy trained bystanders to a cardiac arrest
[15] Includes CPR/defibrillator training and health promotion
[16] Drop in centre for community engagement (specified hours only)
[17] Liveried vehicle, to undertake dynamic area cover and falls response.

a rural CFR scheme covers a larger area made up of several villages/towns. CFR teams in rural areas will be empowered and supported to take ownership for improving resilience within their communities – this may include the recruitment of non-clinical volunteers to assist with local engagement.

In some cases, the size of the population may impede the effective recruitment of CFRs. In addition, there may be insufficient demand to expose CFRs to the range of incidents that is necessary to maintain their skillset and engagement. In such areas where the introduction of a CFR scheme is not yet practicable, we will continue to focus our efforts on equipping communities with the skills they need to intervene in an emergency. This may involve working with community groups, parishes or voluntary organisations. The rollout of **PAD sites** and utilisation of **GoodSAM** will be promoted, to ensure that trained and willing members of the public can be deployed to provide basic life support in an emergency.

Semi-rural areas *(e.g. Horsham, East Grinstead, Haywards Heath, Burgess Hill, Lewes, Uckfield, Heathfield, Hailsham, Crowborough, Sussex Downs, Battle, Rye)*

These areas often have a considerable population and demand, as well as a strong community focus. They offer considerable potential to positively impact response times and patient outcome through the development of strong CFR schemes, and as such, will be treated as a high priority for growth, with the aim of achieving 24/7 coverage. CFR schemes may help the ambulance service to re-engage with the community in these areas, by providing a visible and reassuring local presence. Increased visibility will assist with community engagement, fundraising and recruitment of volunteers. A small number of **Community Hubs** will be trialled – whereby volunteers offer drop-in sessions to members of the community, to improve the accessibility, approachability and visibility of our service and overall engagement.

Urban areas *(e.g. Brighton and Hove, Worthing, Chichester, Eastbourne, Hastings, Crawley)*

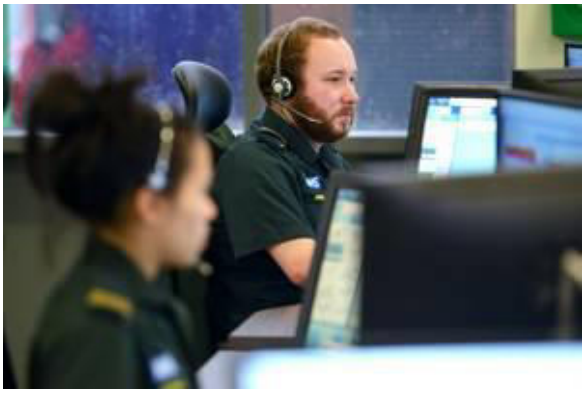
These areas tend to be heavily populated and are often served by an ambulance station/make ready centre. There are usually several vehicles serving these areas due to high demand – these are always prioritised to category one cases. Consequently, immediately life-threatening calls usually receive a prompt response, whilst less urgent calls can sometimes experience longer waits. In these areas, CFR availability will be targeted to peak hours, to assist with high demand. Whilst CFRs will still be used to provide a response to category one calls in their community, **Dynamic Response Vehicles** will allow CFRs to cover a wider area according to local demand and ambulance cover. This will ensure that they can be placed in areas of the highest need. Additionally, these vehicles may be targeted to the most vulnerable lower acuity patients such as elderly fallers, where an early response from a CFR may reduce pain and suffering or prevent exacerbation or complication of their condition.

We will also trial the introduction of **University CFR schemes**, following the success of this initiative elsewhere in the UK.

We will introduce a high performing and resilient method of dispatch

When someone has a life-threatening emergency, every second counts. For community-based resources to make the biggest contribution to patients, they must be dispatched promptly and effectively. We will:

- Introduce clear standard operating procedures for dispatch of community-based resources
- Increase accountability of Emergency Operations Centre staff through the introduction of clear objectives and performance indicators
- Introduce a smartphone-based dispatch tool to all responders, to ensure that community-based resources can be dispatched seamlessly, in the same way as frontline ambulance resources. This will reduce mobilisation and response times, through improved awareness of resources and automatic route calculation
- Expand the use of GoodSAM, to mobilise trained bystanders and off-duty staff/volunteers to patients in cardiac arrest.
- Continuously monitor the contribution of community-based resources, to ensure their effective utilisation.



We will ensure that community-based resources are supported to provide high-quality patient care

Community-based resources usually respond alone and are often required to make critical decisions prior to the arrival of an ambulance. To ensure our volunteers are supported in providing high quality care, we will:

- Ensure that community-based resources can consistently access prompt support from the Emergency Operations Centre
- Improve the accessibility of remote clinical support
- Investigate the feasibility of telemedicine
- Ensure that backup to community-based resources is prioritised

We will better utilise our community-based resources to support vulnerable, low acuity patients

In the last 10 years, the ambulance service has changed significantly to meet the demands of today. Demand has consistently increased year on year, as an ageing population and rates of chronic illness such as COPD, diabetes and heart disease increase. The skillset of clinicians continues to be developed to provide high quality urgent and emergency care that meets patient need, however the primary role and skillset of ambulance service volunteers (such as Community First Responders) has changed somewhat less.

Volunteers have been proven to offer safe and effective care to patients with lower acuity conditions. Elderly, uninjured fallers can experience complications associated with being on the floor, which could be prevented by early intervention from a Community First Responder with appropriate training. Several Ambulance Trusts are already experiencing excellent results from similar initiatives. Community First Responders are well placed to provide early intervention and reassurance to these groups, by reducing distress, preventing avoidable deterioration and promoting recovery.[18] I

In other Trusts, this has proven to improve patient outcome and experience, and reduce pressure on frontline resources who are freed up to respond to higher acuity incidents[19]. As a result, an iterative review and potential enhancement of the CFR scope of practice in line with identified need and capability will be conducted during FY20/21.

In order to better support lower acuity patients, we will:

- Fully review the role and scope of our volunteers to ensure that they meet the needs of now and the future
- Adopt a proactive approach to improving patient experience and outcome, by identifying vulnerable groups
- Trial the deployment of community-based resources as a primary response to elderly fallers, and incidents where there is a concern for welfare

[18] Health Service Journal, 2018. 'Trust pilots a project to empower volunteers to lift non-injury fallers and improve outcomes for older people, resulting in community first responders managing 77 per cent of incidents.'
<https://solutions.hsj.co.uk/story.aspx?storyCode=7019611&preview=1&hash=F405BB74AD2F3852588DC6F5AB575F7A>

[19] Association of Ambulance Chief Executives, 2018. 'Community First Responder Lifting Scheme.'
<https://aace.org.uk/best-practice/swast/>

Recover

The *recover* phase focuses on supporting those affected by emergencies to rebuild their lives or regain confidence. Small acts of kindness following an emergency have been proven to help improve wellbeing, self-confidence and reduce re-attendance.[20] As part of the *recover* phase, we will **review**, **evaluate** and **identify learning**.

Supporting our lifesavers

The psychological and emotional impact of working or volunteering within the emergency services cannot be underestimated. Research by mental health charity Mind found that 91% of ambulance personnel have experienced stress and poor mental health at work – worse than any other emergency service.[21] Volunteers are exposed a wide range of emergency calls, often arriving alone in the first few minutes.

In order to better support our responders, we will:

- Introduce a more consistent and supportive process for debriefing after a difficult incident
- Continue to facilitate regular volunteer team meetings, where they can access peer support
- Educate volunteer team leaders and managers in mental health awareness, so that they can identify the signs that someone may be struggling and offer support
- Work to improve volunteer inclusion, so that they feel part of one team and grow their peer support network
- Develop a culture where the welfare and mental health of our people is always a priority, and where people feel safe to speak up and access support
- Continue to develop volunteer Trauma Risk Management (TRiM) Practitioners

Obtaining feedback

We will seek to obtain regular feedback from volunteers and patients, in order to continuously improve our service. Through improved community engagement, we will work towards a programme of co-design for our services.

[20] Clair Rowe, 2017. 'Community navigation, social prescribing in Brighton & Hove. Interim evaluation & service update April – September 2017.' <www.bh-impetus.org/wp-content/uploads/2017/11/CN-Interim-evaluation-service-update-Nov-2017.pdf>
[21] Mind, 2019. 'Wellbeing and mental health support in the emergency services – our learning and key recommendations for the sector.' <https://www.mind.org.uk/media/34555691/20046_mind-blue-light-programme-legacy-report-v12_online.pdf?_ga=2.251287363.451312531.1576759745-1279506767.1576759745>

Learning lessons

We will strive to create a culture of continuous learning and improvement. To do this, we will:

- Introduce clinical case studies to volunteer newsletters
- Introduce case reviews as part of volunteer continued professional development
- Support volunteers to ask questions, challenge or speak up when things go wrong
- Embed human factors education into Community First Responder training

Measuring success

Initially we will measure our success by:

- Undertaking regular volunteer pulse surveys
- Monitoring volunteer contribution (hours provided and incidents attended)
- Monitoring volunteer contribution to performance (e.g. response times)
- Holding regular engagement evenings
- Achieving *Investing in Volunteers* accreditation by 2023
- Achieving external accreditation for our CFR Education Programme by 2021

As our performance measurement maturity improves, we will look to translate the KPIs above into a more holistic set of measures focussing on clinical and quality impact. This work should help identify the increase in effectiveness and operational efficiencies that the CFR scheme confers to SECAmb as part of a true targeted dispatch model.

Workplan overview

Year 1 will focus on building the foundations required for future success. Significant work has already taken place within the Community Resilience Department to embed good governance and processes. The next stage is to enhance the staffing capacity within the Community Resilience Department in order to deliver years 2 to 4 – this will be achieved through the development of a workforce plan. Work will also be undertaken to finalise the Community Resilience operating model and improve business intelligence metrics that will measure future success.

Years 2 to 3 will focus on enhancing volunteer capacity and capability and implementing service improvement projects. This will include initiatives such as CFR attendance to elderly fallers, use of Dynamic Response Vehicles and trial of University based CFR schemes. Work will also focus on developing a brand identity that will support a highly visible and consistent delivery of services.

Year 4 will focus on strategy evaluation, review and refresh.

Action	Measure	Completion
Prepare		
Develop a Community Resilience Operational Model	Operational model developed and signed off	December 2020
Develop a workforce plan to ensure delivery of Community Resilience Strategy	Workforce plan completed	September 2020
Increase the number of people trained in lifesaving skills	Increase number of people trained to 20,000 per year	March 2024
Develop a branded community resilience toolkit to support year-round community engagement by all	Toolkit developed	December 2021
Enrol SECAmb in the National Defibrillator Network	NDN operational within SECAmb area	September 2020
Review current and future volunteer requirements	Volunteer development pathway in place	March 2021
Develop a volunteer engagement plan	Volunteer engagement schedule in place	December 2020
Implement a volunteer representation network	Volunteer representation network in place	March 2021
Streamline fundraising and corporate identity	Consistent approach to management of charitable funds	March 2023
Introduce a new, externally accredited CFR Education Programme	Achieve external accreditation	March 2021
Introduce high-performance CPR to Community First Responders	Training delivered to all CFRs	March 2021
Engage with Local Resilience Forums to develop Community Resilience	To be actively participating in all Local Resilience Forums	September 2020
Respond		
Implement a new operational model for Community Resilience	Operational model in place	March 2022
Implement an effective method of CFR Dispatch, including the introduction of a smartphone application to all responders	Evident improvements in performance data (e.g. clock start to allocation, response to scene)	December 2020
Expand the use of GoodSAM to reach more patients	Increased GoodSAM deployments	March 2021
Build a CFR Management Information	Dashboard in place	July 2020

Dashboard to better understand service activity		
Improve CFR access to clinical and operational support	Process/procedure in place	December 2020
Pilot the use of Dynamic Response Vehicles to allow more flexible use of CFRs across a wider geographical area	Pilot completed and evaluated	March 2023
Pilot a University CFR scheme	Pilot completed and evaluated	March 2023
Pilot the use of CFRs to attend vulnerable lower acuity patients such as fallers	Pilot completed and evaluated	March 2021
Recover		
Improve the provision of post-incident support to responders	System in place to monitor volunteer welfare follow ups	March 2021
Provide volunteers with awareness of human factors	Human factors training included in CFR Education Programme	March 2021
Introduce case reviews for CFRs	Trust wide programme in place	March 2021
Obtain feedback from volunteers	Pulse surveys carried out annually	Ongoing
Obtain feedback from patients	Feedback mechanism in place	March 2022
Achieve Investing in Volunteers accreditation	Achieve accreditation	March 2023
Strategy review and refresh	Review and refresh completed	March 2022

SECAMB Board

Summary Report on the Audit & Risk Committee

Date of meeting	**16 July 2020**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting were • Update on the Trust's response to COVID-19 • Internal Audit Progress Report • Counter Fraud • Information Governance • Risk Management Review
COVID-19	The committee received an update from the director leading the Trust's response to COVID-19. The established COVID Management Group continues to meet at least three times per week, and the key areas of its focus is currently test and trace; risk assessments for high risk staff; and PPE. There are still lots of uncertainties about the potential second wave, but management is well-engaged with the wider system to ensure we are well placed to respond accordingly. The committee also received a high-level update on the work of the COVID Recovery, Learning and Improvement Group, which is working through opportunities for new ways of working. Overall, the committee is assured by the governance and controls in place to ensure we continue to allocate resources appropriately.
Internal Audit **Counter Fraud**	The Internal Audit reports continue to provide good assurance; ▪ IG Tool Kit – there is good governance and controls. This review supported the assurance management expressed through both the IG assurance paper the committee requested, and the IG annual report; see below. ▪ Health Education England Funding – this review was requested by management and assurance was received that the funding had been allocated in line with its intended purpose(s). ▪ Data Quality – this provided assurance on the accuracy of call data reporting as requested by another board committee. There are still some overdue management actions and while some progress has been made the committee has asked the Chief Executive to ensure these are closed down as soon as reasonably possible. The committee noted the positive SRT submission and explored some of the fraud emerging

	risks. There are no significant concerns from a counter fraud perspective and the committee is assured by the approach being taken, supported by RSM.
Information Governance	An assurance paper was requested to test the extent to which the governance and controls in place are effective. Good assurance was received that the Trust is managing data / information effectively, supported by RSM's review of the toolkit, and the annual report, which is enclosed for the Board's information. The committee explored how we are looking to the future re cyber security, for example, and noted that capacity is something under constant review; noting that additional resource has been brought in to ensure strong information governance during the 111/CAS mobilisation.
Risk Management Review	Whilst the committee is confident in the risk management arrangements in place, it provided some feedback to inform the current review, which is aimed at refining the approach. In particular, the committee is keen to ensure there aren't too many risks, so that the right level of focus can be maintained on the key risks. There is also some work still do to ensure risk scores are slightly moderated; the committee feels there are probably still too many high risks, although it welcomes the reduction in those rated extreme. The committee suggested that management undertake a review of the risks that have been in the risk register for a prolonged period, to understand why this is the case. For example, are they still relevant and / or are we allocating the right resources to ensure they are appropriately mitigated to the target risk score? Overall, there is a good risk management process in place and the committee supports the current review to further refine it.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Information Governance Annual Report 2019/2020

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

Contents

Executive Summary

Information Governance is the term used to describe the framework that brings together the requirements, standards and best practice that apply to the handling of information. It enables organisations and individuals to ensure that information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care.

Information Governance is an enabler for Confidentiality, Information Security and appropriate Information Sharing and predominately covers the following criteria:

- Information Governance Management
- Confidentiality & Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Corporate Information Assurance

Confidentiality and compliance with Data Protection legislation remains at the forefront of our organisation. As an Ambulance Trust South East Coast Ambulance service handles a variety of personal data, this information relates to both our employees and the patients who enter our service. The Trust is geographically challenged, covers a wide remit covering the Kent, Sussex and Surrey localities and has a significant number of partner organisations. It has a high volume of front-line staff all of which process patient data as part of their responsibilities.

The General Data Protection Regulation (GDPR) 2016 / Data Protection Act 2018 implemented on the 25 May 2018 are a strengthening of the former Data Protection Act 1998. This legislation provides individuals with stronger rights over their personal data and the need for organisations to clearly set out their information is used, stored, processed and shared.

Therefore, as a Trust we must ensure there is a legal basis for sharing information, that we clearly document the information which we hold, ensure this is securely held and is only accessible or shared with those individuals or partner organisations who have a legitimate reason (legal basis).

Risk of non-compliance with legislation may result in the Trust receiving financial penalties or Decision Notices by the Information Commissioners Office. Under GDPR there is a significant rise in financial penalties for non-compliance and breaches of data protection can amount to 1-4% of an organisation's global turnover or up to 20,000,000 Euros. This does not take into the account of the reputational damage that such breaches incur.

It is therefore essential that the Trust continues to demonstrate assurance and ensures that information governance awareness remains high profile within the organisation. This is achieved through robust policies, mandatory IG training, completion of Data Protection Impact Assessments, Records of Processing, a fully functioning operational IG Working Group, Privacy Notices and Information Leaflets. In addition, continued collaborative working with partner organisations and strategic information governance groups at a local and national level provides additional assurance.

Overall Risk

There is always a degree of managed risk associated with the processing of personal data and ensuring compliance with legislation. As an organisation key risks associated with information governance include:

- Compliance with statutory timeframes, Freedom of Information and Data Subject Access requests.
- Minimising data breaches
- Ensuring systems which process personal data are secure
- Demonstrating role-based access levels
- Adequate records management in place
- Contracts and Third-party processing

ICO Audit 2019

The Information Commissioners Office undertook an audit of the Trust in May 2019. This reviewed the Trusts compliance with information governance and predominately covered the above criteria.

The audit provided an independent assessment relating to good data protection practice. Its purpose was to review whether the Trust has effective controls in place, together with fit for purpose policies and procedures to support data protection obligations.

Examples of areas covered within the audit included:

- Data protection governance, and the structures, policies and procedures to ensure compliance with data protection legislation;
- Processes for managing both electronic and manual records containing personal data;
- Processes for responding to any request for personal data, including requests by individuals for copies of their data as well as those made by third parties, and sharing agreements;
- Technical and organisational measures in place to ensure that there is adequate security over personal data held in manual or electronic form;
- Provision and monitoring of staff data protection training and the awareness of data protection requirements.

ICO assurance ratings are divided into 4 categories:

1. High assurance
2. Reasonable assurance
3. Limited assurance
4. Very limited assurance

Following the audit in May 2019, South East Coast Ambulance Service overall compliance rating was ‘Reasonable assurance’.

ICO Audit follow up review

A ‘virtual’ follow up audit was completed in January 2020 which like the original audit was led and facilitated by the Head of Information Governance / DPO. The Trust is currently working through the assigned audit actions and is making good progress with 6 actions out of 17 partially completed. The plan is to complete by the end of September 2020 to dovetail to the DSPT submission.

In response to the follow up audit the ICO produced a final report. This was presented to the Executive Management Team and IG Working Group for assurance. The ICO have confirmed that a follow up audit was completed with information relating to such available within the public domain:

Link to ICO website

https://ico.org.uk/action-weve-taken/audits-and-overview-reports/south-east-ambulance-coast-service-nhs-foundation-trust-follow-up/

Summary

This is the third Information Governance Annual Report from the Executive Director of Nursing and Quality. It provides a high-level summary documenting the progress and current IG Framework status within SECAmb during 2019 / 2020 and illustrates the priorities for the forthcoming year.

The report provides information and evidence of the ongoing commitment of the Trust to continue to ensure that data protection principles and legislation are embedded throughout the organisation and illustrates the significant improvements which the Trust has achieved during this time.

The Trust is currently demonstrating that it is working towards a satisfactory level of compliance with its annual Data Security & Protection Toolkit submission. It has a good framework in place, operational IG Working Group, robust Polices and has embedded data protection legislation, General Data Protection Regulation 2016 / Data Protection Act 2018 within its BAU activities.

Areas of improvement have been identified and are illustrated within this report with associated timelines.

Key Achievements 2019 / 2020

- IG Framework in place
- General Data Protection Regulation 2016 and Data Protection Act 2018 legislation embedded within business as usual activities
- Ongoing localised IG awareness training
- Data Security & Protection Toolkit submission 2019
- Positive internal audit with RSM
- Appointment of Deputy SIRO
- Collaboration with Trust ePCR project ensuring all data protection legislation provisions adhered to
- Engagement with outside regulators – Information Commissioners Office
- Collaborative membership within the NAIGG (National Ambulance Information Governance Group) and local IG Groups and networks within the Sussex and Surrey localities
- Operational IG Working Group with robust Terms of Reference and organisation wide membership
- Annual review of Trust IG training to ensure compliance with data protection legislation
- Completion of bespoke IG training within specialised portfolios
- Service visits completed with operational units to ensure compliance
- IG collaboration and attendance at Quality Assurance Visits
- Internal Trust wide engagement now in place with ongoing development.
- Data Protection Impact Assessments fully embedded within PMO function and internal portfolios
- Stakeholder engagement within Trust wide projects

- External / Internal website information updated in line with COVID 19
- Privacy Notices in place and updated Information Leaflets in relation to COVID 19
- IG policies reviewed and updated
- Ongoing Information Asset Register review
- Appointed IAO/IAA's in situ
- Ongoing Information Sharing Agreement review
- Robust FOI publication scheme in place
- Review of contracts to ensure compliance
- Continued working in collaboration with external stakeholders / organisations
- Information Governance Manager in post
- Accredited external Data Protection Officer training sourced and completed by the Head of Information Governance

Key Actions 2019 / 2020

- Baseline review completed in relation to Cyber Essentials + Accreditation
- Progression and completion of ICO Audit Action Plan
- Streamlined process for recording IG training completion
- Complete review and update of mandatory IG training materials during Quarter 4 2019.
- Publication of new training within timescales – Quarter 1 2020
- Continued allocation of time for mandatory IG training
- Ongoing development of the IG Portfolio
- Continued review of Information Sharing Agreements
- Development and 6-month review of the Information Asset Register
- Training and awareness for Information Asset Owners / Information Asset Administrators
- Collaboration with Procurement and Contract portfolios
- Propose a Trust wide model for Registration Authority process
- Additional resource agreed within the Information Governance portfolio to enhance Registration Authority compliance
- Ongoing review of Trust wide records management
- Dedicated portfolio resource for supporting the investigation of IG related DIF-1's
- Development of Information Governance Manager to provide contingency
- External training for specialised roles
- Develop a strategic approach through undertaking 'service visits' and QAV inspections
- Localised IG awareness training
- Complete specialised training for portfolios covering statutory services, Data Subject Access requests and FOI's.

Introduction

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of Trust services, resources and performance. It is therefore paramount that SECAmb has an appropriately robust Information Governance Framework in place. This acts as an enabler to ensure that all confidential information is processed legally, securely, efficiently and effectively, in order to deliver the best possible care to our patients and employees.

Information Governance stipulates / sets out the way in which NHS organisation should handle information, particularly personal / sensitive data. This refers to personal information about identifiable individuals, whether alive or deceased, for whom there is a duty to maintain confidentiality, and includes patients, and employees. The definition also incorporates sensitive data, such as race, political opinion, religion, trade union membership, physical or mental health, sexual life and criminal conviction.

All employees of the Trust, regardless of grade or profession, must adhere to an Information Governance Framework. This also includes any Local Authority employees, medical employees, directly employed, bank, agency, contractors and locum employees working in Trust services. Plus, non-medical employees and internal appointments, seconded staff volunteers and any other iteration of personnel considered staff.

Executive Directors, Directors, Heads of Department, Managers and Team Leads all have a responsibility for promoting and enabling good IG practices within the work environments they manage. Each service in the Trust must ensure that a member of staff within the service has been tasked with departmental responsibilities for leading Information Governance and that there are appointed Information Asset Owners / Information Asset Administrators in place.

This includes but is not limited to ensuring that national and local Information Governance standards are upheld within their department(s). Ensuring that ALL staff complete their mandatory IG training on an annual basis, and advising staff of their responsibilities regarding information security, confidentiality and data quality. They also have a responsibility to contact the Trust Head of Information Governance / Data Protection Officer where necessary regarding issues and/or incidents of concern.

Background

Corporate Responsibility

GENERAL DATA PROTECTION REGULATION (GDPR) 2016 / DATA PROTECTION ACT 2018

The General Data Protection Regulation (GDPR) 2016 & Data Protection Act 2018 are 2 key pieces of data protection legislation which the Trust must abide by. This updated legislation was implemented on the 25 May 2018 and is a strengthening of what was historically in place (Data Protection Act 1998).

The GDPR gives individuals greater rights over how their personal data is used and processed. Under GDPR the penalties and reputational damage for non-compliance are significant. NHS organisations are not immune to these being issued by the ICO, therefore it is imperative that the Trust continues to strengthen and proactively develop a strong IG culture.

The Head of Information Governance / Data Protection Officer continues to take a proactive approach, promoting and incorporating data protection legislation which is now embedded within BAU activities. This has included collaborative working both within the Trust and with external peer groups on a local and national level.

Further development of the Trust public facing website has taken place during 2019 / 2020 with more detailed Information relating to Data Subject Access now available. This was a recommendation following the ICO audit in May 2019. The Trust intranet also continues to be used to promote IG best practice internally.

The Trust continues to embrace a transparent approach which is demonstrated through a variety of Privacy Notices (including a stand-alone Employee Privacy Notice), Information leaflets and a published high-level repository relating to Data Protection Impact Assessments.

Information specifically relating to COVID 19 is available and a bespoke Privacy Notice has been created in line with national guidance issued by NHS England.

Progress to date:

- Data Protection Officer appointed and registered with the ICO
- Deputy SIRO role implemented
- Substantive IG Manager in post
- GDPR embedded within BAU activities
- PMO engagement and IG workstreams in place for project management
- IG Mandatory training reviewed and updated on an annual basis
- Localised IG Awareness training in place
- Internal service visits conducted
- Privacy Notices / Employee Privacy Notice/ Information Leaflets in place.
- Updated website information now published covering Data Subject Access requests
- Continued collaboration with Sussex Wide Information Governance Group, Surrey IG Leads Group and National Ambulance Information Governance Leads Group.
- ‘Third Party’ suppliers contacts reviewed to confirm compliance with legislation.
- Centralised contract repository in place
- Information Asset Register updated

- Internal bespoke training completed within specialised work streams such as Data Subject Access requests
- Data Protection Impact Assessments embedded within the organisation
- Ongoing development of the 'Zone' and updating of public facing website
- FOI publication scheme in place
- Collaboration with STP's
- Information Sharing Gateway implemented

Forward Plan 2020 / 2021:

- Agree and implement a robust Registration Authority model and resource appropriately
- Continued development of key stakeholder roles to support Information Governance
- Satisfactory Data Security & Protection Toolkit submission
- Proactive engagement with STPs, CCG's and the ICS along with partner organisations in relation to the integrating of patient records
- Ongoing contract review to ensure compliance
- Develop a robust process for reporting significant IG breaches within 72 hours
- Continued specialised IG training for key roles
- Strategic plan for ongoing IG awareness within the Trust
- Continued DPIA completion at an early stage of any project or change pragramme to provide IG assurance and highlight privacy risks
- Continued IG representation within Quality Assurance and Private Ambulance Provider visits
- Continued quarterly reporting for Data Subject Access requests
- Continued development of the Information Asset Register in line with 'Records of Processing Activities', Article 30 GDPR.
- Continued IAO / IAA training with accountabilities accepted and understood
- Continued development of intranet and public facing websites

COVID – 19

The current position regarding COVID -19 is unprecedented and at the time of writing remains fluid. As our regulator the ICO has taken a pragmatic approach with regards to the sharing and processing of personal information during the pandemic. A statement was issued on the 15 April 2020 confirming their approach to regulatory actions and the adherence to data protection legislation during this time. This also included reference to statutory processes such as Freedom of Information and Data Subject Access requests.

Whilst it is in receipt of a First General Control of Patient Information (COPI) Notice which is set to run until 30 September 2020, the Trust must still ensure that it continues to adhere to and monitor information governance. At the time of writing key processes predominately relate to interaction with partner organisations, Pubic Health England, the electronic sharing of test results and the utilisation of video conferencing. This list, however, is not exhaustive and is subject to further change.

The Trust has completed key COVID 19 specific IG assurance, in the form of specific DPIA's, Privacy Notices, website information and records of processing activities and will continue to maintain information governance assurance.

Information relating to COVID 19 continues to be circulated by the Head of Information Governance / Data Protection Officer to key stakeholders within the Trust, including the IG Working Group and Covid Management Group. Any COVID 19 IG related reports are also presented and noted by the Covid Management Group as evidence of internal assurance.

Information Governance Framework

Information Governance Working Group

The Trust IG Working Group has been operational since June 2017 and is currently meeting bi-monthly due to the position regarding COVID 19. The decision to reduce frequency to bi-monthly was taken in March 2020 following review and discussion by the group.

To provide assurance, it was agreed that the Head of Information Governance / DPO, Caldicott Guardian and SIRO (Deputy SIRO) would meet in between the IGWG meetings, and this is currently taking place. However, the usual 'open access' to the Caldicott Guardian / SIRO by the Head of Information Governance still applies, and any urgent IG related incidents will continue to be escalated as per process.

The group continues to have positive widespread engagement which has expanded further over the previous year. Membership now includes, Private Ambulance Provider portfolio, Voluntary services and ePCR membership. This is in addition to the Senior Information Risk Owner (SIRO), Deputy SIRO, Caldicott Guardian and Senior Managers.

The agenda is robust with regular reports presented at each meeting by the Head of Information Governance / Data Protection Officer. All meetings are thoroughly minuted with documented actions in place. There is also an escalation process whereby if appropriate issues are highlighted to the Executive Team, with robust Terms of Reference (ToR) in place. Members have clear expectations of their roles and responsibilities.

Assurance level: Reasonable Assurance

Information Governance Training

Fundamental to the success of a robust Information Governance agenda across the organisation is the ongoing development of an IG-aware culture.

SECAmb's objective in line with its mandatory DSPT requirements is to demonstrate that 95% of employees have completed their IG training, this figure is required for the toolkit submission on the 31 March 2020 Data Security & Protection Toolkit submission.

*Final figures for 2019 / 2020 illustrate that the Trust achieved its 92.48% completion. This is a significant completion figure considering the position regarding the COVID 19 pandemic and the pressures which the service is currently under.

It is an acceptable observation to note that based on this trajectory the Trust would have met its target figure of 95% by the 31 March 2020.

IG training is provided to all staff to promote this ethos and ensure that the Trust meets its statutory requirements under the Data Security & Protection Toolkit. The 2020 / 2021 mandatory IG training package has undertaken a full annual review and update by the Head of Information Governance. This was published internally on the Trust training platform 'Discover@ and on target 1 April 2020.

This new updated training material also considers internal incidents / trends which have occurred during 2019 / 2020. It also incorporates ICO audit recommendations and now includes:

1. Additional information relating to Data Subject Access requests and statutory timeframes.
2. Information relating to the 'types' of Data Subject Access requests processed and the contact details for the respective portfolios
3. Access to information systems which hold personal data.
4. The inclusion of a 'tick box' at the start of the training to confirm that IG related policies have been read and understood

Reporting: The completion of all Statutory and Mandatory training is recorded on ESR. This is the 'gold standard' for reporting and is the data source for the Human Resources Power BI application. This Power BI application provides a more streamlined approach and is now used for the reporting of all mandatory training completion, which includes mandatory IG training.

Training Compliance

The Head of Information Governance continues to work collaboratively with the Learning & Development team to ensure that the Trust is compliant with its training obligations. The existing IG training modules are reviewed during Quarter 4 and updated by the Head of Information Governance ahead of re-publication on the 1 April each year.

The updated mandatory IG training module was released on the 1 April 2020 with revised Corporate Induction / Local Induction materials provided in July 2019. These materials now form part of the 'Induction Toolkit' which is available on the Zone and provide localised information relating to good information governance.

Service Visits / Localised training

On a strategic level the Head of Information Governance has continued to develop Trust wide awareness during 2019 / 2020. This awareness is demonstrated through conducting service visits and facilitating localised IG training during 2019 / 2020. This is set to continue during 2020 / 2021.

Service visits ensure that the Trust continues to promote IG awareness within the organisation and measure local compliance. There is now IG representation during QAV's and Private Ambulance Provider visits which provide documented assurance. The Terms of Reference for the IG Working Group were updated in April 2019 to include a 6 monthly PAP report by way of measuring and documenting compliance.

The Head of Information Governance accompanied by the Trust SIRO conducted a formal service visit in September 2019 to the NHS 111 service in Ashford. This visit was supported by clear Terms of Reference and was well received. Following the visit, a formal findings report was issued to the Associate Director of NHS111, Senior Clinical Manager and IG Working Group.

During 2019 / 2020 the Head of Information Governance has conducted localised training sessions within the Trust. These were focused predominately around the processing of Data Subject Access requests and local IG awareness.

Attendance with QAV's, Service Visits and localised training continues to be well received, with positive feedback obtained from attendees and stakeholders. This will set to continue on a strategic level during 2020 / 2021.

Specialised training

Trust IG training is designed to raise general awareness and a local level understanding of information governance which then effectively 'dovetails' to the more specific IG training.

However, there is a requirement for specific / specialised roles within the organisation to undertake additional training. At a minimum this includes the Caldicott Guardian, SIRO, Deputy SIRO, Head of Information Governance and Associate Director of Quality and Compliance.

External practitioner-level DPO training was completed by the Trust Data Protection Officer in February 2020 support this specialised role. The Deputy SIRO and Associate Director of IT have recently undertaken, external SIRO training which was completed in May 2020.

The Trust SIRO and Caldicott Guardian completed formal certified training in February 2019. External accredited training will need to be sourced and completed by these key roles during 2020 / 2021.

Action: Ensure knowledge and expertise remain up to date through annual specialised training during 2020 / 2021. Head of Information Governance will facilitate training to support these key roles within the organisation.

Assurance level: Reasonable Assurance

Cyber Security

Information is our most precious asset and as a Trust we remain vulnerable to cyber threats. It is imperative that the Trust always remains vigilant, have appropriate network security measures in place and that training and awareness remain ongoing.

The national WannaCry cyber-attack experienced by the NHS in May 2017 still serves as an example of how systems can be infiltrated and the need for all staff to remain alert. As part of a national directive, there has been an increased focus on cyber security. This element is incorporated into mandatory IG training; the IG Working Group continues to have active membership from the Trust IT Department

This collaborative working is integral to the satisfactory completion of the mandatory Data Protection & Security Toolkit. The updated toolkit released in May 2018 is based around the 10 National Data Guardian Security Standards, with half of the requirements known as 'Assertions' being cyber security related.

Completed actions: Cyber Security

SECAmb has undertaken a substantial upgrade to its IT infrastructure during 2019 / 2020 to ensure that the Trust is compliant with its Cyber Security and Data Security & Protection Toolkit requirements. This has included:

- Fully implementing a new firewall and switch environment to replace legacy infrastructure.
- Strengthening our external security environment which will see the Trust adopting a nationally provided NHS service.
- Deployment of the national Advanced Threat Protection (ATP) service across all desktop endpoints
- Ensuring Windows applications are up to date
- Implementing a new VPN service
- Upgrading anti-virus software
- Blocking of USB ports as standard for any USB storage devices and creating advanced reporting
- Issuing weekly and monthly security reports by the IT Security Team. These are distributed to the Associate Director of IT, Head of Critical Systems and Head of IT Infrastructure & Networks
- Implementing the nationally recommended BitSight security rating process which provides an overall rating of the Trust security status.

Cyber Essentials+ Accreditation

At the time of writing the Trust is currently seeking clarification from NHS Digital on Cyber Essentials Plus as a mandated accreditation. NHS Digital have stated that the current Data Security & Protection Toolkit 'has CE+ equivalence', therefore there is no need to pursue separate CE+ accreditation. The Trust is currently placing this on hold pending receipt of requirements from NHS Digital.

Data Security & Protection Toolkit (DSPT)

The Trust's Information Governance compliance is measured through the completion of a mandatory self-assessment process of specific standards. This is now known as the Data Security & Protection Toolkit (DSPT) which all NHS organisations and providers of services to the NHS must complete on an annual basis.

This toolkit was revised in April 2019 in line with the 10 National Data Guardian Security Standards and is now based on both data protection and cyber security requirements.

Due to the COVID 19 pandemic, NHS Digital has taken the unprecedented step of allowing organisations to defer their usual submissions from 31 March to the 30 September 2020. This applies to the 2019 / 2020 submission only. Following review by the Trust Head of Information Governance and formal discussion by the IG Working Group the decision has been taken for the Trust to defer until this date.

At the time of writing SECAmb has completed 110 out of 116 requirements and is on track for a satisfactory submission by the 30 September 2020. Progress is monitored by the Head of Information Governance and formally reported as a standing agenda item at the Trust IG Working Group.

Current Assurance level: Reasonable Assurance

Corporate Risk Register

The Corporate Risk register is reviewed on a monthly basis by the Head of Information Governance and Information Governance Manager. IG related risks remain a standing agenda item for the IG Working Group. There is a full escalation process in place where items may be escalated to the Executive Team, this forms part of the groups standing agenda.

Assurance level: Reasonable Assurance

RSM - Internal Audit

To provide internal and external assurance the toolkit submission is audited on an annual basis. This audit effectively 'dovetails' to NHS contracts which stipulate that organisations must attain a satisfactory level and demonstrate assurance.

The agreed audit of the toolkit was completed week commencing 20 April 2020. However, due to the current COVID 19 position and the restrictions on travel this audit was completed in a virtual environment. An initial post audit review has taken place with no major concerns or issues raised although the following statement was given regarding IG training completion for 2019 / 2020.

IG Training

Final figures illustrate that the Trust attained 92.48% completion which is an excellent result and just short of the 95% completion as defined within the DSPT. It is a reasonable assumption to conclude that had the Trust not been managing the COVID 19 pandemic during Quarter 4 2019 the 95% completion requirement would have been reached by the end of March 2020.

The Head of Information Governance has provided RSM with a full background and narrative for inclusion into the final DSPT audit report. This provides an explanation and internal assurance relating to training completion.

At the time of writing RSM have issued a draft report which is has been circulated for review. It is proposed that the final audit report will undergo Executive Team sign off and review by the end of June 2020 with presentation to the Audit Committee in July 2020. The IG Working Group will also have full oversight of the report findings, details of which will be formally documented.

Assurance level: Reasonable Assurance

ePCR Implementation

The Trust is a forward thinking, proactive organisation. During 2019 it achieved the successful roll out its electronic patient care record system. This implementation saw the Trust move away from the historical use of paper-based PCR's to an electronic based solution. The Head of Information Governance / Data Protection Officer was a critical workstream lead for the project ensuring that the system is compliant with Data Protection legislation. Assurance was achieved through the completion of mandatory processes including Data Protection Impact Assessments, Data Flow Mapping, IT security compliance and contract review,

This implementation has resulted in significant benefits to the Trust, its service users and partner organisations. It has improved patient pathways, allowed for the integration and sharing of patient records, will support improved patient outcomes or mandatory clinical audit activities as part of national reporting requirements.

Access is enabled using Trust issued iPads, which are encrypted with role-based access controls in place. The implementation to an electronic clinical patient record also reduces IG risk and ensures the accurate and timely recording of patient data.

Records Management

The NHS Records Management Code of Practice for Health and Social Care 2016 sets out the requirements, and best practice which all NHS organisations in England must comply with in order to manage records correctly.

The Trust holds a localised Records Management policy although reference is also made to the national NHS Records Management Code of Practice for Health and Social Care 2016 (above).

General Information

The benefits of effective records management are protecting our business-critical records and improving business resilience ensuring our information can be found and retrieved quickly and efficiently complying with legal and regulatory requirements, reducing risk for litigation, audit and government investigations, minimising storage requirements and reducing costs

However, organisations are also obliged to meet the legal requirements for the retention and disposal of records in accordance with relevant legislation, particularly the Public Records Act 1958 (PRA 1958), the Freedom of Information Act 2000 (FOIA 2000), the Data Protection Act 2018 (DPA 2018) and the General Data Protection Regulation (GDPR).

The General Data Protection Regulation 2016 and Data Protection Act 2018 (DPA) are the principal legislations governing how care records are managed. These set out in law how personal and sensitive personal information may be processed.

Under Article 30 of the GDPR, organisations need to evidence 'Records of Processing Activities'. This specifically applies to Information Asset Registers, Data Flow Mapping and Records Management repositories and evidences what information assets organisations hold and their processing activities

Records of NHS organisations are public records in accordance with Schedule 1 of the Public Records Act 1958. This includes records controlled by NHS organisations under contractual or other joint arrangements, or as inherited legacy records of defunct NHS organisations. This applies regardless of the records format.

The Public Records Act 1958 requires that all public bodies have effective management systems in place to deliver their functions. For health and social care, the primary reason for managing information and records is for the provision of high-quality care.

The Secretary of State for Health and all NHS organisations have a duty under this Act to arrange for the safekeeping and eventual disposal of all types of records. This is carried out under the overall guidance and supervision of the Keeper of Public Records, who is answerable to Parliament.

The NHS Standard Contract notes a contractual requirement to manage records for those health and social care records in organisations that are not bound by the Public Records Act 1958 or the Local Government Act 1972.

Records Management Review

Current position

As a Trust SECAmb covers a wide geographical remit. It has around 4000 employees and a significant number of sites, spread across three counties, all of which have the potential to hold personal information. There are also a significant volume of historic records held by the Trust following the merger of Surrey, Sussex and Kent Ambulance services in 2008.

The Trust undertook an organisational wide records review to ascertain where documents and personnel records which held. This project was sponsored by HR Executive Director and was completed in 2019.

The project objective was to review all paper and electronic files within the Trust. This included;

- Recording paper files and documenting their location.
- Reviewing the content within the electronic file and confirm where information is held (Papervision/SharePoint)
- Review pre-employment check documents to ensure compliance.

HR PERSONNEL FILES

The Trust is currently working on a project to ensure the accuracy of HR Personnel files. This project commenced in December 2019 and is being completed as a phased approach. The Executive HR Director is the project sponsor.

For transparency in November 2019 the Trust Head of Information Governance / Data Protection Officer informed the Information Commissioners Office (ICO) with details regarding this project. A formal letter was also issued on behalf of the Trust by the SIRO which provided clarification of the Trust position and proposed actions. This information also included details relating to the project purpose and remit.

A further update letter is to be issued to the ICO confirming the current status of this project with revised timeframes confirmed. This notification will be forwarded by the Trust SIRO in keeping with original correspondence, with the IG Working Group continuing to be informed and updated as the project progresses.

HR Transformation Programme

During 2019 a significant number of HR Transformation projects were initiated. All workstreams have necessitated comprehensive IG assurance as they related to the direct processing of personal data relating to Trust employees and were managed through the PMO.

- TRAC – Recruitment system - completed
- E-Expenses for Corporate staff – programme of work ongoing

- Driver Compliance checks - programme of work ongoing
- Trust ID checks – programme of work ongoing
- HR Personnel Files project – programme of work ongoing

Forward Plan 2020 / 2021

Maintain a framework for the audit and control of Trust records. From an information governance perspective, it is recommended that a separate Records Retention schedule is produced to complement the local Records Management policy. This will provide local information regarding record retention times, the recording of information and clearly define the responsibility of local management on appointed Information Asset Owners.

For audit and assurance IAO's will need to document and demonstrate clear records management within their portfolios. Each directorate will 'own' and catalogue those records held, this information will then feed into a Trust wide 'master' database. This repository will 'dove tail' to the Trust Information Asset Register, which holds details around information flows.

Assurance level: Limited to Reasonable Assurance

The Trust must continue with the work undertaken during 2019 regarding records management. This includes placing greater emphasis on appointed IAO's, reviewing information held, cataloguing historical records, ensuring that records are centrally retained and that it continues to build on and update its records management inventory.

Information Governance Policies

Organisation wide policies apply to all relevant staff and are a 'must do' requirement. A policy document is a formal document that is regarded as a legally binding document and therefore its purpose, definitions and the responsibilities outlined within its content must be upheld in order that it may be used to support an individual or the Trust during legal action.

Policies provide a consistent logical framework for Trust action across different functions or directorates. All policies must be reviewed at least every 3 years or sooner if there is a significant change either on a local or national level such as new legislation.

Current position

As part of its framework the Trust has a selection of IG related policies. These policies underpin the Trust compliance with information governance and are accessible through the Zone.

There is one IG related policy which remains outstanding as illustrated blow. This historic policy has been updated and is currently undertaking an internal review with key stakeholders. It is anticipated that this will be published in Quarter 3 2020.

- Patient Video and Photographic Policy

Assurance level: Reasonable Assurance

Data Protection Impact Assessments (DPIA's)

DPIA's became a legal requirement under GDPR (Article 25 Data Protection by Design) and their completion forms part of the Trust IG requirements. These are essentially a 'Risk Assessment tool', which must be completed when new or significant changes to the Trust's processes or systems, using personal / sensitive information are being implemented.

Their role is to ensure that the Confidentiality, Integrity and Availability of personal / sensitive information is maintained and highlight any associated privacy risks.

Current Position

Under GDPR the completion of a DPIA is now a legal requirement. These forms are completed in instances where organisations are implementing new systems or processes involving personal information and are used to highlight any privacy risks associated with the processing of personal data.

The DPIA process continues to be completed within the Trust and is also built into the PMO function to ensure completion within the initial 'scoping' or 'project initiation' stage. They have a multi-layered approach relating to the review and sign off process, which includes initial review by the IG Manager, then final review and sign off by the Trust Data Protection Officer and SIRO.

To support this process a DPIA register is now in place. This is 'owned' by the Trust IG Manager, updated and maintained within the IG portfolio and contains information relating to DPIA's which have been completed.

For transparency information relating to DPIA's is uploaded to The Zone and also our public facing website. This also includes an extract of the DPIA register to evidence that these are being completed and are embedded within the organisation.

DPIA's awareness and information is also referenced within the Trust mandatory IG training modules.

DPIA consideration has also been added to the coversheet for all papers presented to the Covid Management Group ensuring that this important aspect is not neglected during the fast-paced environment of an on-going business continuity incident (BCI)

Assurance level: Reasonable Assurance

Information Sharing Agreements (ISA)

Information Governance is not a 'blocker' it is an enabler for the safe, compliant legal sharing of information. As an organisation SECAmb processes and received a significant volume of personal data, therefore, any sharing of information must have a legal basis in accordance with Data Protection legislation.

It is accepted that the sharing of information between partner agencies is vital to the provision of co-ordinated and seamless provision of care services. The need for shared information standards and robust information security to support the implementation of joint working arrangements is widely recognised.

An ISA is good practice and can be a useful way of providing a transparent and level playing field for organisations that need to exchange information on a regular basis. They provide assurance in respect of the standards that each party to an agreement will adopt.

This ensures that each organisation is aware of their obligations and adherence to Data Protection legislation and those legal and regulatory requirements are met. ISAs are not required where the sharing is for an ad hoc request for information.

However, whilst they must stipulate a lawful basis for sharing confidential information (in accordance with the GDPR) they are not legally binding. Equally, the completion of an ISA is not a prerequisite for automatic data sharing and consent must always be sought unless there is a legal requirement to share information such as public interest / safety or it is in the patient's vital interest.

Should a serious breach occur, which later requires reporting to the ICO, the completion of an ISA will demonstrate that the Trust has undertaken due diligence and has an internal assurance process in place.

It is important to note that in addition to having an ISA in place, organisations must ensure that when data is shared with outside organisations patients / employees are informed of this through Privacy Notices and Information Leaflets.

This is paramount under the Data Protection legislation, which clearly stipulates that all organisations are open and transparent about the processing of personal data.

ALL ISA's are reviewed by the Head of Information Governance, reported to the Information Governance Working Group and signed off by the Trust SIRO. The IG Portfolio now holds a centralised repository of signed ISA's in place, this process is 'owned' by the Trust Information Governance Manager.

Information Sharing Gateway (ISG)

This system provides an electronic repository for holding information sharing agreements, data protection impact assessments and information confirming an organisations compliance with data protection. It has been rolled out across the East Sussex and East Surrey localities with access and collaboration increasing within the coming year.

SECAmb registered with the ISG during late 2019 with the Head of Information Governance, Deputy SIRO and SIRO having full access. It provides a more streamlined approach for the review, ratification and storing of documents and ensures that the Trust can quickly determine which agreements are in place with partner organisations.

Forward Plan 2020 / 2019

Continue with the review and ratification process via the IGWG and Information Sharing Gateway. Utilise the' Zone' and our public facing website to communicate information relating to those agreements which are in place. Provide an 'extract' of the ISA register to evidence that these are being completed and are embedded within the organisation.

Assurance level: Reasonable Assurance

Information Asset Register (IAR)

ALL NHS organisations must have a fully functioning information asset register. This register acts as a repository for all the information assets held within the Trust. It also measures how information is 'flowed' within the Trust and who is responsible for access and use of this information.

Under Article 30 of the GDPR all organisations must have a robust record of their processing activities and this is demonstrated through completion of an information asset register The Trust SIRO has overall responsibility for the IAR.

The Trust must also have appointed *Information Asset Owners (IAO's) and Information Asset Administrators (IAA's) within each directorate who are responsible for their respective information assets and the information they contain. These roles are mandatory in line with IGT and NHS requirements. *IAO's are usually Heads of Department and IAA's are Department Managers

Current position

This is an area of focus within the IG Framework and continues to be a work in progress. The register has been updated to ensure that it is GDPR compliant and includes the 'legal basis 'for sharing information, where the information is held, and whether any information flows are outside of the EEA.

As a 'gold standard' the Trust needs to undertake the following to ensure that it can demonstrate a multi – layered approach and that this is correctly completed:

- Ensure that Contracts (if applicable) fulfil GDPR compliance
- Complete Data Flow Mapping for each information asset
- Undertake a Data Protection Impact Assessment for the information flows

The programme of work continues and is being led by the Information Governance Manager with engagement with Information Asset Owners / Information Asset Administrators.

A 'Roles and Responsibilities' procedure document is now in place for IAO/IAA's. This clearly defines expectations, roles and responsibilities and evidences the Trusts internal assurance process. The Head of Information Governance conducted internal awareness training for these roles in December 2019 and this will continue during 2020 / 2021.

Forward Plan 2019 / 2020

A strategy for the ongoing update and review of the information asset register is under development. This caveat has been written into the IG Working Group Terms of Reference for 2020 / 2021 and will be reviewed on a six-monthly basis with a formal report presented to the SIRO for sign off.

Action: Information Asset Register review to be undertaken in September 2020 and February 2021, this is in line with the revised Terms of Reference for the IG Working Group.

Assurance level: Limited / Reasonable Assurance

Data Flow Mapping

Data Flow Mapping is a mandatory requirement for the DSPT and demonstrates internal assurance. It must be completed on an annual basis and incorporated within an IG work plan for 2020 / 2021. As with previous exercises a formal report to the Trust SIRO was presented at the annual Exceptional IG Working Group on the 27 March 2020.

It is essential that this process is embedded within any significant Trust projects or system changes which involve the processing of personal data.

Completion dovetails to the DPIA process and provides assurance that data flows are compliant with data protection legislation, are securely held and only accessible to those with a legal basis.

Forward Plan 2020 / 2021

Continue with the completion of a Data Flow Mapping exercise on an annual basis in order to provide assurance and meet requirements for the DSPT. This requirement is documented within the IG Working Group Terms of Reference, with the Trust IG Manager responsible for ensuring completion.

Assurance level: Reasonable Assurance

Third Party Contracts

Under GDPR individuals have greater rights over the processing of personal data. All organisations must ensure that any third-party suppliers who process personal data are GDPR compliant. Assurance is demonstrated through contract compliance.

As part of its DSPT responsibilities the Trust must ensure that all contracts are GDPR compliant, that it has a list of Third-Party Suppliers who process personal data and that it has an overarching 'repository' of all contracts held within the organisation.

Historically there were 'pockets' within the Trust which had independently sourced contracts. In some cases, these also included contracts for organisations who process personal information.

In order to provide assurance and meet its DSPT requirements the Head of Information Governance is currently undertaking a review with the Trust Procurement team.

This review was initiated during Quarter 4 2019 with the following objectives:

1. Review and update the Trust centralised contract repository
2. Undertake a Trust wide review to ascertain what contracts are held and by whom
3. Review current contracts to ensure that they are GDPR compliant
4. Obtain contract assurance from Third Party Suppliers

Forward Plan 2020 / 2021

Continue with the Trust wide contract review. Ensure that a process in place to ensure that the Procurement Team are cited on all new contracts. This will confirm compliance but also ensure that the Trust contract repository remains current and up to date.

Ensure that Procurement are included within all directorate contact review meetings. Information Asset Owners (IAO) must be responsible for those contracts within their portfolios, this responsibility includes engagement with procurement regarding contract review and any new service specifications.

Assurance level: Reasonable Assurance

Data Subject Access Requests

Under Article 15 of GDPR individuals have a 'Right of Access' to the personal information held by organisations. This is commonly known as a 'Data Subject Access Request' and is a statutory process.

Within SECAmb the Data Subject Access Request process operates in three distinct teams:

- Legal Services Department – Police, Solicitor, Coroners and Claims
- Patient Experience Team – Individual requests for patient information
- HR – Requests made for Staff/HR related information

The Head of Information Governance has continued to work protectively with those directorates who are responsible for processing such requests. Localised training has been completed during 2019 / 2020 and this is set to continue within 2020 / 2021.

The process is underpinned by Standard Operating Procedures and a Trust wide Data Subject Access request Policy. This policy was independently reviewed by the ICO during their audit in May 2019.

Key recommendations to strengthen the policy further included the following information, which for consistency has now been included:

1. Clarification of statutory timeframes and applying extensions
2. The inclusion of 'verbal requests'
3. Right to Rectification information
4. Right to Erasure information
5. Clearer information relating to organisational silos

Awareness

Following recommendations issued by the ICO the Head of Information Governance has strengthened the mandatory IG training modules further. Additional information is now available relating to Data Subject Access Requests which provides contact information for requests and which portfolio to refer requests to.

Website Information

A further recommendation by the ICO was to improve the information available within the Trust public facing website. This has been reviewed and updated further and now provides clarification of request types with contact details. Confirmation of statutory timeframes and information relating to verbal requests. This update was completed during Quarter 3 2019.

Forward Plan 2020 / 2021

Ensure that the Data Subject Access Request process remains embedded within the organisation. Continue with the quarterly Data Subject Access Request reporting to the IG Working Group covering all key DSAR portfolios within the Trust. This report incorporates volumes, breaches and trends and is presented by the Head of Information Governance.

Assurance level: Reasonable Assurance

Registration Authority – SMARTCARDS

The NHS Spine allows information to be accessed and shared securely through national services such as the Electronic Prescription Service, Summary Care Record, Patient Demographic Service and ESR.

Smartcards are required to access NHS Spine information systems with Registration Authorities roles and responsibilities defined by NHS policy.

NHS Digital develops and maintains the NHS Spine through the Digital Delivery Centre and adequate procedures are needed to ensure all NHS Smartcards and access profiles are issued appropriately.

Registration Authorities are responsible for issuing smartcards to authorised staff with an approved level of access to patient information. This is essential to protect the security and confidentiality of every patient's / employees personal and healthcare information and to ensure that information is accessed with a legal basis.

It is essential that the Trust can evidence that it has robust controls and procedures in place as RA is reliant on having appropriate 'position-based roles' assigned to users. There must be a legitimate reason for access and all new users must comply with e-GIF level 3 identity checks which is a government standard.

The RA Manager is ultimately responsible Trust wide for this process, and for monitoring / troubleshooting system access and overseeing those individuals appointed as RA agent's / RA Super Users / Sponsors who undertake key operational work requirements. In addition to this, the Trust must audit access to the NHS spine on a regular basis. This auditing is undertaken by appointed Data Privacy Officers and is a mandatory process within the RA function.

Current position

From the 1st April 2018 responsibility for the Registration Authority process was transferred to the Head of Information Governance under the Nursing & Quality Directorate. This process necessitates tight controls due to the nature of access to the NHS Spine. Namely Summary Care Record (SCR) and Patient Demographic Service (PDS).

The Head of Information Governance previously completed an overarching operational review which was presented to the IG Working Group in March 2018, this was later updated in September 2019. This review provided a summary and recommendations relating to a Trust operational model and resource.

Due to resource limitations this has not been progressed sufficiently and there are gaps within the process. There is still a considerable volume of work to undertake to ensure that the Trust is fully compliant and a robust 'business model' still needs to be agreed and implemented.

However, additional registration authority roles were allocated in 2019 within the Clinical Operations Team which does provide a level of assurance. These 'super user positions' are in place to ensure the management of clinical role out of SCR and PDS within the EOC.

This will ensure that the Trust is able to utilise the use of NHS numbers which may be drawn down from the NHS spine and information integrated into our CAD system and will support Emergency Operations Centre clinicians to ensure a seamless care pathway.

This is a risk issue for the Trust as it needs to determine level of access versus users and ensure that it does not breach data protection legislation by having roles and positions open in instances where an indivudal has left the Trust.

NHS recommendations are that all Trusts have a minimum of two RA Managers or more (for contingency), although this is dependent on the size of the organisation. Therefore, a further 2

Registration Authority Manager positions are required due to the size and geographical constraints within the Trust.

Forward Plan 2020 / 2021

There is still significant work to be undertaken around this process, but the Trust is starting to formulate a more robust RA function. A review of the organisational users within SECAmb remains ongoing and still needs to be completed. This is being undertaken by the HR directorate.

The IG portfolio has now obtained funding for a substantive Band 5 position, this new role will incorporate dual roles, RA Officer / Information Governance Officer and will support the RA process. However, as this is a new role the JD will require full panel review and assurance, therefore it is not anticipated that this position will go out to advert until end of Quarter 3 2020.

Robust RA training needs to take place, this is currently being sourced by the Head of Information Governance who as part of collaborative working has contacted an established RA team within a partner organisation with a view to sharing best practice. This request has been well received and it is anticipated that training can commence during Quarter 3 2020.

On a strategic level it is anticipated that the Trust Information Governance Manager will also be appointed as an additional RA Manager once appropriate training has been completed. However, a Trust wide business model still requires review, approval, adequate resourcing and implementation.

The risk to the Registration Authority process is currently recorded within the Trust BAF Framework and Corporate Risk Register under 1071. This is reviewed monthly and will remain until a robust framework, model and resource is in place.

Action: Agree a robust Registration Authority process and model within the organisation. Ensure that this is adequately resourced, and accountabilities are defined. Allocation of additional RA Managers to meet the needs of the organisation.

Assurance level: Limited to Reasonable Assurance

IG Incident Reporting – DIF - 1

The internal reporting of incidents is vital to all organisations. SECAmb is a Tier 3 substantially sized organisation, which processes a significant volume of sensitive information. This data applies to both our patients and employees alike.

The recording of Incidents must be treated positively and demonstrates the Trust transparency and openness principles. All staff must feel confident in recording incidents and be assured that the recording of such is valuable in illustrating shortfalls, risks and in some cases highlights the need to improve or change processes.

Incident reporting is integral within the Trust for the following reasons:

- They illustrate that the Trust has an ‘open and transparent’ culture
- Provide excellent ‘shared learning’

- Improve processes and reduce risk

The Trust uses an internal incident reporting system – Datix, a centrally held database used to record IG incidents. In order to demonstrate a sound IG Framework, the Trust must have a robust internal reporting system in place for the recording of IG incidents. This reporting must follow clear, defined end-to-end processes, followed through with clear findings / lessons learnt implemented.

Current Position

Incident reporting is noticeably increasing which is in line with the Trust's desire to promote a positive reporting culture. Historically the organisation was 'under reporting' and therefore the increase in incidents is not necessarily due to increased errors.

Key increases in reporting, are collectively attributed to:

- Raised staff awareness around the importance of incident reporting
- Staff now being confident that the reporting of incidents is not a 'finger pointing' exercise
- An improved culture the Trust with it demonstrating that incidents will be acted upon

The review of DIF-1 forms is undertaken and managed by the Trust Information Governance Manager. Incidents are reviewed and completed with appropriate feedback / shared learning completed. Trends around incidents are identified and if appropriate built into localised training and awareness.

Conversely serious IG related incidents are managed by the Head of Information Governance / Data Protection Officer in line with the national incident reporting tool.

Significant IG breaches must be reported to the ICO within 72 hours and recorded through the Data Security & Protection Toolkit. There is a local process in place whereby the incident is 'graded' by the Head of Information Governance and then reviewed by the Trust Caldicott Guardian and SIRO. This provides assurance and transparency.

In addition to this serious IG breaches are reported to the IG Working Group and within the Trust Annual Report.

Forward Plan 2020 / 2021

Incorporate a robust process and continuity plan for the recording of significant IG breaches within a 72-hour timeline. Continue to develop the recording and managing of IG related breaches within the IG portfolio. This is the responsibility of the Information Governance Manager.

Assurance level: Reasonable Assurance

FREEDOM OF INFORMATION REQUESTS (FOI'S)

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities are required to publish certain information and members of the public can also request information. This also promotes a culture of being open and transparent.

The FOI Act does this in 2 ways:

- Public authorities are obliged to publish certain information about their activities; and
- Members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland.

Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002. All requests received must be responded to within 20 days as per statutory requirements.

The Act does not give people access to their own personal data. If an individual wish to see information a public authority holds about them, they should make a subject access request under the Data Protection legislation, namely GDPR Article 15 Right of Access and the Data Protection Act 2018.

The Trust upholds is obligations under this legislation and has a functioning publication scheme whereby redacted responses are uploaded to its pubic website. It is fully aware of its responsibilities to comply with this statutory process and volumes have been consistent throughout the year. FOI's remain a standing agenda item for the monthly IG Working Group meetings and a quarterly report is presented for assurance.

This statutory process sits within the IG portfolio, is managed by the Information Governance Manager, with the Head of Information Governance / Data Protection Officer as the Trust FOI Lead.

Current Position

Up until Quarter 3 2019/2020 the Trust continued to receive high volumes of FOI requests, averaging around 40-50 requests per month. However, requests have significantly reduced since March 2020 following the COVID 19 pandemic, although volumes continue to be closely monitored by the Information Governance Manager.

The type of requests received can cover all manner of scenarios some of which are convoluted and require information from more than one directorate. Requests are reviewed on a case by case basis, however, where appropriate the Trust will apply an exemption if the request exceeds 18 hours.

The IG Portfolio successfully appointed a substantive FOI Co-ordinator during Quarter 4 2019, who has been in post since the beginning of March 2020. Requests are being adequately managed within the Trust publication scheme which now fully operational and up to date. This had previously been inactive whilst the Trust was managing the process using temporary resource.

For assurance and transparency, the Corporate Register has now been updated and the previous risk recorded in respect of this process has now been closed.

The presentation of a quarterly FOI report to the IGWG will recommence in July 2020. This will focus on trends and request types and provide a level of assurance around this statutory process.

Assurance level: Reasonable Assurance

Conclusion

The IG portfolio has continued to make significant progress during 2019 / 2020. The appointment of a substantive IG Manager in April 2020 and FOI Co-ordinator in March 2020 brings greater contingency to the organisation and will build on the framework which is currently in place. The Head of Information Governance will look to increase the portfolio further during 2020 / 2021 and is currently working on a business case to recruit a substantive Band 5 IG / RA Officer. This will provide much needed support for the RA function within the Trust.

The Registration Authority function still requires further resource and a Trust wide operating model needs to be agreed and implemented. This will continue to be developed during 2020 / 2021.

The General Data Protection Regulation 2016 / Data Protection Act 2018 have been implemented within the Trust although it is recognised that there are still areas within the Trust which require support. Data Protection Impact Assessments are fully integrated within the PMO process and GDPR compliant Information Sharing Agreements are in place. A Trust wide Records Management review is underway, which will strengthen the Trust statutory obligations relating to records of processing activities.

IG awareness within the Trust continues to strengthen. The mandatory training in place is succinct and is supported further by both localised IG awareness training and specialised training. Historic processes and agreements continue to be highlighted and departments take a very proactive approach and work collaboratively with the Head of Information Governance / Data Protection Officer.

A key milestone for the Trust during 2019 / 2020 was the successful implementation of the ePCR system. This new electronic patient record demonstrates that the Trust is a forward thinking, proactive organisation with far reaching patient benefits. There was a significant IG element to complete to ensure that the system was compliant with information governance requirements and this was only achieved through the collaborative working between portfolios and open communication. It must be acknowledged that both IT and IG portfolios work in sequence to ensure that technical and IG components are completed and assured.

The integration of patient systems is an essential part of providing safe, quality patient care. Collaboration with STP's, ICS's and partner organisations continues with positive IG engagement. It is widely recognised that IG is not a 'blocker', it is about the appropriate legal sharing of information and is pivotal to the success of the Trust. Both Patients and Trust Employees have the right and expect their personal data to be kept safe, secure and managed within the bounds of our legal obligations.

This assurance is evidenced through a strategic IG framework which is 'fit for purpose' within the organisation. The Head of Information Governance will continue to build on this, ensure Trust wide engagement takes place and provide regular updates through the Trust operational / executive groups.

Overall Assurance level: Reasonable Assurance

Caroline Smart
Head of Information Governance / Data Protection Officer
June 2020

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	32-20

Name of meeting	Trust Board
Date	30.07.2020
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 priorities and sets out the controls, assurances, and actions. This version includes some proposed changes to the risks included in the BAF risk report, demonstrating the dynamic nature of the risk.
Recommendations, decisions or actions sought	The Board is asked to review the BAF risks, the recommendations in section 4, and confirm it is satisfied that it is sufficiently focussed on the most relevant risk areas.

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. 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 priorities and to seek assurance that adequate controls are in place to manage the risks appropriately.

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

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
Audit & Risk	Information Governance Effectiveness	239
	Data Security and Protection Toolkit	239
	IG Annual Report	239

4. Management Review & Recommendation

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

Risk to be removed from the BAF

i. Risk 269 – Call Answering
On the basis that the Trust has consistently exceeded the national targets since December 2019, the target risk score has been met and will be removed from the BAF risk report. These targets are regularly monitored and so any related new and emerging risks will be readily identified.

ii. Risk 239 – Information Governance
To be closed as the risk score has been achieved. As with risk 269, this will be closely monitored through the toolkit, and so any related new and emerging risk will be readily identified.

iii. Risk 334 – Culture
Following the steer from WWC this risk will be closed and a new one established to link more closely to the roll out of the new strategy and reinforcement of the Trust's values.

Changes in Risk Score

iv. Risk 111 – Workforce
Risk score has been reduced from 20 to 15.

v. Risk 362 – Safe Recruitment
As agreed at WWC, the risk score has been reduced from 15 to 9.

vi. Risk 1300 – Clinical Education
As agreed at WWC the controls and assurances have been updated and the risk score reduced from 12 to 8.

vii. Risk 579 – Clinical Management of Calls
The risk score has been reduced from 16 to 12.

viii. Risk 123 - ARP standards
The risk score is increased from 12 to 16 given the significant dip since the end of June.

Other

ix. Risk 178 – Funding
The risk description has been amended to reflect the link to funding rather than meeting the control total.

5. Conclusion

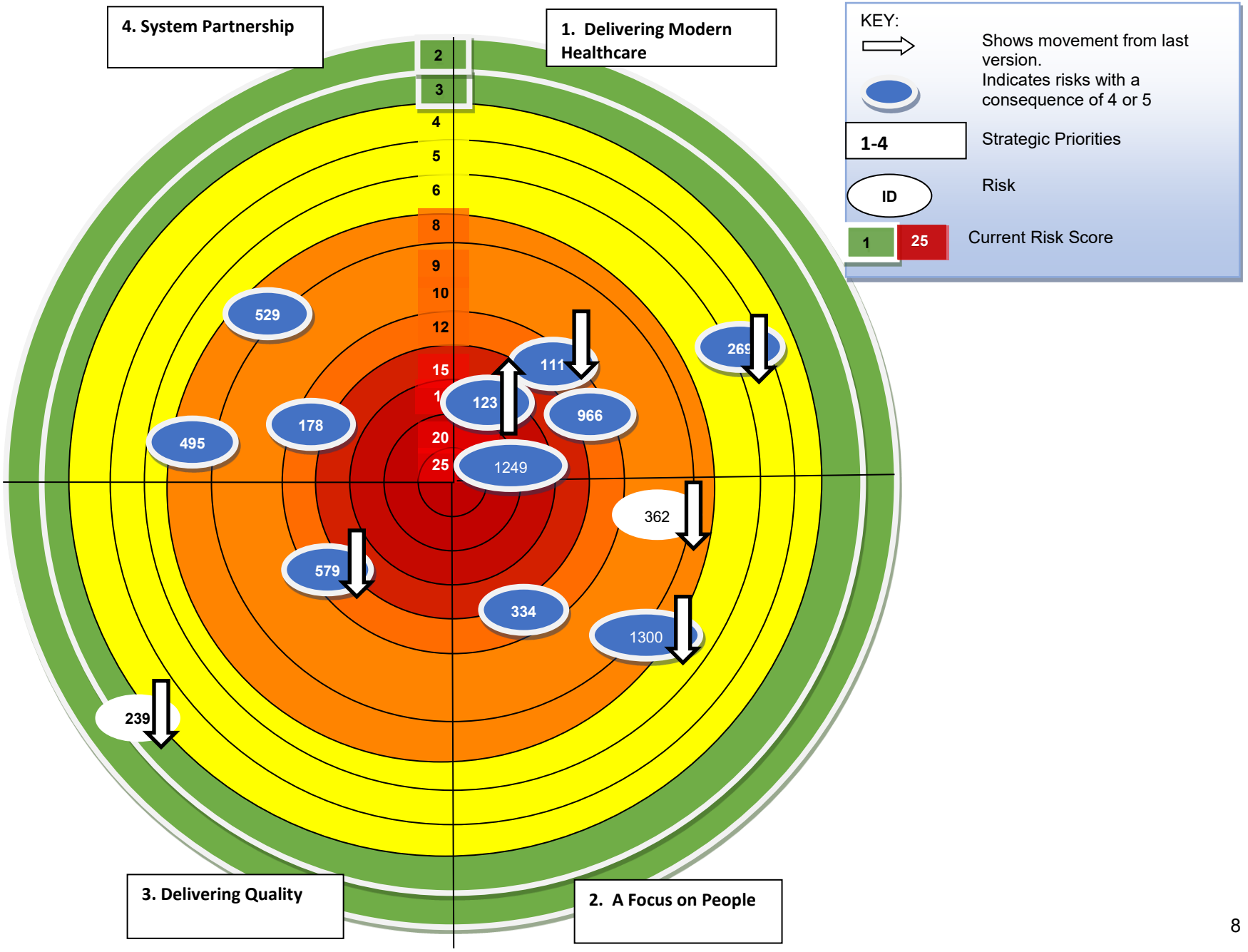
The Executive believes that the BAF risk report is sufficiently focussed on the right high-risk areas that affect the Trust's ability to meet its strategic goals. The Executive will continue to refine the report, so that is clearly sets out the controls, actions and sources of assurance it relies on. The BAF risk report will continue to be used by the Board and its committees, to ensure a risk-based approach is taken to seeking assurance that the risks are being robustly managed.

Dashboard

Link to Priorities	Risk ID / Theme	BAF Dashboard	Initial Score	Current Score	Target Score	Target Date	Board Oversight
1	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	15 ⇩	10	TBC	WWC
1	Risk ID 1249 COVID 19	There is a risk that in the event of an outbreak of COVID-19 in the United Kingdom, the Trust will experience severe disruption to key elements of its service. There would be both immediate and longer-term negative impacts on Trust activity such as; • Reduction in the provision of workforce • Access to sufficient medical consumables equipment (particularly PPE) • Consequent inability to achieve national performance targets	20	15	10	April 2021	AUC
3	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, which may lead to patient harm.	20	12 ⇩	04	April 2021	QPS

1	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	16 ⇕	08	TBC	FIC
2	Risk ID 1300 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	08 ⇓	04	December 2020	WWC
4	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	12	04	March 2021	FIC
1	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	05 ⇓	05	Target Score Achieved	QPS
2	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	09 ⇓	06	December 2020	WWC
1	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	TBC	FIC

2	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	To be closed and new risk established	WWC
4	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	TBC	FIC
3	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	03 	03	Target Risk Score Achieved	AuC
4	Risk ID 529 Change	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.		12	08	04	TBC	FIC


4. System Partnership
1. Delivering Modern Healthcare
3. Delivering Quality
2. A Focus on People
2
3
4
5
6
8
9
10
12
15
20
25
529
111
269
123
966
178
495
1249
362
579
334
1300
239
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Priorities
ID
Risk
1
25
Current Risk Score

Appendix A

Priority 1	**BAF Risk ID 111** Workforce – planned workforce	**Date risk opened: 14.04.2016**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of HR & OD
Risk that the Trust will not deliver the planned workforce as a result of; •inability to recruit to the current gaps •not retaining current staff This may lead to poor patient (and staff) outcomes and experience, and not meeting national performance targets.	**Scrutinising Forum**	HR Working Group
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current Risk Score	**15** (Consequence 5 x Likelihood 3)
	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
Improved EMA recruitment in to the EOC – recruitment currently paused due to full staffing
Manchester Triage (enabler to increase clinical capacity within EOC)
PP Rotational Pilot complete
Different approach to student paramedics ensuring higher number of job offers
Increase in bank staff
Retention Strategy
Reduced time to hire

Gaps in Control

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) sickness rates above the 5.2% target. (+) Turnover improved (-) skill mix (+) leavers reduced (+) NQP and AAP pipeline numbers in line with plan	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Plans to review temporary staffing structure	1. Business Case being developed

Last management review	Executive Management Board	**Last committee review**	02.07.2020 Workforce & Wellbeing Committee

Priority 2	**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)
	Current Risk Score	**09** (Consequence 3 x Likelihood 3)
	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 DBS checks (renewals/no initial) are being regularly monitored. DBS policy has been reviewed

Gaps in Control
Completion of the P Files project

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Internal Audit Reports – pre-employment checks (2017/18); DBS Checks (2018/19); Staff Records (2018/19) (-) Number of files incomplete (+) complete files for recent starters. (+) 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. Revised P Files Project 2. Internal Audit to review DBS check data sources	1. Commenced 6 July and due to be completed by December 2020 2. In progress

Last management review	Executive Management Board	**Last committee review**	02.07.2020 Workforce & Wellbeing Committee

Priority 2	BAF Risk ID 334 Culture – Improving the Trust's culture	Date risk opened: 11.10.2017

Underlying Cause / Source of Risk:		
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	**Accountable Director**	Director of HR & OD
	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	02.07. 2020 Workforce & Wellbeing Committee

Priority 2	**BAF Risk ID** 1300 Clinical Education	**Date risk opened:** **11/02/2020**

Underlying Cause / Source of Risk:	**Accountable Director**	Executive Medical Director
Risk that we will not meet the educational; requirements of 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 • Inadequate facilities	**Scrutinising Forum**	Transforming Clinical Education Programme Board and Working Group
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	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)

Established leadership arrangements
Clinical Education Courses – 2020/21 training plan developed, aligned to current workforce planning requirements.
FutureQuals interim re-audit undertaken with a successful level 1 outcome achieved and significant gaps in actions completed to date
Departmental vacancies almost completely recruited to.

Gaps in Control

Clinical Education strategy
Centre Relocation
Vacancies

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) FutureQuals interim re-audit undertaken with a successful level 1 outcome achieved and significant gaps in actions completed to date	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Clinical Education Strategy under development 2. Centre relocation - 3. Compliance - Work to close the Ofsted improvement plan continues, part time external consultant appointed to lead 4. Recruitment.	1. consultation with the clinical education team scheduled 27/7/20 and first draft due end July/early August 2020. 2. Weekly project group meetings continue; commissioning of new site underway; mapping estates/facilities/IT requirements; staff consultation to commence 3 August 2020 3. Eight week timeline to complete the FutureQuals re-audit actions underway (due 9 September 2020). Awaiting details from Ofsted re their rescheduling of inspections during Covid 4. Interviews for the remaining vacancies to tutor posts scheduled for end July/early August 2020.

Last management review	Executive Management Board	**Last committee review**	02.07.2020 Workforce & Wellbeing Committee

Priority 1	BAF Risk ID 269 EOC – national call answer performance targets	Date risk opened: 24.10.2017

Underlying Cause / Source of Risk:		
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	**Accountable Director**	Director of Operations
	Scrutinising Forum	Teams A/B (EOC)
	Initial Risk Score	**25** (Consequence 5 x Likelihood 5)
	Current Risk Score	**05** (Consequence 5 x Likelihood 1)
	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 Increase Bank through furloughed staff

Gaps in Control

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Call Answer performance – consistently within ARP since December 2019. (+) EMA capacity / reduction in EMA turnover (+) IA report	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.

Last management review	Executive Management Board	Last committee review	09.07.2020 Quality & Patient Safety Committee

Priority 3	**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	**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)

CAD upgrade provides better visibility of the types of calls requiring triage.
Specific EOC improvement plan completed
Overseas recruitment completed – 10 in post.
Implementation of Clinical Support Worker to support patient welfare calling
Clinical recruitment – target of 76 exceeded
Agency pathways clinicians introduced.
Revised EOC/111 governance group

Gaps in Control

Welfare call compliance
Pathways & Clinician Audits / Live feedback

Assurance: Positive (+) or Negative (-)		**Gaps in assurance**
(+) CQC – assured re improvements (+) clinical support (+) ARP performance, esp. Cat 3-4	(-) compliance with welfare calls (+) staff retention	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. See also linked mitigation within BAF risks 111, 123 & 269 2. Review of welfare call policy 3. EOC Audit Restructure	

Last management review	Executive Management Board	**Last committee review**	09.07.2020 Quality & Patient Safety Committee

Priority 1	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 Analyst 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	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
Service Development Improvement Plan	.

Last management review	Executive Management Board	Last committee review	23.07.2020 Finance and Investment Committee

Priority 1	**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	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

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

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

Gaps in Control

Abstraction rates
Hospital Handover delays – lost hours

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Performance Q1 (-) Performance from July. (+) Lost hours from handover delays – much improved (+) recovery efficiency metrics on target. (+) Call answer performance (-) Booked on hours decreasing /self-isolation.	

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Handover Programme 2. Plans in place to ensure staff can return safely to work. 3. Operational recovery actions	1. On-going 2. Risk Assessments / mitigation to ensure all (self-isolating) staff can return to work from 1 August. 3. Monitored weekly.

Last management review	Executive Management Board	**Last committee review**	23.07.2020 Finance and Investment Committee

Priority 1	BAF Risk ID 1249 COVID-19	Date risk opened: 28.03.2020

Underlying Cause / Source of 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. There would be both immediate and longer-term negative impacts on Trust activity such as; • Reduction in the provision of workforce • Access to sufficient medical consumables equipment (particularly PPE) • Consequent inability to achieve national performance targets	**Accountable Director**	Director of Nursing & Quality
	Scrutinising Forum	CRMG
	Initial Risk Score	**20** (Consequence 5 x Likelihood 4)
	Current Risk Score	**15** (Consequence 5 x Likelihood 3)
	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)	
• Business Continuity Incident (20.03.2020) • Establishment of BCI COVID-19 Management Group to act as a single point of decision making (23.03.2020) • Creation of an over-arching COVID-19 Strategic Plan (V2 approved by EMB 31.03.2020) • Creation of an Incident Operating Model (approved by EMB 15.04.2020) • Weekly review of Risk Register at COVID-19 Management Group • Receipt and implementation of national guidance • Continued regular liaison with NACC, NARU, NDOG • Daily SECAmb sitreps shared with external agencies include specifics on staffing cover, supply chain issues and performance impact • Refresh of departmental Business Continuity Plans (March 2020) • Cessation of training programmes, including key skills 2019/20 (18.03.2020). • Deferral of 2020/21 key skills to July 2020. Suspension of Fundamentals first line manager / leadership training • Staff provided with option to cancel A/L booked during April, May or June 2020 (30.03.2020) • Decision to adopt a fast track recruitment process (DBS & references) as a temporary measure (approved by QPS 30.03.2020) • Hotel accommodation offered to staff impacted by household isolation guidelines (30.03.2020)	• Nationally approved extension of visas for NHS staff due to end 01.10.2020 (31.03.2020) • Launch of a centrally coordinated alternative duties hub to identify and match available staff to COVID related workstreams (08.04.2020) • Additional senior management support has been provided to the existing Logistics team • Establishment of county-based equipment hubs at Paddock Wood, Worthing and Banstead to oversee delivery of equipment (18.03.2020) • Restriction of entry into the EOCs and 111 to prevent the spread of infection • Creation and continued issue of Action Cards to guide managers and staff through COVID-related scenarios (17.03.2020) • Implementation of Workplace Pyrexia Checks Protocol (V1.2 issued 20.03.2020) • Expansion of West EOC into the first floor of Trust HQ to follow national social distancing guidelines (approved by EMB 25.03.2020) • Issue of Covid-19 SECAmb Guidance relating to PPE (V1 issued 20.02.2020. V6 issued 03.04.2020) • Provision of serology testing programme (3,260 staff, volunteers and contractors were tested up to 12.07.20) • Introduction (June 2020) of risk assessments, initially for identified at risk groups - BAME staff, and those who are shielding or clinically vulnerable

Gaps in Control

Assurance: Positive (+) or Negative (-)	Gaps in assurance
Performance for Q1 (+) QPS (+)	

Mitigating actions planned / underway			Progress against actions (including dates, notes on slippage or controls/ assurance failing.
• Exploring opportunities to use co-responders in different roles • Agile working pilot for 111 Health Advisors / experienced clinicians • Daily review of action cards by the COVID-19 Management Group • Regular liaison with NHS Supply Chain re PPE • Daily stock take of PPE • Prompt issue of relevant clinical and operational bulletins is continuing			
Last management review	Executive Management Board	**Last committee review**	16.07.2020 Audit & Risk Committee

Priority 4	BAF Risk ID 178 Funding	Date risk opened: 01.04.2020

Underlying Cause / Source of Risk:		
Risk that the funding available to the Trust does not allow it to deliver appropriate patient care due to insufficient resources	**Accountable Director**	Director of Finance & Corporate Services
	Scrutinising Forum	Heads of Finance
	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)
Cost improvement programme (CIP) 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 Active part in SE region system Mid-Year planning review

Gaps in Control
Macro-economic issues facing the NHS Uncertainty of financial architecture of the system Robust & recurrent CIP plans 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 2019/20 (-) level of cost pressures / (-) CIP shortfall	

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
Productivity Group review of efficiency Learning & Improvement Group	

Last management review	Executive Management Board	Last committee review	23.07.2020 Finance and Investment Committee

Priority 4	**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 pace of change (due to COVID) is significant putting pressure on Trust being able to keep up with demand from the system •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 2. Compliance with Cyber Essential Plus through NHS Digital programme of work 3. Continued work on removing redundant systems - Banstead closure 4. Removal of vulnerable systems - website, info.secamb, ibis 5. Share Point review	1. Paused due to COVID 2. Paused due to COVID

Last management review	Executive Management Board	**Last committee review**	23.07.2020 Finance and Investment Committee

Priority 3	**BAF Risk ID 239** Information Governance	**Date risk opened: 21.08.2017**

Underlying Cause / Source of Risk:	**Accountable Director**	Director of Nursing & Quality
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	**03** (Consequence 3 x Likelihood 1)
	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 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 (+) AUC July (+) effective policies	

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'. 2. There are Information Asset Owners in place, and this will remain a standard agenda item for the monthly IGWG meetings.

Last management review	Executive Management Board	**Last committee review**	Audit and Risk Committee 09.07.2020

Priority 4	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	23.07.2020 Finance and Investment Committee

Appendix B
Strategic Priorities

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

Appendix C

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

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

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

Secamb Board

CFC Committee Escalation Report to the Board

Date of meeting	16 July 2020
Overview of key issues/areas covered at the meeting:	The committee updated the **terms of reference** which are included for the Board to approve. It also received an update following the issues reported to the Board in January and reviewed the related **charitable funds procedure**, which is included for information. In terms of the update, the committee acknowledged the progress made and supported the procedure that sets out how we intend to ensure robust management of funds, including monies raised by the different CFR schemes. There is work to do to ensure we engage well with the CFRs, and ensure they understand what we are doing and why; to protect them and the Trust from falling foul of the charity rules. Overall, the committee is assured with the progress being made and agreed with the executive some further actions which it will review in December. The committee approved the **financial report** for the year ending 31 March 2020 and received a really positive update about the **COVID-related charity activity**. A paper was received setting out the approach, reinforcing the need to ensure flexibility in the context of the set criteria for how to use this money.
Any other matters the Committee wishes to escalate to the Board	This was a good meeting that established a clear direction for what the committee expects over the coming months. While there is still work to do, we are in a better position than before. The Chairman will be arranging to meet with CFR leads to ensure they are engaged and understand what we are doing and why.

South East Coast Ambulance Service NHS Foundation Trust

Charitable Funds Committee (CFC)

Terms of Reference

1. Constitution

1.1. South East Coast Ambulance NHS Foundation Trust (SECAmb) was appointed as Corporate Trustee of the charitable funds by virtue of SI 2006 (1623) and its Board serves as its agent in the administration of the charitable funds held by the Trust.

1.2. The Board hereby resolves to establish a Committee of the Board to be known as the Charitable Funds Committee (CFC), referred to in this document as 'The Committee'.

1.3. The CFC will act as the overseer of the Charity via nominated representatives of the Trust Board. For absolute clarity the Trust Board acts as the Corporate Trustee.

2. Purpose

2.1. The purpose of the Committee is to make and monitor arrangements for the control and management of the Trust's charitable funds and to report through to the Trust Board.

2.2. Further details of the Charity can be found on the Charity Commission website https://www.gov.uk/government/organisations/charity-commission

3. Membership

3.1. The Committee shall have not less than three members, appointed by the Board from amongst the Non-Executive Directors of the Trust. One of the Non-Executive Director members will be appointed Chair of the Committee by the Board. The Executive Directors Membership shall comprise the Director of Finance and one other Executive Director. The Chairman of the Trust shall not be a member.

3.2. The membership comprises:

- Michael Whitehouse - Non-Executive Director (Chair)
- Al Rymer – Non Executive Director
- Howard Goodbourn – Non Executive Director
- Executive Director of Finance (Lead Executive Director)
- Executive Director of Operations

3.3 In addition each individual Non-Executive Director 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 three members including the Director of Finance or designate.

5. Attendance

5.1. The Company Secretary or Deputy shall regularly attend meetings.

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

- Head of Financial Accounting

5.3. The Chief Executive, Chairman and other 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.

5.4. The Corporate Services office will provide secretarial duties to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

5.5. Members and officers, other than Non-Executive Directors, 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. Members and officers are required to attend 75% of these Committee meetings.

5.6. 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.

5.7. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency

6.1. The Committee shall meet at least twice yearly.

6.2. 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 conference telephone call 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 other than those specified in these Terms of Reference or by the Trust Board in its Scheme of Delegation.

8.2. The banking arrangements for the charitable funds should be kept entirely distinct from the Trust's NHS funds.

8.3. Separate current and deposit accounts should be minimised consistent with meeting expenditure obligations

9. Duties

9.1. Within the budget, priorities and spending criteria determined by the Trust as Trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006, Charities act 2011 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

9.2. To ensure that the Trust policies and procedures for charitable funds investments are followed.

9.3. To make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The Charities Act 1993
- The Charities Act 2006
- The Charities Act 2011
- Terms of the fund's governing document

9.4. To receive at least three times per year reports from the Director of Finance.

9.5. To oversee and monitor the functions performed by the Director of Finance as defined in the Standing Financial Instructions

9.6. To monitor the Trust's scheme of delegation for expenditure for the levels:

- Up to £1,000 : Charitable funds Accountant
- Between £1,000 and £5,000 : Head of Financial Accounts
- Between £5,000 and £25,000 : Director of Finance

9.7. To approve all individual charitable fund expenditure in excess of £25,000

9.8. Expenditure over £100,000 must have Trust Board approval

10. Delegated Powers and Duties of the Director of Finance

10.1. Director of Finance has prime responsibility for the Trust's charitable funds as defined in the Trust's SFIs. The specific powers, duties and responsibilities delegated to the Director of Finance are:

- Administration of all existing charitable funds
- Provide guidelines with respect to donations, legacies and bequests
- Ensure appropriate banking services are available to the Charity
- Prepare reports to the Trust Board including the annual accounts.

11. Reporting

11.1 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.

11.2 The Committee shall report to the Board annually on its work.

12. Support

12.1. The Committee shall be supported by the Corporate Services' office and duties shall include:

12.1.1. Agreement of the meeting agendas with the Chair of the Committee;

12.1.2. Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings;

12.1.3. Enforcing a disciplined timeframe for agenda items and papers, as below:

i. At least twelve working days prior to each meeting, agenda items will be due from Committee members;

ii. At least seven working days before each meeting, papers will be due from Committee members;

iii. At least five working days prior to each meeting, papers will be issued to all Committee members and any invited Directors and officers.

12.1.4. Recording and circulating formal minutes of meetings and keeping a record of matters arising and issues to be carried forward, circulating approved draft minutes within five working days from the date of the last meeting;

12.1.5. Advising the Chair and the Committee about fulfilment of the Committee's Terms of Reference and related governance matters.

13. Review

13.1. 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.

13.2. 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.

13.3. 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: (23 July 2023

SOUTH EAST COAST AMBULANCE SERVICE
NHS FOUNDATION TRUST

CHARITABLE FUNDS PROCEDURE
July 2020

Introduction

This procedure is set out in two sections. Section 1 deals with the Governance of the Charity. Section 2 with the Financial Administration.

SECTION 1 – CHARITY GOVERANCE

1. Purpose and Legal Context

1.1. The South East Coast Ambulance Service Charitable (SECAmb) Funds is a registered charity (Registered No 1059933) and is the official charity for all funds raised for the benefit of patients of SECAmb.

1.2. The Charity is a separate legal entity from the Trust. The Trust Board holds charitable funds as the sole corporate trustee, and the board members are jointly responsible for the management of those charitable funds.

1.3. The Trust Board nominates members of the Board (both Executive and Non-Executive) to sit on the Charitable Fund Committee (CFC) to administer the funds and make recommendations to the Board.

1.4. The purpose of this procedure is to provide guidance for the receipt and documentation of incoming funds, the requesting of cheque payments and other routines for charitable funds, including the disbursement of funds.

2. Background

2.1. Financing of equipment and services from funds outside normal revenue budgets is increasingly important in maintaining the quality of patient care within the NHS. Such funds are known as charitable funds, the majority of which come from voluntary donation, fundraising initiatives or sponsorship.

2.2. Charitable Funds are not a substitute for government funding. The NHS is required to provide a basic level of care and treatment from government funding.

2.3. Charitable Funds can be used to enhance this level of care but cannot cover the basic costs.

2.4. Actions taken by the charity must be for the public benefit.

2.5. Historically, the Charitable Funds have funded contributions towards staff welfare, mental wellbeing, physiotherapy, hardship following exceptional circumstances i.e. fire/flood, and rest room enhancement equipment.

3. Purpose and Objective

3.1. As set out within with the Charities Annual Report and as per the information held by the Charity Commission, the main purpose of the charitable funds held on trust is:

'to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the South East Coast Ambulance Service NHS Foundation Trust, for expenditure which the Trust does not and cannot obtain funding. In furthering these objectives the Charity seeks to apply expenditure only where a public benefit will ensue, directly or indirectly'

The objectives of the fund as further defined by the Trustees sets out that the fund is to be used for;

> 'any charitable purpose relating to the service provided by the South East Coast Ambulance Service NHS Foundation Trust within the National Health Service that enhances and develops the Ambulance Service, its staff and the patients experience'.

4. Fund Types

4.1. There are two fund types. General and Restricted.

4.2. The General Fund may be used for any purpose within the charitable fund's objectives with the approval of the CFC.

4.3. All other funds are restricted funds, i.e. they may only be used for the site or purpose designated.

4.4. No groups or staff/volunteers should raise or hold funds (e.g. from fundraising, voluntary donations, ad hoc donations) that are not administered by either: official trust accounts (if actually more properly public funds); or The Trust charity fund; or a known independent charity registered with the Charity Commission.

5. New Funds

5.1. New funds will not be created without the approval of the Charitable Fund Committee (CFC). Where a donation is made noting that the donor wishes it to be used, or would like it used for a particular site or purpose, the donation will be credited to an existing fund if one exists that matches the donor's request. Under Charity Commission guidance, a wish or statement of preference does not put a binding commitment upon the charitable fund, so if a suitable restricted fund does not exist, the donation shall be paid into the General Fund.

5.2. If a donor specifies that their gift may only be used for a specified purpose, it will be paid into a restricted fund if one exists for the purpose. If no such fund exists, the Charitable Fund Accountant will write to the donor to request that the restriction is lifted. If the donor insists upon the originally stated purpose, the Charitable Fund Accountant will seek the views of the CFC whether to accept the donation or not. They will consider the increased administration

cost and opportunities to spend on the stated purpose versus the benefit of the donation.

6. Income governance

6.1. Income is usually received at SECAmb Headquarters. Occasionally, donations are made directly to another Trust location. In these circumstances the station staff will be requested to send the remittance and any accompanying correspondence directly to the Charitable Fund Accountant based at SECAmb Headquarters.

6.2. When received, income will be compared to any accompanying letter to ensure it agrees, and for cheques, that the payee, date, words and figures and signature are all correct/present.

6.3. Letters will be checked for the donor's intentions regarding which fund should be credited (see 5. New Funds).

6.4. **Income Acknowledgement**

6.4.1 A letter of thanks acknowledging the amount of the payment will be sent to the donor upon receipt of the fund in the Finance department.
The Charitable Fund will not accept donations from organisations whose income is primarily from the following sources:

- Gambling companies/organisations
- Political parties
- Any other donor with whom an association might potentially bring SECAmb into disrepute.

7. Expenditure governance

7.1 Requests for Charitable fund utilisation are made via the form in Appendix 1 and sent to treasury inbox.

7.2 Such requests that are in the pursuance of staff hardship and support should first come through the Trust Wellbeing Hub for perusal for other avenues of support prior to submission to the Charitable Fund.

7.3 Any requests that require specialist knowledge, such as for medical equipment should be validated by the appropriate Directorate lead as appropriate for use within the Trust.

7.4 All requests are reviewed by the Charitable Fund accountant and the Director of Finance for the appropriateness of the request in line with the Fund's purpose. Further information will be sought if required from the requestor and other employees pertinent to the request.

7.5 If the level of request warrants a wider discussion the CFC Committee will be asked to give its approval.

7.6 All reviews are then fed back to the originator of the request as to whether

funds will be released.

8. Community First Responder (CFR) Fundraising

8.1 All Community First Responders have the option to fundraise under the umbrella of the SECAmb Charitable Fund. When using the Trust's Charitable Number and / or SECamb branding, all monies collected **must be** deposited to the Charitable Fund, and SECAmb's rules and principles followed. This also includes all elements of this policy.

8.2 CFR's are permitted to purchase equipment from their accounts held in the Charitable Fund, provided they relate to a service provided by SECAmb. The Trust Volunteer Services Department administer all requests for purchases which come to the charity and undertake the required due diligence and should provide assurance all Trust requirements have been met before lodging a request with the Charitable fund.

8.3 Where CFR's have established an independent charity in their own right, they must follow the appropriate governance set out by the Charity Commission.

8.4 The Community First Responders are managed by the Trusts Volunteer Services Department. The Executive Director of Operations is responsible for the Volunteer Services Department and is a nominated member of the CFC of the Charitable Fund and as such is able to provide assurance that these conditions are met for each transaction.

8.5 For any other fundraising activity the CFC will be consulted. The current fundraising mechanisms are:

- A Just Giving page with a link from the Trust website
- Membership of the NHS Together Network where NHS funds are distributed following central donations from the public as a result of the COVID crisis
- Ad-hoc donations from the public

SECTION 2 - FINANCIAL ADMINSTRATION

9. Banking and Income Records

9.1 Banking will be undertaken as soon as practicably possible but always within 2 weeks of receipt of item.

9.2 In the first instance, money received will be paid into the Lloyds Bank account.

9.3 Letters and any supporting details will be filed with the monthly income sheet.

10. Cash Book - Income

10.1. As soon as practical, the cash book will be posted with the details of the donation and the fund number to be credited.

11. Expenditure Applications

11.1. Applications for grants will be made in the first instance to the Charitable Fund Accountant, on the approved forms, see appendix 1. They all must be signed by the designated line manager and fund-holder.

11.2. Designated funds will only be spent on items that are deemed eligible for support from charitable funds, and that the procedures used for expenditure are transparent and robust.

11.3. The Trust will also consider other opportunities for income generation on an ad-hoc basis. Examples may include the creation of a 'Just Giving' type account or utilising funds made available such as the NHS Together allocations which was part of a national charitable response to the COVID pandemic. These opportunities will be approved by the CFC.

12. Expenditure Approval

12.1. Where applications are for types of expenditure on the approved list, the Charitable Fund Accountant will:

- Forward to Director of Finance (up to £5,000) for approval
- Forward to Director of Finance or Chief Executive (£5,000 - £25,000) for approval
- Forward to CFC (£25,000-£100,000) for approval.
- Forward to Trust Board (above £100,000) for approval

12.2. The request will clearly state which fund or funds are involved, the amount to be paid from each and the balance that will remain on each. Should a signatory decline to approve, the fund-holder/applicant will be advised.

12.3. If approval is received, the Charitable Fund Accountant will authorise purchase and subsequent payment to the applicant.

12.4. All such payments will be reported to the following CFC for information.

13. Contentious Requests as deemed by the Charitable Fund Accountant

13.1. Where applications are received for normal items but are for a higher than expected value, or are for items not on the approved list and/or not of obvious benefit to the service or the majority of staff concerned, or are outside the objectives of the charitable fund, the applicant will be advised and, if required,

the application will be referred to the next meeting of the CFC for consideration.

13.2. Examples of expenditure that is not charitable, or which does not have the CFC approval for expenditure from any designated fund include:

1. Alcohol
2. Gifts or other rewards for individuals
3. Refreshments for routine meetings
4. Expenditure on events which could have a poor effect on the Trust's reputation.
5. Conference attendance, the subject of which, however commendable, is not likely to benefit patient care
6. Items essential to delivery of the Trust's core services
7. Basic costs relating to a NHS post such as desk, computer uniform etc
8. Gift vouchers in lieu of payment to suppliers or individuals (as HMRC treats these as cash).

14. Requests for Sponsorship

14.1. Where a request is received from a member of staff or other body for sponsorship, this will normally be declined on the basis that donors made their gifts to the South East Coast Ambulance Service Charitable Fund and not to another charity.

14.2. If the application is for assistance towards a SECAmb team taking part in a charitable event, e.g. the 999 sailing challenge, this will be referred to the Chief Executive or Executive Director of Finance as such activities have been viewed as team building exercises from which the Trust derives benefit.

15. Previously Delegated Expenditure Approval

15.1. All expenditure on CFR equipment is required to go through the Trust with the appropriate approval limits in line with Trust governance and SFIs. Thus, the Head of Community Engagement, covering the volunteers, would have the order level approval as appropriate from those documents.

16. Payments

16.1. Once appropriate authorisation has been obtained, orders will be processed and invoices paid by cheque accompanied by a remittance advice to the payee.

16.2. Where payments are for approved applications from staff, the Charitable Fund Accountant will contact the requestor (main contact) to find how they would prefer payment to be made. If the main contact is willing to use their own credit or debit card, they should send the receipt (or a copy of it if the original may be needed for any warranty claims) to the Charitable Fund Accountant as soon as possible. The Charitable Fund Accountant will then draw a cheque payable to the main contact and return it with a remittance advice.

16.3. If a cheque in advance is preferred, the main contact should send the Charitable Fund Accountant a quote from the supplier or a current advert that shows the price. The main contact must ensure that they note the address to

which they want the cheque sent. Once the item has been purchased, the receipt or copy as above must be sent to the Charitable Fund Accountant.

16.4. If payment is to be made direct to the supplier, the main contact must provide the Charitable Fund Accountant with the supplier's contact details including a contact name so that invoicing and payment arrangements may be made. The Charitable Fund Accountant will advise the main contact when the cheque has been sent so that collection may be arranged.

16.5. In the case of wellbeing related payments, other avenues of support would always be evaluated first such as SECAmb Benevolent Fund and The Ambulance Staff Charity.

17. Payment Records

17.1. The Charitable Fund Accountant will ensure that sufficient details of each payment are recorded. All documents relevant to each payment, e.g. the authorised application, invoice/receipt and copy remittance advice shall be filed together in cheque number order in a 'Paid' file.

18. Cash Book - Expenditure

18.1. As soon as practicable, the cash book will be posted with the details of the payment and the fund number to be debited.

19. Payments Security

19.1. Cheque books will be held securely in a locked cash box.

20. Charitable Accounts Banking

20.1. Accounts are currently held with Lloyds Bank and will be reviewed annually to see if any other secure banks or building societies offer better terms. The results will be summarised and presented to the CFC.

21. Bank Statements

21.1. Monthly statements are provided by Lloyds Bank. Statements will be checked to ensure they reconcile to Charitable Fund records, run in date and numerical sequence, and then they will be filed chronologically.

22. Bank Reconciliations

22.1. As soon as the statements for the previous month are received they will be reconciled to the cash book to identify any un-presented cheques, un-cleared credits, payments direct to the account and charges/interest credited. The cash book will be updated accordingly for the direct credit/debit items provided that the Charitable Fund Accountant is satisfied that these are correct and reasonable.

23. Interest Received

23.1. Monthly interest will be allocated pro-rata to the closing balance on each fund's account at the end of each month.

24. Bank Signatories

24.1. Bank account signatories will be the Chief Executive, Executive Director of Finance plus other executive directors and senior staff as approved by the Committee.

25. Bank Mandates

25.1. Changes to the Bank mandates may only be made with the approval of the CFC, or the Chief Executive and Executive Director of Finance should a matter of urgency arise. Any instructions to the bank concerned must be in writing and signed by duly authorised signatories including either the Chief Executive or Executive Director of Finance.

26. Investment

26.1. The Charitable Trust will not invest its funds other than in a secure "high street" bank or building society. Should the Trust receive a bequest in the form of an investment the CFC will confirm if the donation is to be accepted. This is due to the relatively low amounts held and the need for instant access. This will be reviews as required by the Trusts Heads of Financial Accounts and a recommendation brought to the CFC if required.

26.2. Currently one investment is held of 5,000 shares in Haven Housing Ltd. These shares were a bequest to Folkestone ambulance station and provide an income by way of dividend. The shares may only be sold back to the company or to another of the existing shareholders.

27. Legacies

27.1 Any enquiry from an individual seeking information about making a bequest to the charity should be referred to the Executive Director of Finance, who will follow up with the individual concerned.

28. Recording and Reporting

28.1. Currently the Trust records financial transactions using a spread-sheet based system. Consideration should be made of utilising a stand-alone recognised accounting software.

28.2. Fund accounts will be updated monthly after the reconciliation of the bank accounts to the cash book.

All general ledger reconciliations must be completed monthly, signed off by the Charitable Fund Accountant, and reviewed by the Head of Financial Accounting.

28.3. The Charitable Fund Accountant will maintain a list of fund-holders for each fund (e.g. the relevant Clinical Operations Managers for the ambulance stations with their own nominated funds). Statements of balances held will be provided to these principal contacts on a quarterly basis, or upon request.

29. Committee Updates

29.1. The Charitable Fund Accountant will provide a regular update report to the CFC at intervals and in the format as specified by the Committee.

30. Annual Accounts

30.1. Annual accounts will be prepared in accordance with the requirements of local generally accepted accounting practice and the requirements of the Charity Commission. Accounts will be presented to the CFC prior to the annual audit. The audited accounts will then be presented to the Board for final approval and signature prior to submission to the Charity Commission.

Appendix 1

4 Charitable Funds Request.doc

Date: July 2020

Secamb Board

ARC Committee Escalation Report to the Board

Date of meeting	25 June 2020
Overview of key issues/areas covered at the meeting:	The committee reviewed **succession planning** for each executive director, which informed the **annual review of the structure, size and composition of the Board**. The committee concluded that for now the structure and size of the Board is appropriate and agreed some actions to ensure that there are clear and robust personal development plans for both the executive directors and those in deputy roles. Steps are continuing to be taken to ensure a more diverse Board through the current round of (NED) recruitment, and the committee will consider in September what might constitute the future SECamb Board. There was also an annual review of the **fit and proper persons test** and the committee was assured by the paper it received setting out by director how we are compliant with the requirements. The Chief Executive provided a summary of the **appraisals** of each executive director and the committee was assured by both the process and outcomes. Finally, the committee reviewed **executive remuneration** and how it benchmarks against other similar trusts. This has informed an executive remuneration framework that the committee considered; some amendments were suggested, and it will come back for approval in September. In the meantime, the committee approved changes in the remuneration of some directors, based on this new framework.
Any other matters the Committee wishes to escalate to the Board	None.