South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

24 September 2020
10.00-12.30

Via Video Conference

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
37/20	10.00	Welcome and Apologies for absence	-	-	Chair
38/20	10.02	Declarations of interest	-	-	Chair
39/20	10.02	Minutes of the previous meeting: 30 July 2020	**Y**	Decision	Chair
40/20	10.03	Matters arising (Action log)	**Y**	Decision	PL
41/20	10.05	Board Story	-		
42/20	10.15	Chairs Report Incl.BAF Risk Report	**Y**	Information	Chair
43/20	10.30	Chief Executive's report	**Y**	Information	PA
44/20	10.45	Integrated Performance Report 999 Improvement Plan Committee Reports Incl. Annual Reports x4	**Y**	Information	PA
45/20	12.00	Winter Planning / EU Transition	**Y**	Assurance	JG
46/20	12.15	111 CAS Mobilisation	**Y**	Information	DH
Closing					
48/20	12.25	Any other business	-	Discussion	Chair
49/20	-	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: 26 November 2020

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 30 July 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
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary

Chairman's introductions

DA welcomed members and those in attendance and confirmed that the meeting is being recorded via Teams. DA then confirmed that Cheryl Howarth will shortly be joining to observe on behalf of the CQC.

This is the first meeting in public since the very sad passing of Tricia McGregor and DA paid tribute to Tricia and the contribution she made to the Trust Board and the wider NHS.

19/20 Apologies for absence

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

20/20 Declarations of conflicts of interest

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

21/20 Minutes of the meeting held in public 28.05.2020

The minutes were approved as a true and accurate record.

22/20 Action Log

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

23/20 Board Story [10.03 -10.10]
DA introduced the video which helps set the tone for our approach to inclusion.

The Board reflected that this is timely given recent events and the need to bring inclusion more to the fore. DA felt that our record has been good, but there is much room from improvement. He confirmed that he is the Board champion for inclusion and will make sure the Trust continues to be an inclusive organisation.

24/20 Chief Executive Report [10.10 – 10.44]
PA agreed the inclusion video included well thought through messaging and acknowledged that this will make no difference unless we take action; this needs to be both positive and call out when issues arise. We also need to get our recruitment right. PA then confirmed that in the talent inclusion and diversity awards this year we were awarded a gold award for our work.

PA then turned to his report and highlighted the following areas;

- COVID - since the restrictions eased we have seen demand return and we have taken lots of measures to ensure staff safety, linked to the phasing of the pandemic. PA expressed his view that we are in a lull and a second wave will come, which will require us to make sensible assumptions to respond accordingly. Worst case is that the second wave comes in Winter and we are planning for this scenario.
- Performance – the IPR includes May performance which was our best month in terms of performance due to low demand, acuity and improved hours all of which was sufficient to meet demand in 999. 111 was still recovering from March /April and demand was starting to settle. Call handling throughout has been excellent. We are however now behind curve currently in terms of hours versus demand, and this is why performance is worse. In terms of PPE, we have talked at every board meeting about this and the situation hasn't changed; we have never run out, but in April we took the decision that the balance of risk between staff and patients was such that those staff not fit tested successfully were withdrawn from patient facing roles. There are still a number in this position, and we are working to find bespoke solutions for each of them.
- Clinical Education – there was a positive review by Future Quals with level 1 assurance achieved, which demonstrated significant progress. At this point PA took a question from the public received in advance about courses for Associate Ambulance Practitioners and the extent to which their delivery will be managed closely. FM responded by confirming that we can be assured by the quality of programmes, which are delivered by an external partner who are rated very highly.
- Future of 111 – PA explained that we are on track to go live with the new 111 CAS service on 1 October 2020. Some changes in approach nationally and regionally are emerging from the response to COVID, with a move to manage access to emergency services via 111; ' Think 111 First'. There is a pilot currently in Portsmouth and London and there is likely to be fast followers prior to national roll out, probably before Christmas. Our focus is in managing this without affecting the roll out of 111 CAS.
- Clinical and patient care – PA recognised Alan Cowley for his work on spinal injuries. There was a question from the public linked to this, asking whether this has been agreed by all emergency departments within our region. FM responded by confirming that we worked closely with the three local trauma networks who were supportive and agreed to cascade to every unit and local emergency hospital. We also worked with the RNLI, Fire services and others.

In summary, PA was really pleased with our management of COVID, but there is lots still to do to prepare for Winter.

DA thanked PA for his summary and invited questions from the Board.

LM referred to section 4.1.3 of the report about the learning from COVID and asked whether we are going to see how our learning fits with the national picture and other ambulance trusts. PA explained that we are tied

in with the ICSs recovery and learning plans and explained that most of these plans are about the challenges other parts of the system experienced, which we did not, for example turning off services and therefore needing to turn them back on. There are however some links via GP consultations and Think 111 first. DH added that for ambulance services the focus on 'recovery' is different as we never stopped services and so our focus is more on learning and improvement. There are groups where ambulance services nationally share experiences.

MW referenced the local lockdowns in places like Oldham and Leicester and asked whether we have protocols in place to manage this within the system. He also asked about possible consequences of Think 111 First. With regards local lockdowns PA explained that he has talked to colleagues in those two areas and the impact on the ambulance service is not significant as it carries on with normal 999 business. PA did not think 111would be affected in the same way as the first lockdown, where there was big spike due to the initial concerns; the spike in any second lockdown is therefore likely to be lower and we have capacity to manage this. In terms of Think 111 Frist PA accepted there is not a perfect plan, as we are grabbing the opportunity of COVID where we suddenly realised the benefits of someone else controlling the flow to A&E. There are potentially significant consequences and there is awareness of this in the system and so sensible discussions are taking place about how to implement this safely. For example, the two pilots mentioned earlier are only taking 10-15% of demand, so there is a gradual change. JG added that our EPPR team is scanning the horizon for any impacts through the various planning events, and BH confirmed there are already several plans agreed that are ready to go, if needed.

LB referred to the issue in ensuring the right level of operational hours and the adverse impact on 999 performance, asking whether we are getting sufficient hours from private ambulance providers (PAPs). JG confirmed that we are working with two providers to agree more substantial contracts, which means for others they are more ad hoc based on their performance and productivity. He then reinforced the balance between the growth in workforce and use of PAPs which is part of the workforce plan.

25/20 COVID Response Management Group [10.44 – 11.08]

BH explained that the paper aims to give assurance with the arrangements in place to respond to COVID, which builds on the paper provided at the Board meeting in May. BH then took the Board through the areas of focus since May, as set out in the paper.

In the pack is the IPC Assurance Framework, which BH explained was written in a point in time and reviews where we are in relation to IPC; there are no gaps in assurance.

DH updated on the work of the COVID Recovery Learning and Improvement Group (CRLIG) and as discussed earlier the smallest element is 'recovery'. Senior leaders are driving this, and we have reviewed all the decisions at the COVID Response Management Group (CRMG) using an 'adopt adapt abandon' approach. We are also reviewing the trust response to COVID and the opportunities from where we deliver things differently, e.g. new ways of working. AM outlined some of the thinking as lead for the new ways of working workstream, including agile working.

DH then confirmed the governance arrangements whereby the CRLIG is effectively a think tank to generate ideas and develop plans, which then are taken forward within the usual governance framework.

AR noted the various initiatives and asked how we are going to step back to take a more strategic view about how we might provide services in the future. DH explained that emerging themes will be aligned with the strategic direction and related delivery plan.

DA summarised by confirming that the Board committees will continue to review our response to and learning from COVID, to ensure it is coordinated. Overall, the Board can take assurance from our response to COVID and from how this has been governed.

26/20 IPR /Committee Reports (11.08 – 12.09)

PA introduced this new format IPR, which is a work in progress, as set out in the cover paper. He confirmed that there are some issues with way some of the data is presented which will be corrected, but felt it is a good first version and gives a clearer picture about the Trust than the previous version.

Safe:

BH highlighted some things we are doing well including being 100% compliant with duty of candour; an area we have struggled with in the past. Hand hygiene compliance is back up to the 95% target and we saw a dip recently, so it is good to see this improve, especially as we are in a pandemic. SG training is showing 35% and this is because the year changes from March to April; going forward the plan will be to show this as rolling 12 months percentage.

LB noted the improvement in hand hygiene and suggested the Quality and Patient Safety Committee (QPS) reviews vehicle cleanliness as this is another aspect of IPC we have struggled with historically; this is within the annual cycle of business and LB suggested we bring forward to September.

Effective:

FM highlighted the ongoing audit of medicines, which provides assurance that drugs are in date. In terms of the care bundles in page 8 and 16, many are showing an overall improving picture since the introduction of the electronic patient care record (EPCR). FM also specifically highlighted the ECAL metric; this is where a paramedic contacts a senior clinician and records how quickly they call patients back. It contributes to shared decision making and so we are monitoring to ensure reduction in response times.

HG referred to the benchmarking section of the IPR which shows for some areas including cardiac arrest discharged alive we are lowest when compared against other ambulance trusts; he asked why and what are we doing to improve. FM responded by explaining that it is important to look at the cardiac arrest annual report (later on agenda) as the numbers of survivors is really small, and so you get a more accurate picture over a longer period. It is something we are looking at and as set out in the report, figures on an annual basis are under the national norm. Areas we are taking action are listed in the annual report, e.g. getting hands on the chest more quickly and more bystander CPR.

Responsive:

JG explained that it is important to acknowledge that this includes data from May, which was a really positive month. It was the first time we have met all ARP standards, sustained by achieving 99.1% hours which is the best ever. JG explained that between 97-100% hours is what in normal circumstances will deliver ARP standards. Our ability to get these hours in May was due to it being the lowest period of annual leave taken in the Trust's history; we were able to maximise hours despite staff sickness, self-solation and shielding. However, since May we have seen a decline in hours, for a number of reasons, including issues with fit testing PA mentioned earlier and challenges with risk assessments that are taking staff out of patient facing roles.

MW felt that the fundamental issue is longer term resilience. His concern is going into winter and specifically the impact of the decisions taken to get us through the COVID crisis, such as reduced abstraction (leave / training etc.) and how we now catch up with all these things while trying to maximise hours. JG felt training is less an issue as much is online and there has been relatively good completion rates. Annual leave is currently high, but we do have a 3-month lag and so it will be real problem at the end of this year/next given the accrual of annual leave; which is an issue nationally.

MW asked whether we can accelerate recruitment. JG confirmed that attrition is much lower which helps with the recruitment pipeline but there are other challenges, e.g. new starters and NQPs do not all have C1 driving licenses; we have 169 new staff from June. DH added that the Operating Unit Managers (OUMs) are confident with their workforce pipelines, as reported to EMB recently, and several are getting closer to establishment numbers.

AR noted that we are a data rich organisation and asked how we are analysing the data to ensure provision of hours meets the demand. JG confirmed that we review the granular detail by OU.

TP asked whether we need to increase the establishment to reduce reliance on overtime. JG acknowledged that we are seeing overtime fatigue; the level of overtime now is half of what is was in April. DH added that our reliance on overtime will reduce as we recruit to vacancies; overtime is therefore more about meeting spikes in demand. TP accepted this but challenged the executive to think about increasing the establishment in order to better meet these peaks. DA agreed this need consideration and should be picked up by the finance committee.

Action
FIC to review the operational establishment to establish whether this is sufficient to meet the demand and anticipated peaks.

QPS Committee:
LB highlighted the outcomes of the meetings in June and July. The meeting in June focussed on the balance of risk between staff and patients and the paper provided a very detailed timeline which informed the decisions taken by management through March-June. As a committee we were assured by the grip in this area and impressed by openness of the issues and learning. CRMG and QPS has been working in tandem as the report demonstrates.

We then had a scheduled meeting on 9 July and there was a really good set of papers, which clearly articulated the issues and the progress being made. LB confirmed the level of assurances obtained and what follow up has been requested by the committee and commended to the Board the reports coming later on the agenda; cardiac arrest and clinical audit.

DA thanked LB for a very comprehensive overview and for stepping in as Chair of the committee.

Well Led:
DH explained that the financial framework this year in unique, as reported previously to Board and FIC. In terms of awareness and assurance, we continue to be committed to ensuring we are productive and efficient and work is ongoing to ensure robust cost improvement plans. There is a further delay in receiving the financial framework for the rest of the year and so during August and September we will continue on the current basis, i.e. block contract. This links to affordability this year and sustainability thereafter.

AM highlighted two issues. Firstly, that the resourcing pipeline looks healthy for the rest of year as discussed already and, secondly, the focus on absence levels, not just sickness but self-isolation etc. to get staff back to work quickly and safely.

AM also noted that on an annual rolling basis we are at 70% for appraisals and 75% for statutory and mandatory training.

FIC Report:
HG took the Board through the report and the areas of focus during the last meeting; many of which has been covered in this meeting. The committee continues to keep a very close eye on operational and financial performance.

WWC report:
LM summarised the outcome of the most recent meeting, as set out in the report. Generally assured by the improved grip and progress with HR processes and by the opportunities we are taking forward through working with higher education partners.

The committee is committed to doing more to support inclusion and LM mentioned Asmina Chowdhury for her leadership in this area. The committee is also focussing on employee relations and workforce issues, to better understand what is happening so we can focus on the corrective actions.

Finally, LM confirmed that the committee agreed the culture mandate and related BAF risk is outdated and this is being taken forward in a different way.

[Break at 12.09-12.19]

27/20 Out of Hospital Cardiac Arrest Annual Report 2019/20 [12.19 – 12.31]
FM introduced this report and highlighted the following:

- Commended the work of Dean Rigg, Head of Clinical Audit and his team. This is the first time we have had such a report and the ability to share outcomes with acute trusts and OUs.
- Report reviews each link in the chain of survival
- Includes feedback from families and staff
- Compares performance against national data and against the 10 steps for improvement
- Positive: post resus care our patients receive. And for many cases we have CCPs on scene that can provide different interventions
- Focus: speed we get hands on chest; extend bystander CPR and GoodSam
- Listed in recommendation section is progress against the 10 steps.

DA thanked FM for this excellent report.

JG referred to the improvement in the time CPR commences (page 17 figure 8) and asked what has led to this improvement since March. FM reflected that it might relate to improved capacity in EOC. But the 'mean' time hasn't changed very much and so still have some improvement to make.

LB felt the recommendations were very thorough and confirmed that QPS asked for these to be prioritised and dated; it will then review in 6 months' time.

With regards defibrillators, LB asked whether we understand what we might do as a leader to draw community and volunteers into this pathway to meet our aspiration. FM explained that we have had a good response from CFRs and plans to recruit further. LM came back to ask about volunteers / public more generally. FM then outlined some of the things we are considering / doing.

DA summarised that this excellent report helps to demonstrate our aim to continue to drive up standards.

28/20 Clinical Audit Annual Report 2019/20 [12.31 – 12.44]
FM introduced this report explaining that the clinical outcomes indicators are included in the IPR. She then referred to the 13 level 2 audits that reflect areas of concern and outlined some of the findings including closing the learning loop on salbutamol. None of this would be possible, but for EPCR.

There was some questions from the Board about some of the detail within the report, including safety of discharge which LB confirmed is an area of focus at the next QPS meeting, and the extent to which we take adequate action quickly enough following audits, which DA asked QPS picks up to seek assurance that we take prompt action when issues are identified.

Action
QPS to seek assurance that actions taken as a result of clinical audit findings are taken promptly

29/20 Learning from Deaths Report [12.44 – 12.48]
FM confirmed this report builds on the report from May's Board meeting and highlighted the following:

- Increase of deaths in March almost certainly COVID related
- Increase in DNAR / Respect forms
- Increase in professional decisions not to resus was made.
- Overall, vast majority of deaths not avoidable and estimate of care good or excellent.
- Recommendations have been further developed and our end of life care lead ran a webinar with staff to looking at how to better support crews in their decision-making not to resus.
- Finally, work to do on ensuring decisions are well-documented.

DA clarified with FM that there are no concerns to be escalated to the Board and confirmed that the Board supported the proposed actions.

30/20 Community Resilience Strategy [12.48 – 12.55]
JG outlined the key elements of the strategy, which has been a long time in the making, with lots of engagement. This has been produced by the leader of the community resilience team and it is not just a CFR strategy, but one for all volunteers. JG acknowledged some of it is ambitious and we will need to address the scope and capacity of the team.

LB confirmed this has been to QPS and has its support. It is a really key strategy and we are lucky to have very passionate volunteers. We need to address separately how we arrange the governance such that we provide a forum for feedback from volunteers. Also, there is a really positive section on how volunteers help with Cat 3 /4 patients.

DA confirmed that the Board receives this with enthusiasm and approves it, noting that QPS will oversee delivery.

31/20 Audit & Risk Committee Escalation Report [12.56 – 13.03]
MW talked through the main business of the committee as set out in the report, reinforcing the need to clear the backlog of management actions and ensure timely action in future.

MW confirmed that the Information Governance annual report sets out how we discharge our responsibilities with legislation. The committee is assured this is the case but as we develop and increase access to patient information through 111/CAS it is important to be alert to the risks.

In terms of risk management, MW explained that we have a high number of risks and so need to find the balance as there are some that are more management issues. Part of this links to the problem if risks remain on the register too long, they could have a perverse impact and are seen of less importance. The committee has therefore challenged the executive to confirm the balance is right.

On behalf of the Board DA noted the update and formally received the Information Governance Annual Report.

32/20 BAF Risk Report [13.03 – 13.09]

PL outlined the structure of this report and like with committee meetings this is deliberately toward the end of the Board agenda, as it helps as a marker to demonstrate the extent to which the Board and its committees are focussed on the key risks to the organisation. In other words, we use the BAF risks to focus agendas and this approach has recently been commended in an internal audit review which will come to the next meeting of the audit and risk committee.

Section 3 illustrates how the committees have arranged their agendas to reflect the current principle risks. This is set out for assurance to the Board

The risks are by their nature dynamic and section 4 lists some changes;

The three risks to be removed have been covered in this meeting;

- PA mentioned the excellent call handling
- IG controls have greatly improved as set out in the AUC report and annual report.
- WWC report noted the approach to the culture mandate and risk

The other changes relate to changes in risk score and the finance risk description has been amended to reflect the issue with the funding framework as DH mentioned under the IPR.

LB suggested that the score on risk 579 might be too low. BH explained that we are in a much better place than ever partly due to circumstance, and despite the lower risk score, it still remains a high risk.

The Board approved the amendments to the report.

33/20 Charitable Funds Committee Report / TOR [13.09 – 13.15]

MW introduced the report reminding the Board of the discussion in January and the commitment made then to review the governance of the charity. This arise from the visibility of money raised by CFRs under the auspices of the Trust and the related issue of the CFRs having their own registered charities. The executive team has done much since then to review procedures to address these concerns. In the papers we have the TOR for approval and the procedure for support/information.

The Board agreed that we need to engage fully with the CFR leaders to ensure they are reminded of procedures and the reasons why we are taking this approach; which is to ensure we operate within requirements of the Charity Commission.

DH thanked Katie Spendiff for her leadership in ensuring we access funds through COVID and distributed them appropriately.

AM asked whether we are confident we aren't sitting on chartable funds. MW confirmed that we can be, although at times we can be slow often due to the process you have to go through. He agreed it is important to show how we have used funds raised.

The TOR were approved, and the procedure was supported.

34/20 Appointment and Remuneration Committee Report [13.15 – 13.18]
AR outlined the work of the committee and assured the executive directors that we are in best place we have ever been to having a systematic approach to appointments and remuneration, as demonstrated by items covered in the most recent meeting.

35/20 AOB
PL confirmed that we will be inviting members of the public to observe meetings from September, via TEAMS.

36/20 Review of meeting effectiveness
PL felt that the format of the new IPR helped to better link the agenda.

Cheryl Howarth reflected that it has been interesting meeting and on whistle blowing confirmed nothing has come through the CQC for a long time.

There being no further business, the Chair closed the meeting at 13.20

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
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	C	This is added to the WWC COB
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	C	Ongoing - as updated in the FIC escalation report in July
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	Q3 2020/21	WWC	IP	Added to COB and WWC will update the Board via the escalation report
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	C	Added to COB
30.07.2020	26 20	FIC to review the operational establishment to establish whether this is sufficient to meet the demand and anticipated peaks.	JG	Q3	FIC	IP	
30.07.2020	28 20	QPS to seek assurance that actions taken as a result of clinical audit findings are taken promptly	FM	Q3	QPS	IP	

Key

	Not yet due
	Due
	Overdue
	Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	42-20

Name of meeting	Trust Board
Date	24.09.20020
Name of paper	Chair's Report

In August the Trust Board undertook a self-assessment, reviewing specifically the approach and the effectiveness of its meetings. I have used the feedback from this to set out in a slightly different way how we will do business going forward.

From this month, I will now be providing a Chair's report. This will outline the main focus of the meeting and, in the context of our Board Assurance Framework (BAF) risks, which can be found annexed to this report, confirms how the agenda has been planned.

The enduring purpose of SECAmb is to respond to the immediate needs of our patients and to improve the health of the communities we serve. Our strategy and everything we do is to achieve this purpose. Since the last formal Board meeting held in July, the Board and its committees have had two primary focusses:

- Firstly, to ensure immediate action is taken to improve the timeliness of our responses to patients, while addressing the underlying structural issues that will ensure this is sustained in the longer term; in order words to make us more resilient. This is one of our biggest BAF risks.

- Secondly, to ensure we are able to mobilise the new 111 clinical assessment service on 1 October and, working with our system partners, develop 'Think 111 First'. This is a concept that has arisen from the COVID-crisis and very much aligns with one of our strategic aims; to provide leadership in the integration of urgent and emergency care.

One of the aims of this Board meeting therefore will be to hold management to account for the development and delivery of the 999 improvement plan, and agree what support it can provide to tackle some of the structural issues, a key component of which is the future workforce. It will also assess our readiness for mobilising the 111 clinical assessment service and the implications of Think 111 First.

The Board has also been testing our planning for winter. As I have already mentioned, this year this includes mobilising a new 111 service and approach to Think 111, in addition to managing the ongoing consequences of COVID in both our 111 and 999 services; flu; and the impacts of the EU transition. The Audit & Risk Committee scrutinised the winter planning earlier this month and I asked for an update to come to this meeting, so that the whole Board is fully sighted.

The IPR will be the main agenda item and from September I will be asking each of our committee

Chairs to report first before the executive, using the key issues listed in executive summary to order the discussion. The IPR itself contains good quality data and information, and we will use the report to frame the discussion on the key issues and risks, rather than going through the report itself. This is another change brought about following the Board self-assessment feedback. The Board will therefore use the IPR as a way of understanding the main issues and will then focus on holding management to account for improving the position and being clear where support is needed.

As part of the board escalation reports you will see the annual reports that have been considered and which require the Board to formally receive. Some of these are received later than usual due to re-prioritisation of work during COVID.

While it is important to understand what has happened, as a Board more of our time should be spent looking forward and establishing how the Board can support management, for example in investment decisions. Due to the commercial sensitivities, the Board will be considering two business cases when it meets in private. The first is to invest in a capital project to develop a new Make Ready Centre in Banstead. The second is a significant investment in personal-issue powered hoods, which mitigates the issues that emerged during the COVID crisis relating to fit testing.

In the same way our Board committees do, I use the BAF risk report to ensure the Board agenda reflects the key risks to delivering the Trust's strategic priorities. Currently, the principal risk is the achievement of the Ambulance Programme Response (APR) targets – ARP is a proxy for patient safety and quality. The other principal risks impact this and they include delivery of our workforce plan (we are still under establishment which limits our ability to respond in line with ARP); and the consequences of COVID-19. These areas will form the basis of this meeting of the Trust Board.

Before we move on to the main part of the agenda, I also wanted to take this opportunity to update on a few things that have happened since the last Board meeting:

- The Council of Governors has appointed a new independent non-executive director, who has a clinical background. This is a really good appointment and will help ensure good balance of skills on the Trust Board. There will be a formal announcement shortly.

- The CEO and I have commenced our series of MP briefings to brief them on the COVID pandemic and contingency preparations for the transition from the European Union

- With the Chair of our Audit Committee, I contributed to the development of the governance model of the Sussex Integrated Care Service, and attended Chairs' meetings for the main ICS/STP organisations in Kent, Surrey and Sussex.

- I also attended two excellent national briefings; inputted to the strategic direction of ACCE; and took part in regional Chairs meetings with the NHS I Regional Director.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	43-20

Name of meeting	Trust Board
Date	24 September 2020
Name of paper	Chief Executive's Report

1 This report provides a summary of the Trust's key activities and the local, regional and national issues of note in relation to the Trust during August and September 2020. Section 4 identifies management issues I would like to specifically highlight to the Board.

A. Local Issues

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

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

4 As the pandemic continues, EMB is continuing to focus and monitor the impact of COVID-19 on the Trust. In addition to the main weekly meeting, we hold short daily Executive 'huddles' to ensure that there is a frequent opportunity for issues to be raised and discussed and action taken. Specific COVID-related issues discussed recently have included: developing a new Outbreak Control Management Framework, Test and Trace, the Flu vaccine programme, and EU Transition and Winter Planning.

5 Other issues covered by EMB during this period include:

- 999 performance improvement plan – specifically the immediate actions to increase hours
- Workforce Planning – focus on closing the gap in the current establishment
- Strategic Planning /Prioritisation given the competing priorities
- Clinical Education improvements
- Reviewing and prioritising how to take forward the People Plan 2020/21
- 111 CAS Mobilisation and Think 111 First

6 EMB has also considered the following investment decisions:

- Additional capacity on the IT Critical Systems Team
- Banstead MRC and the related relocations of Fleet and Clinical Education teams

7	**Engagement with stakeholders and staff** During recent weeks, 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.
8	During September, the Chair and I are continuing our MP Engagement Programme. On 11th September, I met with the Rt Hon Dominic Raab MP to discuss local issues, including the Trust's response to the COVID pandemic and local performance in his Esher and Walton constituency. There is a series of further virtual meetings planned on 21st, 22nd and 29th September with a number of our other local MPs, with the programme due to continue into October 2020.
9	**Medway Make Ready Centre and new EOC and 111 Centre** We are extremely pleased that during August 2020, our plans to develop a new multi-purpose ambulance centre in Gillingham were given the go-ahead by Medway Council. In what will be a first for SECAmb, the development will include a new Make Ready Centre for the Medway region, as well as 999 and NHS 111 operations centres relocated from Coxheath and Ashford respectively.
10	Ambulance crews currently starting and ending their shifts at Medway and Sittingbourne ambulance stations will, instead, start and finish at the new centre and continue to respond from Ambulance Community Response Posts (ACRPs) across the region during their shifts. Staff based in Sheppey will continue to start and end their shifts from the ambulance station on the island, which is currently undergoing a major refurbishment and upgrade to provide new educational and training facilities.
11	The plans will see the new Make Ready facility housed on the two lower floors of the new centre, while staff currently based at the Trust's East 999 Emergency Operations Centre (EOC) in Coxheath will benefit from a modern open plan office above. The Trust's NHS 111 staff, currently based in Ashford, Kent, will occupy the top floor.
12	Bringing the 999 and 111 services under one roof will allow for greater support for each service, with the modern facilities matching the West Emergency Operations Centre in Crawley, which opened in 2017, and reflects the ambitions of the Trust's Strategic Plan to deliver new integrated urgent care services over a wider area. The development also provides us with greater capacity, allows us to improve the ratio of 999 call taking across its two Emergency Operations Centres and will bring local recruitment opportunities for people across both 999 and 111 services.
13	Building work is expected to begin at the site early next year ahead of it becoming fully operational in 2022. The development will be funded with a previously announced £6.52 million of government capital funding.
14	**Annual Members Meeting (AMM) and Council of Governors meeting** On 4th September we held our first on-line Annual Members Meeting, plus, our Council of Governors meeting was open to the public to attend virtually in real time.

15	We saw just over 250 members and staff join us for these meetings and also enjoyed a lively and engaging Q&A session during the AMM.
16	During the AMM we also launched our new video which captures a range of our staff and volunteers speaking honestly about their experiences during the COVID pandemic. Watching the film, I was reminded of the breadth of the impact on our service during this time, but also extremely proud to see how Trust colleagues pulled together to provide support to each other as part of Team SECAmb throughout the experience.
17	For those who weren't able to join the sessions live, the recording of the AMM and a link to our new video are available on our website here and the recording of the Council of Governors meeting here.
	B. Regional Issues
18	**NHS111 and Clinical Assessment Service (CAS) for Kent, Medway and Sussex** On 17 August 2020, it was announced that the enhanced NHS111 and Clinical Assessment Service (CAS) for Kent, Medway and Sussex is now being mobilised for launch on 1 October 2020. This is the result of a lot of hard work from our Programme Team, who have also had to respond to unprecedented 111 demands during the pandemic.
19	The improved 111 service is the result of collaborative working between local people, clinicians and NHS commissioners in Kent, Medway and Sussex. SECAmb will act as the lead provider with the social enterprise, Integrated Care 24 (IC24), working in partnership to deliver key clinical elements.
20	The CAS will provide 24/7 access to clinical advice and treatment, available over the phone and online at www.111.nhs.uk. Patients will benefit from greater access to a wider range of healthcare professionals, such as GPs, paramedics, nurses and pharmacists. Each of these specialist clinicians will be able to 'Hear and Treat' i.e. listen to the caller's complaints and advise on how to care for themselves or where they might go to receive assistance, set up e-consultations where patients are able to get online, and directly book people into onward urgent care appointments, if they need one. They can also issue prescriptions over the phone where appropriate.
21	As we approach the mobilisation date the of the 1st October, and particularly in the last three weeks we have seen a significant increase in call volumes related to COVID. This increase, as well as the work required for mobilisation, is putting significant pressure on the service. Potential solutions and mitigations to this unplanned activity are being discussed with the Commissioners and the teams are working incredibly hard to stay on top of this and to continue to provide the best patient care possible.
22	**Expansion of Joint Response Unit (JRU)** I am pleased that our latest Joint Response Unit (JRU), delivered jointly with police services across our region, is now being trialled in Worthing. The unit's first shift was on 14th August and in the first few weeks of operation, it has typically attended six incidents per shift,

	requiring minimal back up.
23	The Worthing trial follows on from successful launches in North Kent and Guildford with Kent and Surrey Police respectively and from a Brighton JRU with Sussex Police which began in December 2019.
24	Each JRU differs slightly in its approach but all are targeted primarily at weekends, with the model of having ambulance and police staff crewed on the same vehicle. The aim of a JRU is to either resolve an incident on its own or reduce the amount of resources required from either service.
25	The approach ensures a greater understanding of each services working practices and builds on our already established relationships. I would like to thank everyone involved in each JRU for their continued work in this valuable collaboration.
	C. National Issues
26	**COVID-19 outbreak** In common with the rest of the NHS, SECAmb continues to be impacted by the current COVID-19 outbreak. I remain extremely proud of the way that the Trust has remained focussed on delivering the best service possible, despite the changing circumstances and the on-going impacts of the pandemic.
27	Governance**:** As the pandemic continues, the remit of the COVID Response Management Group (CRMG), the key group that has been in place since the outset to manage the Trust's response to the pandemic, is changing to also take account of broader operational issues including potential winter challenges; it is now called the Operational Response Management Group (ORMG). As with CRMG, the ORMG continues to meet regularly during the week and at weekends, ensuring that all decisions and actions are considered appropriately, as well as other significant operational issues that arise.
28	The key workstreams under the COVID Recovery, Learning & Improvement Group - our people, estates, IT utilisation and new ways of working – are continuing to make good progress with developing plans.
29	Test & Trace**:** In August, we established an internal COVID Test and Trace Cell. In line with the national model, this concentrates on the contact tracing of SECAmb employees, collation of information on Covid-19 positive staff and communication with line managers to establish contacts of the Covid-19 positive staff member. The Cell are also monitoring the movements of any visitors to our sites to ensure that they can be 'track & traced' if required. To date, the internal Cell has supported more than 150 staff through the Test & Trace process. As the difficulties with the availability of testing have begun to affect our operations the cell has also created the ability to source testing for symptomatic and self-isolating staff. Risk Assessments: To support the safety of staff, all NHS Trusts have been asked to

30	undertake risk assessments to identify those staff who are at greater risk of COVID. This includes specific risk assessments for BAME staff and those who were shielding due to pregnancy, age or underlying health conditions, as well as a short risk assessment for all staff.
31	We have worked hard to encourage as many staff as possible to undertake a risk assessment and completed 100% of those required for our BAME staff and those staff who are clinically vulnerable. Out of the wider workforce, 162 staff did not take up the opportunity to undertake a risk assessment despite repeated reminders.
32	**enei Gold Award** On 25 August 2020, we were delighted to announce that we had achieved the TIDE (Talent Inclusion and Diversity Evaluation) gold award from enei (Employers Network for Equality and Inclusion). This is the third year in a row that we have been recognised by the organization, following two silver awards.
33	SECAmb was the only ambulance trust in a record 98 entries and was among only 13 achieving the highly coveted gold award. Other gold winners include IBM UK ltd, the Ministry of Justice and fellow NHS organisation, North East London NHS Foundation Trust.
34	We will use the benchmark report to implement further improvements in how diversity and inclusion is thoroughly embedded throughout the whole organisation and a part of everything we do but it's great to see our continued progress recognised in this way.
35	**NHS Staff Survey** The annual NHS Staff Survey 2020 is due to be launched imminently and there are a few changes this year to account for the current global situation and a new section called 'The Covid-19 pandemic' has been added.
36	The Covid-19 section includes questions on redeployment, remote working, shielding, lessons learned and what worked well. The national invite, reminder letters and e-mail templates will include text about the Covid-19 pandemic and acknowledge that the NHS has never before experienced a year like this one.
37	Despite the addition of COVID-specific areas, much of the survey also remains similar to previous years to maintain comparability and enable comparisons to previous years.
	D. Escalation to the Board
38	**999 Operational Performance** Response time performance during August and September to date remains challenged and variable. As a result, we have not consistently met either the Category 1 or Category 2 standards during this period, which is of concern, given that these are most seriously ill and injured patients. In the last few weeks, we have seen this improve slightly. Our performance against the Category 3 and 4 standards continues to be challenged and

39	unfortunately, we are still seeing 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 and for the Trust as a whole.
40	When analysing our operational performance, it is clear that the main challenge facing us is ensuring we are providing operational hours up to the required levels. 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 increasing levels of sickness and this is significantly impacting, at times, on our performance. There has also been a healthy uptake of annual leave which, whilst creating a further immediate shortfall, is ameliorating the problem later in the year caused by the lower level of leave taken earlier in the year.
41	In response to the current performance challenges, the Senior Operational Team has developed a detailed 999 Performance Improvement Plan which pulls together actions being taken in a number of areas. A key focus of the plan is to maximise the resources available on the road to respond to patients, including by managing our abstractions closely, ensuring that we can safely return as many staff as possible to the workplace and maximising support to the front-line from other areas of the Trust. It looks to gain support from all disciplines and Directorates of the Trust where clinically capable staff are asked to mobilise to support operational delivery where this will not compromise their primary role.
42	The delivery of the Performance Improvement Plan and the impact of the actions being taken is closely monitored by the Operational Response Management Group and by the Executive Management Board.
43	To date, we have seen some overall improvement in our 999 performance, however, production of sufficient operational hours is being significantly hampered.
	111 performance and Think 111 First
44	During recent weeks, we have seen NHS 111 demand increase significantly; it is now well above expected levels and is a pattern that is replicated across all 111 providers nationally.
45	The recent increase in demand appears to be driven by the return to school and the nervousness associated with preventing outbreaks of Covid-19 in that environment, the difficulties getting tested and the increase in Covid-19 concerns generally. All 111 providers are reporting significant increases in demand – this limits the ability for providers to help one another under the national contingency arrangements.
46	Another factor may be the national media around Think 111 First. Think 111 First is a concept which attempts to reduce the undifferentiated (walk-in) activity in Emergency Departments (EDs) this winter, by using the 111 / Clinical Advice Service as a first option. The model is currently being piloted in several areas of England and some areas operated by SECAmb are looking to launch pilots over the coming weeks and months and we have completed a “soft launch” in Medway.
	Discussions with Commissioners and NHS England/Improvement are still ongoing at the time of writing on the volumes that will be expected to pass through this service from the go-live

47	date.
	Violence and aggression towards ambulance staff
48	We are continuing to see a worrying increase in the number of incidences of violence and aggression reported towards ambulance staff, both locally within SECAmb and by our colleagues in other ambulance Trusts. This also seems to be the pattern in the wider NHS and in other emergency services.
49	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 although we are yet to see anyone convicted under this Act for assaulting an ambulance member of staff.
50	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 is an offence and is vital to ensure that appropriate actions are taken by the Police and the CPS.
51	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. However, this remains a concerning and worrying situation.
52	The relevant directors will pick up these issues specifically as part of the Integrated Performance Report.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
September 2020

Data up to and including August 2020

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

Contents

		Page
How to use this report		3
Chief Executive Overview		4
Trust Overview	Strategy, Values & Ambition	5
	Horizon Scanning	6
	System Partnership & Engagement	7
	Domain Overview Dashboard	8
	Current Operational Performance	9
	Summary of Performance Highlights	12
	Summary of Exceptions	13
	Exception Reports by Domain	14
Performance Dashboards	Safe	21
	Effective	23
	Caring	25
	Responsive	26
	Well-Led	28
National Benchmarking	999 Emergency Ambulance Service	31
	NHS 111 Service	32
Appendix 1	Performance Charts	33
Appendix 2	Glossary & Metrics Library	48
Appendix 3	Symbol & Chart Keys	49

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 *****	3

*	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 3: Major pressure (September 2020)

How to use this report

A New Format & Reporting Aspirations

- This is the second time this new format report is coming to the Board.
- 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 have begun to provide reporting a month in arrears, where this is possible.

Performance Dashboards

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

Performance Charts

- In the future, we intend to include trend lines on charts, where it will help the viewer understand the data better, and where possible targets too. We also aspire to include forecasting and performance versus forecast wherever possible.
- **Please note** that the SPC charts are no longer functioning as a licence has lapsed, according to the BI Team. The Team are working on replacing this functionality.

A Focus on CQC Domains

- Our suite of 'aspirational' metrics includes numerous across all domains, and when populated will provide a far more rounded snapshot of performance to the Board.

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

This is the second time the Board has received this new version of the IPR. As outlined on page 3, there are still some developments to complete; the inclusion of more target lines in the graphs, for example. However, I believe it is a much improved report and its aim is to set out the key performance indicators and highlight to the Board through the exception reports where the executive is most concerned. The areas I want to specifically draw the Board's attention to are:

999 performance – The ARP performance targets are a proxy for patient safety and quality. Our specific focus currently is on the improvement plan, which is in the papers. This plan includes the short term actions aimed at increasing hours, which will in turn help us respond to patients more quickly. Despite all our efforts we are not meeting the daily trajectory for hours. There are a number of challenges, which the Board is aware of, including the increasingly difficult issue of COVID-related abstraction. This is not just affecting SECAmb and, at the time of writing, we have seen a sharp increase in the past week. A verbal update will be provided at the meeting confirming the most current position.

While the key focus is ensuring delivery of these short terms actions, the executive team are also beginning to examine the structural issues that will ensure we are more resilient in the longer term. These include consideration of our operational model, our rotas and our level of resourcing.

On a more positive note, it is important to also highlight that despite the challenges our call answer performance continues to be strong.

111 performance / Think 111 First – As confirmed in my Chief Executive's Report, demand in 111 is increasing, as it did before the 1st Wave of Covid-19, which is reflected in some of the key performance indicators. The Operations Director and his team are working really hard to cope and of course they are at the same time in the final stages of mobilising the new 111 clinical assessment service. We will cover this later in the agenda.

In addition, the system is developing the Think 111 First model and the aim is that this will be in place across the region over the coming weeks. We are working with system partners to help ensure we can predict the impact on the 111 service so that we can ensure patients receive care and treatment at the appropriate place.

Violence and aggression to staff – the increase in incidents is a concerning trend and we are continuing to encourage staff to report incidents. Operation Cavell will help to give confidence to staff that as a result we will with our Police colleagues tackle the violence and antisocial behaviour experienced by them and ensure appropriate actions is taken against offenders.

These are just the areas I wanted to particularly draw out from the IPR, but Board members will see the other areas reported as exceptions and the executive will be able to answer any questions on these or any other part of the IPR.

Philip Astle
Chief Executive

Trust Overview:
Strategy, Values & Ambition

Our Purpose

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

Our Strategy

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

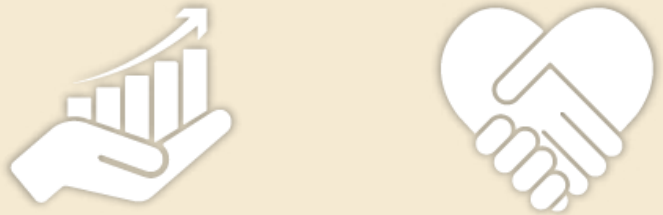
Our Priorities

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

Our Values

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

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



Trust Overview:
Horizon Scanning – September 2020

Strategy

The Board will reflect on the Strategic Delivery Plan elsewhere on its agenda. The internal launch of the new strategy will take place late September/early October through an all staff webinar and accompanied by communications tools being shared with managers to help them engage in meaningful conversations with their teams about our strategy and values. The toolkit will also provide impetus for teams to consider and make local changes to support the strategic objectives. There will be an ongoing programme of communications and engagement ensuring the strategy is real for and understood by colleagues.

Workforce

At 17 September, the number of SECAmb staff in self-isolation was 70, an increasing trend over the last few days (400 at the peak). Total Covid-19 related abstraction (sickness & self-isolation) of WTE is 2.6%, an increasing trend over the last few days (14% at the peak).
The CEO's overview highlights the risk this trend may present.

The Organisational Development (OD) and Quality Improvement (QI) Teams are working together to see whether they can combine their individual strategies to create one Continuous Improvement Strategy that encompasses QI Science and methodology alongside Organisational Development theory and practice and joins all of our improvement efforts together. A paper will shortly be going to the Executive Team to describe the benefits of this in more detail.

Staff Engagement representatives meet monthly as the Staff Engagement Advisory Group. A toolkit for the Staff Engagement reps will support them in increasing their own change agency. We are keen to make better use of survey data to engage staff and make improvements. A meeting is planned with OD, QI and the quality/compliance lead to scope out an idea for IEGs (Improvement and Engagement Groups) in local areas, to feed survey data into, enabling representative groups of staff, including reps and possible future QI fellows, to look at local data together with managers and make improvements on an ongoing basis. This would link continuous improvement with our engagement agenda, achieving improvement through engagement.

Strategic Estates

Four strategic estates programmes are either in train or planned and due for completion between November 2020 and quarter 1 2022-23. Brighton MRC is the first due to be finished and final issues are being overcome around connectivity.

Phase 2 of the development of Worthing station is underway with final specification clarifications around e.g. lighting and blinds due shortly along with orders being placed for furniture. The project is due to be completed in January 2021. Banstead MRC's business case is with the Board this month and, if approved, the planning permissions decision should soon follow and a contractor employed. Finally, our longest term project is the development of Medway MRC, the business case for which will come to the Board for approval in November.

Finance

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, all resources must be used as efficiently as possible.

Business Development

Across the regions, ICS and CCG partners are considering the national direction of 111 First, whereby patents will be encouraged to call 111 and will be provided with appointments for emergency departments and urgent treatment centres. The full impact of this on 111 services is not currently fully understood, however SECAmb are expecting an increase of activity. A full quality impact assessment has been undertaken and SECAmb are working with system partners to understand and mitigate potential risks.

Covid-19 Risk Assessment Framework

We are currently in a position as a Trust that 100% of our BAME and clinically vulnerable colleagues have competed the relevant risk assessment, with only 160 colleagues who have not taken up the offer of a risk assessment, Trust-wide. The next stage of the process is to ensure we have an effective process in place with our managers and governance to follow up risk assessments for BAME and CV colleagues.

Trust Overview:
System Partnership & Engagement – September 2020

Reducing Emergency Dept (ED) conveyance

New Hospital Handover screen functionality will enable Non-ED destinations to be visible. Where handovers are delayed there is now the ability to include commentary for the reasons for the delay. This will enable themes and trends to be identified more easily.

111 First focus – new pathways around Same Day Emergency Care / Ambulatory Emergency Care are being implemented at many Type I Acute hospitals to increase Non-ED streaming. This aligns with the NHS England requirement for all 111 First systems to be in place by December 2020.

Nursing and Care Home focus – Enhanced 999 Frequent Caller reporting from care homes has been rolled out across the Trust's region for system focus and support to specific homes. This provides critical information to newly formed Primary Care Networks and associated multi-disciplinary teams for supporting individual Care Homes as part of the Enhanced Health in Care Homes deliverable from October 2020.

Commissioning

111/CAS contract deliverable for October 2020 and 111 First pilot site agreed for development in Kent during September. Consideration if being given to rollout across Kent and Sussex by December 2020 which includes a predicted 20% increase in 111 call volume.

Trust Overview:
Domain Overview Dashboard (August 2020)

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

Safe

Metric	Aug-20	PD
999 Frontline Hours Provided %	92.50%	▲
Number of Incidents Reported as SIs	5	▲
Hand Hygiene Compliance %	97.00%	▲
Physical Assaults (Number of Victims - Staff)	29	▼
Medicines Management % of Audits Completed	99.00%	●
DBS Compliance %		–
Number of RIDDOR Reports	8	▲
Registered Clinicians Against Plan %		■

Effective

Metric	Aug-20	PD
**Cardiac ROSC Utstein %	45.00%	▲
**Stroke - Assessed F2F Diagnostic Bundle %	97.00%	▼
**Sepsis Care Bundle %	81.00%	▼
**Acute STEMI Care Bundle Outcome %	64.00%	▼
ECAL Mean Response Time	00:23:34	▲
999 Operational Abstraction Rate %	32.60%	▼
Statutory & Mandatory Training Compliance %	75.90%	▼
Clinical Education		■

** Latest data: Jun-20

Caring

Metric	Aug-20	PD
Proportion of Complaints Relating to Crew Attitude %	40.00%	▲
End of Life Care Performance		■
Falls Performance		■
Proportion of Complaints Relating to Dignity and Respect %		■
Dementia Performance		■

Responsive

Metric	Aug-20	PD
Cat 1 Mean	00:07:53	▼
Cat 1 90th Centile	00:14:50	▼
Cat 2 Mean	00:18:57	▼
Cat 2 90th Centile	00:34:57	▼
Cat 3 90th Centile	03:31:37	▼
Cat 4 90th Centile	05:01:24	▼
999 Call Answer Mean	00:00:03	▼
111 Calls Answered in 60 Seconds %	84.00%	▼
111 Calls Abandoned - (Offered) %	2.00%	▼
111 to 999 Referrals (Answered Calls) %	12.40%	▲
Complaints Reporting Timeliness %	96.00%	▲

Well-Led

Metric		PD
Cost Improvement Plan (CIP) (£000s)	£657.00	▲
Surplus/Deficit (£000s)	£-2.00	▲
Disciplinary Cases	4	▲
Collective Grievances	0	●
Bullying & Harrassment Internal	5	▼
Annual Rolling Turnover Rate	12.60%	▲
Annual Rolling Sickness Absence	6.00%	▼
Absence Relating to Mental Health %	12.10%	▼
Absence Relating to MSK %	3.60%	▼
999 Frontline Late Finishes/Over-Runs %	52.20%	▼
Workforce Diversity		■
Staff Successfully FIT-Tested %	88.30%	▼

Symbol Key

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

Current Operational Performance
999 Emergency Ambulance Service (as of 17/9/20)

	Target		Month to Date			Quarter to Date		
Category	Mean	90th Centile	Incidents	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	2140	00:07:35	00:14:06	10356	00:07:45	00:14:37
C1T	00:19:00	00:30:00	1320	00:09:15	00:17:37	6328	00:09:30	00:17:42
C2	00:18:00	00:40:00	17218	00:18:58	00:35:28	79909	00:18:49	00:35:04
C3		02:00:00	10810	01:27:43	03:13:26	51697	01:29:53	03:23:57
C4		03:00:00	170	02:16:09	04:54:39	939	01:58:44	04:50:21
HCP 3			442	01:55:50	03:51:24	2705	02:11:03	04:33:44
HCP 4			320	02:29:25	05:13:40	1825	02:55:47	06:11:14
IFT 3			217	01:44:04	03:55:41	1282	02:12:33	04:46:24
IFT 4			46	02:21:27	04:59:25	277	02:53:11	05:54:36
ST			11247	33.72%		53407	33.55%	
SC			19959	59.84%		94709	59.50%	
HT			2147	6.44%		11049	6.94%	
Count of Incidents			33353			159165		
Count of Incidents with a Response			31206			148116		
999 Mean	Call Answer Target 00:05		35380	00:03		167981	00:03	
999 90th	Call Answer Target 00:10			00:01			00:01	
Trust EOC 999 Abandoned Calls			34	0.1%		117	0.1%	
A0	EOC All Calls		43525			208556		

Current Operational Performance
999 Emergency Ambulance Service (24/8/20 – 13/9/20)

CAT 1

	24/08	31/08	07/09	Last 13 Weeks
Mean	00:07:44	00:07:16	00:07:30	
90th Centile	00:14:21	00:13:59	00:13:54	
RPI	1.61	1.56	1.53	
Count of Incidents	942	924	920	

CAT 1T

	24/08	31/08	07/09	Last 13 Weeks
Mean	00:09:31	00:08:41	00:09:20	
90th Centile	00:17:08	00:17:01	00:17:43	
RPI	1.64	1.54	1.54	
Count of Incidents	591	564	572	

CAT 2

	24/08	31/08	07/09	Last 13 Weeks
Mean	00:16:49	00:17:12	00:18:40	
90th Centile	00:30:39	00:32:18	00:34:21	
RPI	1.07	1.07	1.06	
Count of Incidents	6837	7164	7469	

CAT 3

	24/08	31/08	07/09	Last 13 Weeks
Mean	01:10:04	01:15:03	01:26:52	
90th Centile	02:37:43	02:49:08	03:10:09	
RPI	1.06	1.06	1.06	
Count of Incidents	4870	4820	4792	

CAT 4

	24/08	31/08	07/09	Last 13 Weeks
Mean	01:47:13	01:51:34	02:21:49	
90th Centile	04:21:42	04:06:43	05:04:52	
RPI	1.08	1.02	1.04	
Count of Incidents	92	88	76	

Demand/Supply

	24/08	31/08	07/09	Last 13 Weeks
999 Call Volume	14010	14324	15349	
Incidents	14051	14240	14575	
Transports	8481	8590	8664	
Staff Hours Provided Vs 70400 target	89.6%	93.5%	92.6%	

999 Call Handling

	24/08	31/08	07/09	Last 13 Weeks
Mean Call Pickup Time (Seconds)	2	2	3	
Call Pickup Time 90th Percentile (Seconds)	1	1	1	
Call Pickup Time 95th Percentile (Seconds)	2	2	2	
Call Pickup Time 99th Percentile (Seconds)	26	49	56	
Average Call Length (seconds)	372	382	380	
Abandon Rate	0.03%	0.10%	0.10%	
Staff Hours Provided Vs 4783 target	113.1%	112.4%	119.1%	

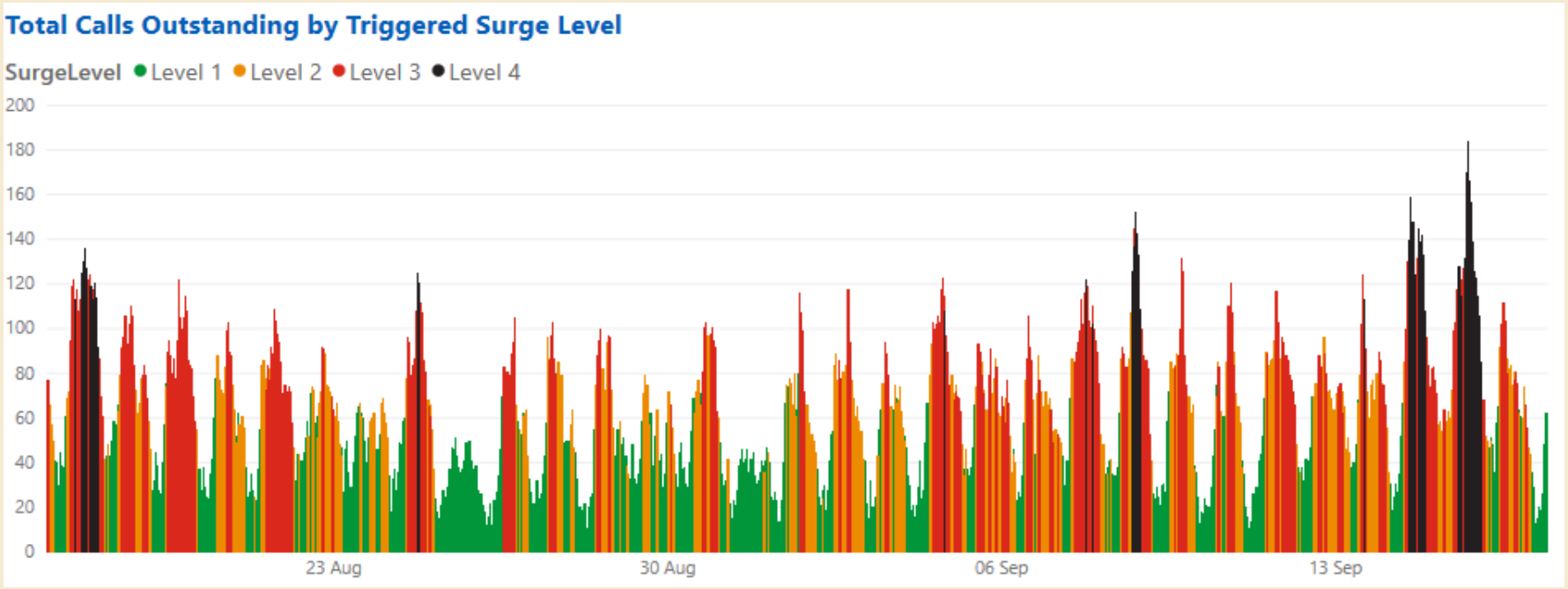
Incident Outcome

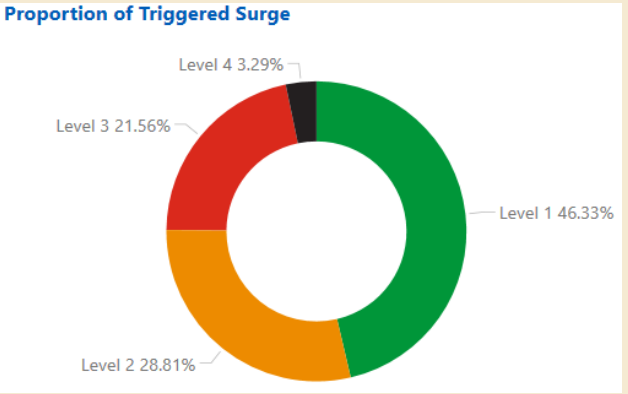
	24/08	31/08	07/09	Last 13 Weeks
See and Convey	60.4%	60.2%	59.4%	
See and Treat	34.0%	33.7%	34.1%	
Hear and Treat	5.7%	6.1%	6.5%	

Call Cycle Time

	24/08	31/08	07/09	Last 13 Weeks
Clear at Scene	01:17:41	01:15:28	01:16:10	
Clear at Hospital	01:46:39	01:46:06	01:47:32	
Hours Lost at Hospital	842	896	906	

Current Operational Performance
999 Emergency Ambulance Service (17/8/20 – 17/9/20)





Surge Management Plan Triggers	
Level 1	Business as Usual (BAU) Ability to dispatch and respond to meet patient needs as identified within Ambulance Response Programme (ARP) metrics
Level 2	**Any of the triggers below:** • 2x Category 1 unassigned for >7 Minutes **or** • 8x Category 2 unassigned for >9 Minutes **or** • 20x Category 3 unassigned for >60 Minutes **or** • 20x Category 4 unassigned for >120 Minutes **or** • 20x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or** • **A combined total of 30 from any of the above triggers**
Level 3	**Any of the triggers below:** • 5x Category 1 unassigned for >7 Minutes **or** • 15x Category 2 unassigned for >9 Minutes **or** • 35 x Category 3 unassigned for >60 Minutes **or** • 35 x Category 4 unassigned for >120 Minutes **or** • 35x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or** • **A combined total of 45 from any of the above triggers**
Level 4	**Any of the triggers below:** • 10x Category 1 unassigned for >7 Minutes **or** • 30x Category 2 unassigned for >9 Minutes **or** • 60 x Category 3 unassigned for >60 Minutes **or** • 60 x Category 4 unassigned for >120 Minutes **or** • 60x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or** • **A combined total of 80 from any of the above triggers**

Trust Overview:
Summary of Performance Highlights

Domain	ID	Performance Highlight
Safe	NHS Pathways (EMA) Audit Compliance	NHS Pathways (EMA) audit compliance has been achieved in the previous 2-months for the first time since July 2019. This is the first time that hours offered to the team met establishment since the EOC Audit moved to the Medical Directorate. Completion of the EOC Audit and Training restructure will allow the team to maintain this level of performance.
Safe	Manual Handling Incidents	The Health & Safety Team are trialling a new process to review manual handling incidents. The department's trainer will be contacting all staff that report manual handling incidents on a monthly basis. The purpose of this is to identify the root causes of the incident and identify any new learning that can be shared with our staff.
Responsive	999 Call Answer (Mean & 90th centile)	SECAmb's call answer performance remains strong despite significant fluctuations in the number of calls answered. In May 2020, there were 54,224 calls rising to 62,772 in July 2020 and 69,541 in August 2020. In July 2020, SECAmb ranked 5th in the national tables for mean 999 call answer time at 2-seconds and 3rd for 90th centile call answer time at 1-seconds.

Trust Overview:
Summary of Exceptions

Domain	ID	Exception
Safe	Physical Assaults (No. of victims – staff)	The number of physical assaults against frontline colleagues has increased significantly during August and sadly continues a trend of higher than usual numbers of assaults.
Safe	Outstanding Actions Relating to Sis (Outside of timescales)	The gap in assurance regarding historic serious incident (SI) recommendations being implemented is due to previous processes within the Trust. Evidence indicates that the revised process now in operation for recent / current SIs does not lead to backlogs in assurance.
Effective	STEMI Care Bundle	Although the Trust has seen improvements in delivery of the STEMI Care Bundle, performance remains below the national average.
Responsive	999 Operational Performance	Attaining the mean C1 performance metric continues to be just out of reach for the Trust. C1 90th performance is being achieved, but with limited tolerance for slippage compared to other Trusts. In July and August, SECAmb failed to meet the C2 mean, and 90th centile for C3 and C4 performance.
Well-Led	Policies & Procedures Outstanding Review	At the end of August, 30 out of 237 policies and procedures were overdue a review. This was 28 out of 235 at the end of July. The shift is not significant but should the trend continue would be of concern.
Well-Led	First-line managers who have received Leadership Training (Fundamentals)	There hasn't been any sustained and systematic training in the previous 13-months. Overall, 49.3% of operational (A&E, EOC, 111) first-line managers have received Leadership Training.
Well-Led	Cost Improvement Plan (CIP)	Although the Trust has met it's £1m CIP target in Q1, fully validated schemes amount to £1.7m, validated scoped and proposed schemes amount to £2.8m, leaving a potential £1m gap for the year

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
Physical Assaults	Standard: Physical Assaults Definition: Number of victims (staff)	The number of physical assaults against frontline colleagues has increased significantly during August and sadly continues a trend of higher than usual numbers of assaults.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Our Head of Health, Safety & Security has been working with Sussex, Surrey and Kent Police Forces to implement Operation Cavell. Operation Cavell is supported by a pact which commits 2-organisations to build trust amongst staff, so they feel confident when reporting assaults and threats. The outcome from this collaborative working is to raise staff awareness and understanding that being assaulted is not an occupational hazard but an offence, in the same way as when a member of the public or a police officer is assaulted. Recently an agreement in principle was achieved with Sussex Police and the Trust to implement Operation Cavell. Over the next 5-weeks we shall prepare the documentation to make this arrangement formal. The Trust will continue the same implementation process with Surrey and Kent Police forces.	Named person: Executive Director of Nursing & Quality Complete by date: Mid-October 2020 in Sussex and thereafter in Surrey & Kent

Performance by Domain
Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
Outstanding Actions Relating to SIs	Standard: Outstanding Actions Relating to SIs Definition: Outstanding Actions Relating to SIs (Outside of timescales)	The gap in assurance regarding historic serious incident (SI) recommendations being implemented is due to previous processes within the Trust. Evidence indicates that the revised process now in operation for recent / current SIs does not lead to backlogs in assurance.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Weekly monitoring of progress via the Serious Incident Group. Operational and EOC / 111 governance meetings to focus on evidence required to sign off the actions.	Named person: Executive Director of Nursing & Quality Complete by date: End-December 2020

Performance by Domain
Effective: Exception Report

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

ID	Standard	Background
STEMI Care Bundle	Standard: STEMI Care Bundle Definition: STEMI Care Bundle delivery	Although the Trust has seen improvements in delivery of the STEMI Care Bundle, performance remains below the national average.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Individual feedback to clinicians was paused due to the COVID-19 pandemic. This is set to resume and will support clinicians to document the care they provide and any relevant exceptions effectively.	Named person: Medical Director Complete by date: Ongoing

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999	Standard: 999 Operational Performance	Attaining the mean C1 performance metric continues to be just out of reach for the Trust. C1 90th performance is being achieved, but with limited tolerance for slippage compared to other Trusts. In July and August, SECAmb failed to meet the C2 mean, and 90th centile for C3 and C4 performance.
	Definition: Delivery of ARP performance	The primary reason for not being able to deliver against the targets has been down to the imbalance of available operational hours necessary to field sufficient Ambulances to meet the activity that we are presented with. With the exception of C2 performance where the Trust was mid-table in the national ranking, SECAmb was at the bottom for C3 and C4 performance and second from bottom for C1 response times. With restrictions on movement being lifted from mid-June 2020, there has been a corresponding increase in incident activity with some exceptionally busy periods during this timeframe but the activity alone is not the primary cause of the issue, but a compounding problem that has further worsened the overall performance delivery. Looking forward the potential for a second Covid-19 spike, the likely impact of the EU Exit transition and increased seasonal activity through Autumn and Winter will further affect the Trust's ability to meet performance.

Action Plan

Actions being taken to mitigate issues:

Resource availability has been identified as the main factor affecting the Trust's ability to meet activity. Performance continues to be impacted by the reduced availability of front-line staff due to several factors including an increase in non-Covid-19 related sickness. Immediately after the release of the lockdown measures there had been a decrease in uptake of overtime related to general fatigue experienced by staff, but this appears to no longer be the case. There has also been a healthy uptake of Annual Leave which whilst creates a further immediate shortfall, is probably now accounting for the more positive overtime uptake.

A Performance Improvement Plan has been created to maximise resource availability which is being continually monitored and adapted as necessary. This plan will monitor and track some key performance related actions that can release or redirect resource hours back to the front line delivery of Double Crewed Ambulances. It will look to gain support from all disciplines and Directorates of the Trust where clinically capable staff will be asked to mobilise to support operational delivery where this will not compromise their primary role.

The plan will measure, at the granularity of hours per day, by day of the week and the inputs and potential benefits to patient care.

Accountable Executive

Named person:
Executive Director for Operations

Complete by date:
Ongoing

Performance by Domain
Well-Led: Exception Report

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

ID	Standard	Background
Policies	Standard: Policies & Procedures Outstanding Definition: No. of Policies & Procedures Outstanding (3-Year Review)	The process and oversight to ensure our policies and procedures are regularly reviewed has been greatly improved over the previous couple of years. Prior to the Covid-19 BCI, the proportion of policies and procedures overdue their 3-year review was stable at around 8% (20 documents). Priorities shifted as we know during the BCI, and the team paused monthly reminders and chasing of teams to keep their documents up to date, recognising that the risk of doing this was minimal. Indeed, many new procedures have been introduced to reflect e.g. PPE requirements during Covid, and oversight / quality maintained through the Covid Management Group. We began reminders to teams / managers at the end of June; however the proportion overdue review rose July to August and so the Board should note this. At end of August, 30 out of 237 policies and procedures were overdue review. This was 28 of 235 at the end of July. The shift is not significant, but should the trend continue would be of concern.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Reminders and direct requests for review of documents are being sent out by the team, and we anticipate greater attention to this from colleagues in the coming months. Reporting to the wider Senior Leadership Team monthly will commence from October to highlight the issue, which was raised at the core SLT meeting on 8 September. We know exactly which documents are overdue review and have risk-assessed them to prioritise supporting colleagues as appropriate. We are discussing the prospect of allowing low-risk documents an additional 6-12 months for their next review, to enable focus on performance and delivery during winter/flu/second 'spike'/EU Exit etc.	Named person: Company Secretary 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
L&D	Standard: First-line managers Leadership Training Definition: First-line managers who have received Leadership Training (Fundamentals)	There hasn't been any sustained and systematic training in the previous 13-months. Overall, 49.3% of operational (A&E, EOC, 111) first-line managers have received Leadership Training.

Action Plan	Accountable Executive
Actions being taken to mitigate issues: Proposals for formal and informal management development and support have been developed and scheduled for consideration by EMB. The proposals have already received initial scrutiny and support by WWC.	Named person: Executive Director of Human Resource & Organisational Development 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
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, fully validated schemes amount to £1.7m, validated scoped and proposed schemes amount to £2.8m, leaving a potential £1m 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. Review meetings with Executive Sponsors and CIP Leads to maintain focus on productivity improvement. Updates in Senior Leadership Team meetings to strengthen ownership and accountability to drive delivery of cost improvement.	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
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-1	Number of Datix Incidents	1057	947	868	1024	1042	1019	1043	1028	834	973	905	940	881	-	-	-	-	▲
QS-2	Number of Incidents Reported as SIs	10	9	8	9	12	7	9	2	5	7	9	10	5	-	-	-	-	▲
WF-15	Registered Clinicians Against Plan %														■	■	■	■	■
999-12	999 Frontline Hours Provided %	85.80%	83.50%	86.80%	89.20%	92.70%	94.80%	90.70%	87.50%	97.30%	99.10%	93.80%	89.30%	92.50%	100.00%	-	-	-	▲
QS-3	Duty of Candour Compliance %	100.00%	90.00%	100.00%	90.00%	91.00%	100.00%	90.00%	100.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	=	-	●
QS-7	Hand Hygiene Compliance %	94.00%	98.00%	89.00%	89.00%	92.00%	90.00%	93.00%	92.00%	95.00%	95.00%	92.00%	82.00%	97.00%	95.00%	-	+	-	▲
QS-8	Safeguarding Training Completed (Children) Level 2 %	48.00%	53.50%	62.20%	66.80%	66.30%	69.80%	72.30%	86.90%	12.30%	35.60%	60.20%	67.10%	69.90%	85.00%	-	-	-	▲
QS-13	Physical Assaults (Number of Victims - Staff)	9	2	2	2	4	10	3	5	3	18	22	16	29	-	-	-	-	▼
MM-1	Number of Medicines Incidents	194	132	111	162	139	149	165	135	112	168	111	146	103	-	-	-	-	▲
MM-3	Single Witness Signature Use CDs Omnicell	3	8	4	9	4	6	4	5	4	2	0	0	14	0	-	-	-	▼
MM-4	Single Witness Signature Use CDs Non-Omnicell	2	7	0	3	3	3	3	4	0	1	0	0	0	0	-	=	-	●
MM-5	Number of CD Breakages	15	8	14	18	19	21	21	11	20	17	17	16	14	-	-	-	-	▲
MM-7	Medicines Management % of Audits Completed	99.00%	100.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	100.00%	99.00%	99.00%	99.00%	100.00%	-	-	-	●
WF-1	Number of Staff WTE (Excl bank and agency)	3564	3602	3624	3710	3689	3685	3667	3667	3734	3768	3784	3793	3806	-	-	-	-	▲
WF-2	Number of Staff Headcount (Exc bank and agency)	3879	3918	3940	4034	4016	4020	4001	4005	4075	4120	4141	4154	4173	-	-	-	-	▲
WF-3	Finance Establishment (WTE)	3791	3803	3811	3860	3940	3920	3924	3905	3905	3905	3905	3800	3816	-	-	-	-	▲
WF-4	Vacancy Rate %	6.00%	5.30%	4.90%	3.90%	6.40%	6.00%	6.50%	6.10%	4.40%	3.50%	3.10%	0.20%	2.60%	-	-	-	-	▼
QS-9	Number of RIDDOR Reports	8	10	8	5	4	2	6	12	2	8	6	11	8	-	-	-	-	▲
NEW WF-16	DBS Compliance %											100.00%	98.00%		100.00%	-	-	-	-
NEW M-20	Compliant NHS Pathways Audits (Clinical) %	84.00%	83.00%	84.00%	80.00%	83.00%	79.00%	80.00%	74.00%	77.00%	80.00%	84.00%	95.00%	95.00%	-	-	-	-	●

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

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

Performance by Domain
Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

	ID	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
NEW	M-21	Required NHS Pathways Audits Completed %											82.00%	102.00%	102.00%	-	-	-	-	●
NEW	M-22	Compliant NHS Pathways Audits (EMA) %											84.00%	84.00%	84.00%	-	-	-	-	●
NEW	QS-17	Outstanding Actions Relating to SIs, Outside of Timescales %													14.00%	0.00%	-	-	-	-
NEW	QS-19	Deep Clean Compliance %									77.00%	107.00%	105.00%	103.00%		-	-	-	-	-
NEW	QS-20	Health & Safety Incidents											43	42	35	-	-	-	-	▲
NEW	WF-24	Staff who have had a Driving Licence Check in the past 12 Months %													79.30%	100.00%	-	-	-	-
NEW	QS-22	Manual Handling Incidents											22	46	30	-	-	-	-	▲
NEW	QS-23	Direct Verbal Abuse Incidents											5	15	16	-	-	-	-	▼
NEW	QS-13	Physical Assaults (Sanctions)	38	25	22	20	33	39	35	15	19					-	-	-	-	-

▲ 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

** Latest data: **Jun-20**

ID	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-11	JCT Allocation to Clear at Scene Mean	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	01:19:20	01:16:03	01:14:37	-	-	-	-	▲
999-11	JCT Allocation to Clear at Hospital Mean	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	01:46:43	01:46:34	01:47:37	-	-	-	-	▼
M-1	**Cardiac ROSC Utstein %	72.00%	57.00%	54.00%	52.00%	50.00%	55.00%	22.00%	42.00%	33.00%	43.00%	45.00%			-	-	-	-	▲
M-2	Cardiac ROSC ALL %	36.00%	33.00%	25.00%	27.00%	23.00%	28.00%	25.00%	18.00%	24.00%	22.00%	24.00%			-	-	-	-	▲
M-12	**Sepsis Care Bundle %	76.00%	72.00%	61.00%	86.00%	87.00%	87.00%	87.00%	87.00%	88.00%	84.00%	81.00%			-	-	-	-	▼
M-3	Cardiac Survival Utstein %	18.00%	37.00%	31.00%	22.00%	29.00%	33.00%	9.00%	31.00%	14.00%	24.00%	31.00%			-	-	-	-	▲
M-4	Cardiac Survival ALL %	7.00%	12.00%	11.00%	5.00%	8.00%	10.00%	7.00%	7.00%	9.00%	11.00%	9.00%			-	-	-	-	▼
M-11	Cardiac Arrest - Post ROSC %	85.00%	82.00%	78.00%	82.00%	75.00%	80.00%	77.00%	78.00%	81.00%	62.00%	74.00%			-	-	-	-	▲
M-5	**Acute STEMI Care Bundle Outcome %	47.00%	58.00%	56.00%	63.00%	65.00%	71.00%	69.00%	73.00%	71.00%	73.00%	64.00%			-	-	-	-	▼
M-6	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	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	02:33:00	03:03:00	02:37:00	03:09:00										-	-	-	-	-
M-8	Stroke - Call to Hospital Arrival Mean	01:17:00	01:22:00	01:26:00	01:30:00										-	-	-	-	-
M-9	Stroke - Call to Hospital Arrival 90th Centile	02:00:00	02:06:00	02:25:00	02:24:00										-	-	-	-	-
M-10	**Stroke - Assessed F2F Diagnostic Bundle %	94.00%	95.00%	92.00%	94.00%	96.00%	97.00%	99.00%	97.00%	98.00%	98.00%	97.00%			-	-	-	-	▼
M-13	Sensitivity of Cardiac Arrest Detection During Telephone Triage %														-	-	■	■	■
M-14	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %														-	-	■	■	■
M-15	Time to Commence Telephone-Guided CPR Mean														-	-	■	■	■
M-16	Proportion of Non-EMS Witnessed Cardiac Arrests 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

** Latest data: Jun-20

	ID	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
	999-13	ECAL Mean Response Time	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	00:24:00	00:25:49	00:23:34			-	-	▲
	999-12	999 Operational Abstraction Rate %											32.50%	32.50%	32.60%	28.00%		-	-	▼
	WF-6	Statutory & Mandatory Training Compliance %	63.50%	65.20%	68.80%	70.20%	70.60%	73.60%	76.60%	83.70%	68.60%	70.80%	75.10%	76.10%	75.90%	100.00%		-	-	▼
	WF-22	Clinical Education																■	■	■
NEW	999-17	Responses Per Incident	1.10	1.10	1.10	1.11	1.10	1.11	1.10	1.08	1.08	1.09	1.10	1.12	1.12	1.09		-	-	●
NEW	999-18	Section 136 Mean Response Time											00:19:17	00:17:16	00:16:57			-	-	▲
NEW	999-19	Section 135 Mean Response Time											00:22:07	04:44:00	00:54:56			-	-	▲
NEW	999-20	ePCR Usage											94.70%	93.80%	95.30%	95.00%		+	-	▲
NEW	999-24	Number of Hours Lost at Hospital Handover	3457	3449	3929	4022	4428	4268	3753	3192	2289	2046	1916	3610	4202			-	-	▼
NEW	999-25	Hours Lost at Handover as a Proportion of Provided Hours %	1.20%	1.30%	1.40%	1.40%	1.50%	1.40%	1.40%	1.10%	0.80%	0.70%	0.70%	0.20%	1.50%			-	-	▼
	WF-23	Recruitment: Advert to Start Date														100.00%		■	■	■

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

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

Performance by Domain
Caring: Performance Dashboard

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

	ID	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
NEW	QS-10	Proportion of Complaints Relating to Crew Attitude %											48.00%	42.00%	40.00%			-	-	▲
	QS-12	Proportion of Complaints Relating to Dignity and Respect %																■	■	■
	M-17	Dementia Performance																■	■	■
	M-18	End of Life Care Performance																■	■	■
	111-6	111 SMS Feedback																■	■	■
	M-19	Falls Performance																■	■	■
	QS-11	Patient Experience																■	■	■

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

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

Performance by Domain
Responsive: Performance Dashboard

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

	ID	Metric	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
	111-1	111 Calls Offered	74832	68451	72487	78017	92173	75904	85080	162194	89757	81333	70230	71925	85338			-	-	-
	111-2	111 Calls Answered in 60 Seconds %	80.80%	78.50%	78.30%	77.50%	78.20%	86.30%	61.50%	16.50%	48.70%	87.90%	93.50%	91.20%	84.00%	95.00%		-	-	▼
	C-2	Number of BCIs											2	2	3	0		-	-	▼
	111-3	111 Calls Abandoned - (Offered) %	3.60%	3.60%	3.80%	3.60%	3.00%	1.90%	8.00%	50.20%	18.60%	1.40%	0.60%	1.00%	2.00%	6.00%		+	-	▼
	111-4	111 to 999 Referrals (Answered Calls) %	15.50%	16.10%	16.90%	15.80%	15.10%	14.50%	12.70%	9.80%	11.90%	13.00%	13.80%	13.60%	12.40%			-	-	▲
	111-4	999 Referrals	8961	8514	9454	9638	10672	8726	7960	5443	6734	8788	8443	8407	8864			-	-	▼
	999-4	Cat 2 Mean	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	00:16:43	00:18:31	00:18:57	00:18:00	00:16:39	-	-	▼
	111-5	A&E Dispositions %	10.10%	10.30%	10.20%	9.70%	9.50%	10.70%	9.70%	6.00%	9.20%	11.60%	13.40%	13.80%	12.70%			-	-	▲
	111-5	A&E Dispositions	5808	5460	5697	5903	6676	6443	6047	3316	5235	7795	8161	8544	9102			-	-	▼
NEW	QS-15	Complaints per 1000 999 Calls Answered											1.00	1.16	0.79			-	-	▲
NEW	QS-16	Compliments per 1000 999 Calls Answered											3.26	3.66	2.75			-	-	-
	999-10	999 Calls Answered	67178	64525	69301	68437	73898	65125	63620	77690	56319	54224	55915	62772	69541			-	-	-
	999-10	Incidents	63107	60410	64407	64620	68798	65363	61110	64209	58064	60484	58653	61196	64489			-	-	-
	999-1	999 Call Answer Mean	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	00:00:02	00:00:02	00:00:03	00:00:05	00:00:02	+	-	▼
	999-1	999 Call Answer 90th Centile	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	00:00:01	00:00:01	00:00:02	00:00:10	00:00:02	+	=	▼
	999-2	Cat 1 Mean	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	00:07:31	00:07:38	00:07:53	00:07:00	00:06:47	-	-	▼
	999-2	Cat 1 90th Centile	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	00:14:01	00:14:34	00:14:50	00:15:00	00:12:02	+	-	▼
	999-3	Cat 1T Mean	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	00:08:59	00:09:18	00:09:43	00:19:00	00:09:51	+	+	▼
	999-3	Cat 1T 90th Centile	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	00:16:40	00:17:51	00:17:38	00:30:00	00:19:57	+	+	▲
	999-4	Cat 2 90th Centile	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	00:31:02	00:34:56	00:34:57	00:40:00	00:32:33	+	-	▼
	999-5	Cat 3 90th Centile	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	02:38:05	03:19:04	03:31:37	02:00:00	01:38:58	-	-	▼
	999-6	Cat 4 90th Centile	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	03:30:44	04:40:05	05:01:24	03:00:00	02:27:08	-	-	▼
	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	01:41:16	02:06:57	02:20:06			-	-	▼
	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	03:39:26	04:20:06	05:01:43			-	-	▼
	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	02:28:17	02:53:34	03:09:26			-	-	▼

▲ 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	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
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	05:23:41	06:15:50	06:29:29			=	=	▼
999-9	Hear & Treat %	5.90%	5.80%	5.80%	6.20%	6.70%	5.60%	6.50%	8.40%	6.70%	5.90%	6.30%	6.60%	7.20%		7.30%	=	-	▲
999-9	See & Treat %	32.40%	31.90%	31.30%	30.80%	31.70%	31.50%	31.80%	37.10%	42.40%	37.10%	34.60%	33.60%	33.80%		33.00%	=	+	▲
999-9	See & Convey %	61.70%	62.30%	62.90%	63.00%	61.60%	62.90%	61.70%	54.40%	50.90%	57.00%	59.10%	59.80%	59.00%		54.20%	=	-	▲
999-10	CFR Attendances	1105	997	1340	1242	1321	1185	1051	785	0	0	75	152	520			=	=	▲
999-10	FFR Attendances	341	266	221	338	398	427	261	243	144	180	192	171	201			=	=	▲
QS-4	Complaints Reporting Timeliness %	77.00%	59.00%	55.00%	55.00%	73.00%	72.00%	78.00%	90.00%	92.00%	86.00%	95.00%	95.00%	96.00%	95.00%		+	=	▲
QS-5	Number of Complaints	78	59	111	91	68	79	66	56	43	48	56	73	55			=	=	▲
QS-6	Number of Compliments	220	147	147	231	148	213	187	197	169	168	191	224	177			=	=	=
QS-14	Learning from deaths: Number of Structured Judgment Reviews														20		■	■	■
NEW 999-14	Time Spent in SMP 3 or Higher %	21.50%	26.60%	42.10%	45.40%	49.90%	15.00%	31.70%	43.90%	3.90%	0.60%	13.70%	29.10%	38.10%			=	=	▼

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

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

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	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
	F-1	Income (£000s)	£19995.30	£19553.00	£19927.00	£20390.10	£22455.50	£21049.40	£19410.00	£23188.60	£21877.40	£22787.20	£22394.00	£22042.00	£22557.10	£21208.40		+	-	▲
	F-2	Expenditure (£000s)	£20271.20	£20094.80	£20177.80	£20023.50	£20877.00	£20227.40	£19428.00	£22280.80	£21877.40	£22787.20	£22394.00	£22052.00	£22558.80	£21208.40		-	-	▼
	F-3	Capital Expenditure (£000s)	£1269.97	£989.00	£1781.00	£845.00	£1022.00	£851.01	£1012.00	£1859.99	£1262.00	£254.00	£862.00	£887.00	£1195.86	£1543.09		+	-	▼
	F-4	Cost Improvement Plan (CIP) (£000s)	£1078.31	£533.75	£467.79	£336.74	£827.15	£574.85	£700.00	£776.00	£0.00	£0.00	£1022.00	£252.00	£147.52	£509.00		-	-	▼
	F-6	Surplus/Deficit (£000s)	£-275.90	£-541.80	£-250.80	£366.60	£1578.50	£822.00	£-18.00	£907.80	£0.00	£0.00	£0.00	£-10.00	£-2.00	£0.00		-	-	▲
	F-7	Cash Position (£000s)	£24597.00	£24561.00	£26496.00	£24966.00	£26136.00	£25758.00	£26577.00	£28326.00	£48150.00	£44676.00	£43742.00	£46283.00	£46647.00	£29534.10		+	-	▲
	F-8	Agency Spend (£000s)	£151.54	£242.64	£-31.85	£364.44	£431.82	£356.12	£-145.00	£145.97	£231.94	£69.41	£285.00	£211.00	£175.00	£367.00		+	-	▲
	WF-5	Objectives & Career Conversation	33.20%	38.60%	42.60%	45.60%	49.60%	56.20%	61.30%	71.70%	5.40%	16.50%	22.90%	28.20%	31.70%	80.00%		-	-	▲
	WF-7	Annual Rolling Turnover Rate	15.60%	15.50%	15.90%	15.40%	14.90%	15.60%	15.90%	15.80%	15.60%	14.80%	13.90%	13.40%	12.60%			-	-	▲
	WF-8	Annual Rolling Sickness Absence	5.50%	5.40%	5.40%	5.60%	6.00%	5.70%	5.70%	5.80%	6.10%	6.00%	6.00%	5.90%	6.00%	5.00%		-	-	▼
NEW	WF-18	Absence Relating to Mental Health %											12.10%	12.00%	12.10%			-	-	▼
NEW	WF-19	Absence Relating to MSK %											4.60%	2.80%	3.60%			-	-	▼
	WF-9	Disciplinary Cases	0	0	1	4	8	6	5	2	6	4	9	6	4			-	-	▲
	WF-10	Individual Grievances	0	2	7	10	7	8	8	6	4	4	8	7	5			-	-	▲
	WF-11	Collective Grievances	0	1	5	1	0	1	2	1	1	0	1	0	0			-	-	●
	WF-12	Bullying & Harrassment Internal	0	1	5	0	4	2	1	2	2	1	2	2	5	0		-	-	▼
	WF-13	Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0		=	-	●
NEW	999-15	999 Frontline Late Finishes/Over-Runs %											47.60%	51.10%	52.20%			-	-	▼
NEW	999-15	Average Late Finish/Over-Run Time											00:45:44	00:45:44	00:43:40			-	-	▲
	WF-17	Workforce Diversity																■	■	■
	999-16	Staff Successfully FIT-Tested %												93.90%	88.30%	100.00%		-	-	▼
NEW	999-21	Provided Bank Hours %											2.90%	2.80%	2.80%			-	-	-
NEW	999-21	Provided Overtime Hours %											7.40%	7.90%	8.10%			-	-	-

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

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

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	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
NEW	999-21	Provided PAP Hours %											9.10%	6.80%	7.20%			-	-	-
NEW	QS-24	Organisational Risks Outstanding Review %													14.00%			-	-	-
NEW	WF-25	Number of Wellbeing Hub Referrals												112	104			-	-	-
	WF-30	Time From Referral to Wellbeing Support Received																■	■	■
	WF-26	Vacancy Rate for Leadership Roles %																■	■	■
NEW	WF-27	First Line Managers who have had Leadership Training (Fundamentals) %											0.00%	0.00%	0.00%	100.00%		-	-	●
	WF-28	Staff Affected by Restructures %																■	■	■
	WF-29	Staff Acting Up/Secondments %																■	■	■
NEW	FL-1	Vehicles Older Than Target Age %											55.00%	55.00%	55.00%			-	-	●
NEW	C-1	Policies & Procedures Outstanding Review %												11.90%	12.60%			-	-	▼
NEW	999-22	999 Remaining Annual Leave FY													42.50%	50.00%		-	-	-

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

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

Month 5 Financial Performance (August 2020)
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

Key Performance Indicators

Month to Date							Year To Date						Full Year					
% PY Var	£000 Prior Year	£000 Plan	£000 Actual	£000 Variance	% Variance		£000 Plan	£000 Actual	£000 Variance	% Variance	£000 Prior Year	% PY Var	£000 Plan	£000 Forecast	£000 Variance	% Variance	£000 Prior Year	% PY Var
12.8%	**19,995**	**21,208**	**22,557**	**1,349**	**6.4%**	**INCOME**	**108,997**	**111,658**	**2,661**	**2.4%**	**99,255**	**12.5%**	**261,924**	**265,532**	**3,608**	**1.4%**	**245,228**	**8.3%**
(15.5)%	14,712	15,638	16,992	(1,354)	(8.7)%	PAY	80,245	84,496	(4,251)	(5.3)%	75,408	(12.1)%	189,997	195,724	(5,727)	(3.0)%	180,287	(8.6)%
(23.0)%	4,521	5,440	5,560	(120)	(2.2%)	NON-PAY	28,096	26,835	1,261	4.5%	25,785	(4.1)%	70,326	68,558	1,769	2.5%	63,316	(8.3)%
(17.3)%	**19,233**	**21,078**	**22,553**	**(1,475)**	**(7.0)%**	**OPERATING EXPENDITURE**	**108,341**	**111,332**	**(2,990)**	**(2.8)%**	**101,193**	**(10.0)%**	**260,323**	**264,282**	**(3,959)**	**(1.5)%**	**243,603**	**(8.5)%**
(99.4)%	**762**	**130**	**5**	**(126)**	**(96.5)%**	**OPERATING SURPLUS/(DEFICIT)**	**656**	**326**	**(330)**	**(50.3)%**	**(1,938)**	**(116.8)%**	**1,601**	**1,251**	**(350)**	**(21.9)%**	**1,625**	**(23.1)%**
94.9%	123	130	6	124	95.2%	FINANCING COSTS	656	338	318	48.5%	653	48.3%	1,601	1,280	321	20.1%	1,352	5.4%
(100.3)%	**639**	**0**	**(2)**	**(2)**	**-**	**SURPLUS/(DEFICIT)**	**0**	**(12)**	**(12)**	**-**	**(2,591)**	**99.5%**	**0**	**(29)**	**(29)**	**-**	**273**	**(110.6)%**
0.0%	2	0	2	2	0.0%	REMOVE CAPITAL DONATIONS/GRANTS I&E IMPACT	0	12	12	-	12	0.0%	0	29	**29**	-	29	0.0%
(100.0)%	*636*	*0*	*0*	*0*	*0.0%*	*ADJUSTED SURPLUS/(DEFICIT) : CONTROL TOTAL*	*(0)*	*0*	*0*	**0.0%**	*(2,579)*	*100.0%*	*0*	*(0)*	*(0)*	-	*302*	*(100.0)%*
% PY Var	Incidents Prior Year	Incidents Plan	Incidents Actual	Incidents Variance	% Variance	**A&E ACTIVITY**	Incidents Plan	Incidents Actual	Incidents Variance	% Variance	Incidents Prior Year	% PY Var	Incidents Plan	Incidents Forecast	Incidents Variance	% Variance	Incidents Prior Year	% PY Var
2.2%	63,149	65,643	64,547	(1,096)	(1.7%)	A&E ACTIVITY per Plan	332,650	302,976	(29,674)	(8.9%)	310,427	(2.4%)	806,987	761,194	(45,793)	(5.7%)	759,359	0.2%
✓	3	1	1		✓	**USE OF RESOURCES RATING**	1	1		✓	3	✓	1	1		✓	1	✓
	Prior Year	Plan	Actual	Variance			Plan	Actual	Variance		Prior Year		Plan	Forecast	Variance		Prior Year	
✗	1,078	509	148	(361)	✗	**CIPS**	1,958	1,422	(536)	✗	3,066	✗	5,515	5,515	0	✓	7,082	✗
✓	1,270	1,443	1,196	(247)	✗	**CAPITAL**	6,238	4,260	(1,978)	✓	6,286	✗	18,510	18,550	40	✗	13,857	✓
✓	24,597	29,534	46,647	17,113	✓	**CASH POSITION**	29,534	46,647	17,113	✓	24,597	✓	22,135	24,770	2,635	✓	28,326	✗
✗	4,084	4,188	4,391	(203)	✓	**WTE**	4,092	4,442	(350)	✗	4,057	✓	4,169	4,315	(146)	✗	4,144	✗
% PY Var	£000 Prior Year	£000 Plan	£000 Actual	£000 Variance	% Variance		£000 Plan	£000 Actual	£000 Variance	% Variance	£000 Prior Year	% PY Var	£000 Plan	£000 Forecast	£000 Variance	% Variance	£000 Prior Year	% PY Var
(15.4)%	152	367	175	192	52.4%	**AGENCY STAFF**	1,894	972	922	48.7%	2,428	60.0%	4,298	3,438	860	20.0%	3,792	9.3%
27.4%	811	738	589	150	20.3%	**PRIVATE AMBULANCE PROVIDERS (PAP)**	3,834	4,544	(710)	(18.5)%	3,867	(17.5)%	6,810	7,481	(671)	(9.8)%	11,197	33.2%

National Benchmarking
999 Emergency Ambulance Service (August 2020)

Key indicators at a glance for August 2020

Primary Triage Software	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
	NHS Pathways	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS

999 Call Answer	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Call Answer Time	00:00:02	00:00:02	00:00:04	00:00:04	00:00:12	00:00:01	00:00:14	00:00:01	00:00:04	00:00:03	00:00:02	00:00:03
Calls Answered	642226	69541	66973	66828	1824	114984	31059	105185	41872	84284	77550	50619
Mean Call Answer Time	00:00:02	00:00:03	00:00:02	00:00:04	00:00:08	00:00:02	00:00:07	00:00:01	00:00:05	00:00:03	00:00:01	00:00:05

Incident Proportions (Over All Incidents)	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	718054	64489	77498	65202	2501	103983	36308	96134	51314	77116	94079	68558
C1 Incidents %	7.09%	6.75%	8.63%	8.47%	4.52%	7.58%	6.84%	8.87%	7.16%	7.87%	6.59%	7.26%
C2 Incidents %	50.01%	50.55%	53.54%	55.80%	44.70%	55.12%	52.84%	51.47%	42.17%	53.33%	43.47%	52.16%
C3 Incidents %	25.70%	31.84%	18.36%	21.03%	32.31%	21.43%	24.34%	17.17%	33.34%	21.96%	37.00%	21.48%
C4 Incidents %	1.60%	0.54%	0.64%	0.34%	1.96%	1.49%	1.04%	3.11%	2.08%	0.78%	1.97%	1.29%

Incident Outcomes	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	7.33%	7.17%	8.26%	8.46%	10.88%	9.48%	7.03%	10.06%	9.79%	4.95%	3.98%	8.75%
See & Convey %	54.18%	57.50%	55.99%	54.52%	54.02%	54.26%	56.13%	54.08%	49.95%	51.86%	52.06%	54.57%
See & Treat %	32.96%	33.73%	33.24%	31.02%	34.15%	30.87%	28.62%	29.21%	34.59%	39.03%	37.76%	28.89%

Response Performance	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:12:02	00:14:50	00:13:22	00:12:56	00:19:20	00:10:49	00:11:09	00:12:35	00:12:05	00:13:58	00:12:09	00:12:44
90th Centile Response Time: C2	00:32:33	00:34:57	00:46:46	00:46:20	00:58:18	00:27:00	00:48:04	00:59:30	00:34:08	00:49:33	00:22:21	00:38:00
90th Centile Response Time: C3	01:38:58	03:31:37	02:14:03	02:30:09	03:11:03	01:21:15	02:36:02	03:27:07	02:08:18	02:52:44	01:02:22	01:34:56
90th Centile Response Time: C4	02:27:08	05:01:24	02:49:31	03:06:17	04:22:32	02:25:10	02:29:36	03:47:57	03:07:46	03:58:17	01:34:53	02:42:23
Mean Response Time: C1	00:06:47	00:07:53	00:07:08	00:07:13	00:09:40	00:06:22	00:06:28	00:07:27	00:06:29	00:07:23	00:06:56	00:07:24
Mean Response Time: C2	00:16:39	00:18:57	00:22:25	00:22:39	00:26:25	00:14:12	00:23:28	00:27:37	00:17:06	00:24:17	00:12:09	00:18:29

National Benchmarking
999 Emergency Ambulance Service Clinical Outcomes (August 2020)

Key indicators at a glance for August 2020

Cardiac Arrest	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Proportion of cardiac arrests discharged alive utstein %	8.93%	9.92%	8.31%	9.20%	25.00%	8.43%	3.91%	7.45%	8.04%	10.47%	9.23%	11.41%
Proportion who had ROSC on arrival at hospital %	30.55%	27.91%	23.56%	34.10%	43.75%	32.53%	30.35%	35.82%	28.64%	30.59%	32.08%	28.78%
Proportion who had ROSC on arrival at hospital utstein %	56.43%	55.32%	54.17%	63.64%	66.67%	59.09%	68.57%	48.48%	50.00%	56.00%	52.46%	57.14%

National Benchmarking
NHS 111 Service (August 2020)

Key indicators at a glance for August 2020

Metric	SECAmb	Care UK	Devon Doctors	DHC	DHU	HUC	IC24	IOW	Kernow Health	LAS	LCW	Medvivo	NEAS	NWAS	SCAS	Vocare	WMAS	YAS
Calls Answered in 60 secs %	69.35%	79.93%	51.62%	35.05%	76.47%	82.74%	90.08%	84.15%	67.33%	96.94%	96.49%	69.21%	53.99%	55.14%	72.94%	72.60%	93.28%	83.84%
Abandoned Calls %	1.97%	2.00%	15.59%	15.42%	1.03%	0.61%	0.22%	3.46%	6.69%	0.19%	0.28%	4.50%	11.77%	6.75%	2.91%	3.76%	0.06%	1.02%
111 to A&E Transfer %	12.86%	11.54%	10.95%	10.62%	7.32%	6.58%	11.26%	14.77%	2.15%	11.44%	11.34%	8.68%	11.11%	9.72%	8.55%	8.89%	10.66%	12.71%
111 to 999 Transfer %	12.58%	12.32%	12.47%	10.86%	10.89%	8.18%	11.97%	12.93%	6.62%	7.50%	8.67%	10.90%	13.21%	10.48%	10.21%	10.73%	12.13%	10.46%

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Appendix 1

Performance Charts

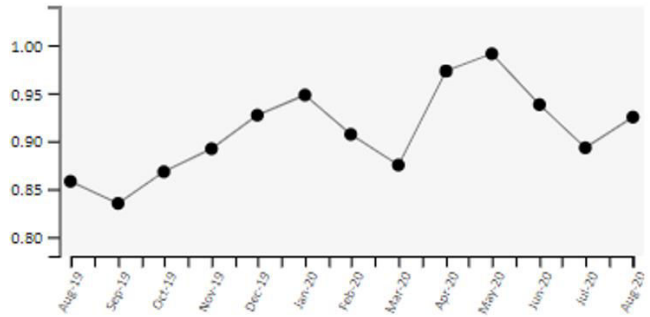
Best placed to *care*, the *best* place to *work*

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

999-12

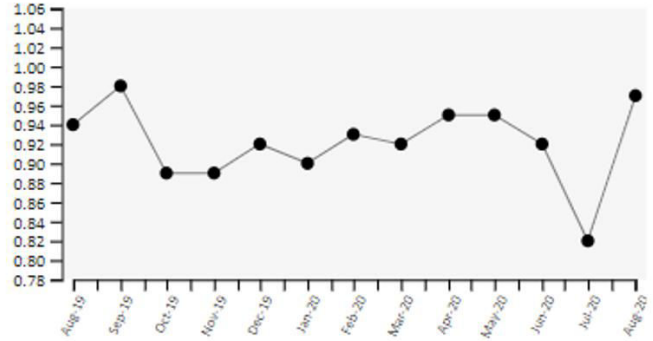
999 Frontline Hours Provided %



August 2020	Target
92.50%	100.00%

QS-7

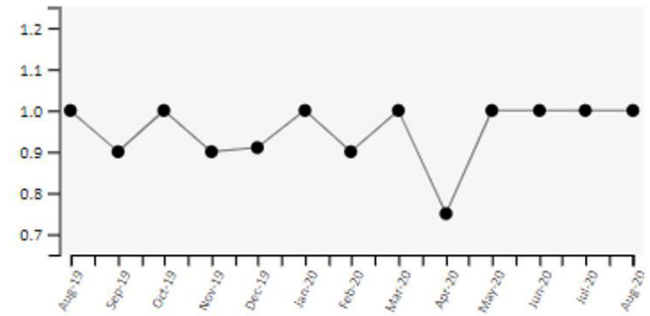
Hand Hygiene Compliance %



August 2020	Target
97.00%	95.00%

QS-3

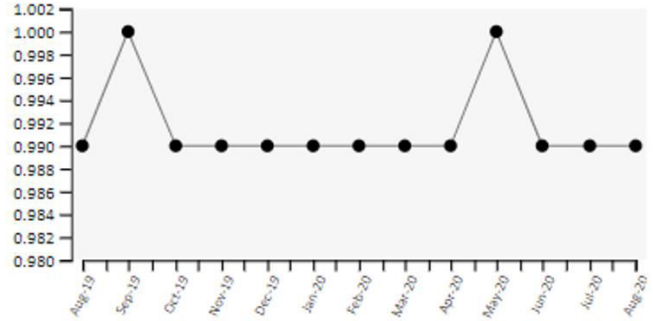
Duty of Candour Compliance %



August 2020	Target
100.00%	100.00%

MM-7

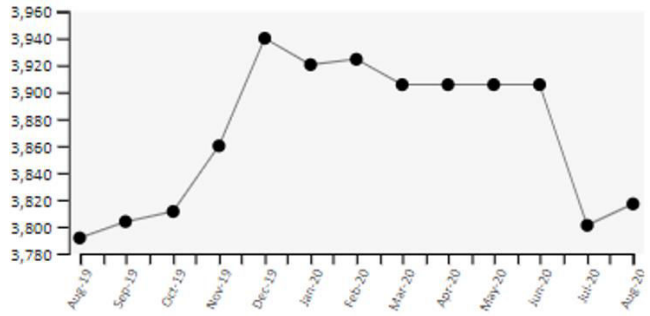
Medicines Management % of Audits Completed



August 2020	Target
99.00%	100.00%

WF-3

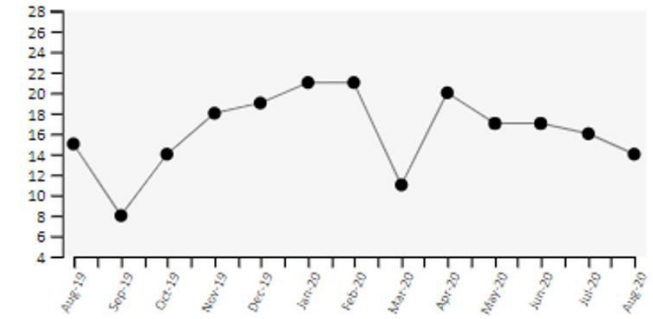
Finance Establishment (WTE)



August 2020	Target
3816	N/A

MM-5

Number of CD Breakages



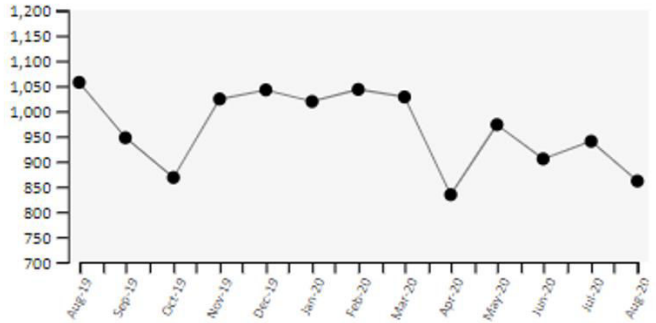
August 2020	Target
14	N/A

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

QS-1

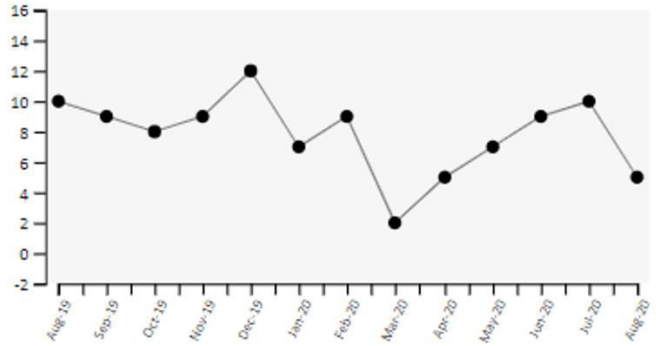
Number of Datix Incidents



August 2020	861
Target	N/A

QS-2

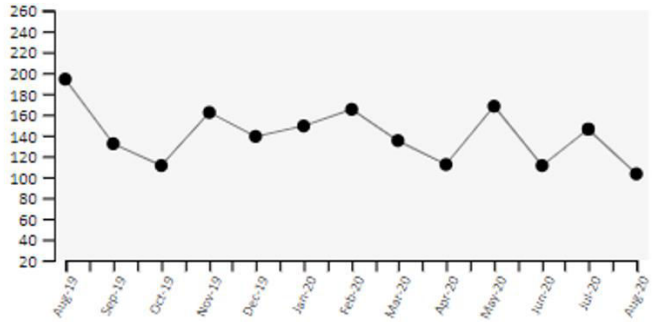
Number of Incidents Reported as SIs



August 2020	5
Target	N/A

MM-1

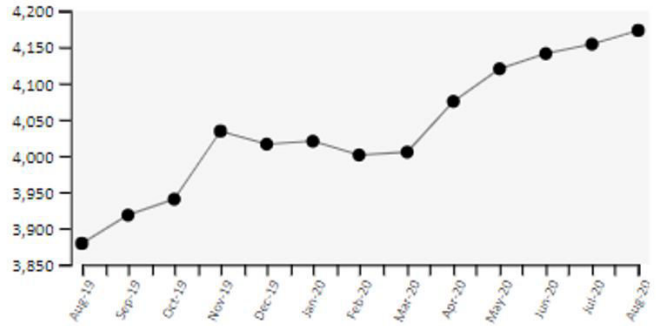
Number of Medicines Incidents



August 2020	103
Target	N/A

WF-2

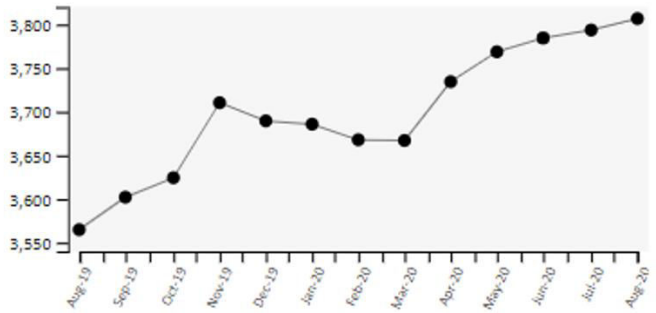
Number of Staff Headcount (Excl bank and agency)



August 2020	4173
Target	N/A

WF-1

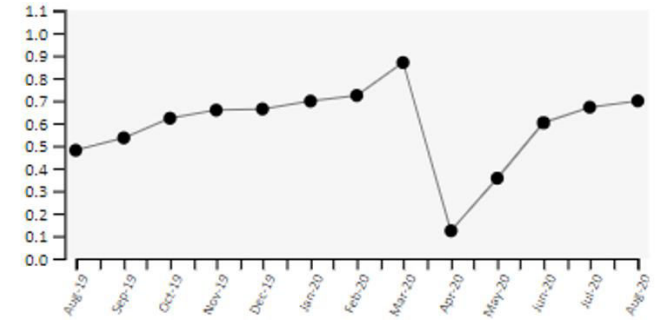
Number of Staff WTE (Excl bank and agency)



August 2020	3806
Target	N/A

QS-8

Safeguarding Training Completed (Children) Level 2 %



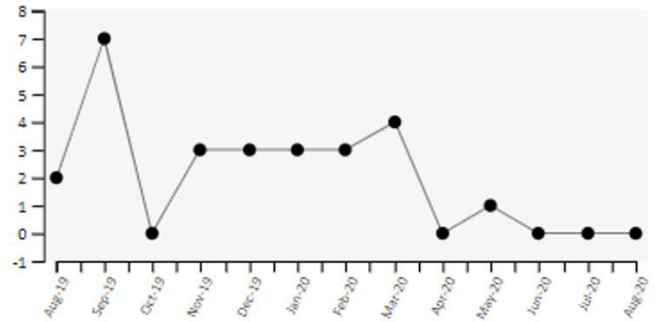
August 2020	69.90%
Target	85.00%

Performance by Domain
Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

MM-4

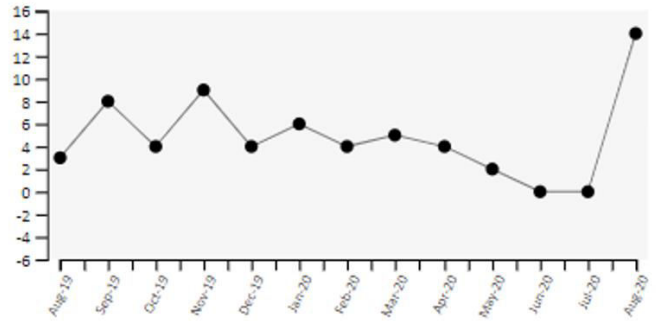
Single Witness Signature Use CDs Non-Omnicell



August 2020	Target
0	N/A

MM-3

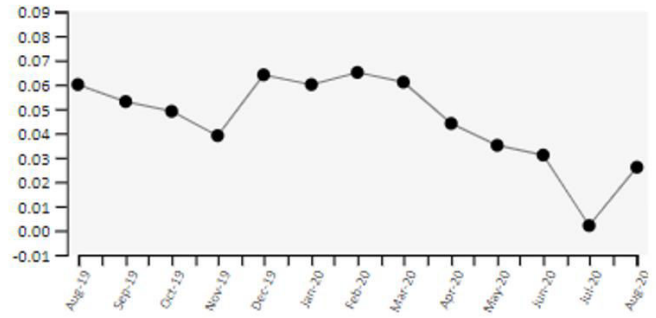
Single Witness Signature Use CDs Omnicell



August 2020	Target
14	N/A

WF-4

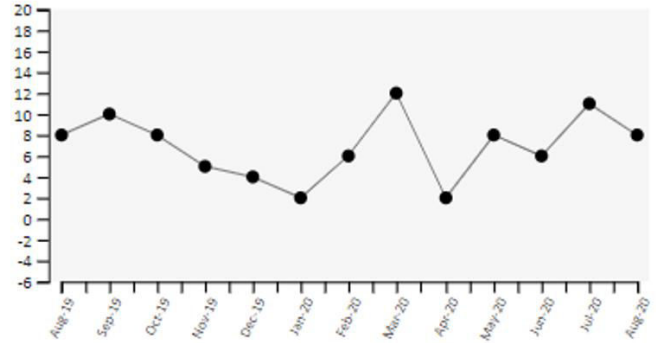
Vacancy Rate %



August 2020	Target
2.60%	N/A

QS-9

Number of RIDDOR Reports



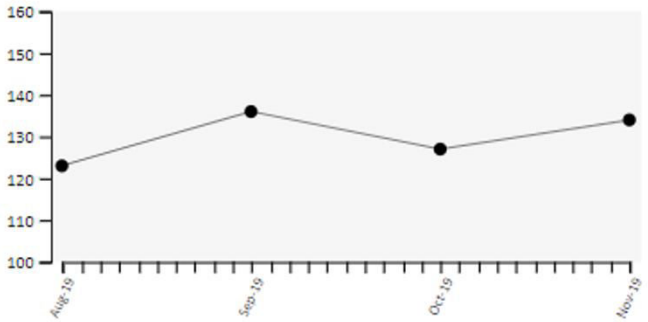
August 2020	Target
8	N/A

Performance by Domain
Effective: Performance Charts

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

M-6

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



Nov-19

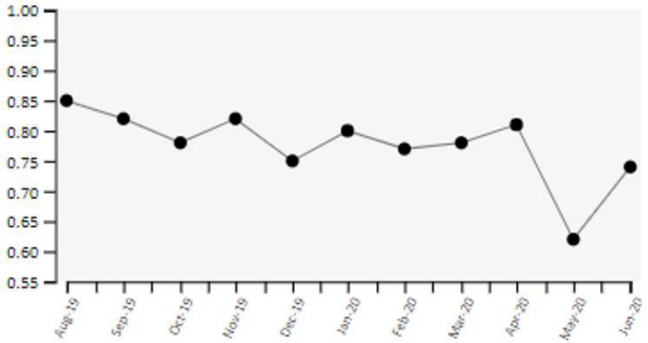
02:14:00

Target

N/A

M-11

Cardiac Arrest - Post ROSC %



Jun-20

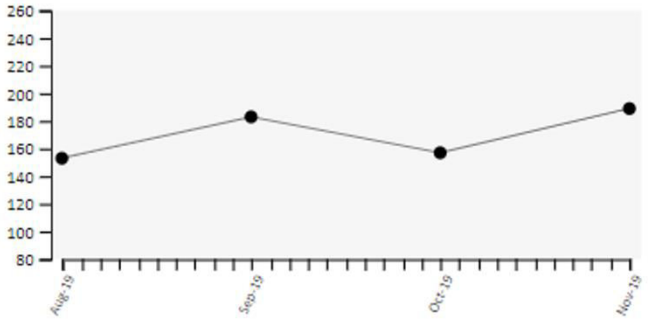
74.00%

Target

N/A

M-7

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



Nov-19

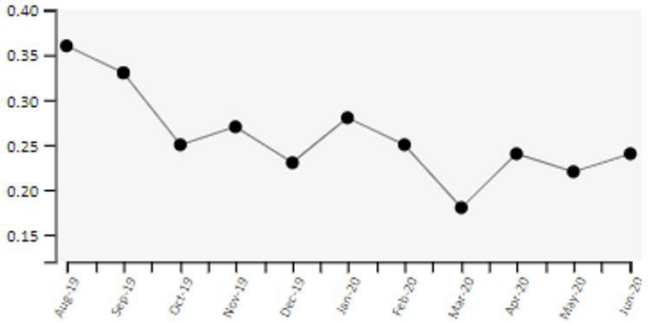
03:09:00

Target

N/A

M-2

Cardiac ROSC ALL %



Jun-20

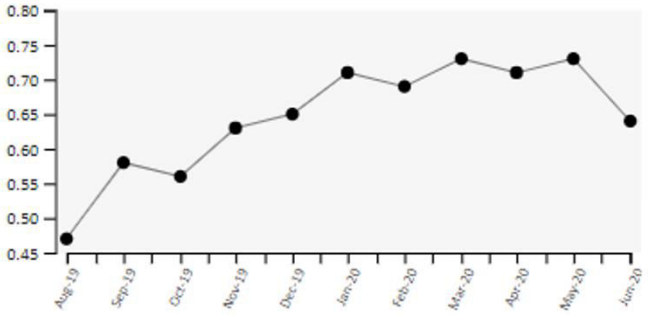
24.00%

Target

N/A

M-5

**Acute STEMI Care Bundle Outcome %



Jun-20

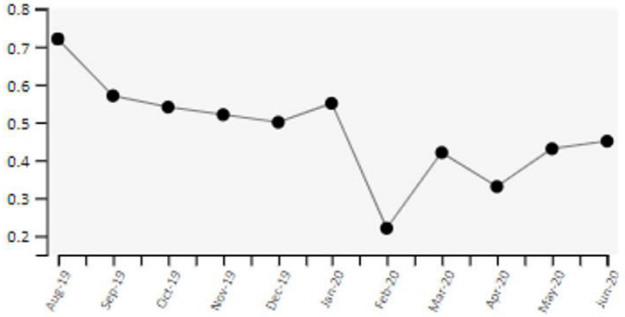
64.00%

Target

N/A

M-1

**Cardiac ROSC Utstein %



Jun-20

45.00%

Target

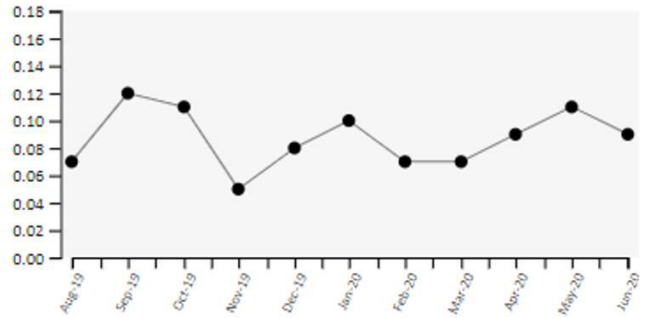
N/A

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 %



Jun-20

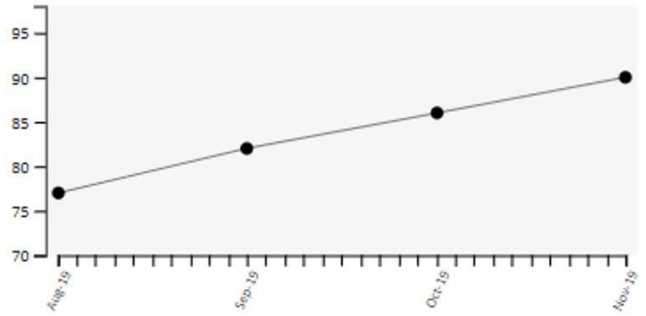
9.00%

Target

N/A

M-8

Stroke - Call to Hospital Arrival Mean



Nov-19

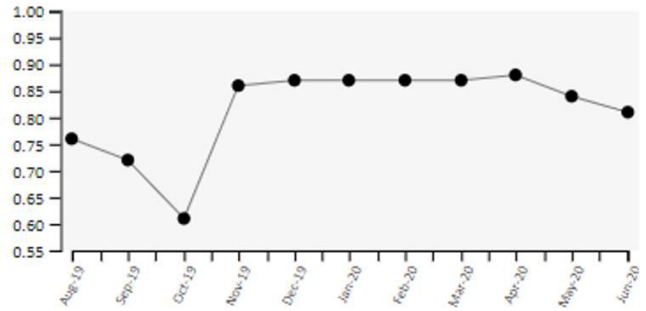
01:30:00

Target

N/A

M-12

**Sepsis Care Bundle %



Jun-20

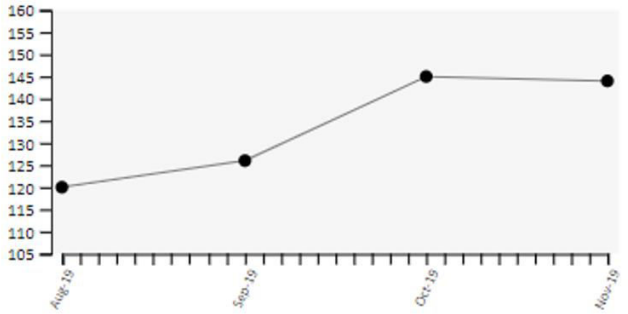
81.00%

Target

N/A

M-9

Stroke - Call to Hospital Arrival 90th Centile



Nov-19

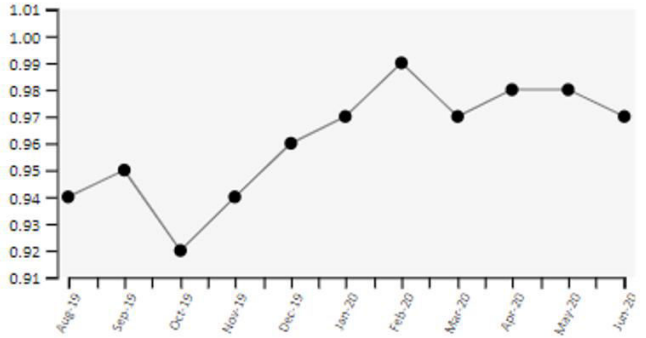
02:24:00

Target

N/A

M-10

**Stroke - Assessed F2F Diagnostic Bundle %



Jun-20

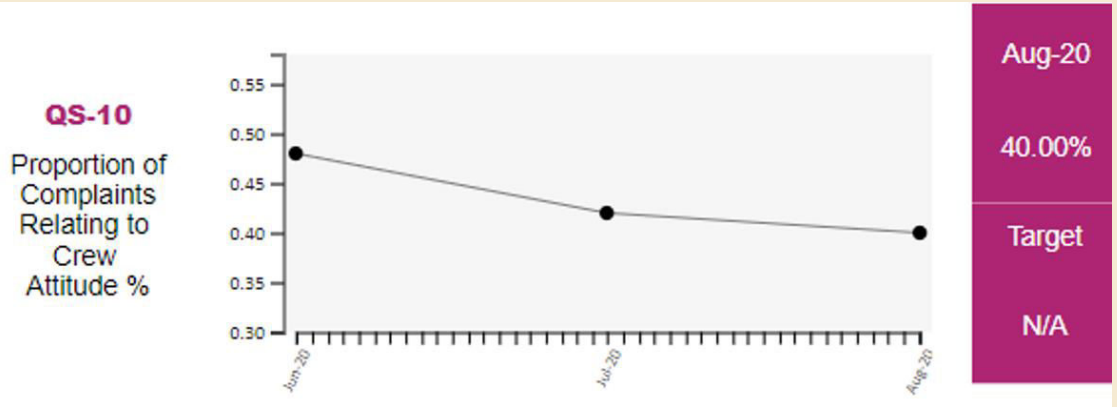
97.00%

Target

N/A

Performance by Domain
Caring: Performance Charts

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

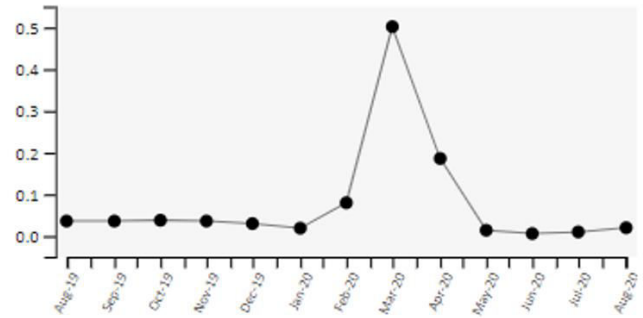


Performance by Domain
Responsive: Performance Charts

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

111-3

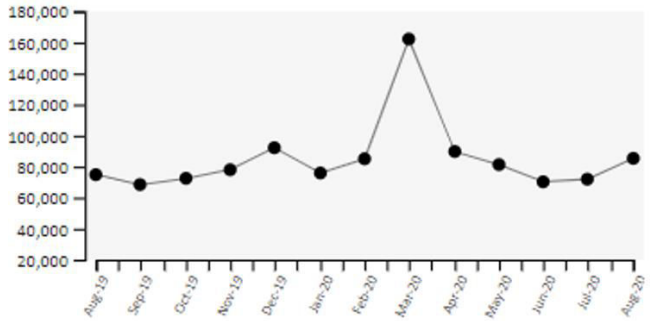
111 Calls Abandoned - (Offered) After 30 Seconds %



August 2020	2.00%
Target	6.00%

111-1

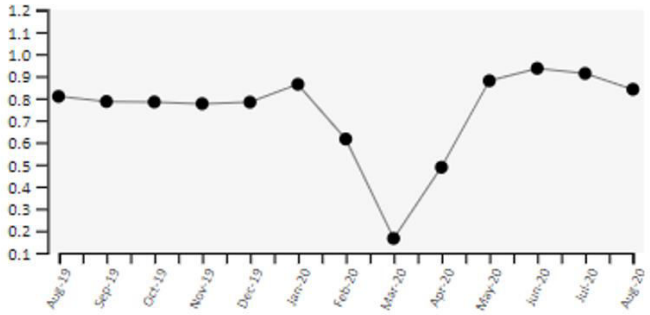
111 Calls Offered Actual



August 2020	162194
Target	N/A

111-1

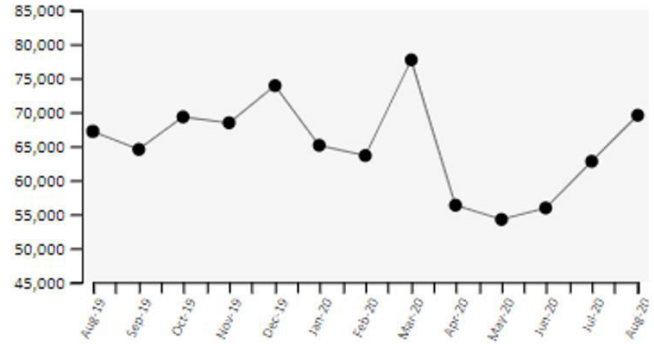
111 Calls Answered in 60 Seconds %



August 2020	84.00%
Target	95.00%

999-10

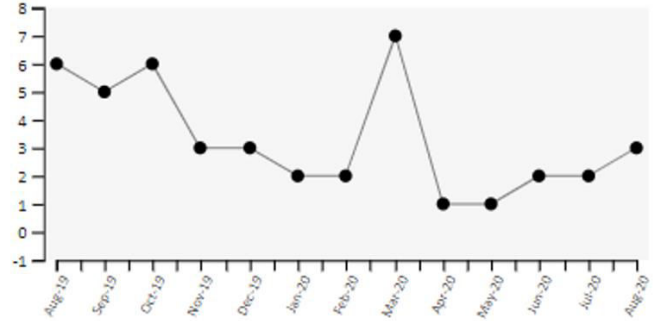
999 Calls Answered



August 2020	69541
Target	N/A

999-1

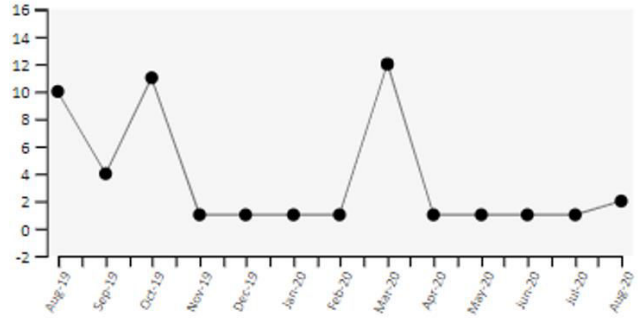
999 Call Answer Mean



August 2020	00:00:03
Target	00:00:05

999-1

999 Call Answer 90th Centile



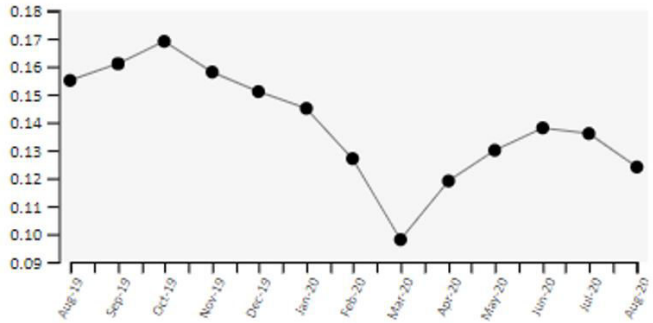
August 2020	00:00:02
Target	00:00:10

Performance by Domain
Responsive: Performance Charts

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

111-4

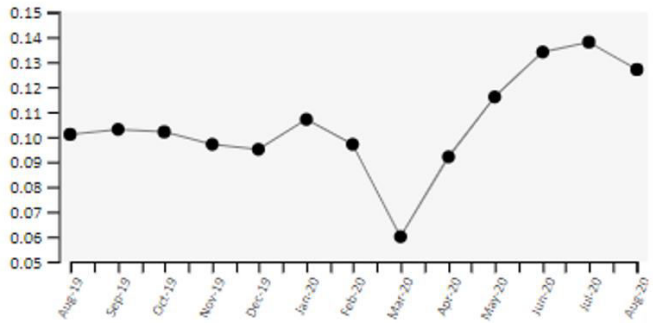
999 Referrals (Answered Calls) %



August 2020
12.40%
Target
N/A

111-5

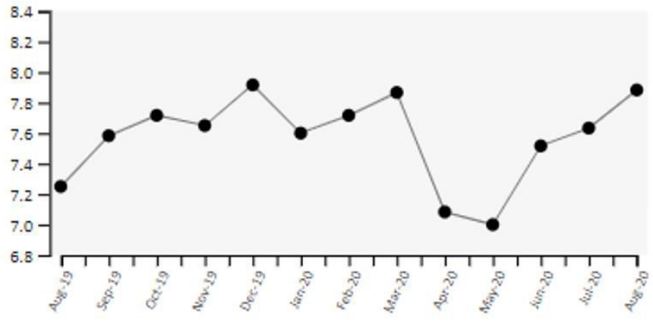
A&E Dispositions %



August 2020
12.70%
Target
N/A

999-2

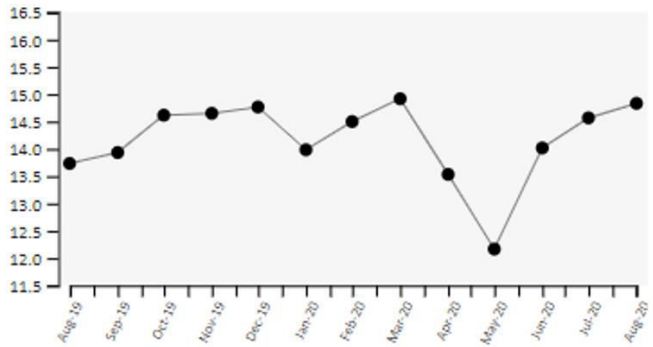
Cat 1 Mean



August 2020
00:07:53
Target
00:07:00

999-2

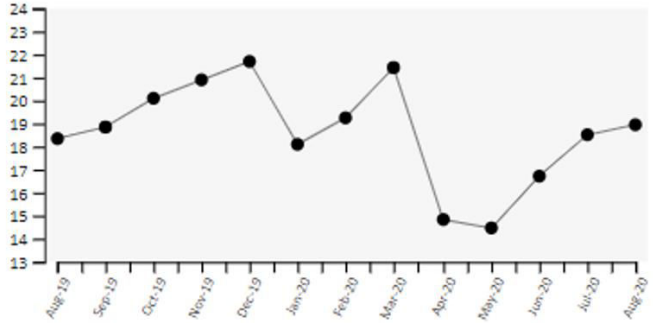
Cat 1 90th Centile



August 2020
00:14:50
Target
00:15:00

999-4

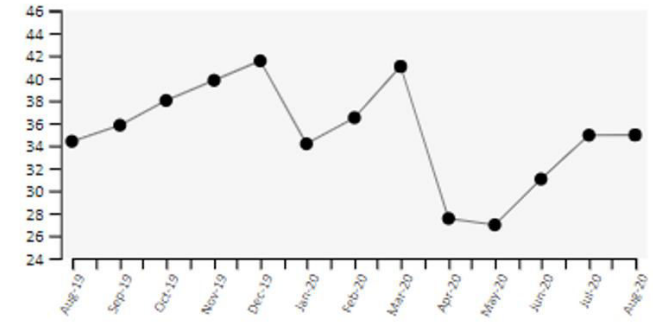
Cat 2 Mean



August 2020
00:18:57
Target
00:18:00

999-4

Cat 2 90th Centile



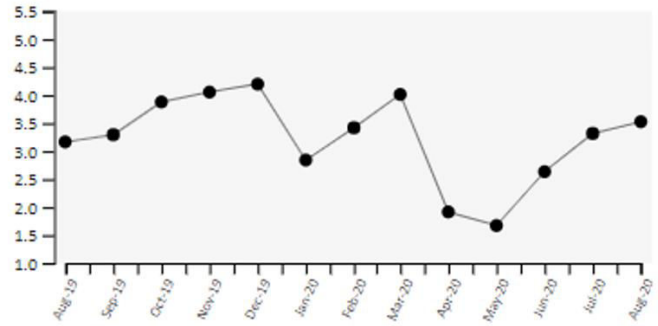
August 2020
00:34:57
Target
00:40:00

Performance by Domain
Responsive: Performance Charts

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

999-5

Cat 3 90th Centile

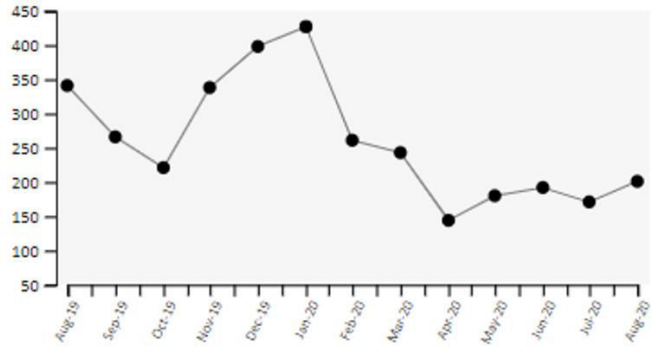


August 2020: 03:31:37

Target: 02:00:00

999-10

Fire First Responder Attendances

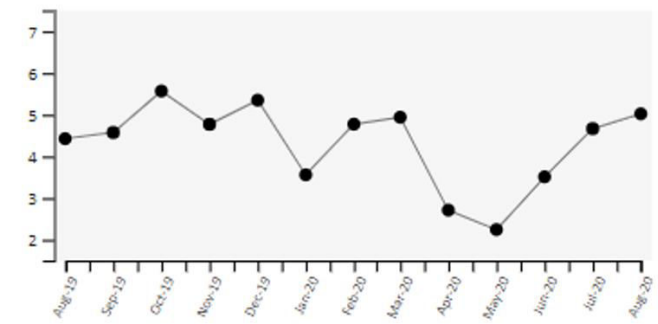


August 2020: 201

Target: N/A

999-6

Cat 4 90th Centile

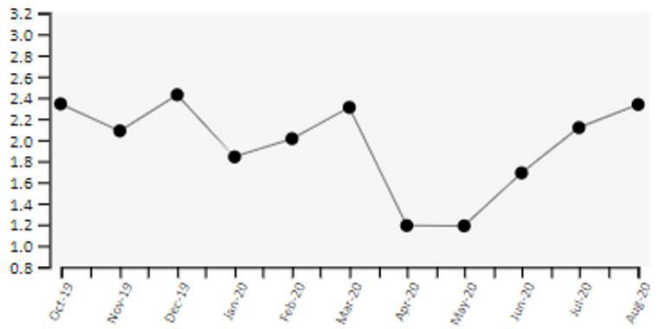


August 2020: 05:01:24

Target: 02:14:44

999-7

HCP 3 Mean

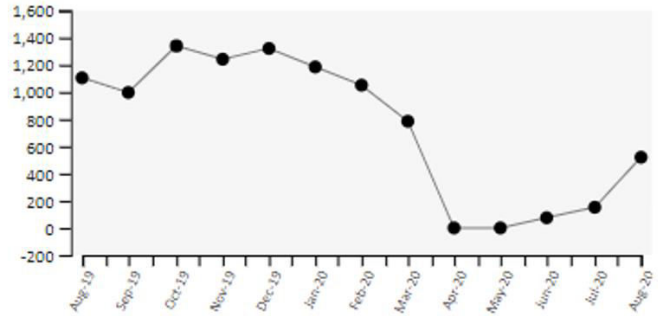


August 2020: 02:20:06

Target: N/A

999-10

Community First Responder Attendances

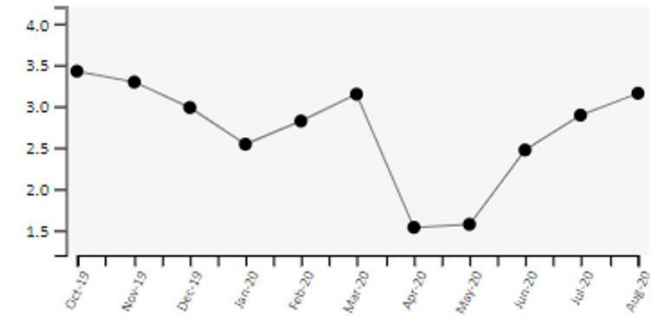


August 2020: 520

Target: N/A

999-7

HCP 4 Mean



August 2020: 03:09:26

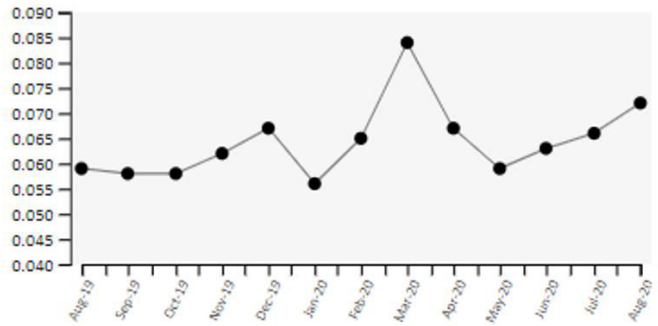
Target: N/A

Performance by Domain
Responsive: Performance Charts

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

999-9

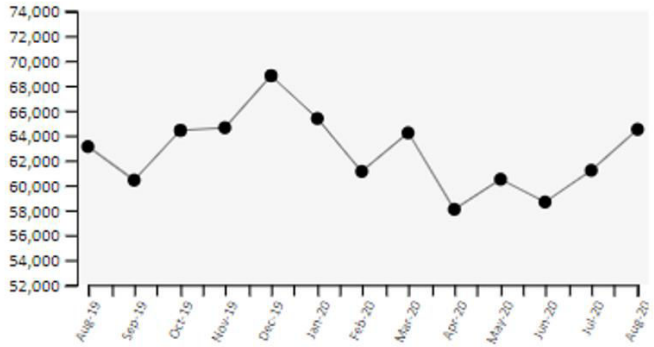
Incident Outcome Hear & Treat %



August 2020
7.20%
Target
N/A

999-10

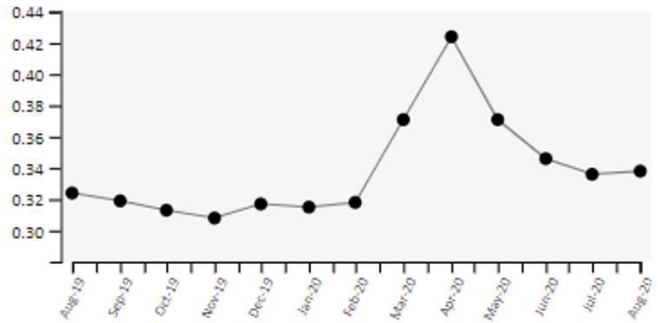
Incidents A7



August 2020
64489
Target
N/A

999-9

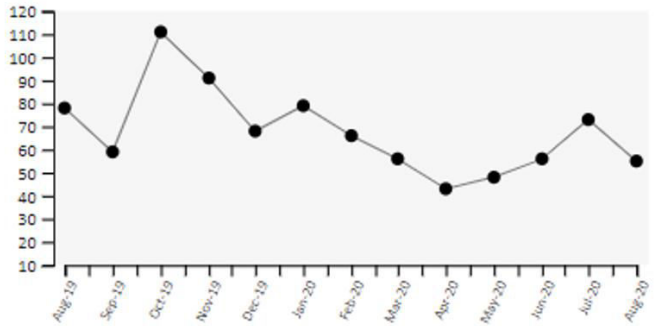
Incident Outcome See & Treat %



August 2020
33.80%
Target
N/A

QS-5

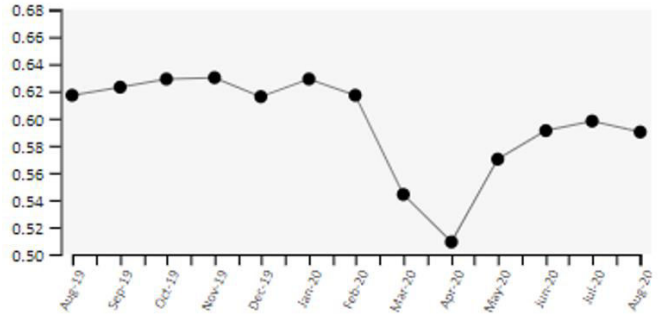
Number of Complaints



August 2020
55
Target
N/A

999-9

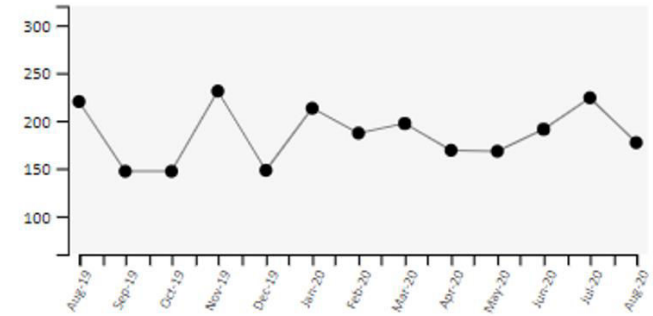
Incident Outcome See & Convey %



August 2020
59.00%
Target
N/A

QS-6

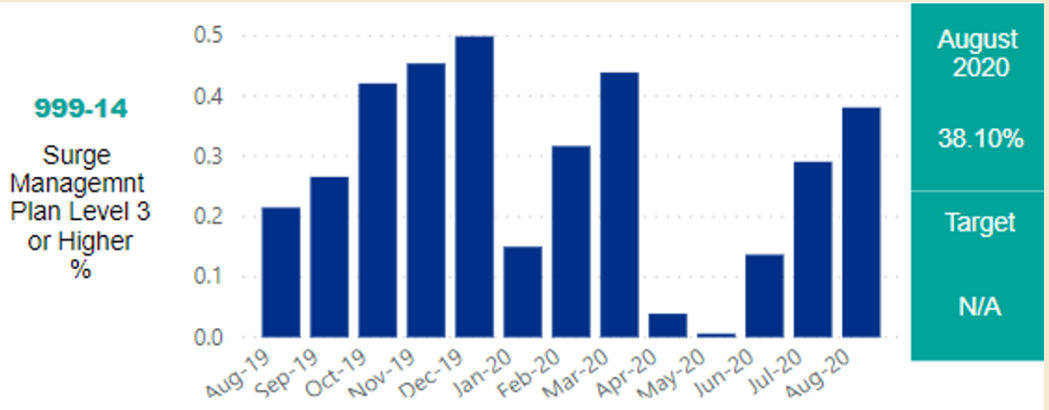
Number of Compliments



August 2020
177
Target
N/A

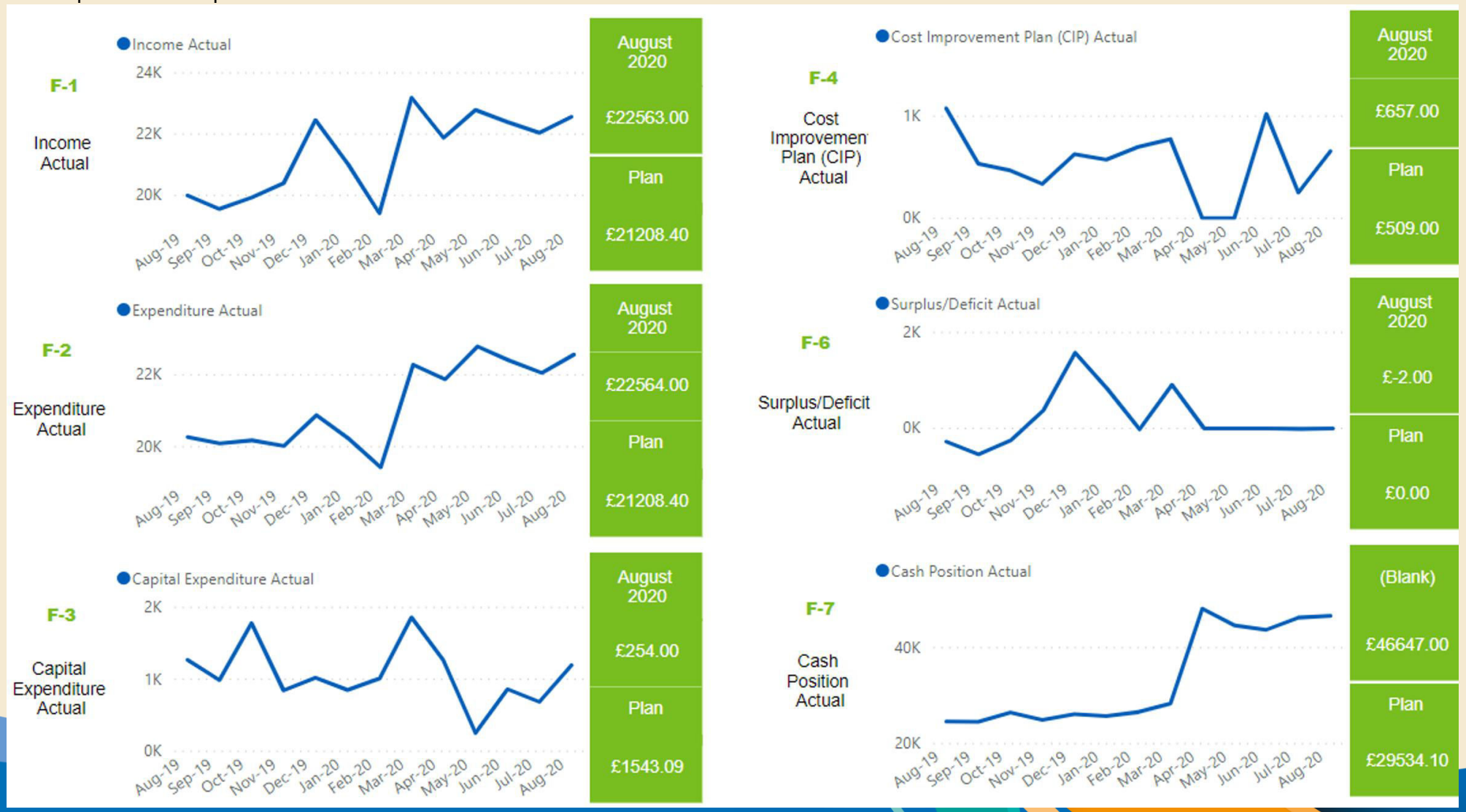
Performance by Domain
Responsive: Performance Charts

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



Performance by Domain
Well-Led: Performance Charts

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

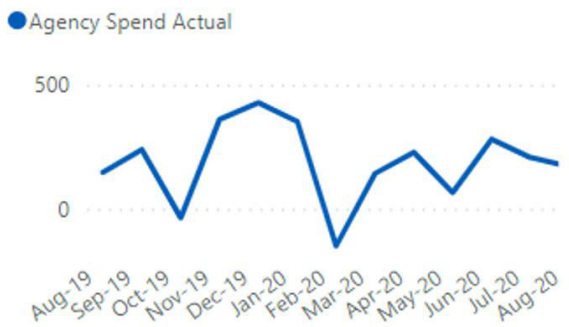


Performance by Domain
Well-Led: Performance Charts

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)



August 2020	Plan
£175.00	£0.00

WF-8

Annual Rolling Sickness Absence %

August 2020	Target
6.00%	5.00%

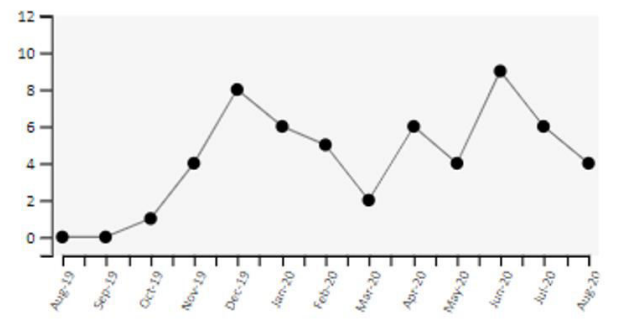
WF-5

Objectives & Career Conversations

August 2020	Target
31.70%	80.00%

WF-9

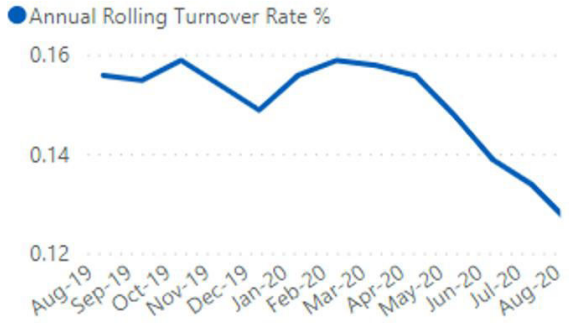
Disciplinary Cases



August 2020	Target
4	N/A

WF-7

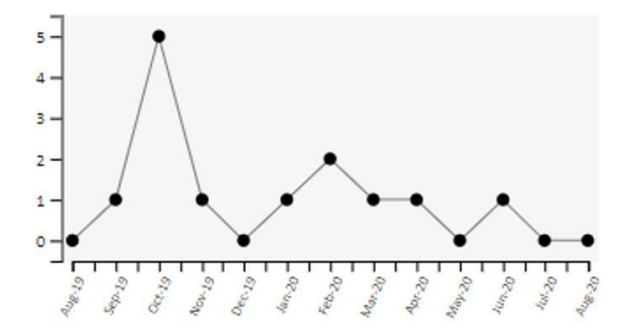
Annual Rolling Turnover Rate %



August 2020	Target
12.60%	N/A

WF-11

Collective Grievances



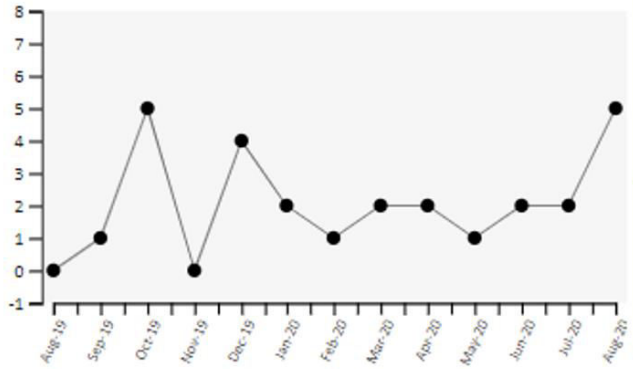
August 2020	Target
0	N/A

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

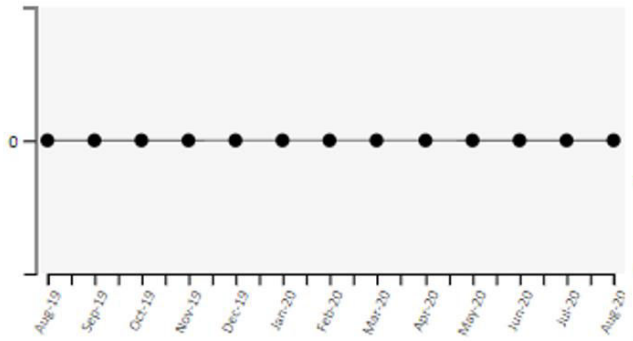


August 2020: 5

Target: 0

WF-13

Whistleblowing



August 2020: 0

Target: 0

Appendix 2

Glossary

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

Appendix 3

Symbol Key

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

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.

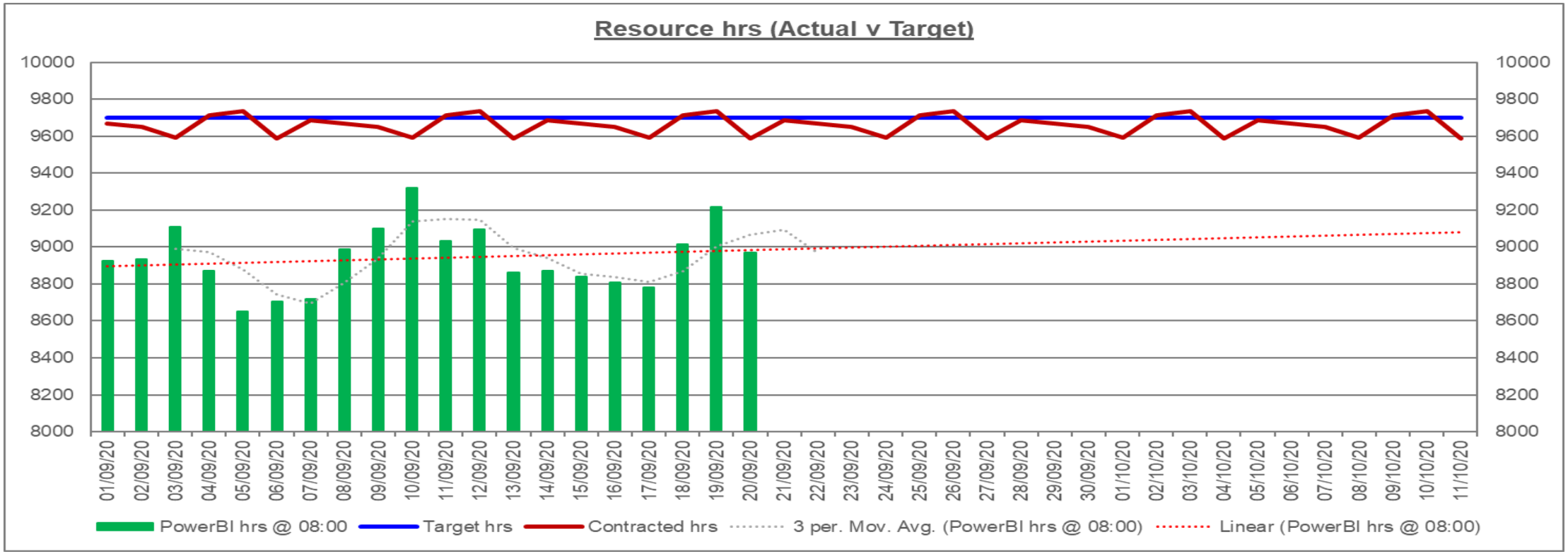
999 Performance Improvement Plan

Key Actions Update: 18/09/20

Joe Garcia, Director of Operations

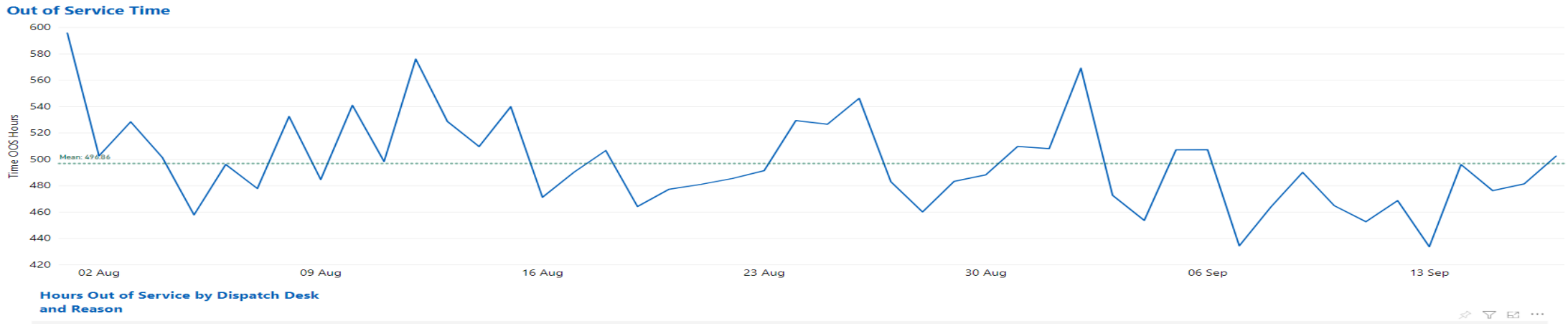
Position to date: Overview

- The 999 Performance Improvement Plan (999 PIP) continues from the earlier plan
- The plan focused on putting additional hours out and improving efficiencies
- Trajectory for improvement based on expected improvement in hours from return of shielding staff, stabilisation of sickness, and reduction in 'not fit tested' and staff in self-isolation as well as monitoring all additional hours provided



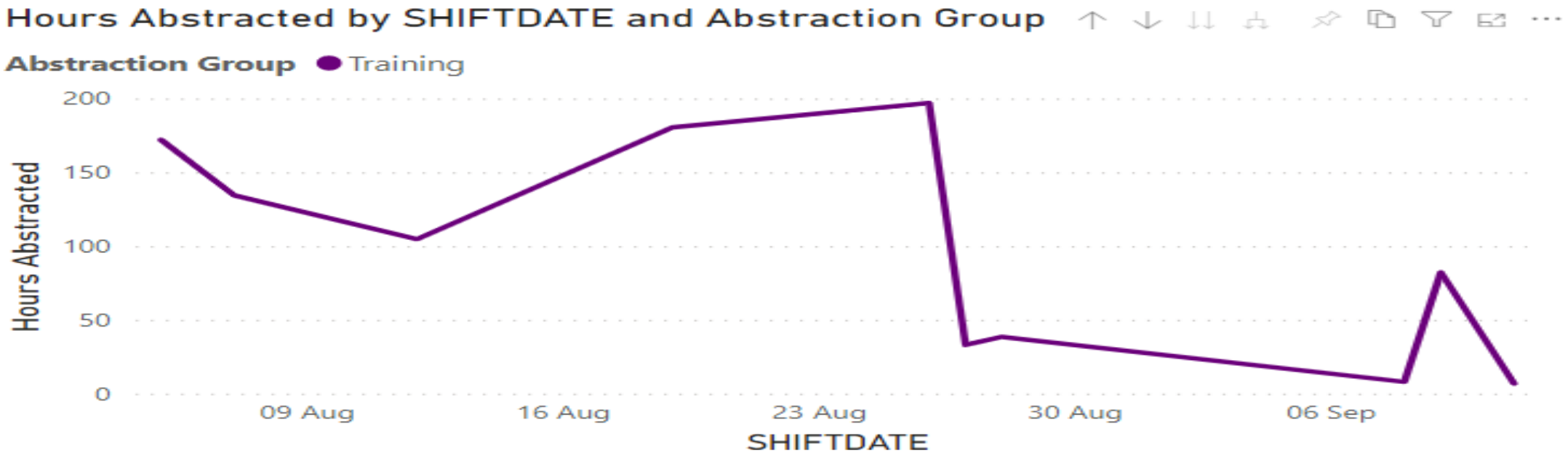
Key actions from 999 PIP (Action 1)

ITEM	ACTION	IMPACT
Refocus of daily 08:30 teams call to improve productivity & efficiency	Include component looking at hrs lost to late sign-ons and on-day out of service reasons.	**August to Date** Late book-ons has also improved, but this is more anecdotal information in terms of actual numbers, but on the calls there is greater understanding of the causes of these losses. Accurate reporting is not available in a simple format at present. There is more to do in terms of addressing it more actively on-day, progress has been positive though.



Key actions from 999 PIP (Action 2)

ITEM	ACTION	IMPACT
Key skills delivery – no sessions during August & early Sept	This is in-line with the plan agreed in Feb/Mar 2020	Complete – no sessions occurred during August Current position is that field ops are 5% behind where they should be due to Covid – this is a positive position. Consideration is being given as to whether to delay this delivery further.

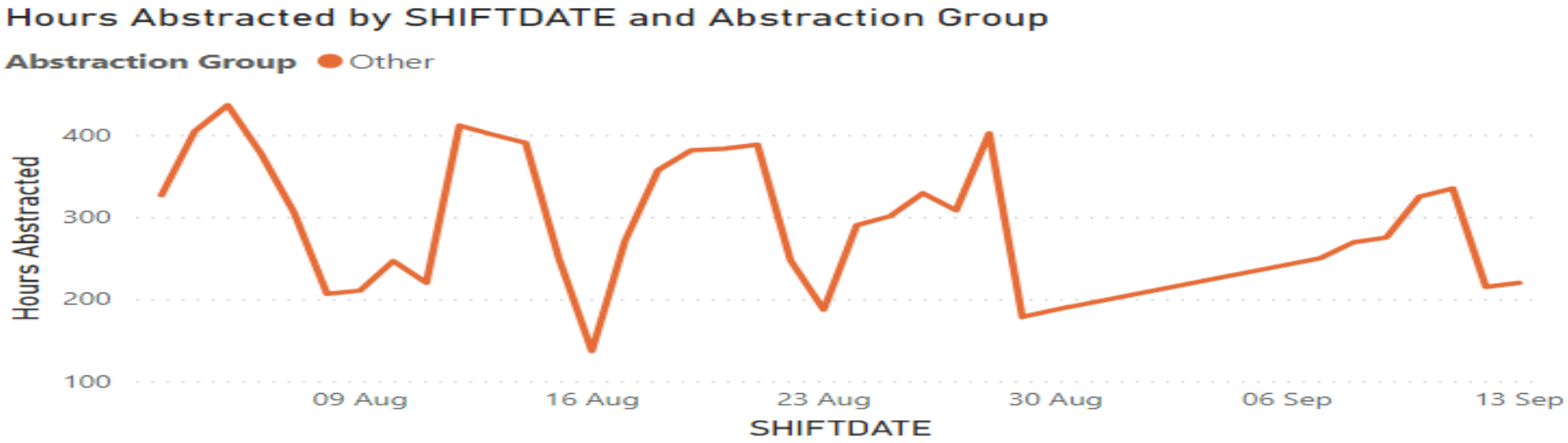


Key actions from 999 PIP (Action 3)

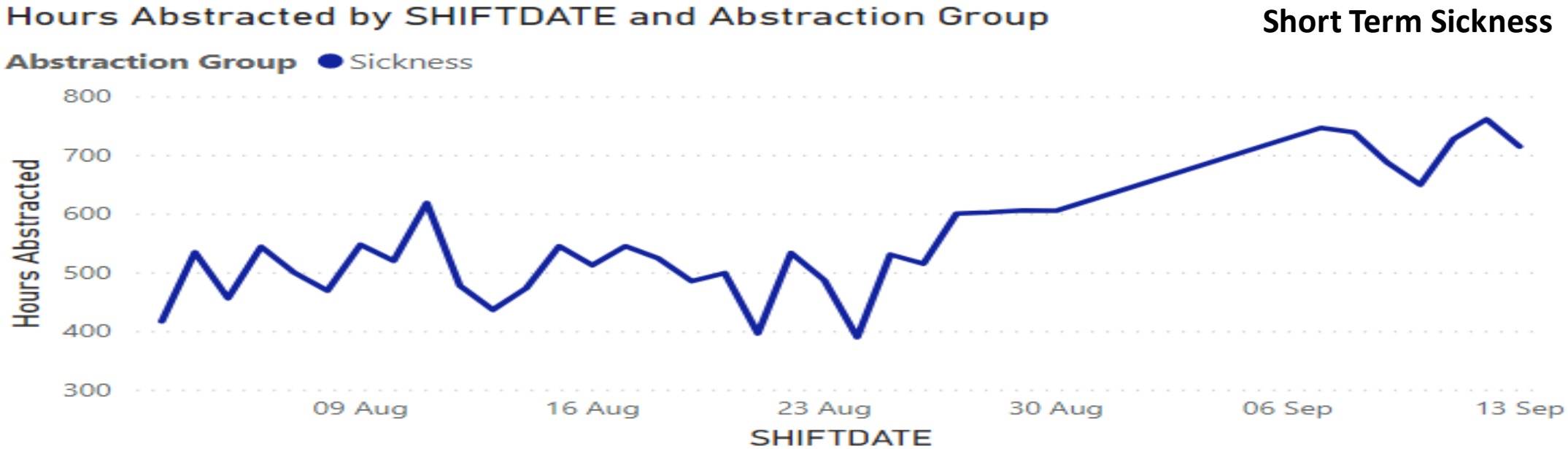
ITEM	ACTION	IMPACT
Meeting attendance reviewed to release clinical staff	All teams/depts to review frequency & attendance at meetings	Mixed delivery – some areas where it was done comprehensively (Nursing & Governance). Very difficult to quantify impact and measure conformance.

Key actions from 999 PIP (Action 4)

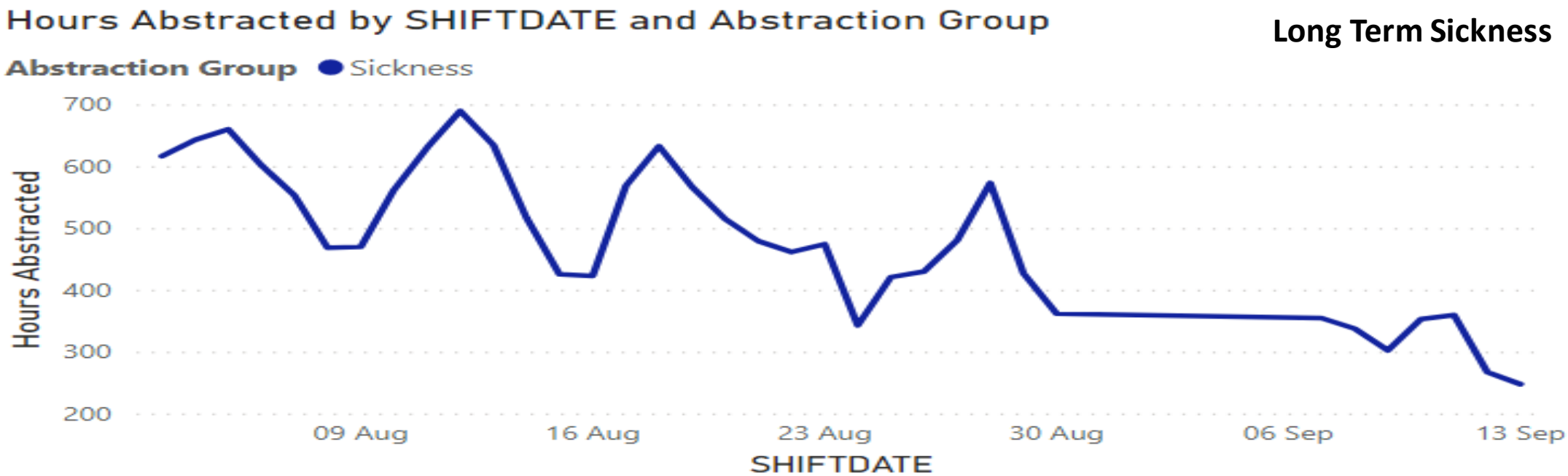
ITEM	ACTION	IMPACT
Clinical staff out of post – consideration for returning to patient facing duties	Review of all those in other roles/areas completed. Particular focus on the return of shielding staff – plans in place for all individuals	**Alternative Duties & Light Duties** As in earlier slide, the hours expected to be realised did not materialise as shown in this trajectory (linked to increase in short term sickness and alternative duties)



Short Term Sickness

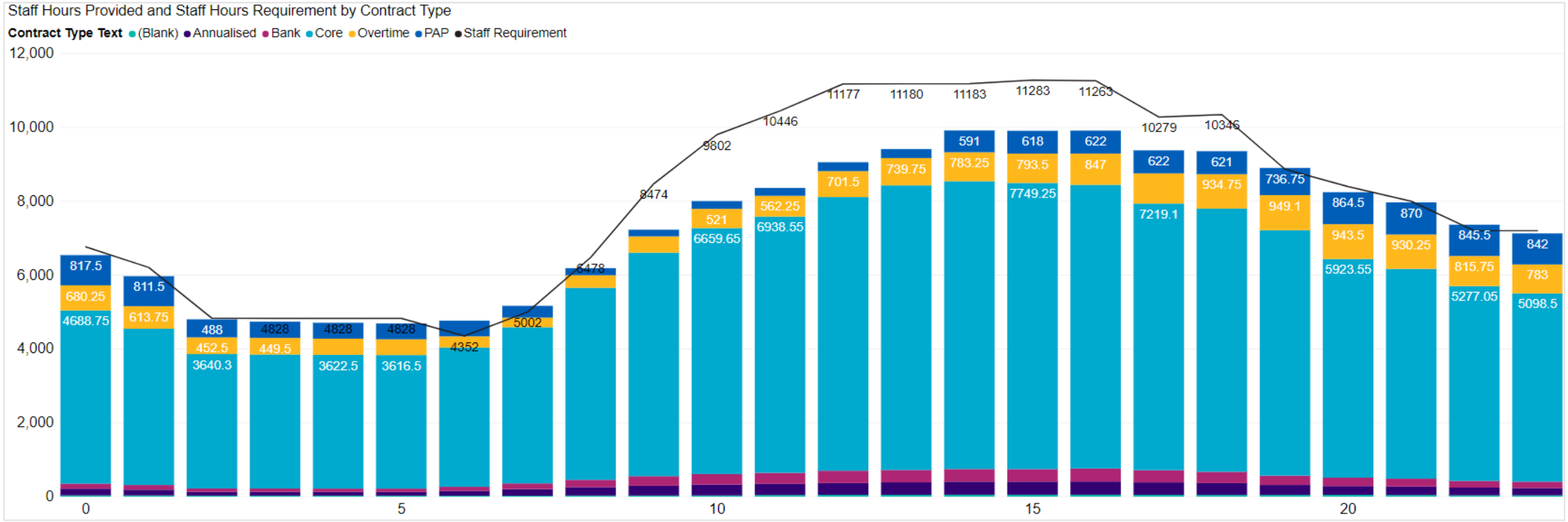


Long Term Sickness



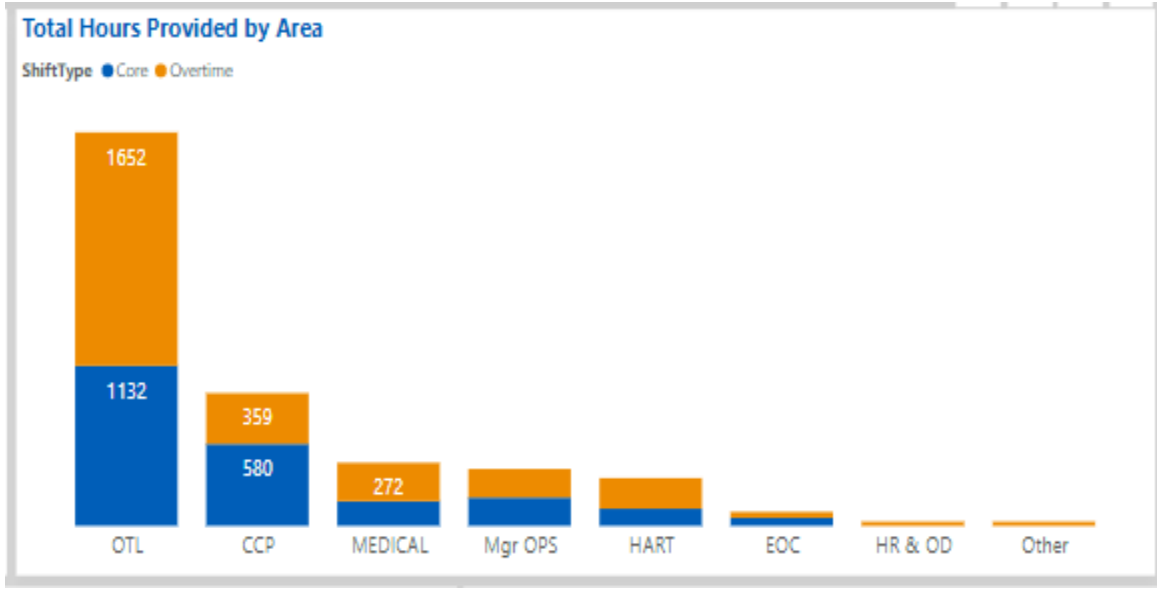
Key actions from 999 PIP (Action 5)

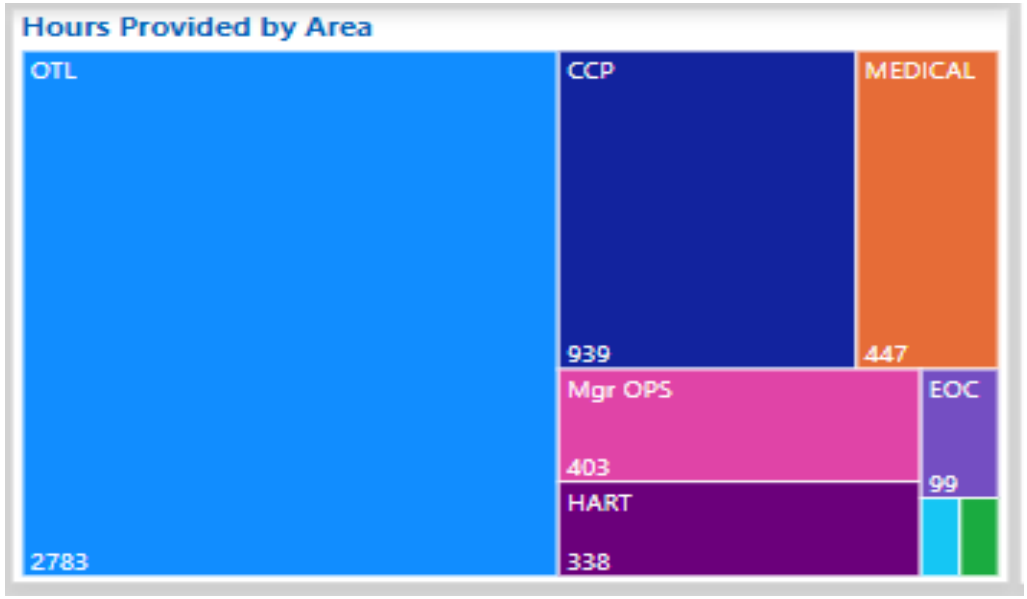
ITEM	ACTION	IMPACT
Incentivise key shifts	Incentivisation plan implemented between 17/08 and 21/09 for DCA shifts between 12:00 and 07:00	This has had marginal impact on the overall volume of overtime but it is demonstrating prioritisation to the incentivised period. **The yellow band is Overtime**



Key actions from 999 PIP (Action 6)

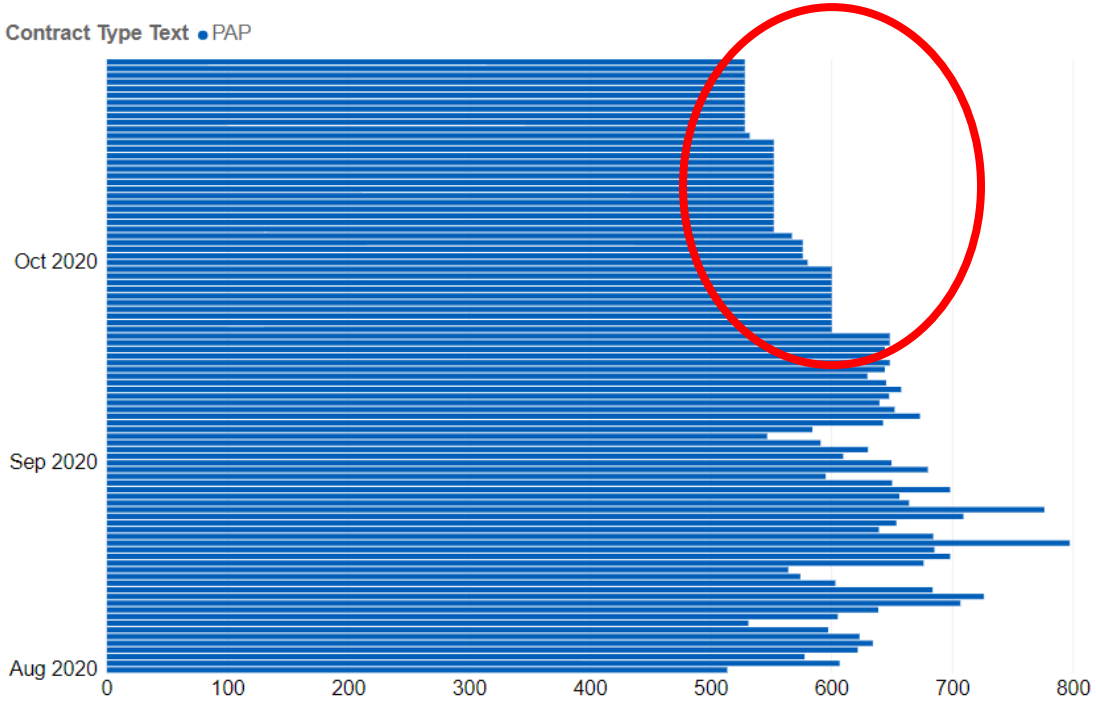
ITEM	ACTION	IMPACT
Additional DCA hours to be provided by clinical managers, CCPs & PPs	Each team to take responsibility to enable this to occur. Max number of PP hubs set and monitored on 08:30 call.	The impact has been very difficult to evidence/calculate until very recently. Anecdotal information on the 08:30 calls identifies extra DCA hrs from CCPs and OTLs is now verified by the latest outputs from the BI team, this activity is a work in progress and evolving quickly.

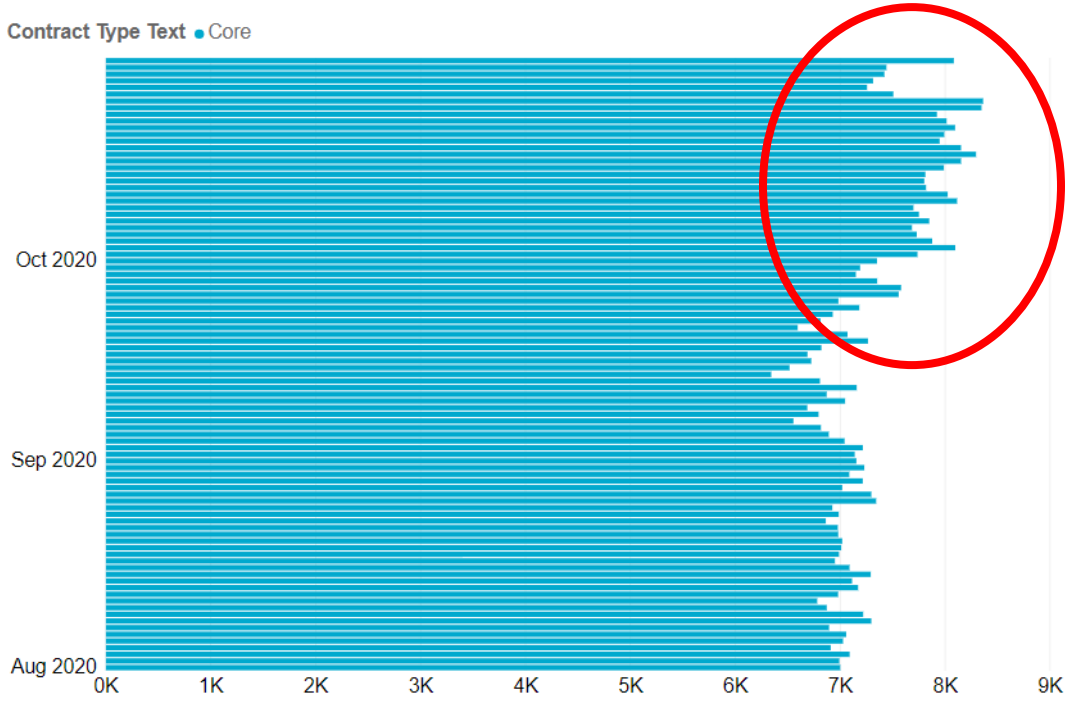




Key actions from 999 PIP (Action 7)

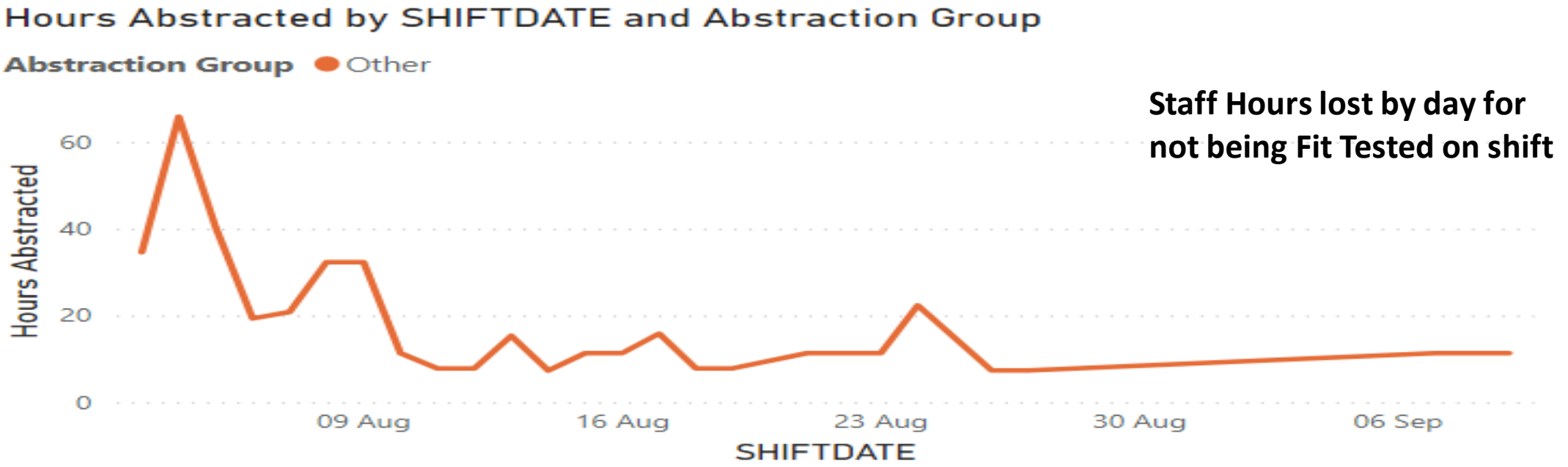
ITEM	ACTION	IMPACT
Increase PAP provision	Work with existing PAP organisations to increase total hrs provided above those contracted.	This has resulted in additional resources on most days since mid-August (as compared with contracted levels) Work is now underway to secure additional hours to compensate for the planned reduction to meet the planned workforce increases during the latter part of the year.





Key actions from 999 PIP (Action 8)

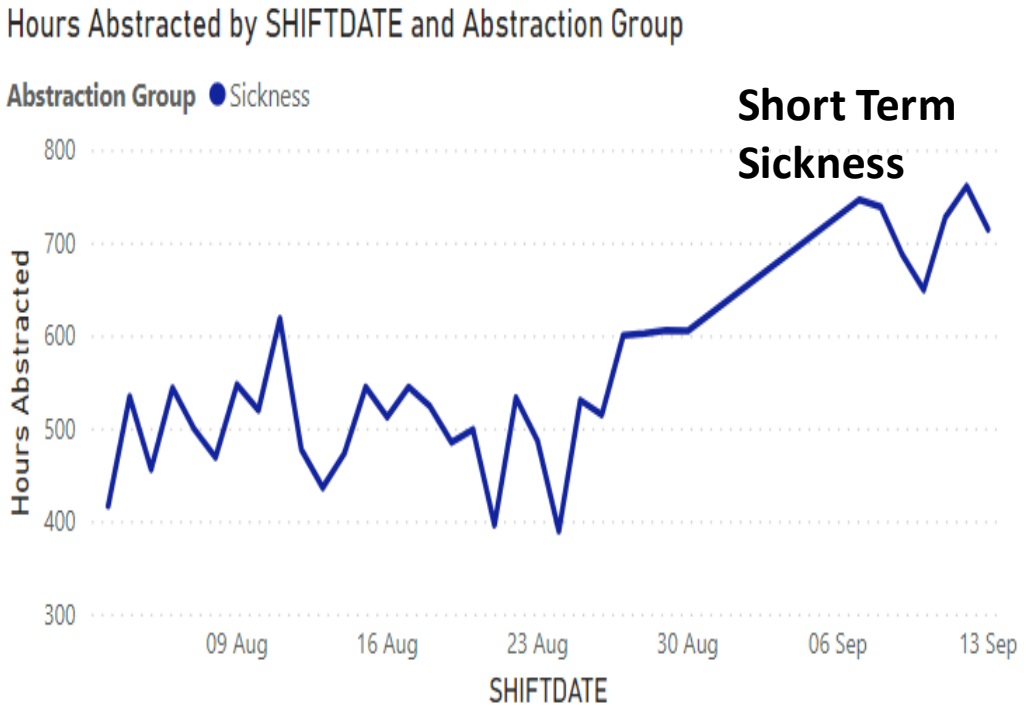
ITEM	ACTION	IMPACT
All staff to have an RPE option	Fit-test all staff on disposable and/or resuable RPE to ensure adequate provision	Significant reduction in loss of hours as a result of non-fit tested/no RPE staff. low levels remain associated with new staff/trainees & students and staff returning from shielding.

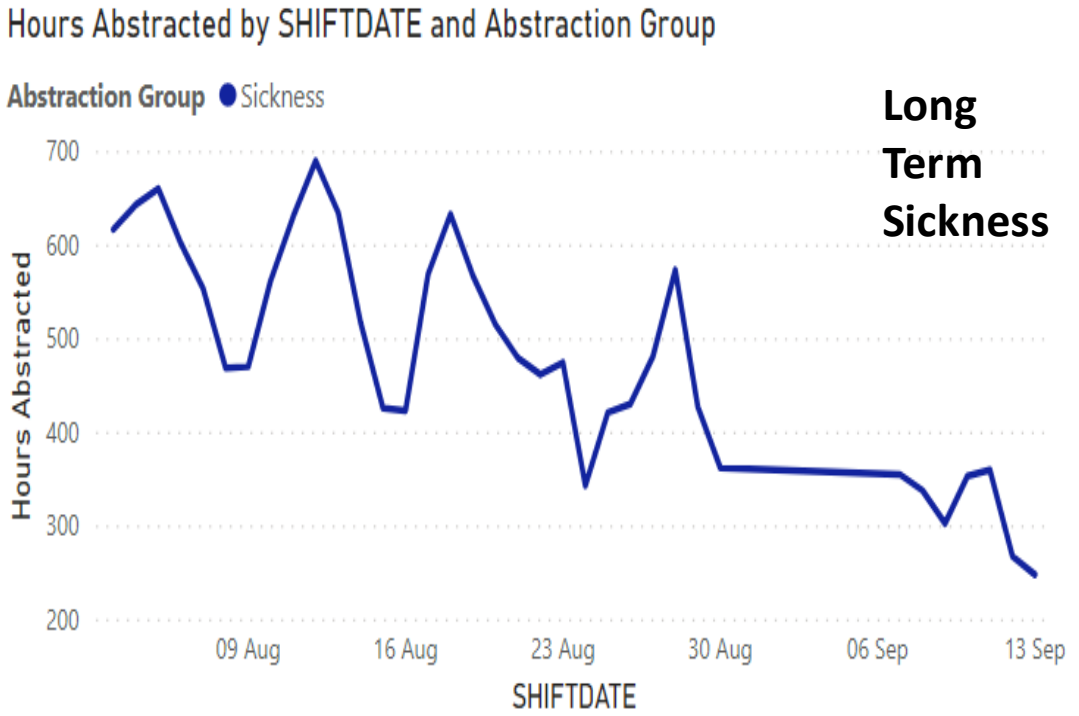


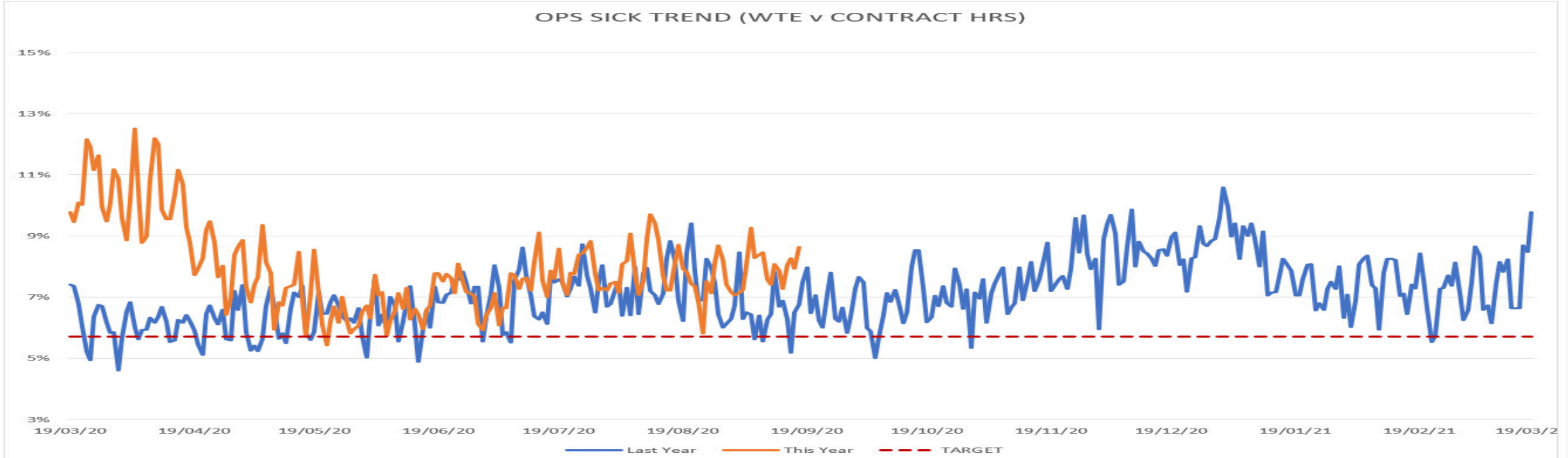
Staff Hours lost by day for not being Fit Tested on shift

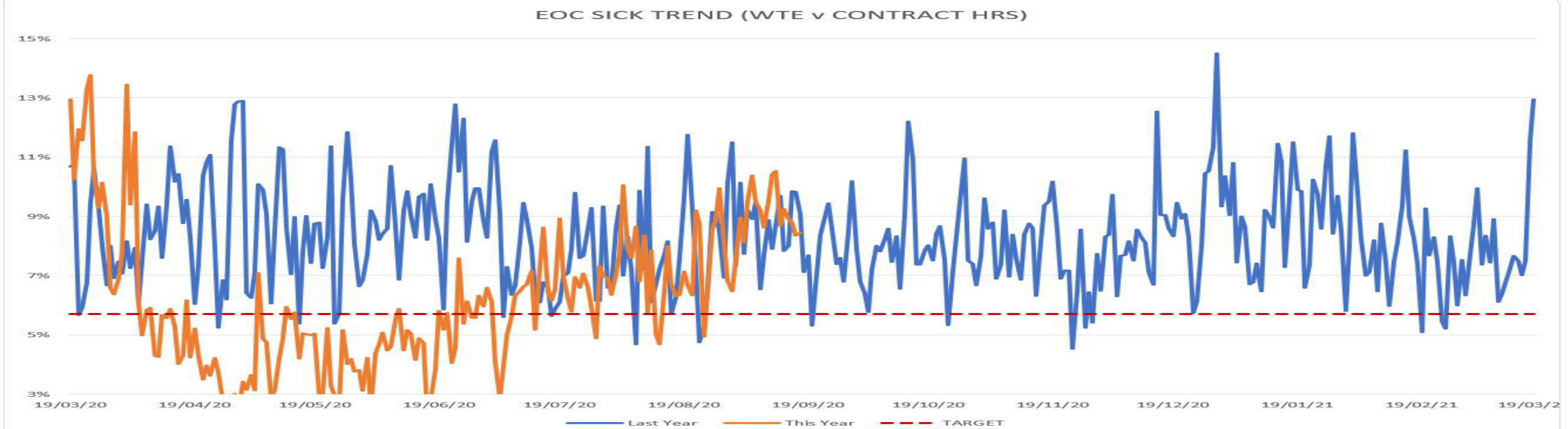
Key actions from 999 PIP (Action 9)

ITEM	ACTION	IMPACT
Sickness management	Managers report significant impact on resources do to national HR guideline	On going issue – this has been raised within the Trust, locally and nationally. ***Hot off the press*:** It is unclear when the NHS Staff Council will revert back to standard Sickness Absence Management actions!






OPS SICK TREND (WTE v CONTRACT HRS)
15%
13%
11%
9%
7%
5%
3%
19/03/20
19/04/20
19/05/20
19/06/20
19/07/20
19/08/20
19/09/20
19/10/20
19/11/20
19/12/20
19/01/21
19/02/21
19/03/2
Last Year
This Year
TARGET


EOC SICK TREND (WTE v CONTRACT HRS)
15%
13%
11%
9%
7%
5%
3%
19/03/20
19/04/20
19/05/20
19/06/20
19/07/20
19/08/20
19/09/20
19/10/20
19/11/20
19/12/20
19/01/21
19/02/21
19/03/2
Last Year
This Year
TARGET

What next?

1. Need for urgent development/resourcing of planning/forecasting capability within the trust – at present reporting is either live or retrospective
2. Continued focus on abstractions – particularly sickness and the 'other' category
3. Need for identification/development of robust simple way of capturing additional clinical hours provided by managers/specialists outside their usual work patterns/rotas
4. Development of productivity and efficiency dashboard. This is underway and expected around the end of Sept and will support continuing actions to reduce on-day out-of-service etc
5. Progress on structural review of rotas and updating of key policies (e.g. end-of-shift and meal break)

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	10 September 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** There was a detailed review of the improvement plan, in particular the abstraction assumptions, the related actions and the reasons why the expected impact has not materialised. The committee accepts that many of the assumptions were reasonable, but despite this there has been more sickness, annual leave, some shielding staff that have moved to alternative duties, in addition to staff being taken off the road following a COVID risk assessment. Sickness is a really difficult issue in the circumstances, compounded by national policy due to COVID resulting in management being unable to manage individual sickness as they ordinarily would do. There is an expectation that this will be rescinded by the end of September when usual sickness management policy can be re-enacted. The committee noted this is an issue for all Trusts, not just SECAmb. For those staff on alternative duties, due to risk assessment and/or personal anxiety, the introduction of personal issue powered hoods should remedy this. The committee received a business case for this which it recommends to the Board. The executive are rightly focussed on the immediacy of improving hours from existing resources, and the committee asked that the current improvement plan be updated to focus on the key actions that will deliver most benefit, and then to update the trajectory as the current trajectory is unachievable. However, taking a broader view of the challenge to ensure sufficient hours, the committee acknowledged that we do not have enough people, reinforcing the short term nature of the improvement plan. To ensure we are more resilient in the longer term we need to address the structural gaps; this relates to things like our operating model and how our rotas work. The committee noted the steps being taken to examine the structural issues, and challenged the executive to develop a robust plan, with timeframes. The committee is concerned that until this is in place, we will continue to recruit to a sub optimal system. Finally, the committee reviewed the current performance compared with other ambulance trusts and noted that we are not an outlier. In terms of assurance, the committee is confident the executive is giving this the right level of focus, but there is much work to do to improve our performance against the ARP standards.

	111 / CAS Mobilisation **Assured** A good update was provided on the progress to mobilisation of this new service on 1 October 2020, including the Go / No Go Plan. The main issue was electronic prescribing and specifically getting Cleric accredited by NHS Digital in time. Plan B is to use IC24's system, but at the time of the meeting there was confidence in getting the accreditation. (Subsequently this has moved on and the Board will receive a separate update about this at the meeting). There was then a discussion about 'Think 111 First' which systems are starting to roll out now, with a long stop date of 1 December 2020. The committee noted the governance in place to ensure this is done safely, via NHSE, and explored some of the risks. In part 2 the Board will be asked to consider the Go / No Go Plan, and the financial plan. **Winter Planning** **Assured** A comprehensive paper was received setting out the plan. The committee was confident the plan is comprehensive, noting that there are separate plans relating to EU transition, which will be reviewed at the Audit & Risk Committee. **PMO** **Partial Assurance** The committee received an update on work and structure of the PMO and how it supports the organisation. An action was agreed to provide assurance that PMO supports *all* projects (save for projects where specific expertise if procured, e.g. 111 CAS) and that staff follow the related governance process. Until then the committee could only be partially assured. The committee also received reports under its section on *Monitoring Performance*, including: **Financial Performance M4/Forecast** There is good confidence in the current financial performance. M5 is similar to M4 in that we are on plan for a breakeven position. Key issues include an underspend in the operations pay budget, for the reasons set out earlier, linked to provision of hours, and a gap in the cost improvement programme. The main financial risk relates to the Trust's underlying position. **Business Cases** The powered hoods business case has been mentioned above, and the committee recommends this the Board. This will significantly mitigate the staff safety and abstractions issues (fit testing) seen during COVID. The committee noted that since 11 February we have completed over 14,000 fit tests. A second business case was considered, relating to the Banstead MRC. This aligns with the estates strategy and capital programme and is recommended to the Board.

	Both business cases will be received by the Board in part 2, due to commercial sensitivities.
Any other matters the Committee wishes to escalate to the Board	It is suggested that some time is set aside at the Board development session in October, to explore the 999 structural issues that require a transformational approach. The Board should also note the significant challenges expected this winter, with a potential second wave and EU transition overlaying the usual winter pressures.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Incident and Serious Incident Annual Report

2019 / 2020

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

Contents

Contents 2

1.0 Introduction 3

2.0 Definitions 3

3.0 Learning Lessons 4

4.0 Incident Reporting 5

5.0 Serious Incidents 11

6.0 Actions from Serious Incidents 17

7.0 Never Events 17

8.0 Statutory Duty of Candour 17

9.0 Central Alerting System 18

10.0 Conclusion 19

1.0 Introduction

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) endeavours to always ensure patients, staff and the public are safe when in our care, and for the quality of the care they receive to be consistently of the highest possible standard. However, even with the best of intentions, inevitably sometimes things go wrong, and occasionally these incidents can lead to harm. SECAmb is committed to investigating incidents when they occur, to ensure causes can be identified and lessons learned to improve practice and reduce the likelihood of a recurrence.

The purpose of this report is to provide an overview of all incidents and their associated workstreams, reported during the period of 1st April 2019 to 31st March 2020. The report will explain the route incidents can take to be investigated, depending on their severity, and the processes that underpin this, it will also highlight any notable themes and explain any actions that were taken to mitigate risks relating to them.

To ensure a holistic representation, and meaningful reflection of the last year's work the report incorporates incident reporting, escalation, investigation, Serious Incidents, the Statutory Duty of Candour and the management of alerts received via the Central Alerting System, as many of these alerts are generated from national incident themes.

It is mandatory, and an intrinsic component of patient safety for all NHS Trusts to report near miss and actual incidents. SECAmb's risk management and patient safety management system is the web-based version of Datix; all incidents, serious incidents, complaints, compliments, CAS alerts, risks, litigation claims and inquests are captured on, and managed within the system. This enables SECAmb to identify and manage risks effectively and efficiently, utilising all the available elements.

2.0 Definitions

Incidents can be defined as any untoward or unexpected event that interferes with the orderly progress of day to day activity; and may have (but not necessarily) led to harm to individual(s) or damage to equipment or property. A near miss incident is an event that could have resulted in an incident but did not, either by chance or well-timed intervention.

Serious incidents (SI) are those incidents where the potential for learning is so great, or the consequences to the affected person(s) / organisation are so significant that they warrant a deeper investigation and response.

Never Events (NE) are SIs that were wholly preventable, because the existence of national guidance or safety recommendations are in place to provide barriers to their occurrence. If a never event occurs, it essentially means that guidance has not been followed.

The statutory **Duty of Candour (DoC)** relates to the necessity for the Trust to be open, transparent and inclusive with patients and / or their families when an incident has occurred, which has led to harm of a moderate or higher degree.

When **harm** is considered it is pertinent to the harm SECAmb are attributable for, not explicitly the outcome for an individual. Harm is categorised the following way:

- Near miss – a prevented incident
- No harm – incident occurred but resulted in no harm to the individual(s)
- Low harm – led to minor treatment of the individual(s)
- Moderate harm – led to further treatment, cancellation of planned treatment or surgical intervention for the individual(s)
- Severe – led to long-term harm or permanent injury to the individual(s)
- Death – led to the death of the individual(s)

The **National Reporting and Learning System (NRLS)** is a national function to which NHS trusts are mandated to submit reportable patient safety incidents. A reportable patient safety incident is an incident that affected, or potentially affected a patient, and the cause can be attributed to SECAmb. Patient safety incidents that are recorded on behalf of another organisation are not reportable to the NRLS. The information gathered by the NRLS is used to both benchmark safety information for NHS trusts for learning purposes and significantly aids the development of safety alerts with NHS Improvement. The NRLS also provide incident reporting data to the Care Quality Commission (CQC).

The **Central Alerting System (CAS)** is a web-based cascading system; it is utilised to issue patient safety, medical device and drug alerts and other safety critical information. Alerts contain background information on why they have been issued, including the related risks and incidents that have occurred nationally and the actions that healthcare organisations must undertake to mitigate the risks and comply with the alert.

3.0 Learning Lessons

Although there are many reasons NHS trusts report and investigate incidents, not least of all because it is a mandatory function, the primary reason is to enable trusts to understand what and where in the organisation incidents are occurring so they can be learned from and improvements made.

During February 2020 the Trust undertook a targeted piece of work to identify how it learns and how learning is embedded both internally and across the wider system. Listed below are some of the key areas that learning has been identified and taken forward.

- Thematic analysis of patient safety event themes, which leads to commissioned deep dives, or more intense analysis;
- Clinical bulletins issued to staff to advise of a change to practice due to specific learning;
- Monthly patient safety event learning posters cascaded via the Operations Improvement Hub to Operating Units (OU);
- Clinical Tail Audits carried out and results fed back to EMAs;
- Shared learning documents routinely issued in the 999/111;
- Key skills - reviewed and refreshed to address themes identified from patient safety events (for both field operational staff and 999/111) and real-life

examples of complaints, serious incidents and safeguarding cases are referred to throughout the training, so staff appreciate the importance and relevance;
- The Trust is a high reporter to NHS Pathways, escalating gaps and areas of concern; this has directly led to changes to the recognition of sepsis markers, the pathway for major trauma crush injuries and major haemorrhage.
- Identification of a significant gap with NHS Pathways which put children with underlying health conditions at risk was identified from a SI early in the Covid-19 pandemic. The Trust immediately liaised with NHS Pathways to highlight the issue which led to a new version being released within a week of the incident occurrence.

The Trust can be confident that learning is embedding:

- Evidenced through quality assurance visits (QAV)- staff refer to serious incidents and changes that have occurred;
- The Care Quality Commission (CQC) recognised that staff were aware of events that had led to improvements;
- Staff more aware of serious incidents, what they are and why we carry out root cause analysis investigations;
- Staff talk spontaneously during accident and emergency visits about serious incidents, clinical bulletins and learning;
- Reduction of 'long lie' serious incidents – the fallers flowchart is embedded;
- When an issue arose with oxygen cylinders running out the SECAmb command structure engaged the wider NHS to ensure the urgent lessons were shared; this led to NASMED creating a national cascade to enable urgent lessons to be shared;

4.0 Incident Reporting

SECAmb insists that all actual and near miss incidents are reported onto Datix to aid the broader adverse event management, identity of risks, analysis of themes and the learning of lessons.

During the past year SECAmb has continued its journey to improve incident reporting which has aided the greater aim of increasing the wider safety culture. The hinderance of the previous culture of blame is largely no longer an issue; raising awareness and training staff on the benefits of reporting incidents, and encouraging them to self-report if they make an error, and to feel safe to do so is supporting this improving culture.

The continuous improvement of incident reporting is shown here, evidencing a successful four-year journey, which continues. Also highlighted within this table is the percentage number of incidents reported per the Trust's activity.

Fiscal year	Number of incidents reported	% increase on previous year	Number of 'jobs' into the Trust	% of 'jobs' resulting in an incident
2016/2017	5906	-	-	-
2017/2018	7510	27%	493842	1.5%

2018/2019	9216	23%	717665	1.3%
2019/2020	11503	25%	760565	1.5%

An increase in incident reporting often raises questions about whether staff are getting better at recognising and reporting or whether more incidents are actually occurring–at this juncture, to give assurance to the reader, it is pertinent to refer to research highlighted within the previous annual report:

During 2007 research was carried out in the United States which found that on average only 5% of incidents that occurred in a healthcare organisation were reported; bearing this in mind, SECAmb can take some assurance that the incidents were likely to have been already occurring but were not being reported.

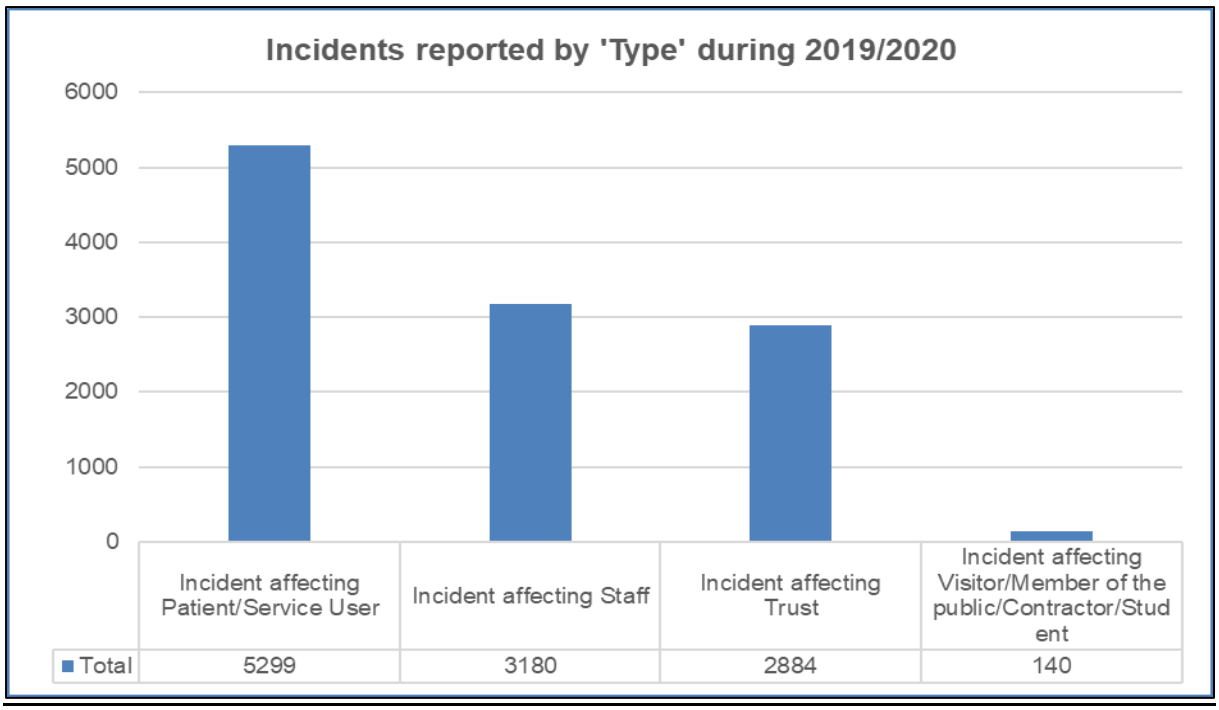
5.7% of incidents reported during 2017/2018 were graded as moderate or above harm, whereas during 2018/2019 the number of incidents reported increased, but the percentage of moderate and above harm incidents dropped to 2.1%, and again during 2019/2020 incident reporting increased again but the percentage of those leading to higher levels of harm reduced to 1.3%. This is significant and should go some way to assuring that more serious incidents were previously being reported, however the lower acuity incidents were perhaps routinely not.

When reported, incidents are categorised as one of four types:

- Incident affecting a patient / service user
- Incident affecting staff
- Incident affecting visitor / member of the public / contractor / student
- Incident affecting Trust

Incidents are categorised this way for two reasons; to help the Trust understand who is being most affected when things go wrong and to aid the onward journey of an incident i.e. patient safety incidents attributable to SECAmb must be submitted the to the NRLS, whereas many staff incidents require notification to the Health and Safety Executive (HSE) via the RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) process.

The following graph shows the number of incidents reported by type during 2019/2020.

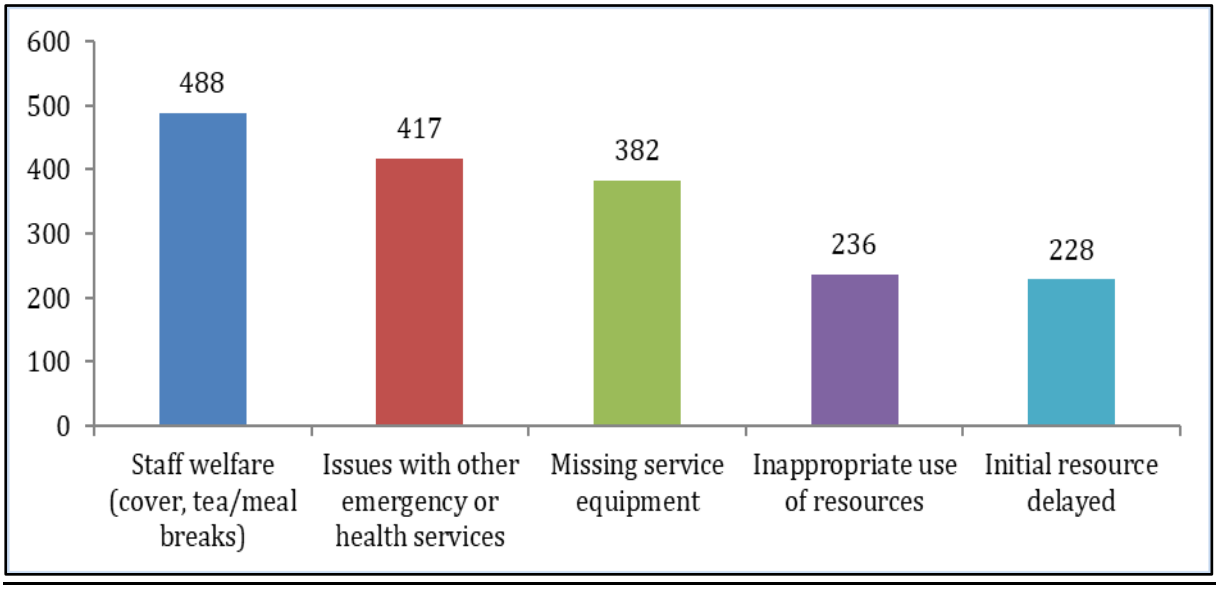


It is also imperative that SECAmb knows what category an incident relates to i.e. medication error, staff injury, delays to attending a patient etc. Incidents are reported against a category and a sub-category so the granular detail can aid the review and thematic analysis.

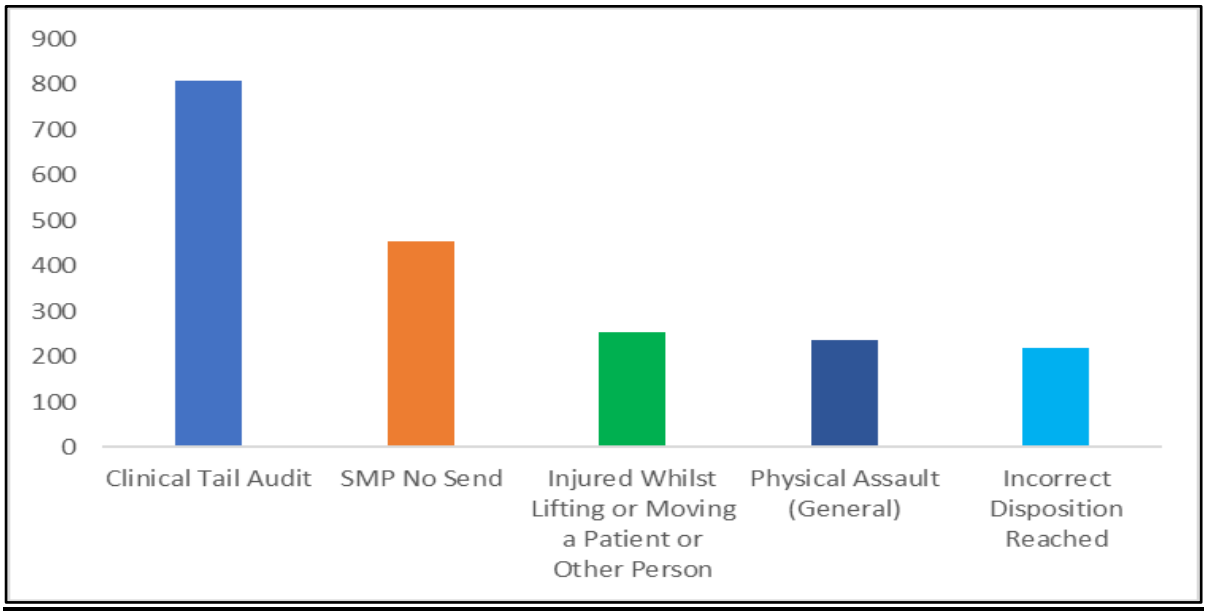
The following two graphs show the change of the top five reported sub-categories from 2018/2019 to 2019/2020.

4.1 Incident sub-categories

Top five sub-categories reported during 2018/2019



Top five sub-categories reported during 2019/2020

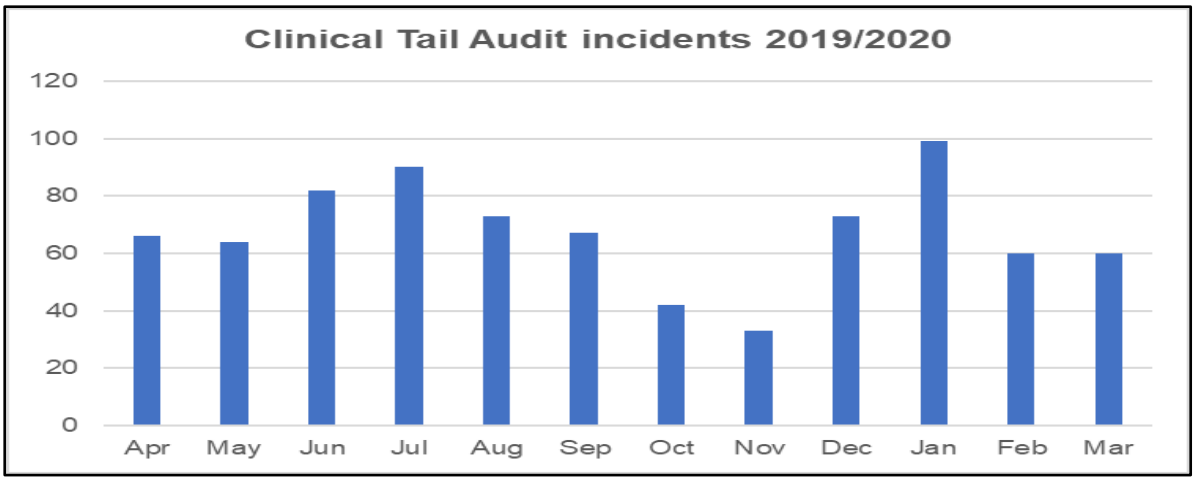


As shown, there is no correlation between the highest reported sub-categories across the two years which is likely to reflect two elements, firstly that improvements have been made to reduce the number of incidents reported under last year's top five and secondly, there has been an increase of incidents either occurring, or being identified across this year's top five sub-categories.

Clinical Tail Audits (CTA) assess the clinical risks to patients that had to wait an excessive period for an ambulance and considers whether the patient was safeguarded via welfare calls. The audit tool utilises a clinical risk matrix; cases that reach a score of ten or above are recorded on Datix as incidents for further investigation.

809 (7%) CTA were reported on Datix during the period, the level of harm recorded for all of them bar one was 'no known harm', and the outlier was recorded as 'low harm'. This reporting number reflects a 335% increase on the previous year which can be explained by the process being newly introduced and being fully implemented during 2019/2020.

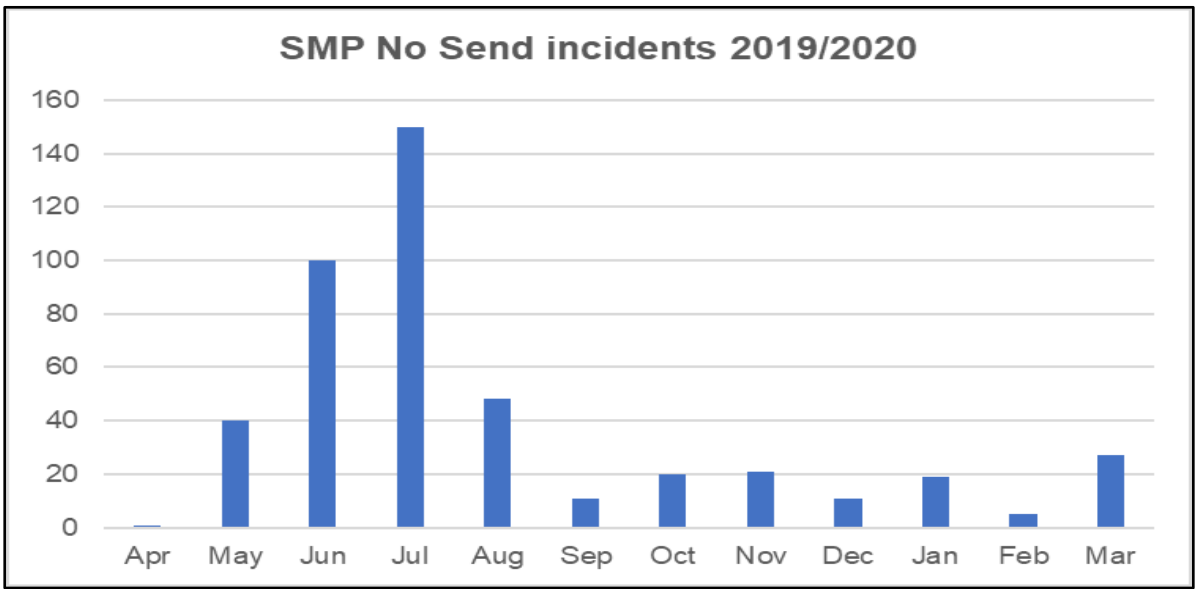
The chart below shows the breakdown of when they were reported throughout the year.



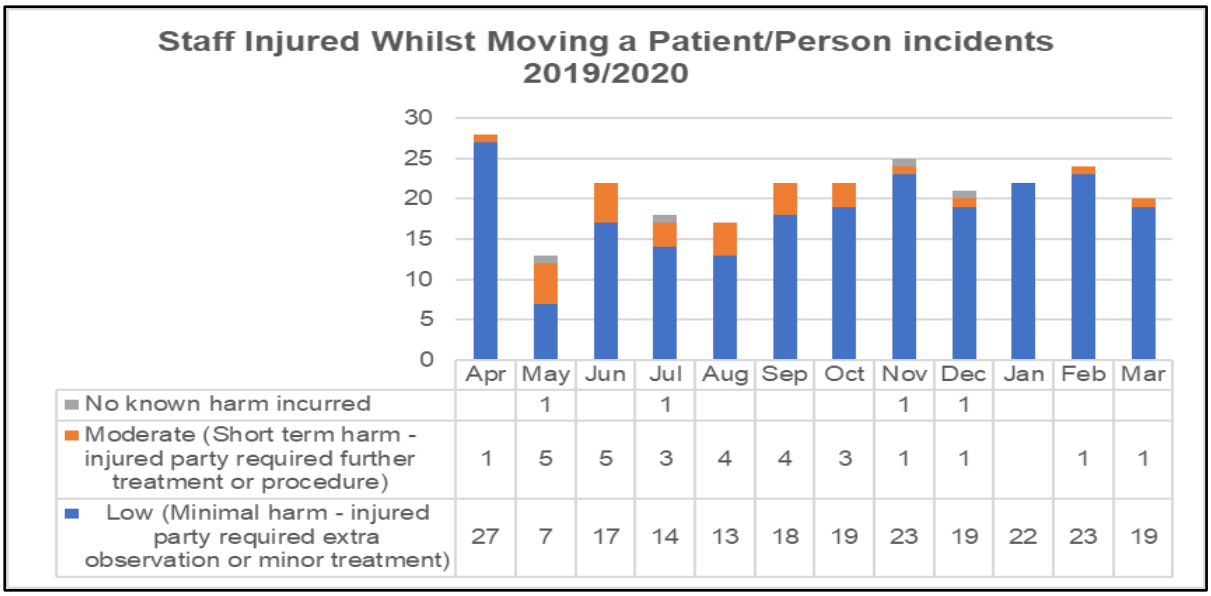
When the Trust is in Surge Management Plan (SMP) level three or four it invokes a 'no send' approach to certain types of calls. When an incident is identified that relates to a SMP no send it is recorded on Datix to assess for any harm that may have incurred from not sending a resource.

453 (4%) no send incidents were reported on Datix during the period, all of which were recorded as 'no known harm' bar one which was 'low harm'. Again, due to the new process being fully embedded this reflects a high increase of 195%.

The chart below shows the breakdown of when they were reported throughout the year.



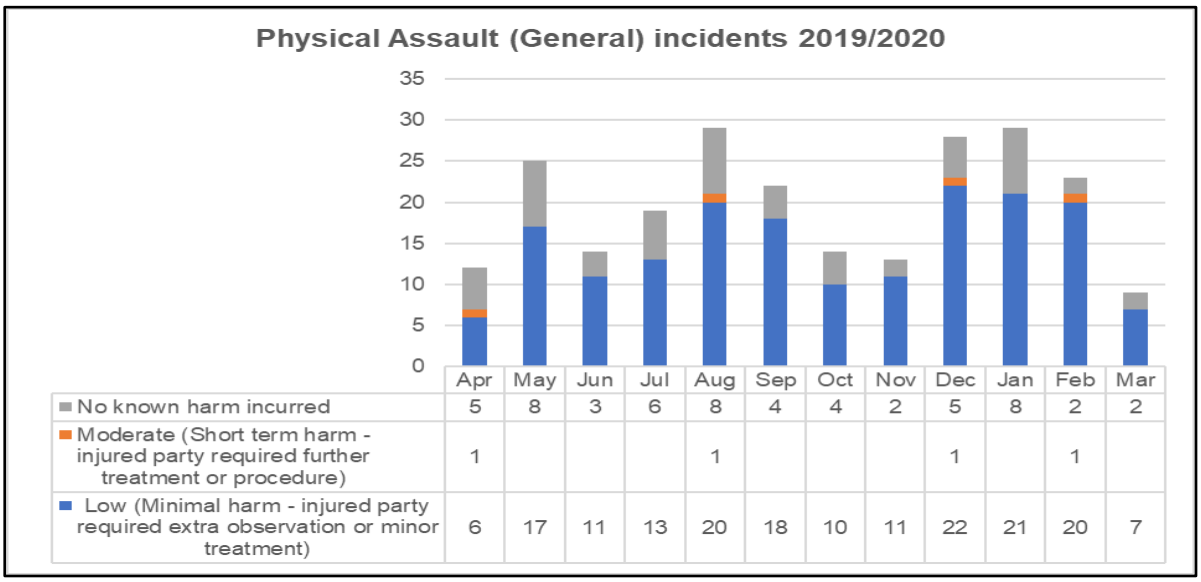
The next highest reported sub-category related to staff injuring themselves whilst lifting or moving a patient or other person. 254 incidents were reported, thankfully the majority of which were recorded as 'low harm'. The incidents captured as 'moderate harm' would have been considered for, and if appropriate reported to HSE via the RIDDOR process. The breakdown is shown below.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No known harm incurred		1		1				1	1			
Moderate (Short term harm - injured party required further treatment or procedure)	1	5	5	3	4	4	3	1	1		1	1
Low (Minimal harm - injured party required extra observation or minor treatment)	27	7	17	14	13	18	19	23	19	22	23	19

Reviewing this sub-category in isolation could be misleading as there are four sub-categories sitting beneath the overarching category 'Manual Handling and Restraining incidents'- 'injured whilst moving a patient or other person'; injured whilst lifting or moving an object or load'; 'stretching or bending injury (other than lifting)'; 'injured whilst restraining a patient'. It is important to look at the category holistically as staff may mis-report incidents under the sub-categories. During 2018/2019 268 incidents were reported as manual handling, whereas during 2019/2020 this increased by 19% to 318 incidents. Over the past two years the Health and Safety Team have been encouraging staff to report these incidents, to provide the Trust a clearer idea of how many injuries are occurring, to ensure the training provided targets the common types.

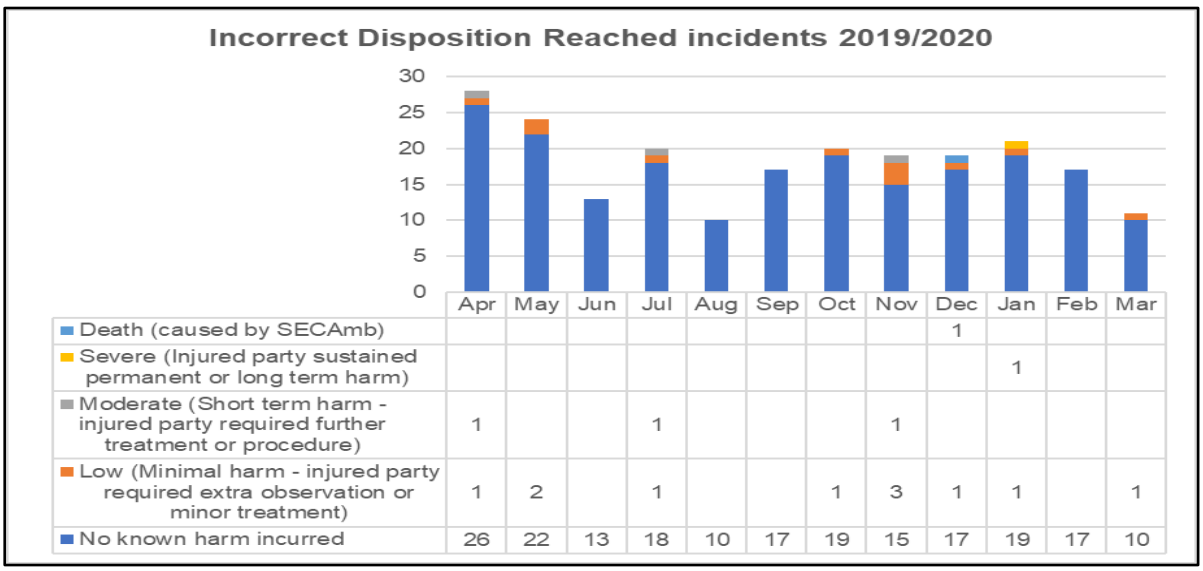
Disappointingly, also in the top five for the year was general physical assault, which predominantly affected staff, with 237 (2%) reported which reflects a 26% increase on the previous year; thankfully most recorded as 'no known harm' or 'low harm' however, this did leave four incidents where moderate harm was inflicted on staff. The breakdown is shown below.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No known harm incurred	5	8	3	6	8	4	4	2	5	8	2	2
Moderate (Short term harm - injured party required further treatment or procedure)	1				1				1		1	
Low (Minimal harm - injured party required extra observation or minor treatment)	6	17	11	13	20	18	10	11	22	21	20	7

Again, the Trust has been actively encouraging staff to report these types of incidents which is reflected in the increase. Sadly, across the NHS staff often view incidents of abuse as simply part of their job and would only routinely report the more serious occurrences.

The last of the top five sub-categories for the period was incidents relating to the incorrect disposition being reached within the 999/111 call centres, with 219 (2%) reported, which reflects an increase of 63% on the previous year. The breakdown below shows that whilst most of the incidents were recorded as 'no known harm' and 'low harm', three of the incidents led to 'moderate harm', one 'severe harm' and one 'death'. The death and two of the moderate harm incidents were declared as serious incidents (SI) and are undergoing root cause analysis investigations.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Death (caused by SECAmb)									1			
Severe (Injured party sustained permanent or long term harm)										1		
Moderate (Short term harm - injured party required further treatment or procedure)	1			1				1				
Low (Minimal harm - injured party required extra observation or minor treatment)	1	2		1			1	3	1	1		1
No known harm incurred	26	22	13	18	10	17	19	15	17	19	17	10

Whilst there is no specific theme around the increase of these incidents, and certainly the general improvement of recognition and reporting will account for much of this, 62 of them were reported by Field Operational staff. These incidents reflect a crew's thoughts on the patient's condition once on scene and their judgement against the disposition they reached through triage. In adherence with the Trust's SI policy those incidents that potentially cause moderate or above harm are taken to SIG for review to be considered for SI declaration; as stated above, three of these incidents were declared a SI.

5.0 Serious Incidents

SECAmb endeavours to consistently undertake open, transparent and thorough investigations to enable learning to be identified, shared and embedded in practice to improve patient safety, and reduce the likelihood of reoccurrence. The Trust utilises root cause analysis methodology, identifying contributory factors of any identified problems.

Serious Incidents (SI) are managed in accordance with NHS England's Serious Incident Framework. Adhering to the stipulated timescales for SI completions has been a challenge for SECAmb in the past. However, the last two years reflect a successful improvement journey, and the portfolio evidences significant improvement

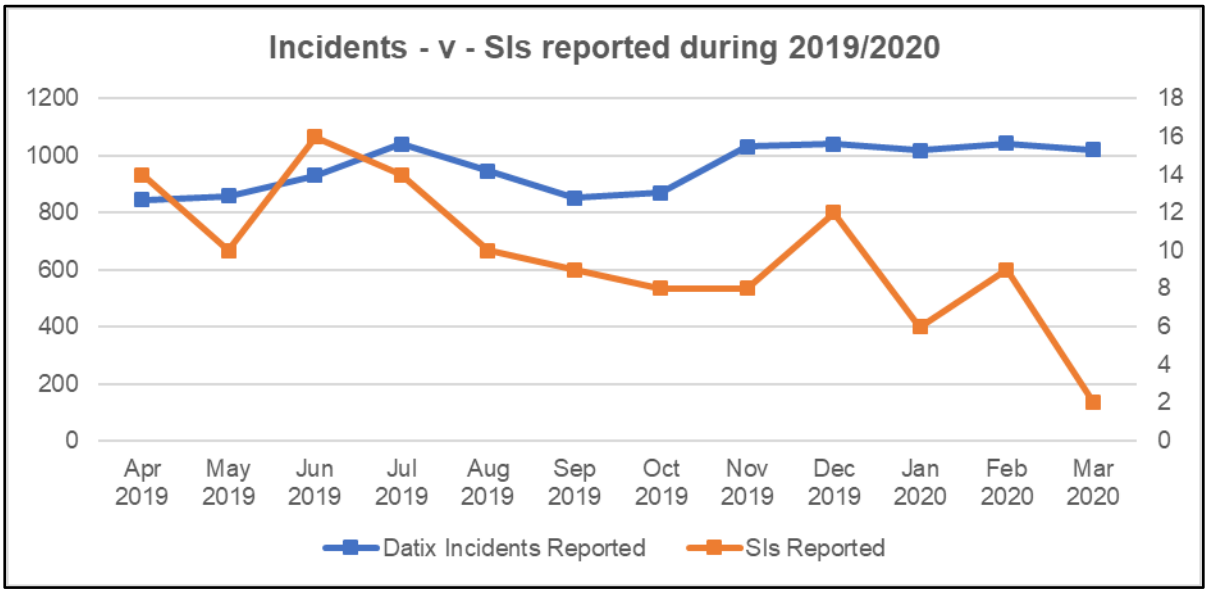
in the recognition and declaration of SIs, the management of the process and the quality of investigations, final reports, and recommendations.

During May 2019 there was reason for celebration in SECAmb as the last of the historic '50' overdue SI were closed which was a momentous achievement. However, targeting these old SI unavoidably led to another, smaller backlog being formed, although they were able to be completed in a much timelier way, whilst still working to prevent further breaches.

The Serious Incident Group (SIG) is a multi-disciplinary group, chaired predominantly by the Deputy Director of Nursing and Quality. The Group meets weekly to review all potential SI. These are identified from incidents and complaints recorded during the preceding week where the grade of harm has been reported as moderate or above, cases identified by the coroner where they have raised concerns about SECAmb and safeguarding/social services concerns. Once declared, the SI is reported to the Lead Clinical Commissioning Group (CCG) via the Strategic Executive Incident System (StEIS). All elements of the SI are recorded within the Datix incident report. Of the SI declared during 2019/2020 79% were identified from incident reports, 12% from complaints and 9% from the other routes mentioned above.

During 2019/2020 SECAmb declared 118 SI, however once investigated, it was agreed with the CCG that 17 of them did not meet the SI criteria and they were de-escalated from SI status, resulting in the net figure of 101 SI. This is relatively comparable to 2018/2019 when 111 were declared.

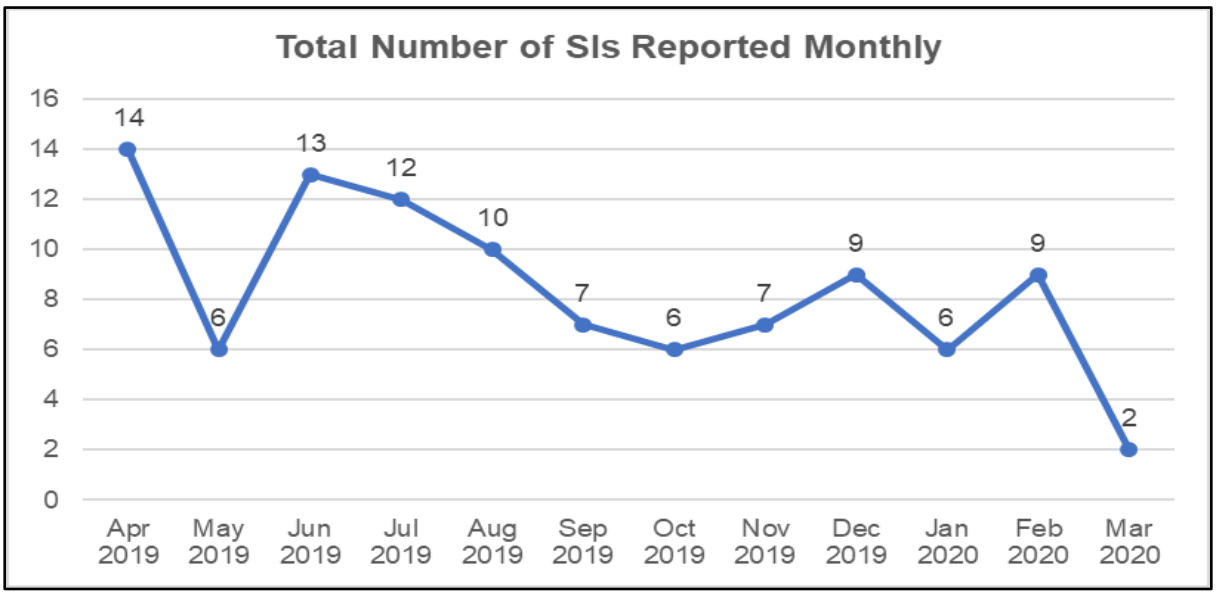
The line graph below shows the number of incidents reported per month alongside the number of SI declared.



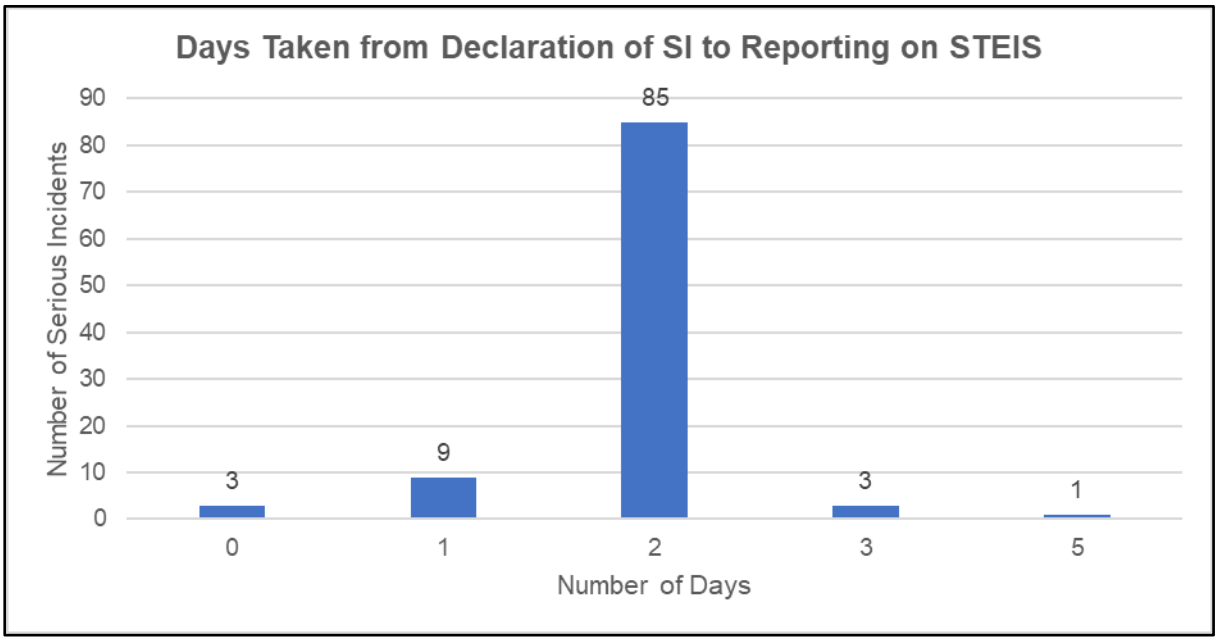
Considering 91% of SI are generated from incidents (11503 reported during 2019/2020) and complaints (938 received during 2019/2020) this equates to 0.8% of key patient safety events resulting in a SI; the previous year saw this figure at 1.08%- the reduction primarily reflects the improvements SIG has made when considering what events meet the SI criteria, or recognising when a SI should be de-

escalated from SI status; it also correlates with the data discussed in the above section where it was identified that 1.3% of incidents reported resulted in moderate harm or above.

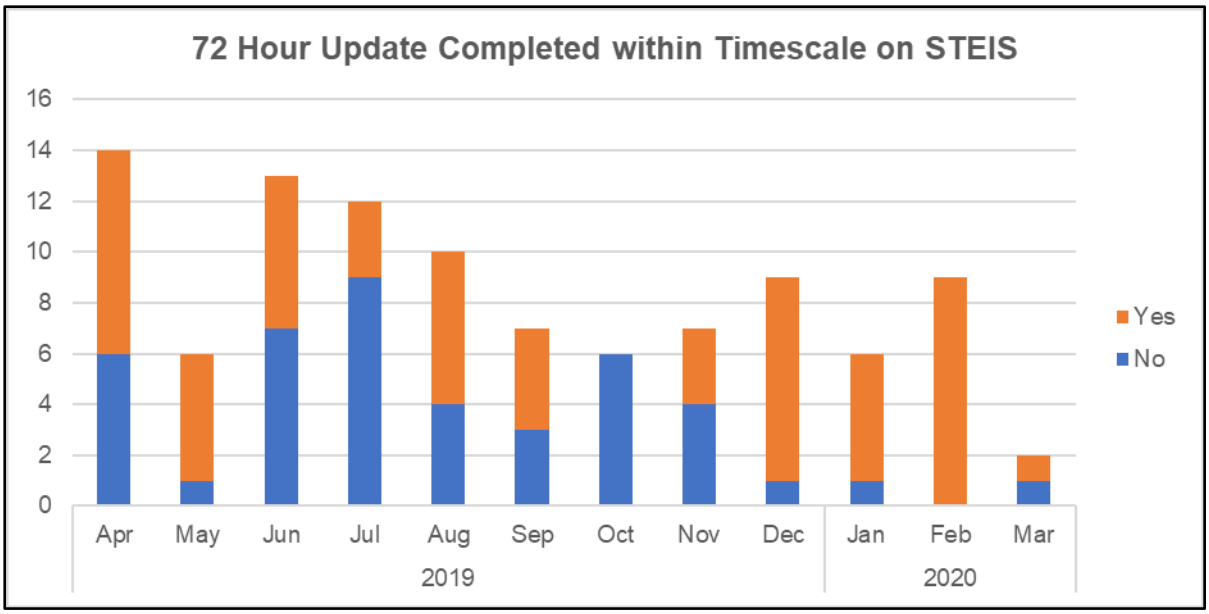
This chart breaks down the number, by month, of SI declared during 2019/2020.



The SI Framework sets out clear timescales the Trust must adhere to for each declared SI, from their declaration on StEIS within 48 hours of identification, the submission of an update within 72 hours of the StEIS report, and the completion of the investigation and submission of the report within 60 working days. The following charts reflect the Trust's compliance with each of these standards.



97 SI were reported within the required timescale, reflecting a 96% compliance rate. The four SI that were declared outside of timescale were delayed due to additional information being required to make the submission on StEIS.



As shown above the Trust struggles to submit 72-hour updates within timescale as there is a requirement to obtain further information from the investigator or relevant operational department. Often this crucial period immediately after a SI is declared is spent allocating an investigator and initial fact-finding to scope an investigation.

When declaring a SI on StEIS most NHS Trusts utilise the StEIS categories to analyse their themes and trends, however, for two reasons SECAmb uses internal categorisation for this; firstly, the StEIS categories relate more to acute hospital trusts, so are less informative for ambulance trusts, and secondly, SECAmb finds it more meaningful to align SI categorisation to the local incident categorisation, this enables better cross theming and adds more value to the analysis.

The table below shows the breakdown for 2019/2020. Delayed dispatch/attendance is the highest reported category with 52 SI, followed by treatment/care with 14 SI declared; this correlates with the findings of analysis of both local incidents and complaints received.

Serious Incident category (as per Datix)	Number of SIs
Clinical Operations A&E	
Delayed Dispatch / Attendance	11
Medication Incident	1
Non-Conveyance / Condition deteriorated	3
Other (Please state)	4
RTC/RTA	2
Staff Conduct	9
Treatment / Care	13
Clinical Operations -EOC	
Delayed Dispatch / Attendance	38
OOH/111/GP Concerns	1
Staff Conduct	1
Treatment / Care	1
Triage / Call management	8

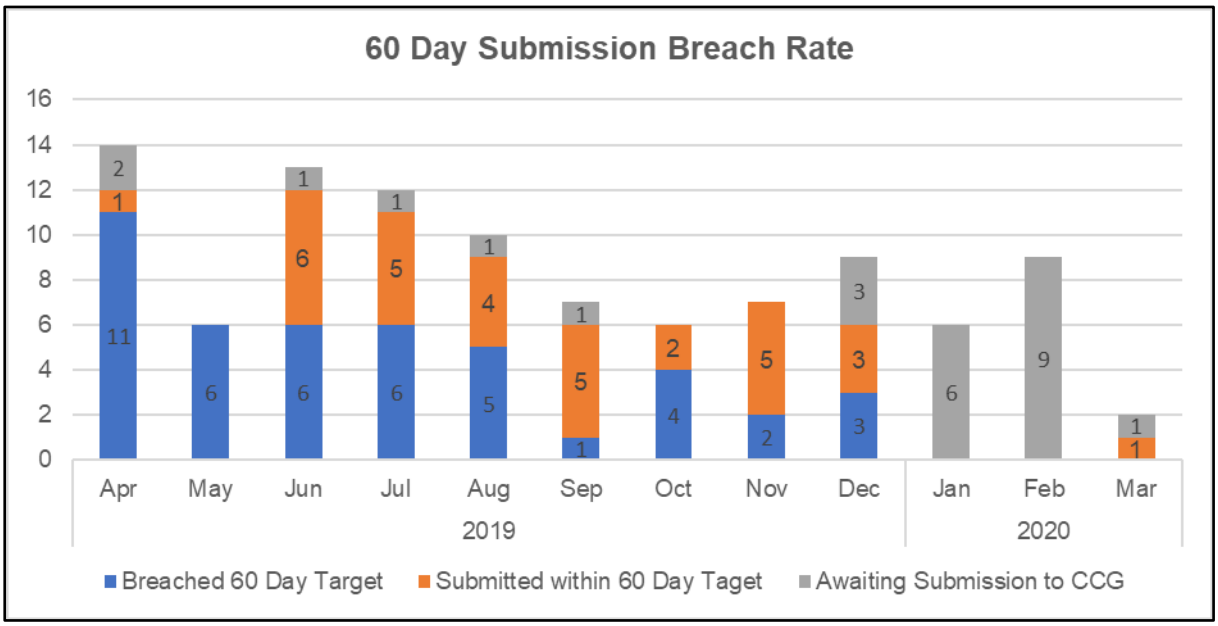
Serious Incident category (as per Datix)	Number of SIs
NHS 111 and Urgent care - 111 service	
Delayed Dispatch / Attendance	3
OOH/111/GP Concerns	2
Triage / Call management	4
Grand Total	**101**

At the time of writing, of the 101 SI declared during 2019/2020 44 (43.5%) breached their submission deadline; this is a significant decrease from 90 (81%) during 2018/2019; The following table shows the number of breached SI at the end of March 2019 and 2020.

Current Status	End of March 2019	% Breached
Breached	31	35%
Total SIs Open	89	

Current Status	End of March 2020	% Breached
Breached	5	11%
Total SIs Open	45	

The following graph shows the breakdown per month of report submissions.



The monumental improvement achieved across the workstream is reflective of the considerable work undertaken during the past two years to strengthen the resources in the SI Team, process map and streamline the SI process, train more SI investigators Trustwide, implement a rolling training programme and improve the support provided to investigators. Whilst the Trust openly celebrates the achievements it is not complacent, acknowledging that more can be done to continue to strengthen processes for further development.

A new Quality and Patient Safety Group for 999/111 was created in Autumn 2019; the Group's terms of reference are specifically pertinent to quality and safety in the

call centres. Unlike previous groups it is fully collaborative with the membership including corporate areas; the Group's Chair is the 999/111 Head of Integrated Governance, and the Trust's Head of Patient Safety is the Deputy Chair. The partnering the Group brings has significantly aided the improvements evidenced above by increasing engagement and bridging an existing gap by welcoming open and honest conversations and challenge. As the Group is now more embedded it has started to receive and review SI reports ahead of their Trust sign off at the SIG, this developing process will ensure more robust recommendations and better ownership of actions.

The Trust also recognised the need for a similar group to exist for Field Operations, as an area that required development was the engagement and collaboration with corporate patient safety teams. The Field Operations Quality and Patient Safety Group was created and met for the first time in February 2020. As with all new groups, the inaugural meeting was to discuss and formulate the terms of reference and membership; the meeting was productive but unfortunately the Group has failed to meet again to further embed due to the Trust's requirement to respond to the Covid-19 pandemic. Plans are in place to take the Group forward once the pandemic eases. Once the Group is established, it is expected the Trust will reap similar benefits as have been evidenced from the 999/111 group.

5.1 Response to Covid-19

Early in the Covid-19 pandemic when the Trust declared a business continuity incident (BCI) a need was recognised for the review and where appropriate and/or possible, adaptations made to some key processes to enable smarter working. The management of SI was one such area that underwent a review, and adaptations were made, and approved at the Trust's Covid-19 Management Group. The change to the process was to ensure learning could be identified and embedded as quickly as possible. The following changes to process were made and remain in place at the time of writing:

- Incidents normally declared a SI to be considered by the SIG for the learning that can be garnered from it; if the root cause and learning is likely to be specifically Covid-19 BCI related an individual SI would not be declared as greater value would be gleaned from the wider post-BCI, however, any immediate learning would be captured and taken forward.

- For the BCI period SI would not be expected to be on the full SI report template, but rather the internal investigation template, as it is quicker to complete, enabling any learning to be identified more quickly.

- All decisions not to declare a SI that would ordinarily be declared would be captured on the Trust's central system for BCI and key decisions. This would evidence the governance process underpinning the decision should the Trust be challenged as part of any future inquiry / coroner's inquest.

- The Trust would be unlikely to declare any internal investigations whilst in the BCI; incidents will be considered either for local investigation or SI.

6.0 Actions from Serious Incidents

Most SI investigations generate an action plan; the actions should work to address gaps identified within a service or care delivery and should, where possible, mitigate against a reoccurrence of the incident. Actions should always be SMART

Specific
Measurable
Achievable
Realistic
Timebound

The Trust has historically met challenges with implementing actions in a timely manner due to them often not being SMART. Last year's annual report spoke of hundreds of open actions going back to 2016; substantial work has been undertaken to both address overdue actions and to ensure that new actions are SMART and able to be taken forward. The table below shows the current position.

Calendar year SI declared	Number of actions generated	Completed actions *(within time and breached)*	Outstanding actions	Breached open actions
2018	385	299	86	86
2019	419	228	191	191
2020	32	17	15	10
Grand Total	**836**	**544**	**292**	**287**

Whilst there remains much work to do to improve this process the 999/111 Quality and Patient Safety Group has proved to have great influence with their actions, so again, it is expected the Field Operations Quality and Patient Safety Group, once fully in place will provide the same level of progress.

7.0 Never Events

There were no never events reported by SECAmb during 2019/2020.

8.0 Statutory Duty of Candour

The Statutory Duty of Candour (DoC) became legislation in November 2014. It is invoked when a reportable patient safety incident occurs, where the level of harm was to a moderate or higher degree. The Duty insists that NHS trusts will communicate with patients and/or their families about the incident as soon as practicable. The Trust policy, in accordance with the NHS Standard Contract, notes the initial DoC contact is to be completed within ten working days, this should also be confirmed in writing, with details of who to contact should they wish to. Patients and/or their families should be invited to raise any specific elements they would like to be included in the investigation and should be kept informed throughout the process. The final element of the Duty is for a meeting to be offered with the patient and/or their families to discuss the findings of the investigation.

During 2019/2020 SECAmb's DoC compliance was 87%; this is measured on whether a conversation with an affected patient and/or their family took place within ten days of the SI being declared, or every reasonable effort to make contact has been undertaken. Of the 101 SI declared, 89 invoked the Duty. DoC was undertaken for the remaining 13% however, this was completed outside of timescale.

Whilst a robust process exists to oversee DoC for SI this is not as effective for those incidents that are not SI, where the level of harm is moderate or higher. During the coming year SECAmb will be concentrating its effort to define the process for such incidents, ensuring the Duty is monitored and met.

9.0 Central Alerting System

SECAmb is committed to embedding learning identified from external routes, the most notable of which is the Central Alerting System (CAS).

Until August 2018 CAS was managed by the Trust's Health and Safety Team but noting how key the alerts are to patient safety as well as wider safety management, the function was transferred to the Datix Team. The Team immediately developed and utilised the safety alerts module within Datix, to ensure the existence of a central repository for all alerts and the evidence of implementation.

Alerts are developed and issued by NHS Improvement, NHS England, Medicines and Healthcare Regulatory Agency, Chief Medical Officer (CMO) or NHS Estates and Facilities. Upon receipt of an alert via CAS, and after an initial assessment by the Datix Team, it is cascaded to the most appropriate leads in SECAmb for ongoing review, dissemination and implementation of actions. Alerts will relate to medical devices, patient safety, field safety notices, drug alerts or CMO alerts. Many alerts are more acute hospital specific and not relevant to ambulance trusts and can be closed immediately after initial review, however there are still many that are more generic and relate to medications or equipment that are relevant.

During 2019/2020 288 alerts were received by SECAmb, the breakdown of their source is shown below.

Alert Generated by	Number received during 2019/2020
Central Alerting System Helpdesk	1
CMO Messaging	14
Department of Health Estates and Facilities	4
Department of Health Supply Disruption	20
MHRA Dear Doctor Letter	1
MHRA Drug Alert	54
MHRA Field Safety Alerts	53
MHRA Medical Devices	37
National Patient Safety Agency	5
NHS England	3
NHS Improvement	1
NHS Improvement, Estates and Facilities	1
SSC Alerts	94
Grand Total	**288**

Of the 288 alerts received nine did not require a response as they were for information only; these alerts were however still shared with the appropriate leads.

Upon receipt, all alerts are disseminated to the most appropriate senior team for assessment and where appropriate, a response. The breakdown below shows their status.

Action Type	Number received during 2019/2020
Action Completed	18
Action Not Required	252
Action Required Ongoing	9
Information Only	9
Grand Total	**288**

27 alerts required action by the Trust, of these nine were closed after their due date and one remains open however, still within its response deadline. Responding to alerts within timescale has been challenging on occasion; whilst it is not a significant problem for the Trust this number does reflect that a third breached. Further improvement to ensure alerts are responded to within time during periods of increased demand or annual leave is required, by ensuring that suitable deputies can respond.

10.0 Conclusion

As predicted in last year's annual report, 2019/2020 has proved to be a very exciting year for patient safety in SECAmb. The year has seen momentous improvements with incident recognition and reporting, fruition of the SI improvement journey and better collaboration with operational areas. All of which has led to greater learning and the embedding of lessons both within the Trust and throughout the wider system.

The Trust does not take these improvements in their stride and will not become complacent as improvement journeys never really end but are continuous.

Acknowledging the Trust will have unprecedented challenges due to the Covid-19 pandemic; the year ahead does still promise improvements and adaptations. Some areas of work planned for 2020/2021 that will garner further improvements are:

- Fully develop and embed the Field Operations Quality and Patient Safety Group;
- Review of the draft National Patient Safety Strategy and the changes to current ways of investigating and learning it brings;
- Further development of the Datix Cloud risk management and patient safety software system which, once rolled out will strengthen the way the Trust can report incidents and analyse the data.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Patient Experience Annual Report 2019/2020

Contents

Contents 2

Introduction 3
Key Achievements 3
Patient and Family / Carer Experience Strategy 2020 - 2025 4
Compliments 4
Complaints 7
Learning from complaints 17
Parliamentary and Health Service Ombudsman 21
Patient Advice and Liaison Service (PALS) 21
Monitoring Systems 22
Reporting Arrangements 23
The Patient Experience Team 23
Conclusion and future areas of development 23

Introduction

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) endeavours to always ensure patients, staff and the public are safe when in our care, and that the quality of the care they receive is consistently at the highest possible standard. However, even with the best of intentions, inevitably sometimes things go wrong, and this can lead to complaints about our service. SECAmb is committed to investigating complaints when they are received to ensure causes can be identified and learned from to improve practice and reduce the likelihood of a recurrence.

The purpose of this report is to provide an overview of all compliments and complaints that were received during the period of 1st April 2019 to 31st March 2020. The report will explain the route that complaints can take to be investigated, depending on their severity, and the processes that underpin this, it will also highlight any notable themes and explain any actions that were taken to mitigate risks relating to them. In addition, the report will highlight key learning that has been identified from complaint investigations.

Key Achievements

- The Patient and Family / Carer Experience Strategy has been now been approved; the Trust Board approval was delayed by Covid 19.
- Improved processing of compliments resulting in staff receiving recognition within a week of receipt.

Patient and Family / Carer Experience Strategy

Our Patient and Family / Carer Strategy was co-designed with stakeholders following three events, one each in Surrey, Sussex and Kent, and a consultation workshop with NHS Improvement / England (NHS I/E). The four events provided us with the opportunity to speak with our patients, their families and carers as well as our staff, and external partners, including Health Watch across the region, to co-develop this strategy. As a Trust we were delighted with the engagement, as it was fundamental in the development of the strategy.

Our vision is that our strategy will also be co-delivered with our partners and we anticipate that over the next five years we will see an increasing influence from patients and their families / carers in the care that we provide. We are also grateful to the support from NHS I/E with the development of this strategy.

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

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

The Board approved the first Patient and Family / Carer Experience Strategy for South East Coast Ambulance NHS Foundation Trust in May 2020.

The first planned workstream arising from the strategy is to review how we collect, collate and triangulate all our data relating to patient experience. It is recognised that whilst we have systems in place currently, they are likely to become more sophisticated over the next year. We will be able to understand more of the experience of our patients and use quality improvement methodology to make changes arising from that feedback.

Compliments

Each year the compliments received by the Trust, thanking our staff for the work they do, far outnumber complaints. Compliments are recorded on the Trust's Datix system (electronic patient safety and risk management software system), alongside complaints, so both the positive and negative feedback is captured and reported back to operational staff. The staff concerned receive a letter from the Chief Executive in recognition of the dedication and care they provide to our patients. During 2019/2020 the Trust received 1,884 compliments, slightly more than the 1,846 received during 2018/19.

Compliments are shared with crews and the leadership team; staff appreciate being recognised and feel valued when they receive compliments, this validates the good work they are delivering and makes them feel part of a successful team. The Trust believes, as with complaints not being recognised or investigated, the same approach should be taken with compliments.

Compliments are often published in the Bee Line, allowing staff to see the good work their colleagues are doing. Compliments received influence morale overall and make a big difference to the overall behaviours of the staff.

Table 1 Compliments by service/operating (OU) area and month:

Op area / Month	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Ashford OU	5	6	4	11	13	10	9	8	6	16	6	12	106
Brighton and Mid Sussex OU	7	3	1	13	17	20	8	21	17	20	8	19	154
Chertsey OU	6	8	6	18	19	13	10	28	18	10	24	27	187
Gatwick and Redhill OU	13	5	6	36	30	18	24	27	17	38	29	28	271
Guildford OU	5	5	8	13	25	8	15	18	12	21	22	12	164
HART	0	0	0	0	0	0	0	0	0	0	0	1	1
Medway and Dartford OU	10	2	10	34	21	20	17	29	24	37	31	19	254
Paddock Wood OU	7	6	3	25	15	8	13	7	14	12	13	18	141
Polegate and Hastings OU	8	4	7	8	26	16	22	28	8	19	19	7	172
Tangmere and Worthing OU	8	3	9	24	30	23	16	23	14	13	9	25	197
Thanet OU	12	3	3	12	20	10	9	26	15	24	20	21	175
East EOC	0	1	0	1	1	1	1	3	1	2	0	2	13
West EOC	2	2	0	1	2	1	2	4	1	2	4	2	23
NHS111	0	0	2	0	1	1	1	5	1	0	0	3	14
Patient Experience	0	0	3	2	0	0	2	1	0	1	2	1	12
Total	83	48	62	198	220	149	149	228	148	215	187	197	1884

Direct feedback and compliments resulting from 999 calls to the Trust's Emergency Operations Centres are more difficult to obtain as calls tend to be very concise and focused. However, examples have been included below where life-saving advice has been provided.

In previous years there were no guidelines regarding the time taken for the Trust to process compliments. This led to crews not receiving their much-deserved recognition in a timely manner. Although there is no statutory requirement for compliments to be processed within a defined period, the importance of processing these as quickly as possible was recognised, and the system was reviewed and revised. This has led to compliments being currently processed and completed within a week of receipt. The 1,884 compliments received during 2019/20 represent one compliment for every 1,205 interactions, meaning that 0.00082% of all calls / journeys attracted a compliment.

Some examples of the compliments the Trust received during 2019/2020 are below:

"Mother wished to thank the call operator for saving her two-day old sons life. They kept her calm whilst in blind panic and helped her administer CPR which eventually worked before the crews arrived and she cannot express the appreciation and thanks as now he is a healthy five-week-old baby."

"Patient called to say thank you to the crew who assisted them, they were extremely empathetic, reassuring and helpful. They were professional throughout and are a credit to SECAmb."

"Mother called our office to say thank you to the crew who assisted her son. They were incredible, reassuring, compassionate and their good humour calmed and helped everybody. They kept both her and her son informed and went above and beyond the call of duty. She is very grateful that they kept her smiling during such a stressful time."

"Patient's sister called to express her gratitude to the team who assisted her terminally ill sister. She explained that the crew were with her sister for hours and made sure that she received the most appropriate care. The crew listened to the sister and family's concerns and made sure that she was taken to a hospice which was the right thing to do at the time. Patient's sister would like them to know they were absolutely brilliant and that they are all very grateful for everything they did on the day."

"A Supported Housing Officer wanted to thank the Emergency Medical Advisor (EMA) for the way they handled their 999 Call. They went on to say that the EMA talked everything through with him in such a cool and way that made it very easy for him and they were very reassuring throughout."

"Wife says that the crew were very helpful, caring and brilliant. They liaised with other services and since then her husband is getting the support he needs. She explained that she is 89 years old herself and she really appreciated all the help they received since our crew's attendance."

Complaints

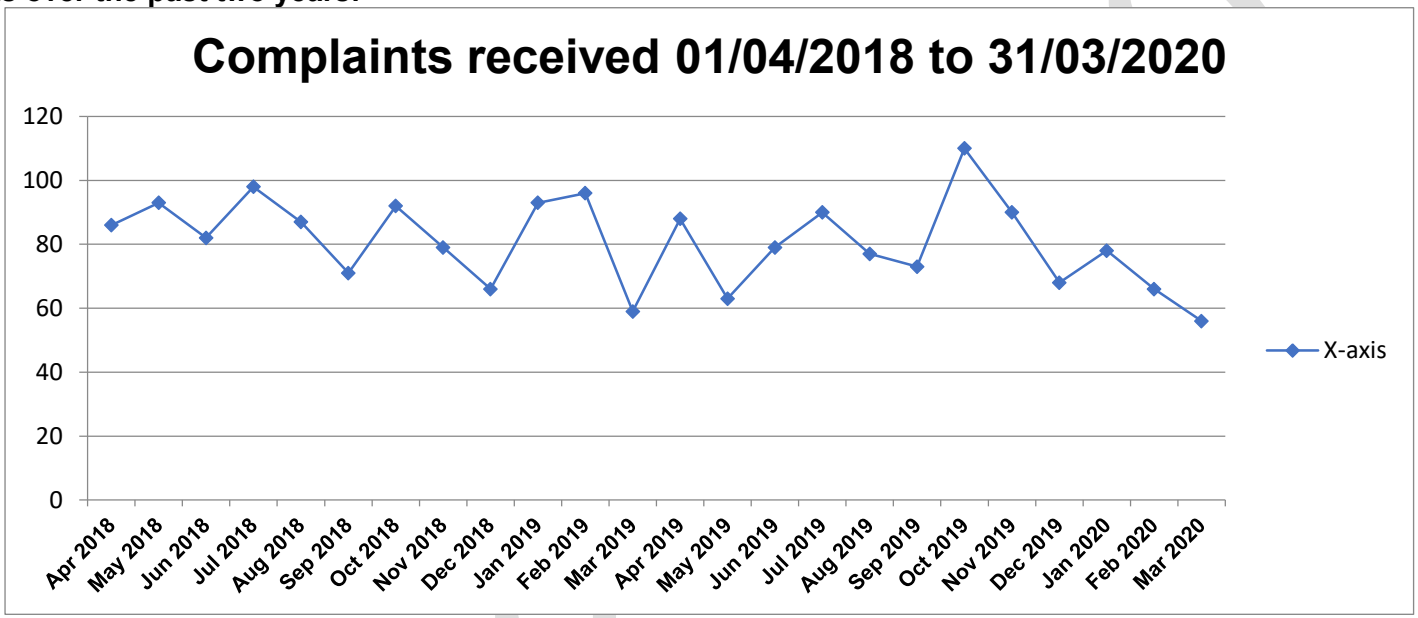
Statistics:

During 2019/20:

- Our Emergency Operations Centre staff answered 777,662 calls.
- Our A&E road staff made 713,052 responses to patients.
- Our NHS 111 staff took 780,902 calls.
- SECAmb received 938 complaints.

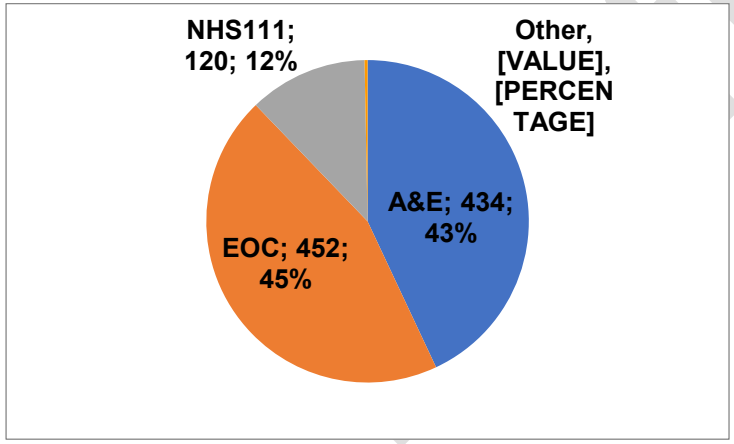
This equates to one complaint for every 2,422 patient interactions, meaning that 0.00041% of all calls / journeys attracted a complaint. Detailed below is a comparison between the complaints received in the past two years which shows a slight reduction in 2019/20 against 2018/19.

SECAmb complaints over the past two years:

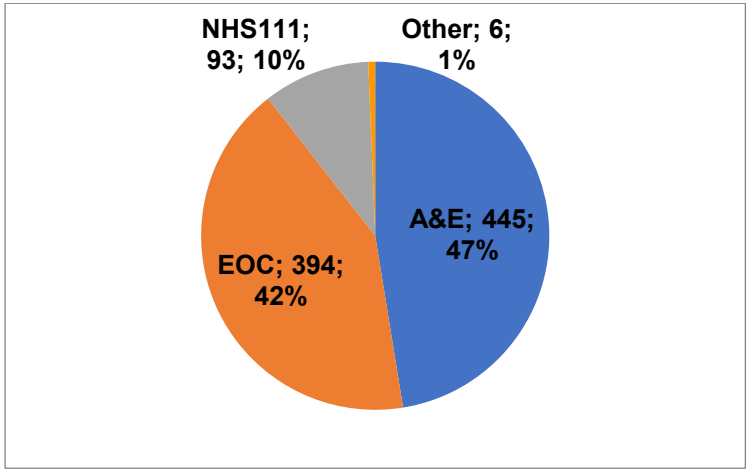


The peak during October 2019 correlates with an increased level of activity experienced across the Trust, with only 34% of the month being in Surge Management Plan Level 1.

2018/19: 1009



2019/20: 938



Complaints by service/operating (OU) area and month:

Service / OU / Month	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
Ashford OU	2	4	5	8	7	4	8	4	5	3	3	3	56
Brighton and Mid Sussex OU	6	6	5	4	6	5	3	6	4	8	3	1	57
Chertsey OU	7	5	3	6	4	7	6	3	4	2	4	5	56
Community First Responder	0	0	0	0	0	0	0	0	0	1	0	0	1
Gatwick and Redhill OU	5	6	10	9	8	3	8	7	4	8	8	3	79
Guildford OU	3	3	6	4	1	5	6	7	3	9	2	2	51
Medway and Dartford OU	10	6	10	11	3	6	8	6	4	9	4	6	83
Paddock Wood OU	4	3	5	3	6	3	6	5	3	4	3	3	48
Polegate and Hastings OU	8	2	4	7	2	5	10	4	4	3	3	4	56
Tangmere and Worthing OU	9	7	9	6	9	6	6	11	8	5	9	8	93
Thanet OU	5	5	3	4	6	4	6	3	4	4	4	4	52
HART	0	0	0	0	0	0	1	0	0	0	0	0	1
East EOC	7	3	7	8	4	5	11	9	5	7	6	5	77

Service / OU / Month	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
West EOC	7	8	7	12	11	10	23	16	10	9	9	5	127
EOC Clinical	0	0	0	0	0	0	0	0	0	0	0	1	1
EOC information Team No Area	0	0	0	1	0	0	0	0	0	0	0	0	1
NHS111	14	5	4	7	10	10	7	9	9	6	7	6	94
Communications	0	0	0	0	0	0	0	0	0	0	1	0	1
Patient Experience	0	0	0	0	0	0	0	0	1	0	0	0	1
Information Governance	1	0	0	0	0	0	0	0	0	0	0	0	1
PALS / Complaints	0	0	1	0	0	1	0	0	0	0	0	0	1
Total	88	63	79	90	77	74	109	90	68	78	66	56	938

Complaints are allocated by the Patient Experience Team to the service / operational unit upon receipt, all complaints regarding timeliness are allocated to and investigated by the Emergency Operations Centres.

Complaints are reviewed and graded according to their apparent seriousness; this ensures they are investigated proportionately. These are:

- Level 1 - complaints that can be dealt with by the Patient Experience Team as they already hold the information necessary to respond to the complaint or can easily obtain it without sending the complaint to anyone else for investigation. These are normally registered as concerns; would be considered as PALS issues in other Trusts.
- Level 2 – a complaint that appears to be straightforward, with no serious consequences for the patient / complainant, but needs to be sent to a manager for the service area concerned to investigate.
- Level 3 – a complaint which is considered to be serious, having had clinical implications or a physical or distressing impact on the patient / complainant, or to be of a very complex nature.
- Level 4 - any complaint which is later classified as a Serious Incident (SI). Once a decision has been taken by the Serious Incident Group to declare a serious incident, the complaint is passed to the SI Team for a root cause analysis investigation to be carried out. The SI Team will liaise with the complainant confirming the process to be followed and responding to any queries.

Most complaints received during 2019/20 were graded as level 2, 863 (92%), with the remaining 75 (8%) as level 3.

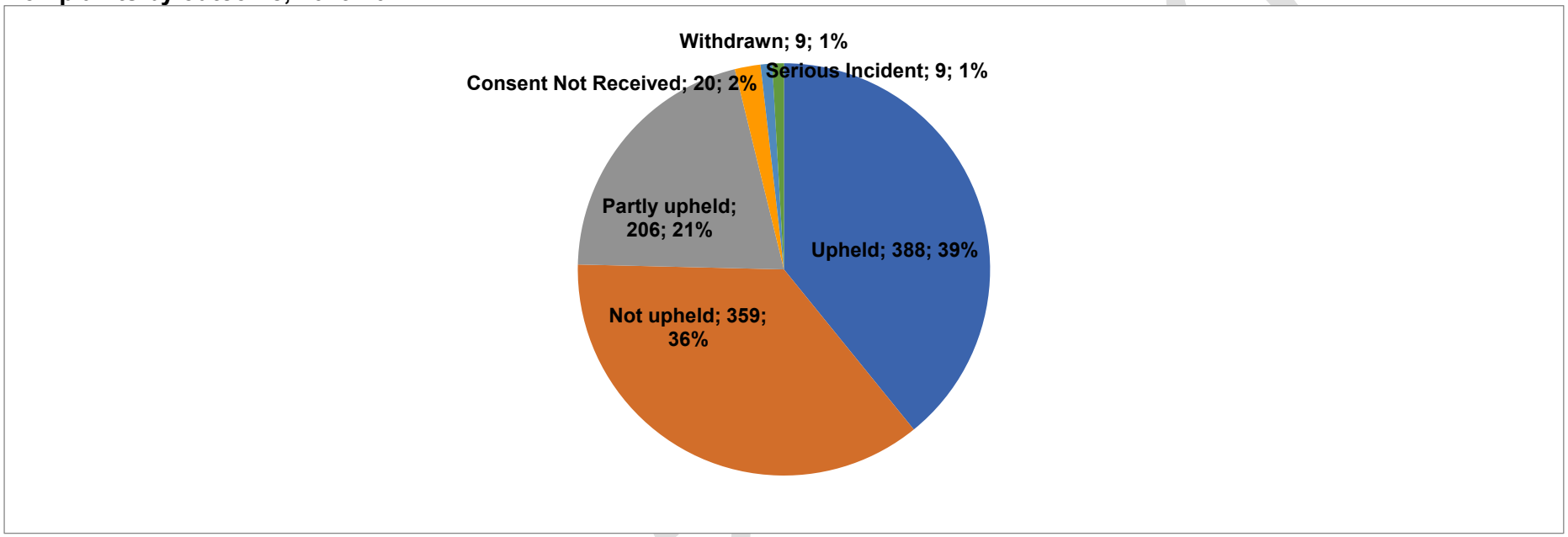
Complaints are categorised into subjects and can be further distinguished by sub-subject if required.

Complaints received during 2019/20 by subject and service area:

Directorate / Subject	A&E	EOC	NHS111	Other	Total
Administration	1	1	2	2	6
Communication issues	15	12	2	2	31
Concern about staff	280	30	14	2	326 (35%)
Information request	1	0	0	1	2
Miscellaneous	6	1	1	0	8
Patient care	138	145	68	0	351 (37%)
Timeliness	1	205	6	0	212 (22%)
Transport	2	0	0	0	2
Total	444 (47%)	394 (42%)	93 (1%)	7	938

When a complaint is concluded, the investigating manager, with input from the Patient Experience Team where necessary, assesses whether the complaint should be upheld, partly upheld or not upheld based on the findings of their investigation. During 2019/20 991 complaints were responded to; of these 60% were found to be upheld or partly upheld. Where a complaint is received which relates to one specific issue, and substantive evidence is found to support the allegation made, the complaint is recorded as 'upheld'; however, where a complaint is made regarding more than one issue, and one or more of these issues are upheld, the complaint is recorded as 'partially upheld'. The outcome from complaints is shown in the figure below:

Complaints by outcome, 2019/20



To enable the Trust to release details of an investigation, consent must be received from the patient or their representative. If this is not received by completion of the investigation the complaint is closed and marked as 'Consent Not Received' and a letter sent to the complainant confirming this, however, any learning resulting from the investigation is still put in place. 1% of complaints received by the Trust are withdrawn by complainants who specifically request an investigation does not take place. 1% of complaints are, after review from the Serious Incident Group, declared a Serious Incident and investigated accordingly, the complainant is kept informed in such circumstances.

Closed complaints by Subject and Outcome:

	Consent Not Received	Not upheld	Partly upheld	Serious Incident	Upheld	Withdrawn	Total
Administration error	0	3	1	0	0	1	**5**
Advice	0	0	1	0	0	0	**1**
Breach of confidentiality	0	4	2	0	3	1	**10**
Communication issues	1	16	4	0	11	1	**33**
condition / comfort of vehicle	0	0	1	0	0	0	**1**
Crew diagnosis	0	14	5	1	5	0	**25**
DOS issues	0	2	0	0	1	0	**3**
Equipment issues	0	0	1	0	2	0	**3**
GP call back delay	0	0	1	0	0	0	**1**
HCP failed to visit	0	0	0	0	1	0	**1**
Inappropriate treatment	0	31	15	1	12	0	**59**
Made to walk	0	2	3	0	1	0	**6**
Miscellaneous	0	2	1	0	3	0	**6**
Not transported to hospital	0	18	14	1	6	0	**39**
Pathways	5	83	35	2	95	2	**222**
Patient injury	0	2	5	0	2	0	**9**
Privacy and dignity	0	2	0	0	0	0	**2**
Request for documentation	0	1	0	0	0	0	**1**
SECAmb policy or procedure issue	0	0	0	0	1	0	**1**
Siren noise	0	1	0	0	0	0	**1**
Skill mix of crews	0	1	2	0	0	0	**3**
Staff conduct / attitude	3	137	79	0	53	1	**273**
Standard of driving	1	23	10	0	11	0	**45**
Timeliness - 111 Response	0	1	0	0	5	0	**6**
Timeliness	10	14	26	4	176	3	**233**
Transport arrangements	0	2	0	0	0	0	**1**
Total	**20**	**359 (36%)**	**206 (21%)**	**9**	**388 (39%)**	**9**	**991**

By far the highest category of complaint which are upheld or partly upheld is timeliness with 202, 20%, followed by staff conduct / attitude with 132, 13% and Pathways with 130, 13%. Timeliness complaints primarily occur when the Trust has implemented its Surge Management Plan Level 3 or 4 and is experiencing high levels of demand for its services. Of the complaints received regarding staff conduct / attitude 48% are upheld or partly upheld and result in significant learning for our staff, this is gained through reflective practice where crews complete a paper on how they would have dealt with a situation differently which is then discussed with their line manager. In some cases, it can also result in formal action via the Trust's Disciplinary Procedure. Any complaint received which relates to the use of NHS Pathways is referred for the call to be audited, the findings are then fed back to the call handler by the line manager, any additional learning identified is put in place.

During 2019/20 63% of complaints were responded to within the Trust's timescale, compared to 95% in 2018/19. The Trust's agreed timescale within the complaint's procedure is for 90% of complaints to be responded to within 25 working days. The reduction in response times was a direct result of the earlier highlighted issues experienced with investigating and responding to EOC complaints, 34%.

Directorate	Complaints closed	Number responded to within 25 working days	% number responded to within 25 working days
A&E	**456**	**382**	**84%**
EOC	**437**	**146**	**34%**
NHS111	**100**	**92**	**92%**
Other	**6**	**5**	**83%**
Overall	**999**	**625**	**63%**

Complaints by service area: A&E field ops

The table below shows the A&E field operation's complaints received by subject. The two main themes of complaints relating to emergency field operations are, as in previous years, 'concern about staff' (which includes complaints about staff conduct, attitude, breach of confidentiality and the standard of driving), 280 (63%), and 'patient care', 138 (31%). These figures correlate with those from 2018/19 which were 'concern about staff', 275 (63%), and 'Patient care', 144 (33%).

OU / Subject	Administration	Communication issues	Concern about staff	Information request	Miscellaneous	Patient care	Timeliness	Transport	Total
Ashford OU	**0**	**2**	**28**	**0**	**0**	**9**	**0**	**0**	**39**
Brighton and Mid Sussex OU	**0**	**1**	**31**	**0**	**1**	**12**	**0**	**0**	**45**
Chertsey OU	**0**	**1**	**17**	**0**	**2**	**17**	**0**	**0**	**37**
Gatwick and Redhill OU	**0**	**1**	**36**	**0**	**1**	**23**	**1**	**0**	**62**
Guildford OU	**0**	**1**	**26**	**1**	**1**	**6**	**0**	**0**	**35**
Medway and Dartford OU	**0**	**3**	**35**	**0**	**0**	**24**	**0**	**0**	**62**
Paddock Wood OU	**1**	**0**	**17**	**0**	**0**	**13**	**0**	**0**	**31**
Polegate and Hastings OU	**0**	**2**	**21**	**0**	**0**	**10**	**0**	**0**	**33**
Tangmere and Worthing OU	**0**	**3**	**37**	**0**	**1**	**16**	**0**	**0**	**57**
Thanet OU	**0**	**1**	**32**	**0**	**0**	**8**	**0**	**2**	**43**
Total	**1**	**15**	**280**	**1**	**6**	**138**	**1**	**2**	**444**

Concern about staff:

Concerns regarding staff feature as one of the top five themes of complaints within the NHS. For the Trust this includes the standard of driving for which there were 45, a slight increase on 2018/19 where 39 were received. In March 2020 the Trust recruited a Fleet Risk Reduction and Driving Standards Manager who reviews all complaints received regarding the standard of driving.

The overall 280 complaints the Trust received regarding concerns about A&E road staff during 2019/20 reflects a slight increase over 2018/19 when 275 were received. However, of those received during 2019/20, 45% (127) were upheld or partly upheld, compared to 54% (149) during 2018/19.

Patient Care:

Complaints about patient care are divided into sub-subjects, which include:

- Crew diagnosis
- Equipment issues
- Inappropriate treatment
- Patient injury
- Patient made to walk to the ambulance
- Patient not conveyed to hospital
- Privacy and dignity
- Skill mix of crew

During 2019/20 we received 138 complaints specifically about the care provided by our road staff and an additional 28 complaints where 'patient care' was a secondary concern i.e. initial complaint regarding timeliness and concerns raised regarding care provided by the crew once on scene, a total of 172 complaints, of which 92 (53%) were upheld or partly upheld, compared to 108 during 2018/19 where 58% were upheld or partly upheld.

64 complaints were received in relation to inappropriate treatment with 32 (50%) of those upheld or partly upheld.

44 complaints were received about patients not having been conveyed to hospital, of these 20 (45%) were upheld or partly upheld.

Crew diagnosis, which is occasionally used interchangeably with non-conveyance (not all misdiagnoses resulted in non-conveyance) accounted for 26 complaints of which 11 (42%) were either upheld or partly upheld.

Complaints by service area: Emergency Operations Centres (EOCs)

Historically, the responsibility to investigate complaints relating to the Trust's Emergency Operations Centres (EOC) sat within the EOC. However, in March 2019, due to a recognised backlog and lack of support for the staff member responsible for these complaints, the decision was taken to move the function and the resource within the Patient Experience Team (PET) to improve the support provided. It became apparent very quickly that only one person being able to undertake this work was a single point of failure for the organisation, and unfortunately shortly after this move occurred the risk was realised when the staff member had an unplanned absence away from the Trust. As an interim measure the Trust secured temporary assistance from colleagues within the Nursing and Quality Directorate and the EOC to help work through the backlog. Subsequently, the Patient Experience Team have secured the services of a permanent member of staff with extensive experience within EOC and full investigation training; they are due to start in June 2020. In the meantime, the back log of complaints within EOC has been cleared.

Complaints received regarding the Trust's EOCs have reduced dramatically over the last two years from 577 during 2017/18 to 452 during 2018/19 and to 394 during 2019/20 representing a reduction of 125 (21%) during 2018/19 and a further reduction of 58 (13%) during 2019/20. The figure below shows the EOC complaints by subject. The two main themes of complaints about the EOCs is, as in previous years, 'timeliness' 205 (52%) and 'patient care' 145 (37%).

	Administration	Communication issues	Concern about staff	Miscellaneous	Call triage	Timeliness	Total
West EOC	**1**	**9**	**11**	**1**	**92**	**137**	**251**
East EOC	**0**	**3**	**19**	**0**	**53**	**68**	**143**
Total	**1**	**12**	**30**	**1**	**145**	**205**	**394**

Timeliness:

By far the highest number of complaints that were received regarding the EOCs were timeliness, 205, although this year has shown a reduction of 47 complaints, just under 19%; 90% of these complaints were found to be upheld or partly upheld. Timeliness complaints are when the Trust does not achieve its target response time; when this is confirmed the complaint is always found to be upheld. The Trust regularly reviews its operational establishment to try to ensure there are enough staff to meet the predicted operational demand, however, often the demand outstrips the number of resources; this work is ongoing as the demand is ever increasing. Significant work has also been undertaken in the EOCs to again, try to ensure patients are safeguarded whilst awaiting a resource; the number of staff made available to complete welfare calls has increased allowing those with worsening symptons to be identified and re-triaged in a more timely manner.

Call triage:

Call triage (NHS Pathways) formed the next highest number of complaints with 174 complaints received where an element of the triage was questioned, with 108 (62%) being upheld in some part. These complaints were often found to be as a result of human error, with staff not correctly following the triage process, some examples of errors made are below:

- selecting the wrong pathway
- insufficient probing of symptoms
- insufficient explanation
- EMA not deferring to clinician
- Clinical Supervisor not using NHS Pathways to reinforce their clinical decision
- not following policy correctly
- issue with NHS Pathways itself

All 999 calls which are the subject of a complaint are audited and feedback is provided to the call taker from the audit by their line manager, all identified learning is put in place via action plans.

Complaints by service area: NHS111

During 2019/20 the Trust received 93 complaints about its NHS111 service, compared to 120 during 2018/19 and 166 during 2017/2018; a decrease of 29% and 28% respectively.

	Administration	Communication issues	Concern about staff	Miscellaneous	Call triage	Timeliness	Total
NHS111	**2**	**2**	**14**	**1**	**68**	**6**	**93**
Total	**2**	**2**	**14**	**1**	**68**	**6**	**93**

Of the complaints received 93, (58%) were upheld in some way.

As with the Trust's EOCs, the highest number of complaints related to call triage; 68 (73%); of those 43, (63%) were upheld in some way. As with complaints about the Trust's EOCs, audits are completed on all calls subject to a complaint and feedback provided to the call taker by their line manager.

Learning from complaints

Lessons identified from complaints throughout 2019/20 have been wide ranging.

741 actions were identified from complaints during the period 01/04/2019 to 31/03/2020. Actions from A&E complaints include feedback provided to the crew both formally and informally, reflective practice, additional training and 'ride outs', when an Operational Team Leader spends the day with a crew reviewing their working practice. Actions from complaints for EOC and NHS111 are equally wide ranging and include feedback provided to the EOC and NHS111 staff both formally and informally, additional training or mentoring, clinical instruction and policy / procedural reviews.

The below shows examples of the more common themes and lessons learnt:

A&E complaints:

Complaint	Investigation Findings
We had an ambulance out to my Grandad in the early hours of Sunday 16th June, we called as he was end of life and was in severe pain with chest pain. We were told the ambulance was on the way with lights and sirens and we should wait outside as the house was hard to find. My partner waited outside for 2 hours in total waiting for them to arrive. We had to call them back as they seemed to not be showing up. When the paramedics did arrive, they did not even come on blue lights. When they walked in, they did not apologise at all for the wait. My grandad was end of life with terminal cancer and all treatment had been stopped recently by his cancer doctor but a DNR had not yet been put in place. When we mentioned this, she repeatedly told us she would be resuscitating him if he were to pass away. We made it very clear this was against his wishes and she did not have to as he was end of life. She continued to tell us we were wrong. This was obviously very distressing for us. We wanted end of life treatment for him at home and asked her advice with what to do. She said he could not have any treatment without going to hospital and this was best for him. We reluctantly agreed for him to go as she was going to leave him with absolutely nothing in place if we refused hospital. He later passed away in hospital, totally against his wishes.	The investigation found that although the crew had the patient's best interest at heart there were obvious communication issues as the family felt they were not being listened to and some of the rationale for decisions were not clearly communicated with them: • EOC were not correct in confirming an ambulance was on route. • Staff came across as forceful and unsympathetic. • No check was carried undertaken to find out if a 'Do Not Attempt Resuscitation' order (DNAR) was in place, family confirmed in place but not on IBIS. • Crew did not explain that patient could stay at home only telling them that they had to go to hospital. Learning: • Crew uncertain about leaving patient at home. • Clearly explaining what is happening and why. Action taken: • Crew met with SECAmb End of Life Care Lead in order to expand their understanding of care pathways in such circumstances.

EOC complaints:

Complaint	Investigation Findings
I received a verbal complaint from a relative of a patient whilst in attendance at an incident. They were incredibly angry with the experience they had whilst on the phone to EOC. I tried to explain to them how our triage process works and why they were asked so many questions. However, in the end we agreed that they would like their concerns investigated. I told them that I would investigate this myself and write back to them via our PALs dept.	As with all complaints about the Emergency Operations Centres an audit of the calls was completed. Following audit, the auditor raised concerns that Pathways questions did not safeguard patients suffering from severe tremor, copies were sent to NHS Pathways who reviewed and confirmed: *"Thank you for submitting the issue regarding severe tremor. This has been reviewed by members of the authoring and training team. Changes were made to the key points of Tremor PW for 18.5 and then work completed for 19.3 to transfer those with tremor symptoms for less than a week to Other Symptoms PW, therefore those with 'acute' symptoms will be interrogated for 'high end' conditions including critical illness. We agreed that these changes would enhance the triage for the symptoms described by the caller, acknowledging the difficulty that the call handler had with these calls, of which we felt were managed well. We will be closing this issue as changes have been applied, many thanks for taking the time to upload these calls for review."*
XX called to say that her 10-year-old son was out cycling with his friend in the woods behind a street of houses, when he fell off and landed in a ditch tangled up with his bike on 26 May between 19:45 and 20:15. His friend phoned for an ambulance. A couple who were in the wood were asked by the call taker to move her son as the ambulance couldn't find him - although they weren't comfortable doing this, they did so. XX says that at this point the ambulance hadn't even arrived. At one point he was unable to feel his legs. He is alright, but very bruised. XX complains that the call taker should not have asked the couple to move her son, as the ambulance crew should always	The investigation found that the Emergency Medical Advisor should have sought clinical involvement before advising the movement of the patient to ensure no further injury was caused as per advice of NHS Pathways. A shared learning document was sent out to all staff inclusive of the dispatch function to ensure that learning has come from this incident and the importance of resource dispatchers and dispatch team leaders knowing that they need to seek clinical advice before moving any patients post injury to ambulance response. The Trust also implemented a new method of working in relation to obtaining remote rural locations utilising "What3Words" ops 298.

Complaint	Investigation Findings
go to the patient.	This was implemented in July 2019. What3Words provides a precise and simple way to talk about locations. The world has been divided into a grid or 3 metre x 3 metre squares each one assigned a unique three-word address. This allows it to be used on a mobile device to quickly determine a user's location.

NHS111 complaints:

Complaint	Investigation Findings
Could you kindly review the following incident that came through as a 111 call Cat 5 C, referred to GP and 4 hours later was dealt by 999 Cat 2 A, as a stroke and the patient died yesterday morning within 2 days of the 111 call. Could you kindly evaluate the original 111 call where she was referred to her GP and 4 hours later the 999 call was made and assigned as Cat 2 with A Priority. The patient was my best friend and ex-partner's mother. She passed away yesterday morning (28/04/2019) at about 1.30 am. The only sad part is the time difference of 4 hours between 111 and 999 calls, because my 'brother in law' who is the full time carer of both his parents, felt reassured enough after the 111 call, to leave his mom alone at home to take his dad for an appointment at Worthing Hospital. If there is an opportunity to use this call as a learning curve, that would be amazing. There are no negative feelings towards the call handler, and I wish only that you evaluate the call to identify whether there is the possibility to learn from this.	Following investigation, the audit found that a more urgent disposition could have been reached had the Health Advisor (HA): • Followed the "New confusion" route through NHS Pathways. • Sought clinical support regarding the combination of symptoms which were not all covered by the NHS Pathway that was followed. The HA received one-to-one feedback from the audit to ensure they understood that clinical support should be sought when the patient has multiple symptoms and the caller is concerned and is not accepting the disposition that has been reached.
I contacted 111 at about 8.30am on 14.12.2019, that morning I had had a purpuric rash for 36 hours which had started on my upper thighs, spreading to lower legs then whole body, with bloody blisters on the gums and front of tongue and bleeding from the mouth overnight. I can't	Following investigation, the Health Advisor accessed the patient as per training which requires ABC's to be accessed as the priority, however due to this a purpuric rash was missed by pathways and an unsuitable disposition was reached.

Complaint	Investigation Findings
remember exactly what I said but, I am sure I mentioned the purple skin rash as well as the mouth symptoms. The algorithm used by 111 took the operative to recommend I consult a dentist in the next few days. If I had followed this advice, it would have put me at great risk of major morbidity even mortality. I had Idiopathic thrombocytopenic purpura with a platelet count of 1. I objected to the decision of the contact who then agreed to pass me on to someone clinical at 111. With a purple rash and bleeding gums- the algorithm should have been set to advice immediate attendance at an A&E, After being transferred by phone by 111 to the OOHs service, I received the correct advice and attended Tunbridge Wells Hospital; A&E. And then received the appropriate emergency in patient treatment.	Taken to pathways user testing, pathways issue rejected. Health Advisor received staff feedback regarding the purpuric rash being missed. The hot topic for Meningitis was also recirculated to all staff. The case has also been discussed with senior clinicians and Operations Managers Clinical. All have the same opinion that Clinical support should have been obtained during the call for advice. There are differing views to whether this is a pathways or training issue as neither pathway would access both symptoms, however all have agreed that the mentioning of the purpuric rash should have been a red flag for the health advisor.

Parliamentary and Health Service Ombudsman

Any complainant dissatisfied with the outcome of a formal investigation into their complaint may take their concerns to the Parliamentary and Health Service Ombudsman (PHSO) for review. When the PHSO's office receives a complaint, they contact the Patient Experience Team to establish whether there is anything further the Trust feels it could do to resolve the issues. If we believe there is, the PHSO will pass the complaint back to the Trust for further work. However, if the Trust believes that local resolution has been exhausted, the PHSO will ask for copies of the complaint file correspondence to review and investigate themselves.

In the year 2019/20 the PHSO contacted the Trust and asked for copies of 11 complaint files, the cases are still with the PHSO being reviewed. There were three cases updated from 2018/19, two of which were not upheld and the third the Trust were asked to write an apology to a complainant as they felt we did not fully explain our findings or provide them with the appropriate reassurances.

Patient Advice and Liaison Service (PALS)

PALS is a confidential service to offer information or support and to answer questions or concerns about the services provided by SECAmb which do not require a formal investigation.

The table below details the number of PALS enquires received by the Trust during 2018/19 and 2019/20:

Type	2018/19	2019/20
Concern	**52**	**57**
Enquiry	**40**	**25**
Information request	**348**	**327**
Total	**440**	**409**

Most requests for information are Subject Access Requests under the Data Protection Act, where patients or their relatives require copies of the patient care record (PCR) completed by our crews when they attended them, or recordings of 999 or NHS111 calls, for a range of reasons. These requests are dealt with in accordance with the General Data Protection Regulations. The implementation of the new Electronic PCR has streamlined this process.

Other contacts are requests for advice and information regarding what to expect from the ambulance service, people wanting to know how they can provide us with information about their specific conditions to keep on file should they need an ambulance, calls about lost property, and on occasion, families wanting to know about their late relatives' last moments.

Monitoring Systems

The Trust has continued to improve the incorporation of the electronic reporting system (Datix) into the complaints process which has improved the ability to produce accurate reports and streamline the audit process. With the purchase of Datix Cloud, the latest most up to date version, it is hoped this will improve further once implemented.

In October 2018 the Trust embedded protocols for the weekly review of all open complaints; the report is sent each Monday to all investigating managers and copied to directors and senior managers, and sets out all open cases under investigation within their areas, this includes a reminder of the due dates for reports to be returned to the Patient Experience Team. This is continually being adapted and improved. This has

helped to prevent complaints from becoming overdue and resulted in a current total number of open complaints for the Trust at the end of the year 2019/20 of 34.

Reporting Arrangements

Monthly compliance of internal complaints timescales is reported to the Trust Board within the Integrated Performance Report. Additional management assurance is also provided to the Quality and Patient Safety Committee. Patient stories are provided to each board meeting and available through the Trust website.

The national return for complaints with the NHS is the KO41a return. This data is submitted on a quarterly basis to the NHS Digital via their online portal.

The Patient Experience Team

The overarching responsibility for complaints, PALS and compliments sits with the Patient Experience Team. The work is diverse and brings the team into contact with many patients and their families, some of whom are struggling with mental illness, disorders or bereavement. Whilst many of these contacts are constructive, there have been occasions when team members have had to deal with highly complex and stressful or distressing situations. Supportive work began with the team in terms of resilience in 2018 and continues, including meeting with the Trust Mental Health Team.

Conclusion and future areas of development

The Trust continues to develop the rigour of complaints investigations. The Head of Patient Safety has developed training for Trust investigators ensuring that all complaints, incidents and serious incidents are investigated, using the appropriate level of investigation, to the same high standard which lead to more tailored and appropriate learning outcomes.

During the Covid-19 pandemic the Patient Experience Team have taken on a greater responsibility for investigating some Level 2 complaints in order to ease the necessity for operational staff to be taken off the road to complete investigations.

South East Coast Ambulance Service NHS

NHS Foundation Trust

Controlled Drugs

Accountable Officer

Annual Report 2019-20

Author: Carol-Anne Davies-Jones, Chief Pharmacist

1. Introduction

1.1. The NHS has embarked on a journey to become one of the safest healthcare systems in the world as part of the NHS Long Term Plan.

1.2. NHS England has a statutory duty to ensure that safe systems are in place for the management and use of controlled drugs. This is to prevent harm to patients and staff from any misuse of controlled drugs.

1.3. Controlled Drugs (CDs) are drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful.

1.4. This is the third Controlled Drug Accountable Officer (CDAO) annual report prepared by South East Coast Ambulance Service (SECAmb). Health and social care organisations are responsible for making sure that they have arrangements in place to assure the safe and effective management of Controlled Drugs (CDs) and for making sure that these systems are working effectively. In addition, all healthcare professionals have a duty to ensure that Controlled Drugs in their own practice are managed safely

1.5. The CDAO for the Trust is the Executive Medical Director who is the Board member with responsibilities for medicines optimisation and controlled drugs. The day to day management of CDs across the Trust is devolved to the Chief Pharmacist who is the Deputy CDAO.

2. Our Statutory Duty

2.1. Controlled Drugs are essential to modern clinical care and are also drugs that are especially addictive and harmful. They include strong painkillers, stimulants, tranquilisers, and anabolic steroids, and are subject to high levels of regulation as a result of government policy.

2.2. There is a degree of complexity surrounding the laws relating to medicines and CDs, but in general terms the main legislative points to note are:

2.3. The Misuse of Drugs Act 1971 (MDA 1971). This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

2.4. The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments). In response to the activities of Dr Harold Shipman legislative changes were introduced into the 2006 Health Bill strengthening the governance arrangements for Controlled Drugs in England.

These arrangements were described in detail in the Controlled Drugs (Supervision of Management and Use) Regulations 2006. This regulation came into force in January 2007. The Controlled Drugs (Supervision of Management and Use) Regulations 2013 came into effect on 1 April 2014 and will cease to have effect at the end of 31st March 2020. The 2013 Regulations contain a sunset clause to provide that they expire on 31st March 2020. Regulation 3 removes this clause. Regulation 4 inserts new regulation 1A which introduces a requirement on the Secretary of State to carry out a statutory review of the 2013 Regulations and to publish a report of that review by 30th March 2025, and to then publish subsequent reports every 5 years.

2.5. The aim of the regulations is to strengthen the governance arrangements for the use and management of controlled drugs. It is essential that NHS England enforces robust arrangements for the management and use of CDs to minimise patient harm, misuse and criminality.

2.6. The Misuse of Drugs Regulations 2001 defines those persons who are authorised to supply and possess controlled drugs while acting in their professional capacities and describes the conditions under which these activities may be carried out. In these regulations' consideration must be given to such activities as supply, possession, prescribing, audit and record keeping relevant to that particular drug

2.7. The Controlled Drugs (CDs) used within SECAmb are:

2.7.1. Morphine sulphate injection (Schedule 2)

2.7.2. Ketamine injection (Schedule 2)

2.7.3. Midazolam injection (Schedule 3)

2.7.4. Diazepam emulsion for injection (e.g. diazemuls) – (Schedule 4 part 1)

2.7.5. Diazepam rectal tubes (Schedule 4 part 1)

2.8. Within the regulations, Trusts are permitted to treat non-CD medicines as CDs if they are considered to carry a risk of dependency or misuse; this may apply on a Trust-wide basis, or at an individual Trust site, and may be a temporary or permanent measure. Similarly, certain CDs may be subject to more stringent controls than is required by their Schedule.

2.9. SECAmb manages all Controlled Drugs under the control levels required of Scheduled 2 Controlled Drugs. This is irrespective of which Controlled Drugs' schedule they fall under. This is to ensure increased control around Controlled Drugs activities within SECAmb. The only exception to this is Diazepam rectal tubes (Schedule 4 part 1).

3. Role of Controlled Drugs Accountable Officer

3.1. Each NHS organisation is required to appoint an CDAO with overall responsibility for the safe use and management of CDs within the organisation. SECAmb as a designated body must appoint a Controlled Drugs Accountable Officer (CDAO) who is responsible for overseeing governance arrangements for management of CDs within SECAmb. The SECAmb CDAO is the Executive Medical Director, who is also a member of the Board.

3.2. The SECAmb CDAO must be registered with Care Quality Commission (CQC). The CQC must be informed when a SECAmb CDAO is removed and a new CDAO appointed.

3.3. The CDAO must ensure that all concerns about incidents that involve or may have involved improper management or use of CDs by a healthcare professional (or other staff, responsible individual or medical practitioner working on behalf of the trust) are properly recorded. This task may be delegated to an appropriate member of staff by the CDAO.

3.4. To ensure that SECAmb complies with all relevant legislation around the storage, supply and use of controlled drugs (CDs).

4. CQC Domains (Safe; Caring; Responsive; Effective; Well led)

4.1. Although Controlled Drugs are addressed under the CQC medicines management standards which are part of the 'safe' CQC domain, these also relate to all the other CQC domains.

4.2. CQC report published August 2019 stated "*The trust had clear systems and processes to safely prescribe, administer, record and store medicines. We found a high standard of audit and quality control processes to monitor the management and administration of medicines. We saw outstanding practice in the management of controlled drugs*".

4.3. The CQC scrutinise and report on how well NHS trusts and other agencies work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people.

4.4. As part of this work the CQC publish their findings annually, together with recommendations on how the safe use and management of CDs can be improved.

5. Controlled Drug License

5.1. The Chief Pharmacist renewed SECAmb Home Office Controlled Drugs license at the beginning of 2019. It was issued in March 2019 and expired in March 2020. A new licence has not been issued as the Home Office will perform a compliance check when COVID restrictions have been lifted. SECAmb continues to work under the conditions

of the previous licence. Chief Pharmacist has contacted Home Office and Controlled Drugs Liaison Officers (CDLOs) about the current arrangement.

5.2. Controlled Drugs in schedules 2, 3, and 4 (part 1) must be denatured before being disposed of. Healthcare staff that are lawfully in possession of these can do so, but should ensure they have a T28 Exemption Certificate from the Environment Agency that allows this on the relevant premises. All denaturing should be witnessed by another person, and in the case of stocks of schedule 2 Controlled Drugs it must be witnessed by a person authorised by an Accountable Officer or Home Office license in accordance with regulation 27(3).

5.3. A T28 license was renewed in the Trust in 2020. T28 Exemptions are valid for 3 years from date of issue.

6. Management of Controlled Drugs

6.1. In responding to the legislation there are essentially four core elements of work:

6.1.1. Developing and implementing robust processes for the use of controlled drugs

6.1.2. Monitoring the use of controlled drugs and making timely and effective interventions when necessary

6.1.3. Assessing the robustness of systems through self-assessment, inspections and audit

6.1.4. Identifying and sharing concerns through the Local Intelligence Network (LIN)

6.2. The following Policies and SOPs are authorised for use at SECAmb to improve the safety, security and governance of controlled drugs. All policies and procedures are in date.

6.2.1. Administration of Controlled Drugs

6.2.2. Controlled Drugs Possession Using Body Worn Pouches

6.2.3. Changing Security Codes for Medicines Storage

6.2.4. Controlled Drug Stock Checks and Reconciliation

6.2.5. Disposal of Controlled Drugs

6.2.6. Expiry Date Checking and Rotation of Medicines

6.2.7. Ordering and Distribution of Medicines (in draft)

6.2.8. Receipt of Medicines from External Suppliers (in draft)

6.2.9. Record Keeping and Controlled Drug Register Entries

6.2.10. Use of the Omnicell Emergency Access Barcode

6.2.11. The Medicines Policy

6.2.12. Controlled Drugs Policy

7. Monitoring the use of Controlled Drugs and Internal Governance

7.1. Any issues or concerns related to Controlled Drugs are often reported via the SECAmb electronic incident reporting system, Datix. These usually relate to the following categories: governance issues (i.e., not following procedures), patient related incidents and unaccounted for Controlled Drugs.

7.2. All incidents involving Controlled Drugs should be reported to the Accountable Officer. This provides assurance that any risks have been mitigated and prompts any action to be taken if they are not. Reporting also allows for the identification of themes in reported incidents from which learning can take place.

7.3. Potential concerns are raised either directly with the Trust's CDAO or Chief Pharmacist or via reported medication incidents from the Trust's Datix database. The CDAO and Chief Pharmacist receive all CD incidents.

7.4. We strongly advocate a 'Just Culture' in which healthcare staff are supported to be open about mistakes to allow valuable lessons to be learnt so the same errors can be prevented from being repeated. We help people to investigate, to reflect, to learn and to take action to prevent a recurrence.

7.5. Example of governance issue is SOP not being followed, patient related issues involved incorrect dosage administered and unaccounted for Controlled Drugs can occur when the member of staff has inadvertently taken home their CDs at the end of their shift.

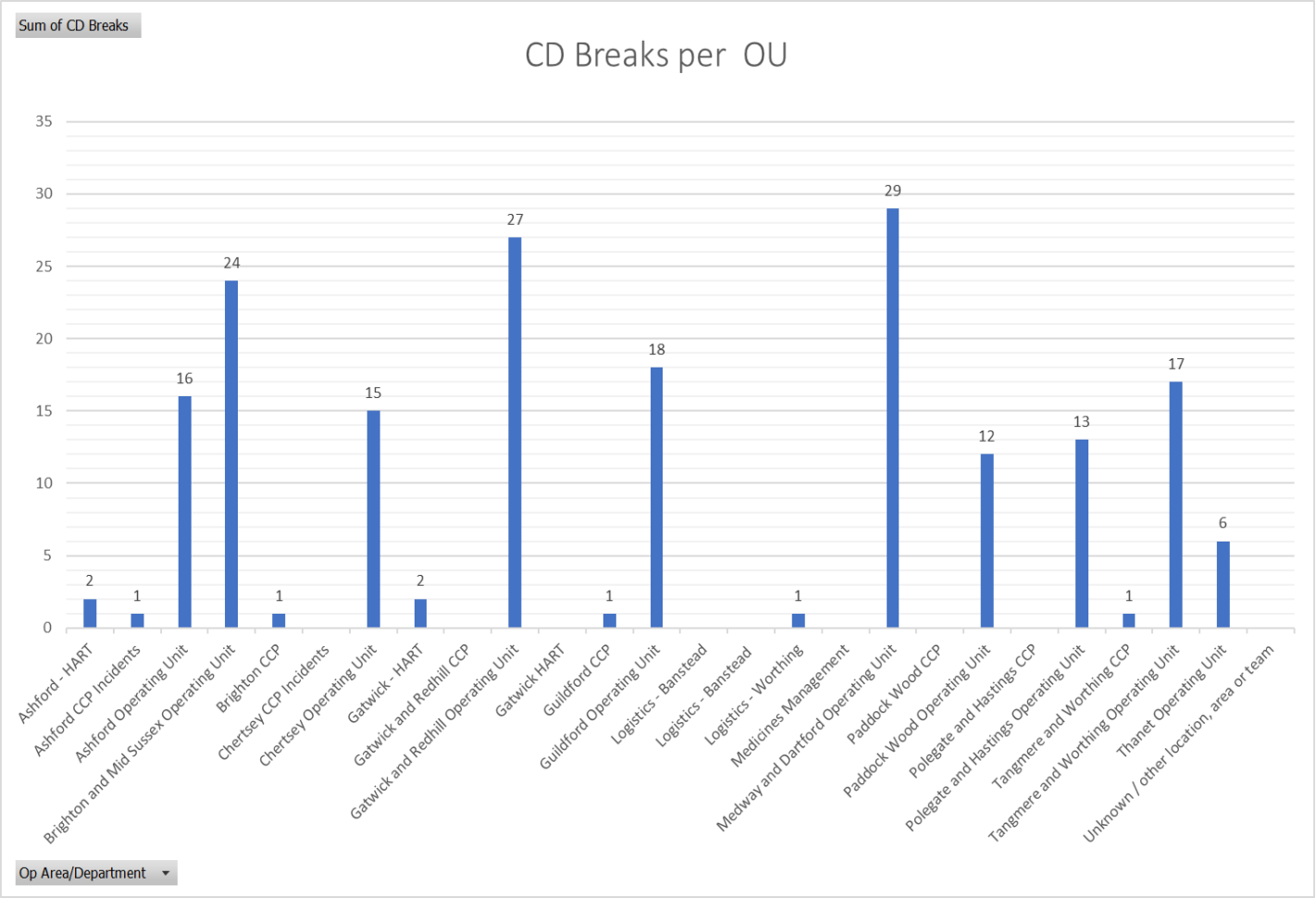
7.6. Chief Pharmacist on behalf of the CDAO continues to maintain a database to allow CD monitoring and auditing. A 'Record of Concerns' regarding relevant individuals is also maintained.

7.7. Number of CD incidents 2019/20

2019/20	Number of CD incidents submitted
Qtr1	**139**
Qtr2	**144**
Qtr3	**122**
Qtr4	**126**
Total	531

7.7.1. The percentage of individual CDs for all category's incidents submitted are as follows:

Controlled Drug	Percentage of incidents reported
Midazolam	4%
Ketamine	5%
Morphine	65%
Diazepam	27%

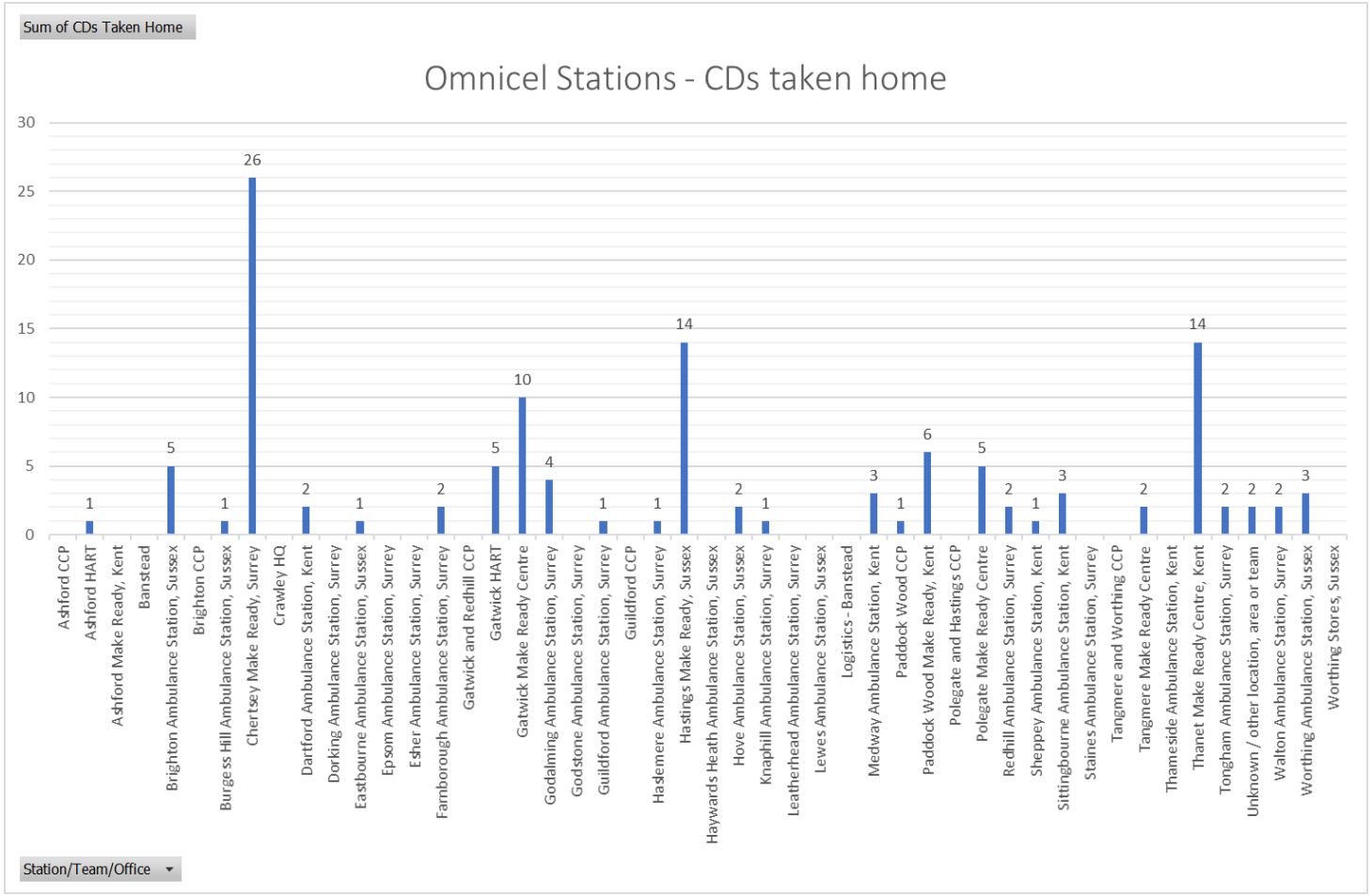


7.8. CD breakages

7.9. CD breakages 72% happened with staff from Omnicell sites. This is mainly due to staff leaving their CDs on the drawers of the Omnicells and they roll off.

Author: Carol-Anne Davies-Jones, Chief Pharmacist

7.10. Three highest areas for CD breakages were in Brighton, Gatwick and Redhill, Medway and Dartford Operating Units.



7.11. Of the CDs taken home the Omnicell sites make up 80% for the year

7.12. High level of CDs taken home in error was at Chertsey OU.

7.13. Other CD incidents submitted included SOP errors, reconciliation errors and 'other' please see appendix D for example of breakdown by station sites.

	Count of CD Breaks	Count of CDs Taken Home	Count of Doop / Wastage Errors	Count of Reconciliation / Discrepancies	Count of Administration Errors
Qtr1	52	35	17	13	3
Qtr2	46	34	17	20	3
Qtr3	39	26	15	21	3
Qtr4	49	27	19	11	4

7.14. Administration errors remains low at 13 an example of incident submitted was an end of life care patient administered 10mg morphine instead of 1.25mg-2.5mg.

7.15. Harm remains a low percentage of CD incidents recorded

Event being reported caused HARM / INJURY	1%
Event being reported caused NO HARM / INJURY	96%
Event being reported was prevented from occurring - NEAR MISS	3%

8. Lessons Learned

8.1. The personal CD pouch system was implemented in October 2017. Although now in operation for over two years there continue to be reports of staff inadvertently taking their CDs home in their pouch. These incidents are recorded as incidents and followed up by local managers. Medicines governance team monitoring for repeat offenders. Chertsey saw a spike in this activity and the CDAO was informed and discussions were held with staff. A repeat offender was interviewed by their Senior Manager and subsequently by the CDAO. This issue has now completely resolved at Chertsey.

8.2. Reporting continues to be very labour intensive for medicines team. The medicine team will be reviewing their ways of reporting on Datix. Communications have been sent to include more information in the Datix reporting system to allow for more detailed and relevant reporting.

8.3. The Medicines Governance Group meets bimonthly, CD reports are presented at each meeting, examples of these reports can be found in Appendix A. The trends all lend themselves towards Omnicell sites. There is a requirement to ensure the rest of the Trust now become electronic due to the potential for incidents that may not be captured from non-Omnicell sites.

8.4. Feedback from staff indicated concern about the policy for destruction of morphine drawn up by front-line staff and then only partially administered, due to patient pain control being achieved by doses less than 10mg. There was some evidence that staff were avoiding DOOP(Destruction of Old Pharmaceutical) process. A review of available DOOP pots is underway with SECAmb with Chief Pharmacist. A company has been commissioned to look at developing multiuse small DOOP pots for use for the duration of each shift. The electronic patient care record to be updated with 'CD witness' box so that all CD waste can be dealt with at the patient's side and not brought back to station sites.

8.5. PowerBI team have created a dashboard providing monthly updated data showing trends in CD audit reports, including CD breakages and medicines incidents involving CDs. The medicines team will continue to work with PowerBI to ensure accurate reporting of CDs for the Trust.

8.6. Omnicell do not have necessary software to accept back CDs to the cabinets due to Omnicells being created for hospitals as dispensing cabinets whereas in prehospital care we withdraw CDs 'just in case'. A Medway Operational Team Leader (OTL) has developed a workaround for the Omnicells utilising Excel analysis software. Following a successful trial the Trust needs to move forward with formalising this across all Omnicell sites. This will reduce errors in returning CDs as it reduces the amount of information on the screen but captures all the information needed.

8.7. The majority of the CD incidents are raised from Omnicell sites leading to concern that incidents may be missed on those sites with manual reporting. The Trust needs to look at electronic systems for non-Omnicell sites to aid reporting. Abloy® have worked with Chief Pharmacist and Operations Improvement hub to instigate pilot project utilising data analysis of their Cliq ® key system to improve CD governance data from non-Omnicell sites within SECAmb. There are currently 15 Omnicell sites and 21 non-Omnicell sites at SECAmb.

8.8. In February 2019 the Chief Pharmacist undertook consultation with medicines team at Paddock Wood medicines distribution centre. One of the drivers for the consultation was for medicines team to receipt in medicines rather than the logistics team, due to errors observed in process relating to safe and secure handling of CDs. The consultation finished in June 2019. As of July 2020 all CDs are now handled by

medicines team at main central stores in Paddock Wood. This has addressed the issues and processes are currently been standardised by trained medicines team.

9. Internal Audits and assurance

9.1. Quarterly Medicines Inspections

9.1.1. The Medicines Governance inspection reviews the safe and secure handling of CDs. Appendix C.

9.2. OTL weekly audits

9.2.1. Reconciliation checks of all CDs, this looks at activity (sign in/out) and administration.

9.2.2. The checks which include the safe and secure handling of CDs are completed weekly using the App on their trust issued iPad. This data is collected across the Trust by the Operations Improvement Hub.

9.3. Unannounced CDLO Inspections

9.3.1. The CDLO will produce a standard report from unannounced visits for the CDAO and Chief Pharmacist.

10. External Governance of the Management of CDs

10.1. SECAmb CDAO and Chief Pharmacist reports to the CDAO for NHS England (Kent, Surrey and Sussex) via quarterly reports and attendance at the Controlled Drugs (CDs) Local Intelligence Network (LIN) meetings.

10.2. Organisations that do have their own Accountable Officer (designated bodies) are required to send a summary of concerns relating to controlled drugs in an 'occurrence report' to the accountable officer at NHS England. This information is requested every three months and can be submitted online at www.cdreporting.co.uk.

10.3. Local agencies are required to share information and intelligence about the use of CDs in the health and social care sector. The CD LIN allows for sharing of information across several organisations including the Care Quality Commission and the police. This provides access to a network where particular concerns can be discussed

10.4. The Medicines Governance team compile a quarterly occurrence report. The occurrence report should contain details of any concerns that the ambulance Trust has regarding its management or use of CDs; or confirmation that it has no concerns to report regarding its management and use of CDs.

10.5. Copies of the quarterly reports to the CD LIN can be found in the **Appendix B**.

10.6. Role Police Controlled Drugs Liaison Officer (CDLO)

10.6.1. The Police Controlled Drugs Liaison Officer (CDLO) may carry out unannounced spot checks of CD reconciliation.

10.6.2. The CDAO or Chief Pharmacist contacts the CDLO for all incidents involving missing CDs.

10.6.3. CDLOs are invited to join Medicines Governance team during their quarterly inspections of ambulance stations when service pressures allow. This provides external scrutiny of Medicines Governance inspections and fosters working relationships with the 6 CDLOs responsible for SECAmb sites

11. Summary and Recommendations

11.1. SECAmb is committed to continuing to improve and align its policies and procedures for the management of medicines including controlled drugs, to ensure that good practice is consistently applied across SECAmb and that all staff are aware of their responsibilities. This is evident from our recent CQC report.

11.2. The Quality and Patient Safety Committee, which reports to the Trust Board, is assured that Controlled Drugs (CDs) are managed to a safe level within SECAmb and comply with the CD regulations. SECAmb needs to continue to be vigilant in its governance of CDs and ensure their safe and appropriate clinical use and to continue to make improvements.

11.3. Work needs to continue with Omnicell Ltd to ensure the CD software is fit for purpose for pre-hospital care. Workarounds are in place, but this can lead to error and so the software needs to be developed and purchased or an alternative product sourced.

11.4. Over half the Trust remains on paper. Main percentage of reporting can be seen from Omnicell sites due to the nature of extraction of the reports. Work needs to continue in replacing all non-Omnicell sites with Omnicells or seeking an alternative electronic register for these sites.

Appendices

Appendix	Title	Document
A	Example of Medicines Governance Group Monthly CD Report	V3.2 - CD Breakages August 2019.docx V3.2 - CD Breakages January 2020.docx
B	Example of Quarterly CD LIN Reports	NHS England Occurrence Report SE
C	Example of Quarterly Medicines Team Inspections Omnicell and Non-Omnicell site	Burgess Hill - Non-Omnicell Station Medway - Omnicell Quarterly Medicines I
D	Example of CD incidents submitted by station sites	Breakdown%20of%20CD%20Incidents%

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**17 September 2020**
Overview of issues/areas covered at the meeting:	This meeting was observed by three member of the Council of Governors and had three primary focusses with each one linking directly to the three BAF risks aligned to the committee: ▪ HR Workstreams – BAF Risk 362 ▪ Workforce Planning and Delivery – BAF Risk 111 ▪ Clinical Education – BAF Risk 1300 **HR Workstreams Update Partial Assurance** E Time Sheets: The committee received the internal audit management letter confirming assurance that we are on course to implement the E-Timesheets project successfully. Specifically, that the intended aims for the project have been clearly outlined and are aligned to wider Trust strategic objectives, and that there is evidence of appropriate stakeholder engagement and project management support, with extensive trials underway to test the robustness of the new system and accuracy of data recorded. Phase 2 of RSM's review will be scheduled to coincide with the completion of the initial trials in order to assess the first roll-out of the e-timesheet system in an operational unit. The committee then heard from management who confirmed the project RAG has moved from Green to Amber, as the pilot for E-timesheet trials has identified a number of risks requiring resolution ahead of go-live. The Executive will hold the Go/No Go meeting, scheduled for the end of October 2020. E Expenses: The RAG for this project is Amber. From management's perspective this is now ready to be rolled out to operational staff; it is already in use for support services, EOC and 111 staff. There is a meeting planned with staff side to seek their support and then this will happen. P Files: The RAG for this project is also Amber. The target date for completion remain December 2020 and the committee explored progress to date, and the key issues and risks. It acknowledged the call on staff at present and the many competing priorities and reinforced the importance that we can be assured in the completion of every personnel file.

There have been a verity of approaches and a further change has begun made possible by the new TrustID system; this provides direct document transfer (no need for scanning) and allows staff to send their documents from home, rather than having to bring them in to work. The committee noted that the issue is predominantly about the eligibility of documents, rather than them being missing and/or lost.

An update will be provided to the committee next time on the overall number of files outstanding and the trajectory to December, including driving licenses which is a separate workstream.

Workforce Resourcing & Delivery **Partial Assurance**
A detailed review was undertaken of this years' workforce plan and the approach going forward to ensure we are fully established. In-year we are circa 40 short against plan. This is impacting the ability to ensure sufficient hours and the underspend against budget (see finance committee report), although the committee did acknowledge the improvement this demonstrates from recent years where the gap was in the hundreds.

A comprehensive paper was also received setting out the different approaches for the rest of this year and in to 2021 and beyond. The committee supported the executive to effectively over-recruit, with the aim of getting nearer the budgeted establishment. It is mindful of the financial risk of this approach and concluded that if it is well planned and targeted to anticipate need, this risk could be managed. This is also acknowledging that currently the gaps are being filled with more expensive resource e.g. PAPs.

Overall WWC supported the approach and thanked the executive for a good set of papers that both described the issues and the solutions.

Clinical Education **Not Assured**
Firstly, and in the context of the earlier workforce discussion, the committee noted the proposal clinical education is exploring to accelerate the workforce plan.

There was then a wide ranging discussion about clinical education, in terms of the improvement plan, the training plan for the year, and key skills. With regards key skills we are just 5% behind plan which is good given the impact of COVID. There are many elements to the improvement plan, one of which being the actions arising from the Future Quals review. There is good confidence in the actions taken to date, but these are quite narrow in scope. The committee remains much less assured with the overall improvements in the delivery of clinical education, reinforced by the recent issues that emerged that require management review; this is subject to a root cause analysis. The papers did not clearly enough define the issues, the actions taken and then specifically how these actions have changed things such that the shortcomings identified will not recur. Management accepted this and at the extraordinary meeting next month an assurance paper will be received, setting this out.

That said, the committee did acknowledge all the efforts of the clinical education team.

	The committee explored how staff are feeling and heard that morale is in some areas still quite low, but the management team is doing much to ensure greater awareness of the issues and what needs to be fixed through regular engagement with the staff. There was also a paper updating the committee on the status of the Higher Education Institute (HEI) partnerships and education programmes with which SECAmb is involved and that are managed by Clinical Education. The committee heard that partnerships with HEIs and with HEE remain good despite a very challenging environment over the last 12 months. Changes to senior roles and reporting structures within Clinical Education, the requirements of the Transforming Clinical Education Project Board, the need to suspend SECAmb's placement provision during the first wave of COVID and issues with the in-service recruitment to SGUL have required considerable focus and effort to overcome. Improved staffing within the Higher Education Team provides an opportunity to restore workstreams that have had to be delayed and to improve wellbeing. There was then a discussion about how we might wish to restructure and simplify the relationships we have the with the various HEIs, to ultimately assure the committee that we manage education training and development in the most cost effective way.
Any other matters the Committee wishes to escalate to the Board	Due to the delay the **Diversity and Inclusion – Workforce Race and Disability Equality Standard Repor**t could only really be noted by the committee. It is annexed to this report for the Board's considered review. The Board should also note the ongoing Payroll tender; a Contract Board is established, and the committee will receive regular updates.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2020 Submission

1. Introduction

1.1. This report provides the outcomes of the 2020 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submitted to NHS England in advance of the 31st August 2020 deadline. Full results are provided in Appendix one.

1.2. The report also sets out the proposed action plan to deliver progress against both the WDES and WRES over the next 12 months.

1.3. The Inclusion Working Group (IWG) monitor the overarching action plan (Appendix two), which is updated each year to maintain and deliver progress against the metrics.

2. Background

2.1. **Workforce Race Equality Standard (WRES)**

2.1.1. The WRES was introduced by the NHS Equality and Diversity Council (EDC) for all NHS Trusts and Clinical Commissioning Groups in April 2015. This was in response to 'The Snowy White Peaks' a report by Roger Kline which provided compelling evidence that barriers, including poor data, are deeply rooted within the culture of the NHS. The report highlights a clear link between workforce diversity of NHS organisations and better patient access, experience, care and outcomes.

2.1.2. The WRES formed part of the standard NHS Contract as of the 1 April 2015. From April 2016 it was also included as part of the CQC inspection standards, and lack of progress against the WRES was highlighted within our most recent CQC report.

The nine WRES metrics cover:

- Four workforce metrics – data provided showing comparison of the experience of Black and Ethnic Minority (BME) employees and candidates
- Four NHS Staff Survey findings – Key Findings 18, 19, 27 and question 23b; all specifically focus on the experience of employees from an Equality and Diversity perspective.
- A metric aimed at achieving a Board that is broadly representative of the population served.

2.2. **The Workforce Disability Equality Standard (WDES)**

2.2.1. The WDES was commissioned by the Equality and Diversity Council (EDC) and developed through a pilot and extensive engagement with Trusts and key stakeholders. It was mandated through the NHS Standard Contract in 2019/20.

2.2.2. Ten evidenced based metrics, (Appendix one) not dissimilar to the WRES, enable NHS organisations to compare the experiences of disabled and non-disabled staff.

This information is to be used to develop local action plans designed to enable demonstrable progress against the indicators of disability equality.

The WDES ten metrics cover:

- Three workforce metrics of which metric one (workforce composition) and metric two (recruitment) replicate the WRES metrics, whereas metric three looks at the likelihood of disabled staff being taken through the formal capability process in comparison to non-disabled staff.
- Six NHS Staff Survey findings
- A metric aimed at comparing the workforce composition against Board representation by
    - voting membership of the Board
    - Executive membership of the Board

2.3. Both WRES and WDES are designed to ensure effective collection, analysis and use of workforce data to address the under-representation and experience of Black Minority Ethnic (BME) and disabled staff across the NHS. Research suggests the experience of minority staff and the extent to which they are valued by their organisations is a very good indicator of both the climate of respect and care for all within NHS trusts, as well as of how well patients are likely to feel cared for.

3. WRES Key findings 2019

3.1. The key findings of the results are provided below:

3.1.1. There has been an increase in the BME workforce from 144 people on 31st March 2019 to 201 people on 31st March 2020. This increase (13.9%) is higher than the overall growth rate of the organisation (6.92%) and BME staff now make up 5% of all Trust staff. The progress is the largest percentage increase in a single year since we began reporting against the WRES in 2015. However, the Trust continues to be unrepresentative of the population it serves.

10.3% staff in non-clinical roles are from a BME background in comparison to 3.3% within clinical. The increase within clinical roles may be attributed to international recruitment and a diversifying of registered clinicians and allied health professionals in SECAmb with the introduction of the Clinical Assessment Team in EOC and 111. Overall increases in support services may have benefitted from the location of Trust Headquarters in a more ethnically diverse area and change in EOC/111 workforce strategy.

The area served generally has a lower ethnic diversity than the England average of 20.2 %, and South East England (SEE) at 14.8%, except North West Surrey, which is higher, and Crawley, and Dartford and Gravesham that are on a par. Surrey Downs is higher than the SEE, and 4 CCGs listed below are on a par with or close to SEE. These results fit with SEE at 14.8%. which has a lower than England average.

- North West Surrey 20.7% (above England)
- Crawley 20.1% (=England)
- Dartford, Gravesham and Swanley (=England)
- Surrey Downs 15.9% (above SEE)
- Surrey Heath 14.5%
- Medway 14.5%
- Guildford and Waverley 14.1%
- East Surrey 13.7%

	Non Clinical 2020			Clinical 2020		
	White	BME	Not Stated/ Not Given	White	BME	Not Stated/ Not Given
Total HC by ethnicity	866	103	33	2854	98	63
Percentage by ethnicity	86.43%	10.28%	3.29%	94.66%	3.25%	2.09%
Total Clinical HC	1002			3015		
	Non Clinical 2019			Clinical 2019		
	White	BME	Not Stated/ Not Given	White	BME	Not Stated/ Not Given
Total HC by ethnicity	1161	77	41	2336	67	73
Percentage by ethnicity	90.77%	6.02%	3.21%	94.35%	2.71%	2.95%
Total Non- Clinical	1279			2476		

Table one: Ethnicity breakdown for 2019 and 2020 by clinical and non-clinical workforce.

The table above shows the workforce as at 31st March 2019 and 2020, showing a 34% growth in the BME workforce in Non-Clinical, now showing at 10.28% of the non-clinical workforce overall. Some of these increases maybe a result of new roles due to the increase in organisational size over the past 12 months, which will have been supported by the location of the Trust Headquarters in one of the more ethnically diverse areas in our patch. There was a 46% growth in the BME workforce in Clinical taking the BME workforce in this area to 3.25% overall. It is likely that this is partly a result of the diversification of clinical roles across the Operations directorate. Appendix three provides a breakdown of staff by ethnicity by directorate and OU.

Despite an overall increase in BME headcount, there is a need to identify possible retention issues, with BME staff making up over 10% of all leavers in the last financial year. Appendix four provides a breakdown of Trust leavers by OU and directorate, and also shows that BME staff were 1.79 times more likely to leave the organisation than their White counterparts.

3.1.2. Metric two of the WRES measures the likelihood of BME candidates from shortlisting being appointed in comparison to their White counterparts. This figure continues to show that BME candidates are less likely to be appointed from shortlisting than their White counterparts in SECAmb, but there has been progress made. In 2019/20 BME staff were 1.31 times less likely to be appointed. This is a reduction from 1.54 times less likely in 2018/19.

Employee recruitment by race	2018-19						2019-20					
	Application		Shortlisted		Appointed		Application		Shortlisted		Appointed	
	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%

White	7757	85.67%	5484	89.70%	1445	93.05%	7675	82.60%	3697	87.78%	1005	90.20%
BME	1173	12.96%	554	9.06%	95	6.12%	1455	15.50%	461	11.00%	95	8.40%
Undisclosed	124	1.37%	76	1.24%	13	0.84%	145	1.50%	52	1.20%	11	0.90%
Total	9054	100.00%	6114	100%	1553	100%	9275	99.60%	4210	99.98%	1111	99.50%

Table two: Employee recruitment by ethnicity breakdown for 2018-19 and 2019-20

3.1.3. The table above shows the number of applicants at each stage of the recruitment process, and we can see there is around a 2% increase in candidates from a BME background at application, shortlisting and appointment stage in 2019/20.

It is difficult to attribute this improvement to any one specific intervention, however over the last year there has been a more conscious effort to ensure diversity in the imagery used by the Trust as this is known to create a sense of belonging and ability for candidates to see themselves within an organisation. This alongside the increased diversity in roles may have supported this increase.

In July 2020, the IWG noted that 60% of interviews in the Trust continued to be conducted by colleagues who have not received interview/ assessment centre training. With the support of the Executive Management Board, the HR directorate have been able to put in place actions to address this with a completion date of January 2021 to increase the numbers of trained staff who can support the interview process. It is hoped that by ensuring all staff who undertake interviews are appropriately trained we will be able to reduce the likelihood of White staff being appointed over BME staff, achieving parity in this metric and bring about greater equity in the recruitment process.

3.1.4. The 2019/20 figures show that BME staff continue to have an increased likelihood of being taken through the formal disciplinary process in comparison to White colleagues. However, there has been a significant reduction in this over the past 12 months. In 2019/20 BME staff were 1.25 times more likely to be taken through a formal disciplinary. This is down from 2.27 times more likely in 2018/19. As this is calculated on a two-year rolling average this equates to a total of eight cases over a two-year period involving BME staff, of which two were in the last 12 months.

Although, the numbers are small, the figures are calculated as a ratio and therefore comparable with data for employees who have declared ethnicity as White.

	Likelihood of White staff entering the formal disciplinary process	Likelihood of BME staff entering the formal disciplinary process	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff
SECAmb 2020	1.59%	1.99%	1.25
SECAmb 2019	1.83%	4.16%	2.27
SECAmb 2018	1.94%	3.12%	1.61
SECAmb 2017	1.99%	1.65%	0.83

Table three: Relative likelihood for BME staff entering the formal disciplinary process compared to white staff

The NHS England report A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce notes that although there have been year on year improvements against the WRES metrics generally, only ambulance trusts continue to see deterioration against this metric. However, the sector average for this metric in 2019 was 1.39 against a national average of 1.22.

3.1.5. The 2019/20 data continues to show a decline in relation to BME staff undertaking non-mandatory training and CPD in comparison with White colleagues. In the 2018/19 reporting period, BME staff were 1.14 times less likely to access non-mandatory training and this has dropped further to 1.37 times less likely.

SECAmb reports against all non-mandatory training and Continuing Professional Development (CPD) recorded on Online Learning Management (OLM) system. Lack of capacity within the Organisation Development team saw a pause placed on all in house non-mandatory training in 2018/19 and although a relaunch of the first line managers programme did take place in March 2020, this has had to be paused again due to COVID19.

3.1.6. Three out of four staff survey related metrics saw improvements in BME staff experience in this reporting period. The 2019 staff survey saw an increased completion rate by BME staff with 96 respondents identifying as BME up from 73 the previous year. This made up 4.6% of the total survey responses for 2019 and 52% of BME staff in the organisation overall (based on ESR data for BME staff in September 2019).

3.1.7. Metric five, the 2019 staff survey saw a very small decrease in White staff experiencing harassment, bullying and abuse from members of the public / patients but an 8% increase for BME staff. This third consecutive increase fits with national reports of increased levels of hate crime towards BME people in England and Wales and anecdotal reports from members of the Trust BME staff network. In 2019, 42.1% of BME staff reported experiencing harassment, bullying and abuse from members of the public / patients, up from 34% the previous year. For White staff this figure was 48.1% in 2019 down from 49.3% in 2018.

Ambulance trusts observed the highest rates of harassment, bullying or abuse from patients, relatives or the public, for both BME (39.4%) and White (47.7%) staff.

3.1.8. The latest staff survey figures show that for metric six, there were improvements for both BME and White staff. In 2019, 26% of BME staff and 30% White staff experienced harassment, bullying and abuse from colleagues. There was an 10% decrease for BME staff reporting against this indicator and a 5% decrease for White staff.

3.1.9. Metric seven noted an increase in both BME and White staff believing the Trust provides equal opportunities for career progression. This figure increased from 47% to 55% in the 2019 staff survey for BME staff. However, the increase for White staff was smaller, and negative comments within the qualitative feedback were noted around promotion of national positive action schemes from the NHS Leadership Academy. In the 2019 survey, 66% of White staff believed the Trust provided equal opportunities for career progression.

However, these improved figures continue to be well below the NHS averages of 69.9% (BME staff) which has seen a year-on-year deterioration in this statistic since

2015 and 86.3% for White staff. Ambulance trusts remain the worst performers overall for both BME (56.2%) and White (71.1%) staff believing that their organisation provides equal opportunities for career progression or promotion.

3.1.10. Both BME and White staff reported lower levels of discrimination from a manager / team leader or other colleagues in this reporting period. This was down from 23% in the 2018 staff survey to 15.8% for BME staff in 2019. White staff reported a small decrease 13.2% to 11.5%.

Despite being the only sector to report an improvement against this data in both 2018 and 2019, ambulance trusts reported the highest percentage of BME staff experiencing discrimination from a manager / team leader or other colleagues at 17.2% (BME staff) and 10.5% (white staff) nationally.

3.1.11. The Trust reported an improvement in Board diversity for this reporting period, and we continue to have 100% declaration of ethnicity at Board level.

3.2. The NHS Long term plan has set out a clear commitment to the WRES, funding this workstream until 2025. As part of this, every NHS organisation will be required to set a target for Black, Asian and Minority ethnic (BAME) representation across its leadership team and workforce by 2021/22, aiming to ensure that senior teams more closely represent the diversity of the communities they serve.

3.3. In addition, the NHS People Plan, published on 30th July also focusses on the need for organisational leaders to take action and create an organisational culture where everyone feels they belong – in particular to improve the experience of our people from Black, Asian, and Minority Ethnic (BAME) backgrounds. There is evidence that where an NHS workforce is representative of the community that it serves, patient care and the overall patient experience is more personalised and improves.

4. WDES Key findings 2019

4.1. The key findings of the Trust's WDES results are provided below;

4.1.1. Metric one looks at the number of staff by disability, non-disability and no disability declaration as recorded on the Electronic Staff Record (ESR)

The Trust has reported a 3.5% disability declaration on ESR against an NHS average of 3%, however this is in contrast to a Trust declaration of 27% (564 responses) on the 2019 NHS staff survey. Unlike other sectors of the NHS, our Trust and the wider ambulance sector report a decline in declaration as pay band increases, and an increase in those choosing not to declare. This is illustrated in the data below (table four).

Reasons for non-declaration are numerous, including lack of understanding for disclosure; an individual's perception of their disability, access to systems to update, lack of trust / fear that declarations would be accessed inappropriately. The level of disability declaration via ESR dropped in 2019/20 but increased in the 2019 staff survey.

As per the wider national picture in England, Unknown/Null declarations increased with seniority in SECAmb.

4.1.2. Metric two of the WDES measures the likelihood of disabled candidates from shortlisting being appointed in comparison to their non-disabled counterparts.

At 1.02 this figure shows parity in that our disabled candidates are as likely to be appointed from shortlisting as their non-disabled counterparts. The Trust operates a disability confident scheme which guarantees an interview for candidates declaring a disability who meet the essential criteria. There is a small improvement in this area from the 2019 figure of 1.08, but we are unable to attribute this improvement to any specific action taken. It is possible that the improvement may have been as a result of increased focus on reasonable adjustments and an awareness of the need to support candidates in this area.

The Trust is performing well against this metric nationally which sees that Non-disabled job applicants were more likely to be appointed from shortlisting compared to disabled applicants (relative likelihood of 1.23) and in comparison to the ambulance sector average which also identified that Non-disabled job applicants were more likely to be appointed.

	Clinical 2020							
	Disabled		Non - disabled		Unknown/Null		Overall	
	H/C	%	H/C	%	H/C	%	H/C	%
Cluster 1 (Bands 1 - 4)	43	2.5%	639	62.8%	571	34.7%	1253	41.6%
Cluster 2 (Band 5 - 7)	56	3.2%	1122	69.6%	534	27.2%	1712	56.8%
Cluster 3 (Bands 8a - 8b)	2	9.1%	32	65.9%	12	25.0%	46	1.5%
Cluster 4 (Bands 8c - 9 & VSM)	0	0.0%	1	33.3%	3	66.7%	4	0.1%
Cluster 5 (Medical & Dental Staff, Consultants)	0	0%	0	0%	0	0%	0	0.0%
Clinical totals	101	3.3%	1794	59.5%	1120	37.1%	3015	75.1%
	Non-clincal 2020							
	Disabled		Non - disabled		Unknown/Null		Overall	
	H/C	%	H/C	%	H/C	%	H/C	%
Cluster 1 (Bands 1 - 4)	19	4.8%	157	56.2%	246	39.0%	422	42.1%
Cluster 2 (Band 5 - 7)	16	5.3%	246	61.8%	195	32.9%	457	45.6%
Cluster 3 (Bands 8a - 8b)	5	4.4%	37	50.0%	42	45.6%	84	8.4%
Cluster 4 (Bands 8c - 9 & VSM)	1	2.3%	18	43.2%	20	54.5%	39	3.9%
Non-clinical totals	41	4.1%	458	45.7%	503	50.2%	1002	24.9%
Totals	**142**	**3.5%**	**2252**	**56.1%**	**1623**	**40.4%**	**4017**	**100%**

Table four: WDES metric 1, Workforce data

4.1.3. Metric three measures the number of staff taken through the formal capability process based upon a rolling two-year average. Data analysis ahead of reporting showed an average of six formal capability cases in the last two years, none declared a disability and three declared no disability. As a result, the Trust has reported a figure of 0 against this metric.

4.1.4. Metrics four to nine use data taken from the NHS staff survey results. This year 564 (27%) of respondents declared a disability, and 1,512 (73%) of respondents stated they did not have a disability. In comparison, ESR declaration rates show 40% of staff do not have a disability declaration recorded, whereas only 32 respondents skipped the anonymised disability declaration on the staff survey.

4.1.5. Metric four, looks at the percentage of staff experiencing harassment, bullying or abuse from; patients/service users, their relatives or other members of the public; managers; from other colleagues in the last 12 months.

In all cases, the data shows that disabled staff are more likely to experience harassment, bullying or abuse, and that this was most likely to come from patients/service users, their relatives or members of the public. However, all of the results were an improvement on data from the previous year and results also showed that disabled staff were slightly more likely than non-disabled staff to report the behaviours experienced at 40.8% to 39.6%. This was also reflected in the WDES annual report (published March 2020) which showed that both disabled and non-disabled staff at ambulance trusts reported the highest rates of harassment, bullying or abuse from patients/service users, relatives or other members of the public (52.7% for disabled staff compared to 47.01% for non-disabled staff).

		Disabled		Non - disabled	
		H/C	%	H/C	%
4	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	556	52.50%	1509	46.1%
	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	557	30.70%	1502	15.4%
	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	548	28.10%	1474	16.8%
	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	342	40.10%	737	39.6%

Table five: WDES metric 4, Workforce experience of harassment, bullying or abuse as taken from 2019 staff survey.

4.1.6. Metric five, the 2019 staff survey showed that fewer disabled staff than non-disabled staff believe that the Trust provides equal opportunities for career progression with an increasing difference of 12% overall. This figure was 56.2% (down 1%) for disabled staff and 68.7% for non-disabled staff. This is in comparison to 64% for the Trust overall.

4.1.7. The latest staff survey figures show that for metric six, 9.4% more disabled staff than non-disabled staff said they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, at 39.7%. However, there is an improvement in this area for both disabled and non-disabled staff from the 2018 staff survey results. There was also a similar difference in the percentage of disabled staff (27.8%) vs non-disabled staff (34.1%) who report they are satisfied with the extent to which their organisation values their work.

Nationally, compared to other trust types, ambulance trusts had significantly more disabled staff (48.12%) who reported feeling pressure from their manager to come to work against 32% in England overall.

4.1.8. Metric eight looks at the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. The question is taken from the NHS staff survey and differs from the Equality Act 2010 wording which requires employers to provide reasonable adjustments. 62.7% of staff who declared a

disability in the survey responded positively and stated the Trust had made adequate adjustments., This metric also recorded an improvement on the previous year from 58.6% in 2018.

4.1.9. Metric nine is split into two parts and looks at the overall engagement score from the NHS staff survey for disabled and non-disabled staff. As per the other survey scores, the score for disabled staff was lower than the score for non-disabled staff at 5.8 and 6.4. The second part of the metric (9b) asks “Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?”. The Trust is able to respond positively to this question having relaunched the Enable network in 2018.

4.1.10. Metric 10 reported 100% disability declaration at Board level. 13% of Board members declared a disability.

5. Next steps

5.1. A meeting of Inclusion Working Group members and subject matter experts convened on 20th July 2019 to review results and propose actions to deliver further progress over the coming year. This was discussed and approved by an extraordinary IWG on 28th August.

5.2. It was agreed that the action plan for WRES, WDES would be combined and integrated with the action plan for the Trust Equality Objective (‘The Trust will improve the diversity of the workforce to make it more representative of the population we serve’). Progress against this is monitored and reviewed at IWG meetings, with regular reports going to the HR Working Group.

5.3. The Workforce Wellbeing Committee (WWC) are asked to note the contents of this report. Additionally, the WWC is asked to support progress against this work by monitoring progress at appropriate intervals.

5.4. The Trust Board will be asked to approve publication of this report.

Report prepared by : Asmina Islam Chowdhury, Inclusion Manager

Appendix One, Workforce Race Equality Standard 2016-2020

			2015	2016	2017	2018	2019	2020
Metric 1	**Overall workforce headcount**		3527	3262	3483	3337	3757	4017
	Overall % visible BME		2.30%	3.03%	3.59%	3.84%	3.80%	5.00%
	BME headcount		82	99	125	128	144	201
Metric 2 - Relative likelihood of white candidates being appointed from shortlisting compared to BAME			1.8	3.84	1.26	1.57	1.54	1.31
Metric 3 - Relative likelihood of BAME staff entering formal disciplinary process compared to white staff			0.65	1.08	0.82	1.6	2.27	1.25
Metric 4 - Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME			1.32	1.23	1.36	0.84	1.14	1.37
Metric 5 - KF 25. Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.		**BME**	52.00 %	39.39 %	58.82 %	30.77%	34.00%	42.10%
		WHITE				51.00%	49.30%	48.10%
Metric 6 - KF 26. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months.		**BME**	30.77 %	27.27 %	44.12 %	32.69%	36.00%	26.00%
		WHITE				42.10%	35.00%	30.00%
Metric 7 - KF 21. Percentage of BME staff believing that Trust provides equal opportunities for career progression or promotion.		**BME**	50.00 %	66.67 %	48.00 %	61.29%	47.00%	55.20%
		WHITE				60.20%	65.70%	66.00%
Metric 8 - Percentage of BME staff who have		**BME**	32.00 %	15.63 %	27.27 %	13.00%	23.00%	15.80%

personally experienced discrimination at work in the last 12 months from Manager / team leader or other colleagues		**WHITE**				15.80%	13.20%	11.50%
Metric 9 - Board representation	**White**			-	69.23 %	100.00 %	100.00 %	93.30%
	BME			-	0.00%	0.00%	0.00%	6.70%
	NULL			-	30.77 %	0.00%	0.00%	0.00%

WRES 2020 - metric 1

Please note, due to small numbers, data for consultants and any payband where the numvers are below 5 have been replaced with an asterisk has been removed.

	Non-Clinical 2020				Non-Clinical 2020%			Clinical 2020				Clinical 2020 %		
	WHITE	BME	Not Stated/ Not Given	totals	WHITE	BME	Not Stated/ Not Given	WHITE	BME	Not Stated/ Not Given	Totals	WHITE	BME	Not Stated/ Not Given
Under Band 1	0	0	0	0	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 1	0	0	0	0	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 2	42	9	0	51	82.4%	17.6%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 3	216	24	7	247	87.4%	9.7%	2.8%	869	28	11	908	95.7%	3.1%	1.2%
Band 4	109	11	*	124	87.9%	8.9%	3.2%	329	14	2	345	95.4%	4.1%	0.6%
Band 5	134	10	8	152	88.2%	6.6%	5.3%	694	18	18	730	95.1%	2.5%	2.5%
Band 6	147	28	*	179	82.1%	15.6%	2.2%	589	27	14	630	93.5%	4.3%	2.2%
Band 7	110	13	*	126	87.3%	10.3%	2.4%	324	11	17	352	92.0%	3.1%	4.8%
Band 8A	49	*	*	55	89.1%	5.5%	5.5%	32	0	*	33	0.0%	0.0%	0.0%
Band 8B	24	*	*	29	82.8%	6.9%	10.3%	13	0	0	13	100.0%	0.0%	0.0%
Band 8C	14	*	*	16	87.5%	6.3%	6.3%	*	0	0	*	0.0%	0.0%	0.0%
Band 8D	9	*	0	10	90.0%	10.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 9	*	0	0	*	100.0%	0.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
VSM	10	*	0	11	90.9%	9.1%	0.0%	*	0	0	*	0.0%	0.0%	0.0%
Total	**866**	**103**	**33**					**2854**	**98**	**63**				
Percentage	**86.43%**	**10.28%**	**3.29%**					**94.66%**	**3.25%**	**2.09%**				
Total Clinical	**1002**							**3015**						

	Non-Clinical 2019				Non-Clinical 2019 %			Clinical 2019				Clinical 2019 %		
	WHITE	BME	Not Stated/ Not Given	Totals	WHITE	BME	Not Stated/ Not Given	WHITE	BME	Not Stated/ Not Given	totals	WHITE	BME	Not Stated/ Not Given
Under Band 1	0	0	0	0	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 1	*	0	0	*	100.0%	0.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 2	189	15	10	214	88.3%	7.0%	4.7%	0	0	0	0	0.0%	0.0%	0.0%
Band 3	267	12	*	281	95.0%	4.3%	0.7%	603	15	9	627	96.2%	2.4%	1.4%
Band 4	222	15	8	245	90.6%	6.1%	3.3%	219	5	*	226	96.9%	2.2%	0.9%
Band 5	147	9	6	162	90.7%	5.6%	3.7%	484	9	19	512	94.5%	1.8%	3.7%
Band 6	132	9	*	143	92.3%	6.3%	1.4%	699	27	21	747	93.6%	3.6%	2.8%
Band 7	113	10	5	128	88.3%	7.8%	3.9%	287	11	19	317	90.5%	3.5%	6.0%
Band 8A	33	*	*	39	84.6%	7.7%	7.7%	27	0	*	30	0.0%	0.0%	0.0%
Band 8B	24	*	*	29	82.8%	6.9%	10.3%	14	0	0	14	100.0%	0.0%	0.0%
Band 8C	15	*	*	17	88.2%	5.9%	5.9%	*	0	0	*	0.0%	0.0%	0.0%
Band 8D	5	*	0	6	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0.0%	0.0%
Band 9	*	0	*	*	75.0%	0.0%	25.0%	0	0	0	0	0.0%	0.0%	0.0%
VSM	9	0	0	9	100.0%	0.0%	0.0%	*	0	0	*	0.0%	0.0%	0.0%
Total	**1161**	**77**	**41**					2336	67	73				
Percentage	**90.77%**	**6.02%**	**3.21%**					94.35%	2.71%	2.95%				
Total Non-Clinical	**1279**							**2476**						

Workforce Disability Equality Standard 2020

		Clinical 2019								Clinical 2020							
		Disabled		Non - disabled		Unknown/Null		Overall		Disabled		Non - disabled		Unknown/Null		Overall	
		H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%
	Cluster 1 (Bands 1 - 4)	21	2.5%	535	62.8%	296	34.7%	852	34.4%	43	2.5%	639	62.8%	571	34.7%	1253	41.6%
	Cluster 2 (Band 5 - 7)	51	3.2%	1098	69.6%	429	27.2%	1578	63.7%	56	3.2%	1122	69.6%	534	27.2%	1712	56.8%
	Cluster 3 (Bands 8a - 8b)	4	9.1%	29	65.9%	11	25.0%	44	1.8%	2	9.1%	32	65.9%	12	25.0%	46	1.5%
	Cluster 4 (Bands 8c - 9 & VSM)	0	0.0%	1	33.3%	2	66.7%	3	0.1%	0	0.0%	1	33.3%	3	66.7%	4	0.1%
	Cluster 5 (Medical & Dental Staff, Consultants)	0	0%	0	0%	0	0%	0	0.0%	0	0%	0	0%	0	0%	0	0.0%
1	Clinical totals	76	3.1%	1663	67.1%	738	29.8%	2477	65.8%	101	3.3%	1794	59.5%	1120	37.1%	3015	75.1%
		Non-clincal 2019								Non-clincal 2020							
		Disabled		Non - disabled		Unknown/Null		Overall		Disabled		Non - disabled		Unknown/Null		Overall	
		H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%	H/C	%
	Cluster 1 (Bands 1 - 4)	36	4.8%	418	56.2%	290	39.0%	744	57.8%	19	4.8%	157	56.2%	246	39.0%	422	42.1%
	Cluster 2 (Band 5 - 7)	23	5.3%	267	61.8%	142	32.9%	432	33.5%	16	5.3%	246	61.8%	195	32.9%	457	45.6%
	Cluster 3 (Bands 8a - 8b)	3	4.4%	34	50.0%	31	45.6%	68	5.3%	5	4.4%	37	50.0%	42	45.6%	84	8.4%
	Cluster 4 (Bands 8c - 9 & VSM)	1	2.3%	19	43.2%	24	54.5%	44	3.4%	1	2.3%	18	43.2%	20	54.5%	39	3.9%
	Non-clinical totals	63	4.9%	738	57.3%	487	37.8%	1288	34.2%	41	4.1%	458	45.7%	503	50.2%	1002	24.9%
	Totals	**139**	**3.7%**	**2401**	**63.8%**	**1225**	**32.5%**	**3765**	**100%**	**142**	**3.5%**	**2252**	**56.1%**	**1623**	**40.4%**	**4017**	**100%**

2	Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.	1.08				1.02			
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0				0			
		Disabled		**Non - disabled**		**Disabled**		**Non - disabled**	
		H/C	**%**	**H/C**	**%**	**H/C**	**%**	**H/C**	**%**
	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	435	53.80%	1283	47.0%	556	52.50%	1509	46.1%
	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	434	33.20%	1278	20.2%	557	30.70%	1502	15.4%
	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	434	28.60%	1270	18.9%	548	28.10%	1474	16.8%

	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	261	37.50%	630	37.8%	342	40.10%	737	39.6%
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion.	322	57.10%	882	67.5%	390	56.20%	1001	68.7%
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	337	42.70%	758	33.1%	463	39.70%	897	30.3%
7	% staff saying that they are satisfied with the extent to which their organisation values their work.	437	20.80%	1282	30.3%	564	27.80%	1500	34.1%
8	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	263	58.60%			354	62.70%		
9a	The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	439	5.7	1291	6.3	564	5.8	1512	6.4

9b	Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes) or (no)	Yes				Yes			
10		**Disabled**	**Non - disabled**	**Unknown/Null**	**Overall**	**Disabled**	**Non - disabled**	**Unknown/Null**	**Overall**
	Difference (Total Board - Overall workforce)	3%	-51%	49%		10%	31%	-40%	
	Difference (Voting membership - Overall Workforce)	9%	-39%	30%		21%	19%	-40%	
	Difference (Executive membership - Overall Workforce)	-4%	-35%	39%		11%	30%	-40%	

Appendix Two. Integrated equality action plan 2020-21

Equality objective 2017-2021 - "The Trust will improve the diversity of the workforce to make it more representative of the population we serve"

This action plan combines actions to deliver improvements against the Trust equality objective, WRES, WDES and Gender Pay Audit.

Action	Aim	Lead	Linked to metric	Recommended timescales
1. Increase the diversity of the Board across both the Executive and Non-Executive team with an aim to increase both gender and ethnic diversity.	To acheive a Board representative of the communities we serve, with a particular focus gender and ethnicity. Board ethnic diversity currently 6.9% (1/16) BME Board gender diversity currently 19% (3/16) female	Chief Executive Officer and Trust Chair	WRES metric 1 and 9 Equality delivery system 3.1	July 2021 (extended from August 2020)
2. Develop and implement an Associate Non-Executive Director programme.	To develop a pool of Black, Asian and Minority Ethnic Associate NED's that will benefit both SECAmb and our wider region. At present, only 4.6% of posts at 8a and above are held by BAME staff.	Company Secretary	WRES metric 1 and 9 Equality delivery system 3.1	December 2020 (extended from April 2020)
3. Work with NHS partners in an area of high ethnic diversity to deliver a multi-agency careers and recruitment event.	To increase recruitment from underrepresented BME communities by engaging with NHS partners to deliver a collaborative recruitment open day. At present, only 5% of our total workforce is from a BME background	Operating Unit Manager/ Head of Workforce	WRES Metric 1 and 2, WDES metric 1 and 2, Equality delivery system 3.1	April 2021 (extended from August 2020)
4. Identify and mitigate barriers to having work experience placements within SECAmb.	To implement a process to enable to young people with disabilities to take up work placements within	Head of Workforce	WRES Metric 2, WDES metric 2 Equality delivery	Dec 2020 (extended from Dec 2019)

	SECAmb and help us progress towards being a Disability Confident level (3) employer. 3.5% of staff currently declare a disability. 40.4% staff choose not to declare.		system 3.1 and 3.6	
5. Develop a model of community engagement with under-represented community groups	To increase engagement with BME and other underrepresented groups, develop community relationships and diversify our talent pool.	Head of Workforce	WRES Metric 1 and 2, WDES metric 1 and 2, Equality delivery system 3.1	April 2021
6. Establish a multi-disciplinary panel to review cases ahead of progressing to a formal disciplinary/ capability investigation.	Ensure an equitable application of disciplinary and capability policies. Staff from a BME background are 1.25 times more likely to be taken through a formal disciplinary process than their White colleagues	Head of Employee Relations	WRES Metric 3, WDES metric 3 Equality delivery system 3.4	Dec 2020 (extended from 31st August 2020)
7. Launch, communicate and regularly audit the new Trust wide exit interview process which will ensure all staff receive a telephone / face to face exit interview.	To identify potential training needs, trends and learning to maximise staff retention.	HR Special Projects	WRES metric 1 WDES metrics 1, 7, 8 and 9a, Equality delivery system 3.6	End of Sept 2020 (revised from end Q4 2019)
8. Devise and deliver an awareness campaign that demonstrates the value of workforce diversity monitoring across the Trust.	Increase diversity declaration rates on ESR across the Trust to better understand and meet the needs of our workforce.	Head of Workforce	WRES Metric 1, WDES metric 1 Equality delivery system 3.6	31st March 2021 (revised and extended from 31st March 2019)
9. The Trust will support the delivery of the following positive action programmes as previously agreed; • Reverse mentoring • Springboard Women's Leadership programme	To create a level playing field and more equitable outcomes to support development of those belonging to underrepresented groups within SECAmb	Inclusion Manager	WRES 1, 2,4,8 and Gender Pay Gap	April 2021 NB. Stepping up does not have a virtual delivery format at present.

• NHS Leadership Academy Stepping Up Programme				
10. Design and implement a process to ensure diversity within interview panels and assessment centres.	To provide a better candidate experience, decrease the impact of unconscious bias and pro- group favouritism in the hiring process and imbalance between certain groups.	Head of Workforce	WRES metric 1, 2 and 8	January 2021
11. Develop an inclusive Comms and Engagement strategy which has a clear plan to promote inclusiveness and create a culture of diversity	Promoting SECAmb as an accessible and inclusive employer of choice and service provider, thereby attracting a more diverse pool of candidates, promoting a positive workplace culture and better patient experience.	Head of Comms.	WRES metric 1, 2, 6,7,8 and 9, Gender pay gap	March 2021
12. To develop and implement a Flexible Working Charter and a new role for a Senior Flexible Working Champion.	Promoting SECAmb as an inclusive employer of choice, improve job satisfaction, retention, wellbeing, and employee engagement.	Head of HR BP's	Gender Pay Gap, Equality delivery system 3.2, 3.5 and 3.6	January 2021

The following actions from the 2019-20 have been reviewed by the IWG and recommended for closure as they have been completed, superseded or integrated into Business as usual processes.

Actions for closure	Aim	Lead	Linked to metric	Current timescales	timescales	Action status
1. Develop and implement a reasonable adjustments passport with support from members of Enable, Trust's Disability and Carers network	To improve the experience of disabled staff within SECAmb and improve manager awareness of the need to support reasonable adjustments.	Asmina Islam Chowdhury - Inclusion Manager	WDES metric 7 and 8 Equality delivery system 3.5	December 2019	Action complete	**Action complete**

2. Undertake a deep-dive analysis of all BME formal disciplinary cases for 2018-19.	Identify potential inconsistencies in application of policy	WRES Expert	WRES metric 3 Equality delivery system 3.4 and 3.6	End Q3	Action complete. No discrepancies identified in 2019/20	**Action closed.**
3. Work with the Inclusion Team to ensure Diversity and Inclusion content of all management and assessment training.	Diversity and Inclusion is appropriately embedded and regularly assessed	Katy Larkin & Jo Lightfoot – Acting Heads of Learning and OD	WRES Metric 3 and 7 WDES metric 2 and 5		Action is outstanding from 2018/19. Content of all training due to be revised with inclusion input	**T&FG recommend that this action is closed as this should be part of BAU.**
4. Review the process of current recruitment monitoring reports for BME and / or disabled candidates with the support of Workforce Planning.	Ensure the most effective process is implemented and part of the HR transformation work stream	Sophie May - Resourcing Manager	WRES Metric 1 and 2 WDES metric 1 and 2	End of Q3	Action complete Yearly recruitment data can now be provided via trac and will be monitored via the HRWG.	**Action complete. HRWG to discuss how data will be utilised going forward.**
5. Explore ways the Trust can deliver better community engagement via our volunteers	Increase capacity for a programme of engagement with BME communities which will build awareness of careers within the ambulance service.	Greg Smith - Voluntary Services Manager *With support from, Membership manager & Inclusion Manager*	WRES Metric 2 and 9, WDES metric 2 and 10	Was due end Q3 2019	Action paused due to COVID19	**T&FG recommendation that this action is closed.** Members felt that lack of diversity within current volunteers would not provide any tangible benefits.

6. Develop key performance indicators to ensure the use of tailored messaging that promotes the importance of a diverse workforce is integrated throughout the Culture Programme. Ensure that Corporate and Local induction processes are included.	Action designed to develop clear commitment to message	Katy Larkin & Jo Lightfoot - Acting Heads of Learning and OD	WRES metric 1 and Equality delivery system 3.1	Was due end of Q3 2018	**Action is outstanding from 2018/19. Culture mandate has now been closed (June 2020)**	**T&FG recommend that this action is closed.**

Appendix three. BME and disabled staff by Directorate and Operating Unit 2019-20

Ethnicity by Directorate (D/ate)	BME		Not Stated/Not Given		White		Grand Total	
	H/C	% of D/ate	H/C	% of D/ate	H/C	% of D/ate	H/C	% of Trust
278 EP3 Chief Executive Office	2	4.65%	2	4.65%	39	90.70%	43	1.06%
278 EP3 Director of Finance & Corporate Services	16	22.86%	2	2.86%	52	74.29%	70	1.73%
278 EP3 Director of Human Resources	12	16.22%	1	1.35%	61	82.43%	74	1.83%
278 EP3 Director of Operations	161	4.44%	83	2.29%	3380	93.27%	3624	89.57%
278 EP3 Director of Quality & Safety	3	5.88%	1	1.96%	47	92.16%	51	1.26%
278 EP3 Director of Strategy & Business Development	4	25.00%		0.00%	12	75.00%	16	0.40%
278 EP3 Medical Director	5	2.98%	9	5.36%	154	91.67%	168	4.15%
Grand Total	**203**	**5.02%**	**98**	**2.42%**	**3745**	**92.56%**	**4046**	**100.00%**

Ethnicity by Operating Unit (OU)	BME		Not Stated		White		Grand Total	
	H/C	% of OU	H/C	% of OU	H/C	% of OU	H/C	% of OUs
278 EP6 111 Urgent Care	40	11.53%	11	3.17%	296	85.30%	347	10.62%
278 EP6 EOC East	12	5.85%	3	1.46%	190	92.68%	205	6.28%
278 EP6 EOC West	14	5.43%		0.00%	244	94.57%	258	7.90%
278 EP6 OU – Admin & Management – East	2	1.50%	7	5.26%	124	93.23%	133	4.07%
278 EP6 OU – Admin & Management – West	5	3.65%	4	2.92%	128	93.43%	137	4.19%
278 EP6 OU – Ashford	3	1.72%	2	1.15%	169	97.13%	174	5.33%
278 EP6 OU – Brighton	4	1.90%	4	1.90%	203	96.21%	211	6.46%
278 EP6 OU – Chertsey	9	5.42%	1	0.60%	156	93.98%	166	5.08%
278 EP6 OU – Dartford & Medway	5	1.68%	4	1.35%	288	96.97%	297	9.09%
278 EP6 OU – Gatwick & Redhill	12	3.53%	7	2.06%	321	94.41%	340	10.41%
278 EP6 OU – Guildford	3	1.90%		0.00%	155	98.10%	158	4.84%
278 EP6 OU – Paddock Wood	3	1.89%	5	3.14%	151	94.97%	159	4.87%
278 EP6 OU – Polegate & Hastings	6	2.54%	11	4.66%	219	92.80%	236	7.23%
278 EP6 OU – Tangmere & Worthing	5	2.05%	7	2.87%	232	95.08%	244	7.47%
278 EP6 OU – Thanet	7	3.48%	1	0.50%	193	96.02%	201	6.15%
Grand Total	**130**	**3.98%**	**67**	**2.05%**	**3069**	**93.97%**	**3266**	**100.00%**

Disability by Directorate (D/ate)	No		Not Declared/Unknown		Yes		Grand Total	
	H/C	% of D/ate	H/C	% of D/ate	H/C	% of D/ate	H/C	% of Trust
278 EP3 Chief Executive Office	18	41.86%	23	53.49%	2	4.65%	43	1.06%
278 EP3 Director of Finance & Corporate Services	29	41.43%	35	50.00%	6	8.57%	70	1.73%
278 EP3 Director of Human Resources	28	37.84%	44	59.46%	2	2.70%	74	1.83%
278 EP3 Director of Operations	2051	56.59%	1437	39.65%	136	3.75%	3624	89.57%
278 EP3 Director of Quality & Safety	26	50.98%	24	47.06%	1	1.96%	51	1.26%
278 EP3 Director of Strategy & Business Development	8	50.00%	8	50.00%		0.00%	16	0.40%
278 EP3 Medical Director	97	57.74%	63	37.50%	8	4.76%	168	4.15%
Grand Total	**2257**	**55.78%**	**1634**	**40.39%**	**155**	**3.83%**	**4046**	**100.00%**

Disability by Operating Unit (OU)	No		Not Declared/Unknown		Yes		Grand Total	
	H/C	% of OU	H/C	% of OU	H/C	% of OU	H/C	% of Ous
278 EP6 111 Urgent Care	127	36.60%	199	57.35%	21	6.05%	347	10.62%
278 EP6 EOC East	105	51.22%	90	43.90%	10	4.88%	205	6.28%
278 EP6 EOC West	126	48.84%	114	44.19%	18	6.98%	258	7.90%
278 EP6 OU – Admin & Management – East	94	70.68%	36	27.07%	3	2.26%	133	4.07%
278 EP6 OU – Admin & Management – West	92	67.15%	43	31.39%	2	1.46%	137	4.19%
278 EP6 OU – Ashford	109	62.64%	62	35.63%	3	1.72%	174	5.33%
278 EP6 OU – Brighton	142	67.30%	56	26.54%	13	6.16%	211	6.46%
278 EP6 OU – Chertsey	94	56.63%	66	39.76%	6	3.61%	166	5.08%
278 EP6 OU – Dartford & Medway	171	57.58%	116	39.06%	10	3.37%	297	9.09%
278 EP6 OU – Gatwick & Redhill	202	59.41%	132	38.82%	6	1.76%	340	10.41%
278 EP6 OU – Guildford	106	67.09%	50	31.65%	2	1.27%	158	4.84%
278 EP6 OU – Paddock Wood	102	64.15%	50	31.45%	7	4.40%	159	4.87%
278 EP6 OU – Polegate & Hastings	140	59.32%	87	36.86%	9	3.81%	236	7.23%
278 EP6 OU – Tangmere & Worthing	141	57.79%	96	39.34%	7	2.87%	244	7.47%
278 EP6 OU – Thanet	122	60.70%	73	36.32%	6	2.99%	201	6.15%
Grand Total	**1873**	**57.35%**	**1270**	**38.89%**	**123**	**3.77%**	**3266**	**100.00%**

Appendix four: BME and disabled leavers by Directorate and Operating Unit

Leavers Ethnicity by Directorate (D/ate)	BME		Not Stated/Not Given		White		Grand Total		Likelihood of BME staff leaving over White Staff
	H/C	% of D/ate)	H/C	% of D/ate)	H/C	% of D/ate)	H/C	% of Trust	
278 EP3 Chief Executive Office	1	10.00%	0	0.00%	9	90.00%	10	1.26%	2.17
278 EP3 Director of Finance & Corporate Services	5	50.00%	1	10.00%	4	40.00%	10	1.26%	4.06
278 EP3 Director of Human Resources	5	25.00%	2	10.00%	13	65.00%	20	2.52%	1.96
278 EP3 Director of Operations	54	7.52%	20	2.79%	644	89.69%	718	90.43%	1.76
278 EP3 Director of Quality & Safety	0	0.00%	0	0.00%	8	100.00%	8	1.01%	0.00
278 EP3 Director of Strategy & Business Development	2	28.57%	0	0.00%	5	71.43%	7	0.88%	1.20
278 EP3 Medical Director	1	4.76%	1	4.76%	19	90.48%	21	2.64%	1.62
Grand Total	**68**	**8.56%**	**24**	**3.02%**	**702**	**88.41%**	**794**	**100.00%**	**1.79**

Leavers Ethnicity by Operating Unit (OU)	BME		Not Stated/Not Given		White		Grand Total		Likelihood of BME staff leaving over White by OU Staff
	H/C	% of OU	H/C	% of OU	H/C	% of OU	H/C	% of OUs	
278 EP6 111 Urgent Care	27	13.37%	4	1.98%	171	84.65%	202	29.88%	1.17
278 EP6 EOC East	10	10.64%	1	1.06%	83	88.30%	94	13.91%	1.91
278 EP6 EOC West	3	3.06%	1	1.02%	94	95.92%	98	14.50%	0.56
278 EP6 OU - Admin & Management - East	1	10.00%	2	20.00%	7	70.00%	10	1.48%	8.86
278 EP6 OU - Admin & Management - West	0	0.00%	2	16.67%	10	83.33%	12	1.78%	0.00
278 EP6 OU - Ashford	0	0.00%	1	6.25%	15	93.75%	16	2.37%	0.00
278 EP6 OU - Brighton	2	8.33%	1	4.17%	21	87.50%	24	3.55%	4.83
278 EP6 OU - Chertsey	1	3.85%	1	3.85%	24	92.31%	26	3.85%	0.72
278 EP6 OU - Dartford & Medway	1	2.56%	0	0.00%	38	97.44%	39	5.77%	1.52
278 EP6 OU - Gatwick & Redhill	0	0.00%	0	0.00%	26	100.00%	26	3.85%	0.00
278 EP6 OU - Guildford	1	4.00%	0	0.00%	24	96.00%	25	3.70%	2.15
278 EP6 OU - Paddock Wood	1	5.26%	0	0.00%	18	94.74%	19	2.81%	2.80
278 EP6 OU - Polegate & Hastings	2	5.56%	2	5.56%	32	88.89%	36	5.33%	2.28
278 EP6 OU - Tangmere & Worthing	0	0.00%	3	13.04%	20	86.96%	23	3.40%	0.00
278 EP6 OU - Thanet	1	3.85%	0	0.00%	25	96.15%	26	3.85%	1.10
Grand Total	**50**	**7.40%**	**18**	**2.66%**	**608**	**89.94%**	**676**	**100.00%**	**1.94**

Leavers by disability and directorate (D/ate)	No		Not Declared		Yes		Grand Total		Likelihood of disabled staff leaving over non-disabled
	H/C	% of D/ate)	H/C	% of D/ate)	H/C	% of D/ate)	H/C	% of Trust	
278 EP3 Chief Executive Office	3	30.00%	6	60.00%	1	10.00%	10	1.26%	3.00
278 EP3 Director of Finance & Corporate Services	4	40.00%	6	60.00%	0	0.00%	10	1.26%	0.00
278 EP3 Director of Human Resources	6	30.00%	13	65.00%	1	5.00%	20	2.52%	2.33
278 EP3 Director of Operations	303	42.20%	371	51.67%	44	6.13%	718	90.43%	2.19
278 EP3 Director of Quality & Safety	3	37.50%	5	62.50%	0	0.00%	8	1.01%	0.00
278 EP3 Director of Strategy & Business Development	4	57.14%	3	42.86%	0	0.00%	7	0.88%	#DIV/0!
278 EP3 Medical Director	11	52.38%	9	42.86%	1	4.76%	21	2.64%	1.10
Grand Total	**334**	**42.07%**	**413**	**52.02%**	**47**	**5.92%**	**794**	**100.00%**	**2.05**

Leavers by ethnicity and Operating Unit (OU)	No		Not Declared		Yes		Grand Total		Likelihood of disabled staff leaving over non-disabled staff
	H/C	% of OU	H/C	% of OU	H/C	% of OU	H/C	% leavers by OU	
278 EP6 111 Urgent Care	40	19.80%	150	74.26%	12	5.94%	202	29.88%	1.81
278 EP6 EOC East	23	24.47%	61	64.89%	10	10.64%	94	13.91%	4.57
278 EP6 EOC West	31	31.63%	62	63.27%	5	5.10%	98	14.50%	1.13
278 EP6 OU - Admin & Management - East	7	70.00%	2	20.00%	1	10.00%	10	1.48%	4.48
278 EP6 OU - Admin & Management - West	4	33.33%	6	50.00%	2	16.67%	12	1.78%	23.00
278 EP6 OU - Ashford	9	56.25%	6	37.50%	1	6.25%	16	2.37%	4.04
278 EP6 OU - Brighton	15	62.50%	6	25.00%	3	12.50%	24	3.55%	2.18
278 EP6 OU - Chertsey	18	69.23%	7	26.92%	1	3.85%	26	3.85%	0.87
278 EP6 OU - Dartford & Medway	30	76.92%	8	20.51%	1	2.56%	39	5.77%	0.57
278 EP6 OU - Gatwick & Redhill	17	65.38%	7	26.92%	2	7.69%	26	3.85%	3.96
278 EP6 OU - Guildford	19	76.00%	5	20.00%	1	4.00%	25	3.70%	2.79
278 EP6 OU - Paddock Wood	15	78.95%	4	21.05%		0.00%	19	2.81%	0.00
278 EP6 OU - Polegate & Hastings	23	63.89%	11	30.56%	2	5.56%	36	5.33%	1.35
278 EP6 OU - Tangmere & Worthing	16	69.57%	5	21.74%	2	8.70%	23	3.40%	2.52
278 EP6 OU - Thanet	17	65.38%	8	30.77%	1	3.85%	26	3.85%	1.20
Grand Total	**284**	**42.01%**	**348**	**51.48%**	**44**	**6.51%**	**676**	**100.00%**	**2.36**

The "relative likelihood" is calculated as follows:

Descriptor	White	BME
Number of staff in workforce	3745	203
Number of staff leaving	702	68

- Likelihood of White staff leaving the organisation (702/3745) = 0.187
- Likelihood of BME staff leaving the organisation (68/203) = 0.335
- The relative likelihood of BME staff leaving the organisation compared to White staff is therefore 0.335/0.187 = **1.79 times greater.**

SECAMB Board

Summary Report on the Audit & Risk Committee

Date of meeting	**10 September 2020**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting were ▪ Progress with the Internal Audit Plan ▪ The Trust's response to COVID-19 ▪ Business Continuity Planning Incl. EU Transition ▪ Governance of 111 CAS ▪ Declarations of Interests (DOI)
Internal Audit Plan	The Internal Audit reports continue to provide good assurance, specifically in this reporting period for the following areas: ▪ Complaints / Data Quality – the Board will see from the Patient Experience Annual Report that while there have been challenges with timeliness, this has improved since the end of 2019/20. ▪ Governance & Risk Management – the committee is really pleased with the improvements in this area and supports the executive's plan to develop our approach to risk management further. ▪ Financial Governance & Sustainability during COVID – this review concluded substantial assurance with how decisions have been made during the crisis. There was also a positive advisory review related to the planning for the E-Time Sheets project. This is covered in the report from the Workforce & Wellbeing Committee.
COVID-19	The committee noted that the governance for the response to COVID continues to be strong, as reported to the committee and Board previously. The management group has however broadened its scope to ensure we respond effectively to the winter pressures, which this year includes COVID and a potential second wave, and EU transition. There was an update on the new COVID Recovery Learning and Improvement Group, which is described as a think tank aimed at helping to develop workstreams which will then follow usual governance and ensure good alignment with the Trust's strategic direction. The committee reinforced that it exists to promote good governance as an enabler of innovation, so the outputs of this Group is really important.
Business Continuity Planning / EU Transition	The committee sought assurance that we have the right business continuity processes in place. It is confident with the overall planning and confirmed there are the range of BC plans in place. In terms of the risks to service deliver arising from the end of the EU transition period in January, these are well rehearsed from the planning last year and system planning is starting to ramp up. The committee asked that an update be provided on this to the Trust Board, to include winter planning more broadly, given the number of issues that are likely to make winter really

	challenging.
111 CAS	This is also an agenda item for the Trust Board, and what the committee specifically explored was the governance arrangements with the sub-contractor. As some of this is commercially sensitive a separate update will be provided in part 2.
DOI	The paper provided good assurance that we are doing all we should be with regards the management of interest. This was supported by the view of Internal Audit who through Counter Fraud helped to design our policy.
Risk Management / BAF	The committee supported the approach to risk management as outlined above and reviewed some of the specific risks aligned to the committee. As confirmed to the Board in July, the committee is assured there is a good risk management process in place.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	45/20

Name of meeting	Trust Board
Date	24 September 2020
Name of paper	Winter 2020 Planning Framework
Responsible Executive	Joe Garcia, Executive Director of Operations
Authors	Anne Harvey, Emergency Preparedness, Response and Resilience Manager
Synopsis	The Winter 2020 Planning Framework has been developed to provide assurance of the arrangements that will be put in place over the Winter 2020 period. This will enable the Trust to mitigate the combined challenges of Winter and associated pressures, the possibility of a Covid-19 resurgence during this time and the possible impacts of the end of EU transition period 31st December 2020 which takes place during the critical winter period. This framework covers the winter period, normally defined as being from 1st November to 31st March with specific emphasis on the critical period. Historically, this is the festive period from early December to mid-January.
Recommendations, decisions or actions sought	For Assurance

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Both a QIA and EIA have been approved.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Winter 2020 Planning Framework

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

Document Sign Off

Version:	V1.0
Name of originator/ author:	Anne Harvey
Responsible management group:	Covid Management Group
Directorate/team accountable:	Operations/EPRR Team
Winter 2020 Planning Framework:	
Approved by:	Covid Management Group
Date approved:	21/08/2020
Fit for purpose according to:	Executive Management Board
Date approved:	02/09/2020

Date issued:	09/09/2020
Date next review due:	TBC
Target audience:	All trust staff /NHS systems
Replaces (version number):	New Plan

Document Control

Review/comments:

Person/ Committee	Comments	Version	Date
Anne Harvey	Initial review and development of plan.	V0.1	July/Aug 2020
Resilience Forum Winter Planning Group.	Input from key stakeholders to review and update or provide narrative to respective sections of the plan.	V0.1	July/Aug 2020
EPRR Team	Winter 2020Risk Assessment completed	V0.1	11/08/2020
Resilience Forum Winter Planning Group and EPRR Team	Circulated for review and comment	V0.1	17/08/2020
EPRR Team	Document reviewed and updated	V0.2	18/08/2020
Anne Harvey	Updated with review of feedback from Resilience Forum Winter Planning Group.	V0.3	20/08/2020
Covid Management Group	Submitted for approval	V0.3	21/08/2020
Covid Management Group	Plan approved	V1.0	21/08/2020
Teams A	For information	V1.0	24/08/2020
Executive Management Board	For ratification	V1.0	02/09/2020

This is a Live Document and will be subject to review and update in a dynamic operating context.
The latest version will be updated onto the Trust website

Contents

Document Sign Off 2
Document Control 3
Contents 4
1. Introduction 6
1.1. **Planning Assumptions** 6
1.2. **Associated Documents** 7
2. Intent 8
2.1. **Strategic Intention** 8
2.2. **Tactical Intention** 8
3. Scope 8
3.2. **Trust Response to Covid 19** 9
3.3. **EU Transition Arrangements** 9
4. Review of Winter 2019 9
5. Risks 10
6. Method 11
6.1. **Activity Profiling** 11
6.2. **Operational Resource Planning** 12
6.3. **Staff Abstraction** 13
6.4. **Financial Incentives for Targeted shifts** 13
6.5. **Surge Demand Mitigation** 13
6.6. **Increasing Operational Capacity and Effectiveness** 13
6.7. **Maintaining Key Management Priorities** 15
7. Command and Control 16
8. NHS Winter Resilience Planning 17
8.1. **Hospital Handover Delays** 17
8.2. **Hospital Diverts** 18
8.3. **NHS Operational Pressures Escalation Levels (OPEL)** 18
9. Major Incident 19
10. Business Continuity 19
11. Key Support Services 19
11.1. **Fleet Resource Planning** 19
11.2. **Make Ready** 20
11.3. **Logistics Resource Planning** 20
11.4. **IT/EOC Systems** 21
12. Infection Prevention and Control 21

12.1. **Flu Vaccination Programme** 21
12.2. **Seasonal Influenza and Norovirus Outbreaks** 21
12.3. **Personal Protective Equipment (PPE)** 22
13. Staff Welfare 22
14. Communication 22
15. Review 23
16. Distribution 23
16.1. **Internal Distribution** 23
16.2. **External Distribution** 23
Appendix A: Risk Assessment 25
Appendix B: Key Contacts 29

1. Introduction

This plan is designed so that the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) can meet the challenges a winter period brings, whilst maintaining a sustainable service throughout the winter period.

Historically increased activity during the winter period has presented significant challenges to the Trust, it is recognised that these demands are not always those placed directly onto the Trust but can be those affecting the wider health and social care system.

Winter 2020 is anticipated to be no exception, set against the impacts of the Covid19 pandemic and possible Covid 19 resurgence, along with service delivery impacts which may be the result of EU Exit transition arrangements. The difficulties presented by these factors when combined with similar situations in partner organisations across the wider health community, may make the challenges of this winter even more acute and unpredictable.

This document is intended to draw on the experiences of past winters and of the Covid19 response and integrates recommendations, guidance and criteria for winter 2020 planning.

1.1. Planning Assumptions

This plan has been developed based on the following planning assumptions;

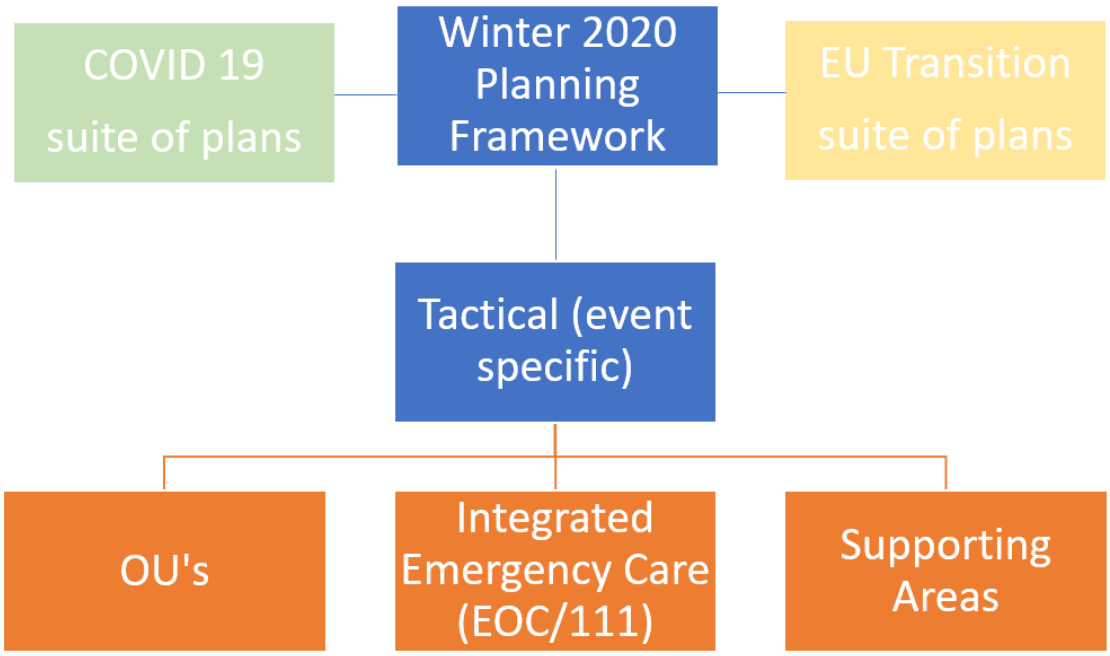
- The trust has in place a process to monitor anticipated activity and deliver the required resource to meet this anticipated activity.
- The Trust has in place a set of internal escalation triggers, which are effective and work to mitigate the risk posed by surge conditions.
- The Trust will be able to provide the additional resources required to meet surge conditions.
- The trust will, when necessary provide support for other priority areas to ensure delivery of trust objectives.

Should the above conditions not be met, the mitigation provided by this winter plan will be lessened. With the above conditions adequately met this plan should provide sufficient mitigation to ensure a manageable winter period.

The document concentrates on several year-round processes and key seasonal initiatives that will deliver robust resilience during the winter period and ensure engagement with local health systems. It is designed to offer assurance at a strategic level that the levels of preparedness for winter in SECAmb is high and that this will contribute to the resilience of the whole system. It also serves as an overarching plan to bring together the arrangements detailed in the individual Operating Unit, Emergency Operations Centre and SECAmb 111 winter plans.

This is a live document and will be subject to review and updated accordingly throughout the Winter planning period.

Plan Structure



1.2. Associated Documents

This plan is not intended to replicate or replace existing Trust plans or guidance and should be used in conjunction with the following associated documents**:**

- Operating Unit Winter Plan(s)
- Contact Centre Winter Plan(s)
- Resourcing Escalatory Action Plan (REAP)
- Surge Management Plan (SMP)
- Clinical Handover and Transfer of Care Procedure
- Major Incident Plan & Additional Contingencies
- Business Continuity Management Policy
- Business Continuity Management Plan & Associated Documents
- Command & Control Procedure
- COVID-19 Strategic Plan;
- COVID-19 Incident Operating Model;
- COVID-19 Pandemic Test and Trace Cell SECAmb Staff Procedure;
- COVID-19 Outbreak Control Management Framework
- SECAmb EU Transition Plan(s)
- Infection Prevention Ready Procedure
- Infection Prevention and Control Manual
- NHS England Operational Pressures Escalation Level Framework (OPEL)

2. Intent

The intention of this plan is to provide sufficient arrangements and options to manage this anticipated demand and mitigate the associated risks in accordance with the visions and values of South East Coast Ambulance Service NHS Foundation Trust.

2.1. Strategic Intention

- Maintain a clinically safe and effective service that meets the clinical needs of all our patients
- Mitigate and minimise the impact to the wider NHS
- Inform the public and maintain public confidence
- Ensure sufficient assets are available to manage the event to maintain service delivery to national standards
- Ensure a swift return to normality in the event of an incident

2.2. Tactical Intention

- To ensure patient safety is at the centre of our actions
- To have a predefined Command and Control Structure in place to ensure the operational demand is managed effectively
- To maintain core services through the effective use of escalatory framework
- To ensure that staff welfare is considered by providing refreshments and adequate breaks within the constraints of the demands being placed on the service.
- To ensure staff safety through continuity of supply of Personal Protective Equipment in respect of PHE/NHS guidance.
- To work with partners to mitigate demands and limit the impact on the wider NHS

3. Scope

This plan covers the winter period, normally defined as being from 1st November to 31st March with specific emphasis on the critical period, historically, this is the festive period from early December to mid-January., However given the additional challenges of Winter 2020, this critical period may begin earlier or be extended further.

Analysis of historical data for this period will be utilised to predict potential periods of increased demand, however it is important to recognise that the other impacts (Covid, EU Exit etc) brings a high level of uncertainty to this period. Therefore, any plans produced will be required to maintain a high level of adaptability.

3.1. Christmas and New Year

There will be specific arrangements for the key dates over the Christmas and New Year period, which include provision of additional operational resources and appropriate, focused managerial support. These arrangements may be extended in response to challenges posed by prolonged increased activity, system pressures, seasonal flu and other challenges.

This year, there are the additional challenges of the Christmas public holidays going into a weekend, where there may be long periods of people off of work and limited access to primary care during this time and the EU transition period due to end on 31st December.

3.2. Trust Response to Covid 19

The Trust's response to COVID-19 has evolved over time to reflect the needs of staff and patients and to ensure that the Trust is meeting the specific actions, outlined by NHSEI that all NHS organisations should take. Throughout the Covid-19 response, maintaining staff and patient safety as well as delivering a safe service has been a key objective of the Trust. As we move into the next phase of the response a further objective is to ensure that robust governance and processes are in place to support the timely reporting and management of COVID-19 outbreaks, hospital acquired infection and associated staff absence.

It is still unclear how the COVID-19 virus will progress throughout the approaching months, with a high likelihood of a 'second peak'. The Trust's response to COVID-19 will continue to be closely monitored by the COVID-19 Management Group and inevitably may be revised in order to ensure we continue to best service our staff and our patients.

3.3. EU Transition Arrangements

The UK left the EU on 31 January 2020 and entered a transition period which is due to end on 31st December 2020. The Trust had a number of plans and mitigation measures in place for EU Exit. Ensuring cognisance of potential issues and dependencies, the Trust continues to engage with Local Resilience Forums (LRF)and NHS partners in planning for EU transition.

Building on learning identified from EU Exit debriefing and considering new arrangements for EU transition we will continue to develop the plans and arrangements required for the end of the transition period.

4. Review of Winter 2019

A review of arrangements put into place for Winter 2019 has been undertaken, with areas of good practice to be fed into the planning for this year. The Trust has also engaged with local systems to review the challenges of Winter 2019, key themes around areas that worked well and areas for improvement have been identified and will support system Winter 2020 preparedness planning.

Concerns/ areas for improvement include:

- Daily management calls were stood down in order to focus on the call volume and patient response, it was identified that this may have contributed to a lack of focus on wider system issues including hospital handover delays and system capacity.
- A main challenge for the trust was an increase in short term sickness over the Christmas period. Specifically, Christmas day and Boxing day.

Actions taken include:

- Additional Clinicians in EOC and Urgent Care Hub set up where workforce allows,
- Band 7 Paramedic Practitioner rotational models developed,
- Longest one waiting vehicle (LOWV) and Joint Response Unit (JRU) have been further developed and rolled out.
- Acute pathways support - ongoing work to improve and establish acute pathways.
- Improved Hear & Treat and direct referrals focus

5. Risks

Risks are multifactorial and involve internal and external factors. Whilst planning is completed on the basis of what is known or can reasonably be expected to happen, factors may impact on planning outside of that process. Delivery risks are based on predicted and actual demand, patient facing vehicle hours available, hospital handover delays, sickness, significant disruption of service or major incidents and other external factors such as events or weather issues.

Key risks identified in respect of Winter 2020 include;

- Potential Covid 19 resurgence in conjunction with known winter pressures
- Winter Flu pandemic
- Increased Activity
- EU transition ends during critical winter period
- Adverse Weather
- Potential for Public Disorder

While the full health sector picture is not fully known, the report “Preparing for a Challenging Winter 2020-21”[1] provides an in-depth analysis of the risks and challenges to the NHS in the coming months. It is anticipated that the challenges identified will add to the winter pressure challenges normally experienced by the wider NHS & social care system and in turn will likely impact on ambulance service activity.

A risk assessment for the Winter period is provided at Appendix A

[1] https://www.gov.uk/government/publications/covid-19-preparing-for-a-challenging-winter-202021-7-july-2020

6. Method

The delivery of this plan will be achieved through comprehensive operational and organisational arrangements, which are designed to provide a quality service to meet the needs of our local communities. The overall strategy will be delivered through the supporting plans, as detailed in the Plan Structure Framework so that the arrangements remain sufficiently flexible to match more local workloads.

The operational arrangements include the identification of 'key dates' of anticipated high demand which are derived from analysis of historical data. Such predictions will be subject to adjustment based on shorter-term impacts such as forecasts of severe weather, high seasonal flu levels, fuel shortages or other Business Continuity challenges including industrial action within or outside of the NHS.

This section of the Plan describes the processes to predict, monitor and mitigate the demands that are likely to be placed upon the Trust over the winter period, and looks to ensure delivery of service is maintained during surges in demand or reduced capacity.

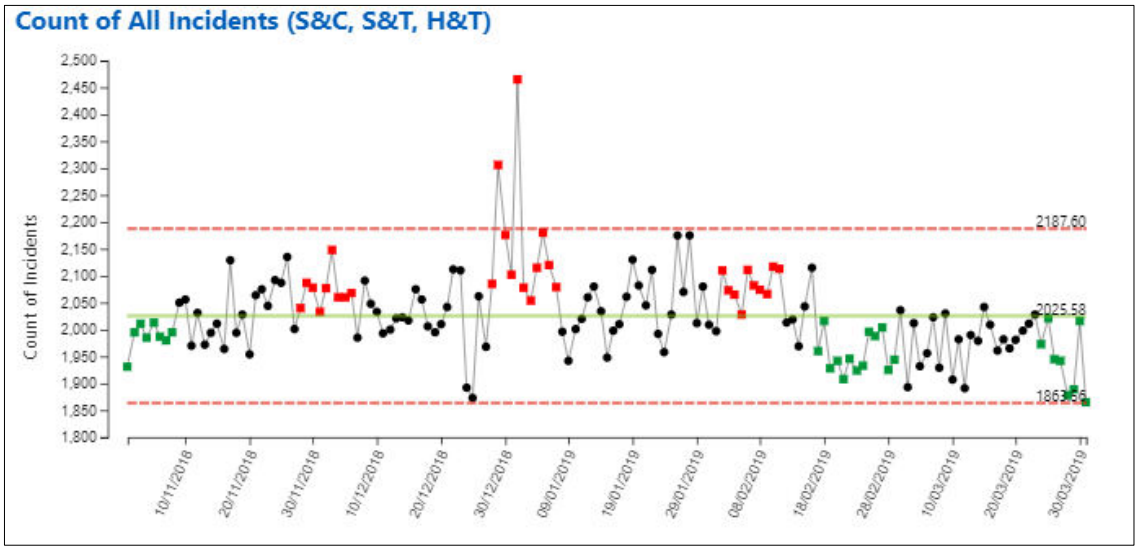
6.1. Activity Profiling

Activity profiling is based on demand and capacity review assessment. Analysis of past activity, present performance and growing demand produces a view of the levels of activity anticipated over the winter period and gives us an indication of when we might see demand peaks this winter.

However, this is not an exact science and it is recognised that the Trust may experience unplanned short-term/sustained periods of increased activity, therefore, demand and capacity is reviewed on a regular basis by Teams A, the Trust's senior operational leaders to consider factors which may change predictions, in order to manage resourcing and provision of operational hours.

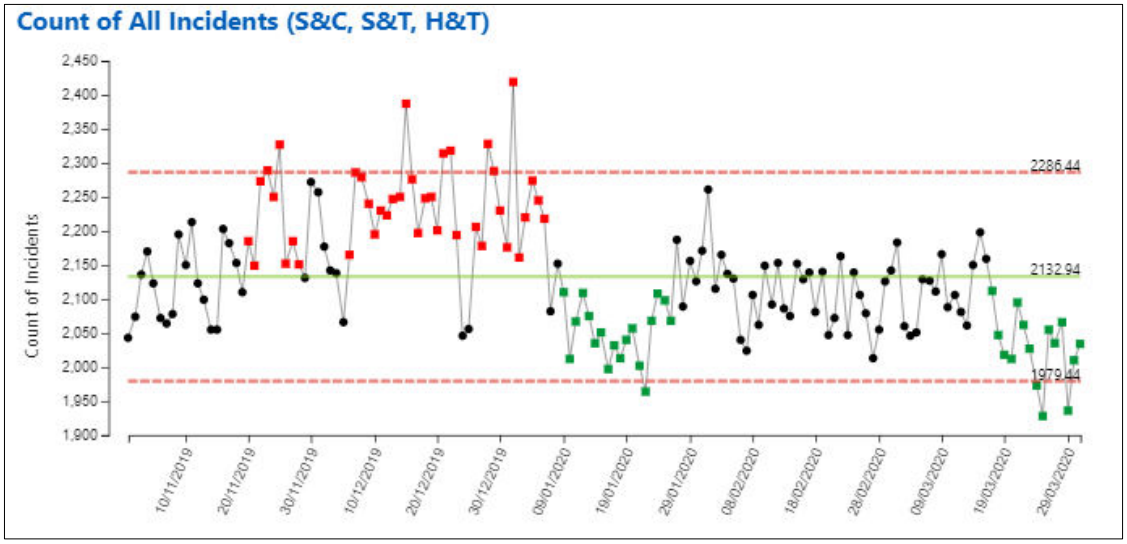
The following graphs show the activity over the winter period (November to March) for the previous two years.

Winter 2018



The trajectory for 2018 -19 reflects the implementation of the Ambulance Response Programme (Nov 2018) and the improved quality of data reporting due to the new CAD.

Winter 2019

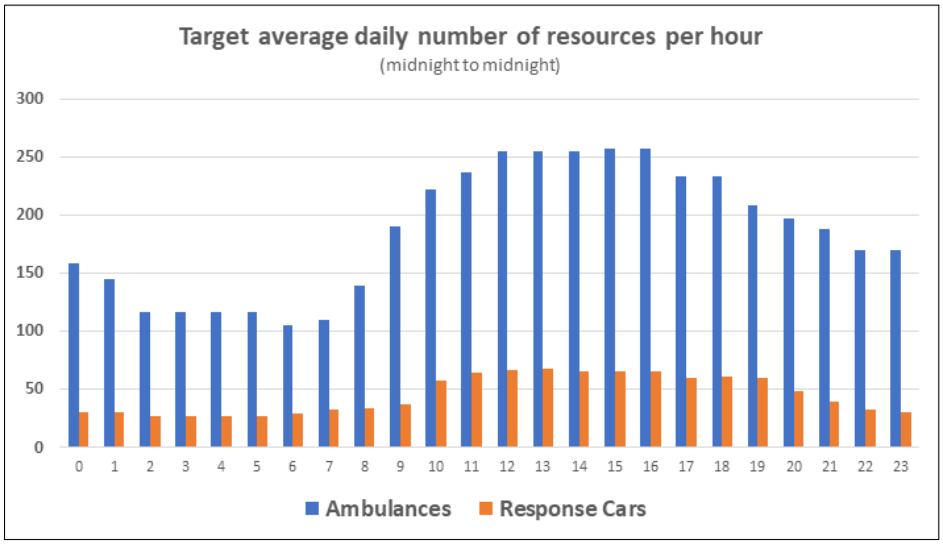


- indicates sustained period of average normal variation.
- indicates sustained period above average normal variation.
- indicates sustained period below average normal variation.

6.2. Operational Resource Planning

The Trust's scheduling teams, in conjunction with the OU leadership are responsible for providing operational resources in line with the Demand and Capacity Review. This also applies to the Contact Centres (Emergency Operations Centre & 111) with regard to call handling, clinical advisory and dispatch functions.

The scheduling teams role is to populate staff rotas up to six weeks in advance, with an objective of meeting the daily target hours per day, per week. The planned/target provision of operational staff hours is 65,150[2] hrs per week, these are then broken down per day to reflect demand. The average daily picture for the pattern of resourcing is represented in the graph below, however, as there is little to differentiate from day to day this provides a high-level view.



[2] Commencing September 1st, 2020

As we move towards the winter period a more accurate picture of the available resource against the predicted demands will emerge. This will be kept under constant review by Teams A to ensure that risk periods are identified, and mitigating actions are put in place.

6.3. Staff Abstraction

The Trust's Annual Leave Policy details the arrangements for annual leave over the Christmas period, which limits annual leave abstraction at 50% of normal levels. All short notice leave will be authorised at Operational Unit Manager level or above.

In addition to the above arrangement it is proposed that there are no abstractions other than pre-booked annual leave.

6.4. Financial Incentives for Targeted shifts

To incentivise and maximise overtime uptake, consideration will be given to provide overtime rates outside those available under Agenda for Change but only for specific days/shifts as required. The Trust's Operations Team will work in collaboration with both the Trust's Financial Directorate and staff-side to ensure a uniformity of approach to the issuing of incentives.

6.5. Surge Demand Mitigation

The Trust maintains a comprehensive surge escalation framework to augment service delivery during periods of increased activity:

Resource Escalatory Action Plan (REAP)

The Trust's REAP identifies rising trends in operational and organisational demands and facilitates escalation/de-escalation through the nationally set REAP levels.

Trigger mechanisms have been established through REAP arrangements that allow the Trust to respond to substantial increases in demand, in either specific areas or Trust wide. The Trust's REAP status is formally reviewed every week by the Director of Operations at the Teams A meeting, change to Reap Level is authorised by the Executive Management Board

REAP arrangements remain active at all times.

Surge Management Plan (SMP)

The SMP is utilised by the Trust from its EOC's in situations of surges in call volume, which result in the supply of ambulance service resources being insufficient to meet the clinical demand of patients. The more flexible and immediate nature of this plan will often mean that it provides a more effective and expedient response to surges in demand that are likely to be for short durations**.**

6.6. Increasing Operational Capacity and Effectiveness

6.6.1. Emergency Services Collaboration

The Trust has well established links with the other emergency services and is constantly seeking new ways of collaborative working with partners in order to increase efficiency or reduce demand on one or more emergency services. Examples of these activities are:

Co-Responding- Kent Fire and Rescue Service (KFRS) are our only FRS service colleagues that undertake this activity. However, each Fire and Rescue Service will consider other methods of assistance such as assisting crews with manual handling and deploying Liaison Officers to EOC on a case by case basis.

Forced Entry – All partner FRSs carry out this activity on behalf of SECAmb, unless time critical, crews must be on scene and make reasonable efforts to safely gain entry prior to requesting FRS support.

Joint Response Units (JRU) - The JRU is a Trust vehicle crewed with a Band 6 Paramedic and 1 or 2 Police Officers. This crew will attend a range of incidents for both services where a combined response may be required. These units generally operate to the night-time economy and are currently available in North Kent, Guildford, Brighton and Worthing. Operating hours vary in each location.

In hours the Emergency Services Collaboration Manager (ESCM) can facilitate this and out of hours the Trust Tactical Advisers can provide a link to other emergency services as the need arises.

6.6.2. Community First Responders

During the period of this plan Operating Units will highlight to the Community Resilience team where community first responder (CFR) schemes may support resourcing gaps. CFRs and Fire and Rescue responders (Kent FRS only) can respond to all category of calls. All have appropriate PPE to be patient facing and support the Trust during Covid-19 pandemic along with clear supporting guidance. Only CFRs those that have been fit tested and trained in appropriate PPE have their call sign available on the CAD to book on.

Requests for additional community first responders in hours will come through the Community Resilience Team in the first instance. During the Out of Hours (OOH's) period, EOC will cascade a message through the Response Desk targeted at local OUs that require operational support. The Community Resilience Team (in conjunction with the SECAmb communication team) will consider the use of social media to cascade messages where appropriate to CFRs. Again, during the OOH's period, this will be led through the SECAmb communications team.

During high periods of demand where conference calls are held to ascertain situational awareness and review resource against demand, consideration must be given to the use of CFRs and Fire and Rescue responders to assist the Trust in providing a timely response to our patients.

6.6.3. Response Capable Managers

During periods of severe pressure on service delivery, response capable mangers may be redeployed from their normal duties to support the delivery of operational

service as required. Teams A will work with Departmental Heads and managers to ensure that they are targeted effectively to support operational response when required, as it is recognised that there are a number of key work areas, which if not maintained and continued may cause additional problems and issues.

To ensure that the Trust maintains the capability to respond to a range of issues/incidents that may arise, on-call Strategic and Tactical Commanders and the Tactical Advisors should not be tasked to operational shifts, they can, however be called upon to provide support within the Command Hub(s) as required.

6.6.4. Private Ambulance Provision (PAP)

PAP is used throughout the year to support gaps in establishment and is currently provided under Direct Award Contracts. We also have the ability to request additional hours above the direct award contract level where PAP is eligible through the NHS framework.

6.6.5. Additional Funding Initiatives

The Trust may have to respond to ad hoc funding bids for winter initiatives, where short notice funding has been made available as experienced in previous years.

6.6.6. **Paramedic Practitioner (PP) Urgent Care Hubs**.

The PP Urgent Care Hubs have been introduced as an initiative to improve operational effectiveness. The function of the PP urgent Care hubs is to support operational staff in providing Emergency Clinical Advice Line call backs at a local Operating Unit level and providing supported clinical decision making with the aim to increase See & Treat, reduce Job Cycle Time and See & Convey to Emergency Departments especially for the Cat 3 / 4 Frailty cohort.

6.7. Maintaining Key Management Priorities

It has been identified that the following management duties will continue to be prioritised in addition to maintaining an operational response to patients;

- Focused HR Attendance Management support
- Return to work interviews
- SI’s
- Incident investigations
- Complaints
- Patient Experience Team support
- Appraisals

In order to maintain these key functions, support may be requested from other Directorates and work areas within the Trust. Directors and functional Heads will identify staff within support functions/alternative duties who could undertake identified tasks under the guidance of senior/operational managers.

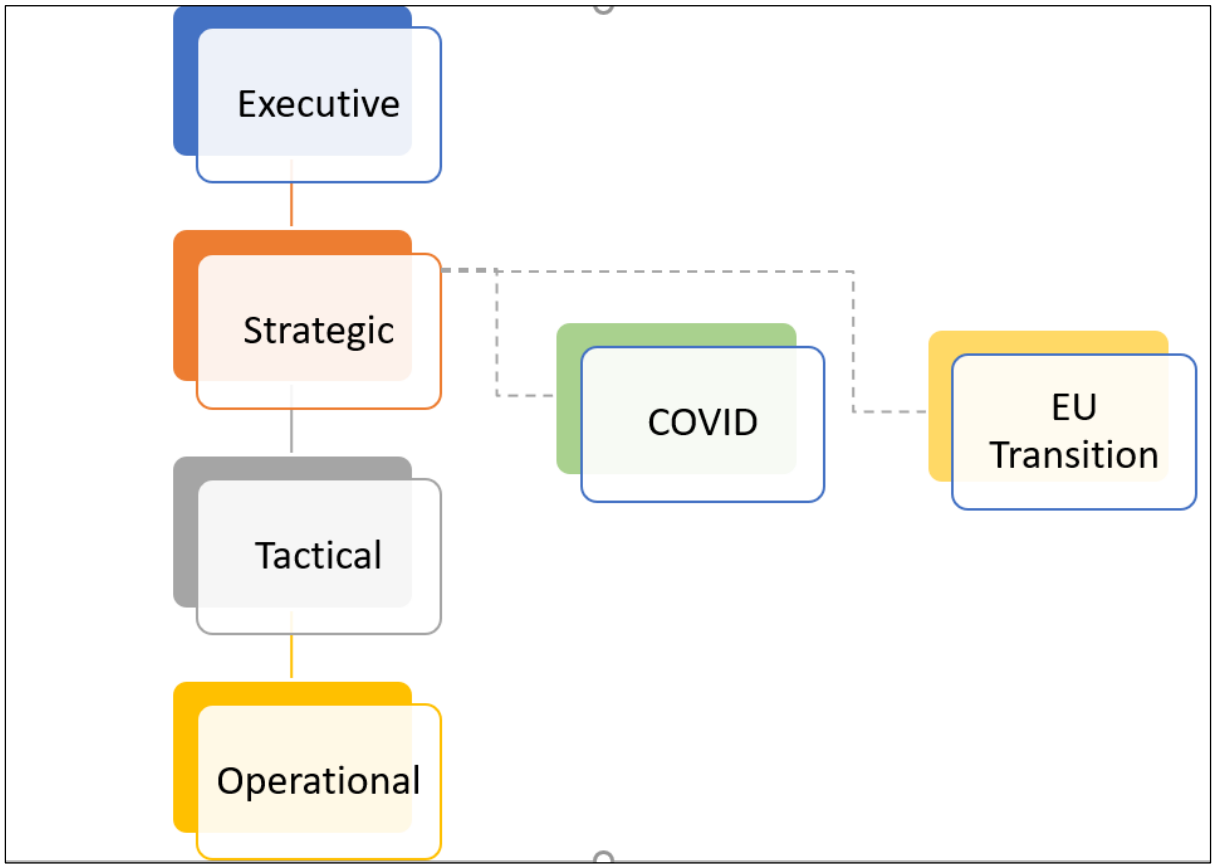
7. Command and Control

The Trust's recognised command structure will be in place throughout the winter period, details of which can be found on the on-call rota, accessible on the Trust's intranet and rostering system. In the event that external partner organisations need to contact the Trust on-call commander(s), initial contact will be made via the respective EOC Managers West & East who will escalate as required.

During the period of this plan day to day responsibility of operations remains with the Director of Operations (or their nominated deputy). They are responsible for triggering a Trust wide response if the demands are outside the scope of normal procedures.

In addition, the Trust has implemented a dedicated Command Structure to manage the Covid 19 response. Command capacity will be reviewed and flexed if necessary, in respect of EU transition arrangements.

Winter 2020 C2 Structure



The following table outlines additional measures to be considered to support an extended command structure in the event of increased pressure on Operations.

Item	Details
Winter Pressures	Additional teleconferences may be implemented to supplement the existing programme of oversight and control.
Strategic Suite	The Director of Operations (or their nominated deputy) may consider establishing a Strategic Command Hub within the Strategic Suite to support the Trust's normal management and command structures.
Tactical Command Hub	A tactical operations and performance hub is currently operational, providing 24/7 cover. There may be a need to supplement this with additional resource capacity to enable additional functions and duties.
Clinical Oversight	The Senior Medical Advisor will provide clinical oversight to review risks and impacts to patients and provide senior level clinical support and advice.

8. NHS Winter Resilience Planning

Recognising the continued increase in pressures on the wider health system over the winter period, NHS England and NHS Improvement has circulated guidance to all Clinical Commissioning Groups and NHS providers regarding planning for winter.. For Winter 2020, the NHS Winter Operating Model has been expanded to address the challenges of Covid 19 2nd wave and EU Transition..

In line with this guidance and the operational priorities set out the Trust will continue to engage with the wider NHS through A&E Delivery Boards and Collaborative ICP/ICS/STP sessions in order to influence and shape local initiatives, whilst continuing to focus on delivering 999 and 111 core services safely and timely. Additionally, the Trust Strategy and Partnership will continue to engage with and seek assurance from the systems that their plans have sufficient capacity to manage surges in demand, any concerns will be escalated through established processes.

8.1. Hospital Handover Delays

System wide pressures can result in significant ambulance handover and turnaround delays at acute hospitals across the Trust region, with delays having an impact on the Trust's ability to deliver a safe service to patients wating for a 999 response in the community. Hospital handover delays increase during the winter when there is an increased need for urgent and emergency care services. This leads to a mismatch between capacity and demand and is associated with poor patient flow.

This winter will see this effect compounded by the already pressurised system. There is a risk that due to the need for social distancing to be implemented in Emergency Departments (EDs) and the wider hospital, handover delays will increase, particularly at sites where there are challenges around hospital estates.

Locally SECAmb continues to work closely with hospital colleagues and other partners across the region as part of system wide programme of work to reduce handover delays. The focus is on streamlining processes and embedding best practice at Emergency Departments (EDs) to improve handover and flow. The programme also focuses on raising awareness and improving crews' ability to access existing community pathways to safely reduce the number of avoidable conveyances to hospital. Work with system partners also focuses on developing new pathways both in the community and at hospital sites including direct conveyance to non-ED destinations e.g. same day emergency care units (SDEC). Direct conveyance to non-ED destinations supports the NHS111 First delivery and helps reduces congestion in EDs, improves patient experience and safety, and reduces handover delays in EDs

At times of increased pressure and when handover delays create significant problems, the trust will continue to work closely with hospital colleagues to seek early resolution using established locally agreed escalation processes .The trust's Clinical Handover and Transfer of Care Procedure (which replaces the Immediate Handover Standard Operating Procedure and the Conveyance Handover and Transfer of Care Procedure) supports operational and clinical staff in managing handover delays with actions to be taken and points of escalation.

8.2. Hospital Diverts

A system wide SOP for hospitals requesting an ambulance divert is in place and ensures requests are managed in a consistent way supported by an appropriate governance framework. The SOP has recently been reviewed with input from commissioners and hospital colleagues across Kent, Surrey and Sussex. The final agreed version will be sent out to all A&E delivery boards (AEDB) , ahead of winter

8.3. NHS Operational Pressures Escalation Levels (OPEL)

NHS England has distinct escalation levels in the management of surge pressures as set out in OPEL, which standardised local, regional and national escalation levels to respond to severe pressures on the NHS. These levels are used by the wider health community. To ensure a consistent approach the Trust's REAP has adopted the same system of escalation over four levels with related triggers and actions.

Adverse Weather

As part of business as normal procedures it is the responsibility of the Emergency Preparedness, Response and Resilience Team to monitor any approaching adverse weather via Met Office and Local Resilience Forum (LRF) alerts. The Trust's Tactical Advisors provide a 24/7 on call arrangements and act as a single point of contact for external agencies to alert for incidents or significant events.

Tactical Advisor SPOC: 0330 332 6231

Warnings of any potential adverse weather are communicated through the daily Team E calls and to on-call commanders, relevant managers and functional heads.

At times of severe weather during the winter period or access via difficult terrain, the Trust needs to be able to deploy four-wheel drive (4x4) resources to provide access to patients and retrieval to road-based resources.

The Trust operates a variety of vehicles with 4x4 capability across its geography and a range of operational staff across the organisation are trained to drive these vehicles. All the Trust's ambulances/response cars have all-weather tyres fitted in readiness for adverse weather conditions.

The Trust also maintains a contract to hire in additional 4x4 vehicles to support with staff movement. These will be deployed under the direction of Tactical Commanders in preparation for or during any adverse weather.

The Trust also has Memorandum of Understandings (MOU's) in place with Voluntary Aid Societies (VAS) who can also mobilise 4x4 vehicles and ambulances as required to support operations. In addition, Memorandum of Understandings (MOU's) are in place with volunteer 4x4 groups to provide assistance at times of severe weather.

Around 40 Community First Responders have their own 4X4 vehicles. A contact list is held by production and during an emergency or BCI situation, for example inclement weather, the CFR volunteers can be called upon to support the Trust in either responding to patients within their communities or moving Trust staff from A to B such as EOC staff.

The Logistics department robustly plans for the distribution of supplies of winter stock to Trust estate in advance of and throughout periods of adverse weather.

The Trust's Major Incident Plan, Additional Contingencies provides further guidance and information specific to adverse weather.

9. Major Incident

In the event of a Major Incident being declared during this period, procedures as detailed in the Trust's Major Incident Plan will be followed. Please refer to the Trust's Major Incident Plan and Additional Contingencies and EOC Action Cards for further information.

10. Business Continuity

In the event of a (further) Business Continuity Incident being declared during this period, procedures as detailed in the Trust's Business Continuity Plan(s) will be followed. All service areas have been asked to review their business continuity arrangements in light of the risks identified in this framework.

11. Key Support Services

11.1. Fleet Resource Planning

Fleet services are responsible for ensuring that the Trust's vehicles are available to operations when required to meet their peak demand. However, this must be based on an effective working relationship between operational managers and vehicle maintenance staff. This will ensure that vehicles are presented for scheduled

maintenance and MOTs when requested without affecting performance and that vehicle utilisation is maximised by robust monitoring and implementation of driving standards and vehicle damage.

There are a number of measures for the Fleet Department to take to ensure that vehicle availability is maximised and particularly through Q3 and Q4; these include:

- All MOTs being rescheduled to avoid November and December
- Damage repairs will be 'bundled' to be undertaken in batches (unless it requires to be done for safety / road worthiness).
- All decommissioning of old vehicles will be slowed down so we can utilise these additional resources where possible.
- The Fleet Department has an escalatory Plan which ensure that additional maintenance capacity can be applied during periods of higher demand.
- The Fleet Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of vehicles within the system.

There are risks associated with being able to provide sufficient vehicles to meet peak demands, however we are currently refreshing our fleet to increase vehicle numbers.

11.2. **Make Ready**

The Make Ready system is responsible for cleaning, restocking and checking equipment on ambulances and SRVs in readiness for operational shifts.

The Make Ready system has an escalatory plan, that may be implemented during periods of increased pressure, which extends the Make Ready programme, and allows for vehicles to be "hot loaded", in that they are not put through the full Make Ready system to ensure that sufficient vehicles are available for operational response.

Contractual arrangements are in place with the Make Ready provider to enable optimal staffing levels over the Christmas period.

11.3. **Logistics Resource Planning**

The Logistics Support Department are responsible for ensuring that all Trust locations have the availability of medical consumables, gases, medical paperwork and sundry items to ensure that the Operational vehicles can be maintained to the required stock levels for effective patient treatment and care.

There are a number of measures which can be taken by the Logistics Support Department to ensure that stock levels are pre-positioned and maintained to ensure maximum availability, particularly in the lead up to and through Q3 & Q4, and may factor in the following;

- Medical equipment servicing is not planned during the Q3/Q4 period.

- Medical consumables stock is uplifted to account for the increase in demand.
- Medical gas supplies are uplifted and pre-positioned in certain Trust areas to allow for increase in demand.

The Logistics Support Department will support and work alongside the Make Ready and Vehicle Preparation Programme (VPP) to ensure efficient turnaround of equipment and consumable requests required to support the vehicles within the system.

11.4. IT/EOC Systems

The Head of Information Management and Technology is responsible for ensuring 24-hour IT support which is delivered through an on-call system.

Dedicated support is provided to the EOCs by the EOC Systems team, again through an on-call system.

Additional arrangements for the provision of on-site support for key dates such as New Year's Eve will be in place

12. Infection Prevention and Control

12.1. Flu Vaccination Programme

The Executive Director of Nursing and Quality is responsible for the delivery of the seasonal influenza vaccination programme for Trust staff. Staff communications processes will be run prior to and throughout the winter period to encourage uptake.

Following an established model, specially trained Trust clinicians will be available at workplaces across the Trust to undertake vaccinations. We anticipate that the vaccination programme will start as soon as the vaccine has been produced and distributed to areas. Last year the Trust was one of the leading Ambulance Trusts with a 77% uptake, this year NHSE/I directive is for 100% of staff to be offered flu vaccination therefore the aim is to get as close to 100% as possible.

12.2. Seasonal Influenza and Norovirus Outbreaks

Any flu or norovirus outbreaks in the community are monitored by the IPC Team via the Public Health England Daily Outbreaks reporting system (these reports are also shared on a daily basis with 111). Local IPC Alerts will be sent out as and when required as well as regular updates on procedural compliance to IPC Universal Standard Precautions for staff to maintain.

Any flu or norovirus outbreaks within the Trust will be investigated and managed by the IPC Team with all necessary actions put in place. This will include local IPC Champions supporting the team and occupational health support from Optima.

The IPC Team will also liaise with EOCs, Make Ready Teams and Production Desk to provide advice on the decontamination requirements for vehicles and staff involved in any possible post treatment / transportation contamination issues.

The Trust's Pandemic Influenza Plan has been maintained in line with national guidance. Due to the variables associated with pandemic flu there are no specific triggers for implementing pandemic specific arrangements, therefore the Trust response to a pandemic influenza outbreak will be guided by the NHS response.

12.3. **Personal Protective Equipment (PPE)**

Covid-19 and changes to how the NHS Supply Chain works will mean challenges around the supply of many key items of PPE that ensure operations are maintained. The following items are some examples of stock that can no longer be ordered through NHS Supply Chain (a full list can be found at https://www.ppe-dedicated-supply-channel.co.uk/ppe-product-listing/) :

- Type IIR surgical Masks
- FFP3 masks for use in level 3 settings
- Coveralls
- Clinical Waste bags
- Gloves

These items rely on a "push pallet" delivery system which Trusts currently have very little influence over. Any adverse weather such as flooding or significant snow that affects the distribution element of the supply chain may have a profound effect on the ability to resupply key items. This is made more challenging as many items of PPE are not currently held in enough numbers to provide prolonged reserves.

There is a possibility that worst case scenario EU Exit impacts disrupting UK ports of entry could also disrupt the acquisition and distribution of stock as described above.

The Trust continues to look at alternative PPE in place of FFP masks for staff use, and will work with procurement and operations to determine requirement for a strategic reserve of PPE to reduce reliance on NHS Supply Chain.

13. Staff Welfare

The Trust understands that the health and wellbeing of all our staff is of paramount importance and recognises the extraordinary challenges being faced by staff, more so during this Covid-19 pandemic.

The Wellbeing Hub provides an entry point for employees to obtain emotional and wellbeing support, signposting and access to appropriate services in a timely manner can provide to staff where necessary.

The Wellbeing hub has collated a wide range of self-help resources and information on support services that have been made available for all staff, on The Zone. Guidance is also available to managers on how to support their staff and the wellbeing services available.

14. Communication

During this period the Trust's internal and external communications will include general and specific communications which support the delivery of this plan. Led by

the Trust's Communications team this will include internal and external messages some of which will be prepared based on foreseeable issues including the following:

- Adverse weather
- Stay Safe messages
- Extended periods of excess demands or in advance of known key dates
- Staff communications

The team will continue to engage with Local Resilience Forum and NHS communications teams to ensure co-ordinated messaging.

Operating Unit Managers, Operations Managers and Operational Team Leaders will be responsible for liaison with operational staff within their Operational areas, as well as engaging with key stakeholders such as hospitals, CCGs and A&E Delivery Boards/Integrated Care Systems.

The Trust Business Account Managers will act as commissioner liaison and provider through engagement with the Lead CCGs and A&E Delivery Boards/Integrated Care Systems.

15. Review

The Executive Director of Operations has overall responsibility for this plan.

This is a living plan and will be subject to review through the Trust Resilience Forum, as we continue to develop this plan prior to implementation, and throughout the Q3/Q4 period as required.

During periods of extended escalation, the Executive Director of Operations will report to the Executive, who will review the on-going impact of escalation on the Trust.

An exercise will be undertaken as part of winter preparation in the preceding period to ensure readiness. In addition, testing of the plan will be undertaken through attendance at NHS winter capacity exercises across the Trust's region.

16. Distribution

16.1. Internal Distribution

- Teams A
- Senior Leadership Team
- Executive Management Board
- Communications Team (for publication on Staff Zone)
- Operational Manager
- Strategy and Partnerships Managers
- EPRR Team
- CMT

16.2. External Distribution

- NHS England and NHS Improvement -South East
- Lead Commissioners
- Integrated Care Systems

Appendix A: Risk Assessment

No	Description of Hazard	Existing Controls/Actions in Place	Risk Rating L x C = R		
1	**Covid-19, Second wave resurgence** The worst-case scenario is that infections reach epidemic levels again, putting serious strain on the Trust and the wider NHS due increased operational demand, staff absence and supply chain interruption.	• Covid-19 Strategic Plan • Covid-19 Operating Framework • COVID-19 Pandemic Test and Trace Cell SECAmb Staff Procedure; • COVID-19 Outbreak Control Management Framework; • Executive Oversight by the CMG • Dedicated Covid Management Team in place • Multi-Agency Response Plans via the LRFs	4	4	16
2a	**Winter flu and other winter related illnesses** There is a risk that COVID 19 cases may be conflated with traditional flu cases and winter illnesses. Symptoms are similar and it will be difficult to discern which is which. This may lead to the continued job cycle time increase seen due to donning and doffing of appropriate PPE for potential COVID 19 cases and may also impact on PPE burn rates.	• Covid-19 Response Plans • Executive Oversight by the CMG • Tactical Hub dynamically monitoring hospital performance • PPE management group oversight	4	4	16
2b	**Serious winter flu outbreak and other winter related illnesses - System Pressures** Each winter the wider NHS and Social Care sees and increase in influenza and other seasonal infectious diseases that will impact on urgent activities in the health and social care systems. A compound risk is that patient flow issues will be exacerbated, and some pathways disrupted	• The Trust continues to engage in system wide Winter Planning • There are a number of contingency plans in place to mitigate surges in activity including: SMP, REAP and BC Plan • Tactical Hub dynamically monitoring hospital performance	4	4	16

	due to procedures put in place for Covid 19 protection. In turn this can result in significant ambulance handover and turnaround delays at acute hospitals across the Trust region, with delays having an impact on the Trust's operations and affect our ability to respond to demand.	• Operational Commanders available and low threshold to deploy to provide on-site supervision and liaison including implementation of the Trust's Clinical Handover and Transfer of Care Procedure.			
3	**EU Exit Transition** The UK left the EU on 31 January 2020 and entered a transition period until 31 December 2020. If the UK does not reach an agreement with the EU before 31 December 2020, this will likely create a similar scenario the 'Day 1 No Deal' situation that the Trust was previously planning for. As a result of this there may be significant impact on several areas of SECAmb as an organisation.	• All EU Exit identified risks are recorded on the Trust Risk Register and will be reviewed in light of EU Exit Transition. • The Trust continues to engage with LRFs and wider NHS partners across the region in planning and exercising	4	4	16
4	**Adverse Weather** There is a potential for adverse weather during this period which could further exacerbate the challenges faced at this time, when resources are under pressure.	• Adverse weather preparation and planning arrangements • Trust 4x4 fleet and authorised drivers • MOUs with 4x4 volunteers and multi-agency response with LRF partners	4	3	12
5	**Supply Chain** There is a potential for Supply Chain shortages including PPE, uniform and fleet. This may be due to increased use of PPE, delays in production of items; the impact on the ability to import goods and internal and external distribution impact due to staffing.	• Covid 19 planning considered elements (specific to PPE) • EU Exit Transition planning considered elements • PPE management group oversight • Contact being made with suppliers re key products; • Maintenance of stock levels; • Effective planning of supply requirements e.g. uniform, PPE etc; • Effective procurement process to understand delivery and supply implications.	4	3	12

6	**Staff absence** Staff absence above the expected norm. This may be due to a range of causes such as; influenza and other winter respiratory illnesses, Covid-19, self-isolation (awaiting results for/still symptomatic), adverse weather etc.	• Business Continuity Management plan • Departmental business continuity plans • REAP • SMP • Planning assumption alignment/workforce planning • COVID-19 Plans /action cards • HR BC Plan • Wellbeing Hub	4	4	16
7a	**Public Disorder** There is a risk of increased criminal activity against staff including physical assault, verbal assault and theft of personal and trust property.	• Trust security management policy/procedures and support.	3	2	6
7b	**Public Disorder** There is a risk that trust staff, vehicles and property may become embroiled at public order events. However, staff are not equipped or trained to attend public order events and may unwittingly as a result of moral pressure commit to an area that is unsafe and as a result may suffer injury, fear, stress and fatigue. If there are multiple public order events occurring and trust staff are required to attend several, without a break, due to the unavailability or lack of resources then these factors maybe further exacerbated. Public disorder and planning for this may be exacerbated by the uncontrolled nature and unknown or unexpected hazards that may occur.	• Multi-agency information sharing • Use of JESIP principles to plan for known and unknown events.	3	3	9
8	**Organisation Reputation** Failure to plan for, mitigate and manage the forecast increase demand over the winter period and provide a safe service to our patients could lead to damage to the Trust's reputation.	• Engagement with CCG's, NHSE&I, PHE and system partners throughout planning, preparedness and response to maintain confidence across the system of robust arrangements within SECAmb • Patient Survey Responses	2	3	6

		• Friends and Family Test • Communications activity reports to EMB • Communications and Engagement Plan			
9	**Activity flow from SECAmb111** Previously throughout this period 999 has seen an increased activity flow from SECAmb111	• The SECAmb111 Escalation Plan is in place to mitigate pressure on the 999 service.	3	3	9
10	**PTS Provision** The Trust is not commissioned to provide PTS, if the PTS providers do not maintain robust resourcing over this period, this could impact on A&E departments when hospitals booked discharges are required to enable capacity.	• This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards and links into wider NHS/system Winter Resilience Planning.	2	3	6
11	**High Dependency Intermediate Care Transfers** The Trust is not commissioned to provide high dependency intermediate care transfers, except when this is shown to be an escalation of care.	• This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards and links into wider NHS/system Winter Resilience Planning.	2	3	6
12	**Access to Primary Care** The Christmas and New Year bank holidays result in an extended weekend. There is limited access to primary care throughout this period adding to Ambulance/NHS111 activity.	• This risk will need to be addressed through continued engagement with 999 commissioners and the Local Delivery Boards and links into wider NHS/system Winter Resilience Planning.	2	3	6

Appendix B: Key Contacts

To be updated

Policy in Development

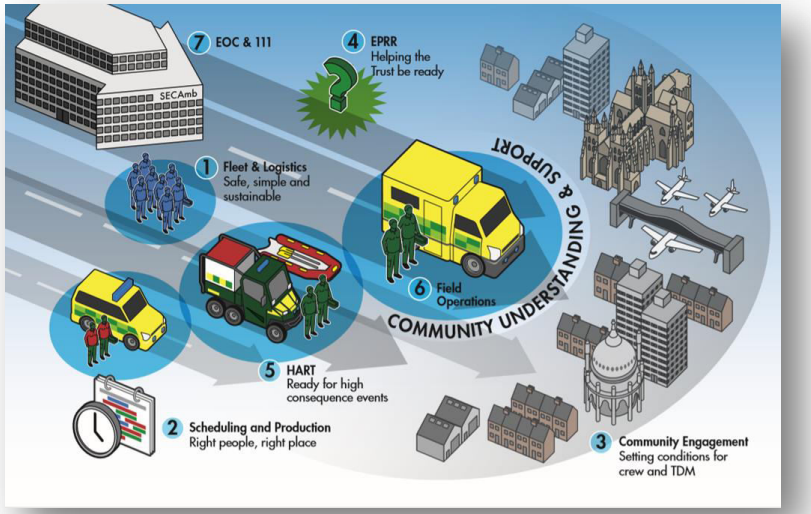
EU Transition Planning Update

24th Sept 2020

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

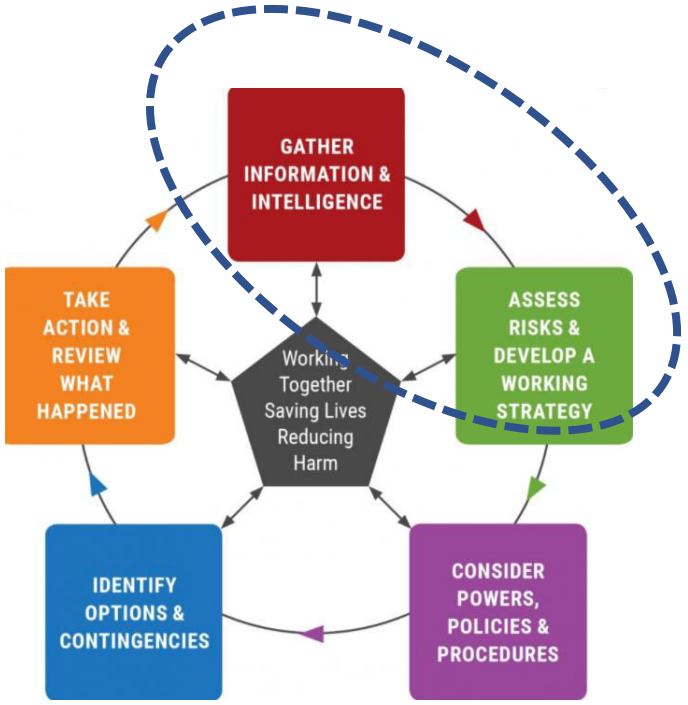
Scope

- Introduction
- Key Principles
- RFIs
- Strategic view of COVID Peak2, EU Transition, Winter Pressures
- View from Highways England [Not yet approved]
- Planned Workstreams
- Next Steps



Key Principles

- The ‘intensive scrutiny’ mechanism has been implemented in order to make sure that EU Exit is a trust-wide effort
  - Not just East as West is also impacted
  - Not just Operations, it is all colleagues
  - Not just WTE, Bank, CFR, PAP, Co-Responders
  - Not just Trust, other NHS locations, Air Ambulance et al
- The aim is to pull the experts from across the Trust and avoid ‘surprises’
- In the ‘Gather Information and Intelligence’ phase of JDM



Requests for Information?

General

Trust strategic intent

Trust Risk

Acute liaison

Trust Command Structure TCG and SCG etc. engagement

DSM and MSM

M26 assurance

Staff mapping

Funding

Reporting Arrangement

Existing Plan Review

Brock Manston from Day 1 or triggered?

North Kent Group

Supply chain concerns

Polegate

Contra Flow intervention response

PPCI/Stroke/Trauma

Paddock Wood MRC

NHS Supplies Maidstone

Thanet MRC

A249 roadworks will these be completed or ceased for 31st Dec

Covid Testing Site

Medical Plan? Other draft plans on RD

Use of Deal and Whitstable bases.

LEROS Barracks and Military support

Ashford MRC

M20 J10 and 10a TMP

MOJO site – assurance that vehicle movements will not gridlock Junctions, Police to provide a clear route through. Operating plan including Medical required.

WHH – Pathways

Pilot of DSM for a week

Brock M20 from day 1 or triggered?

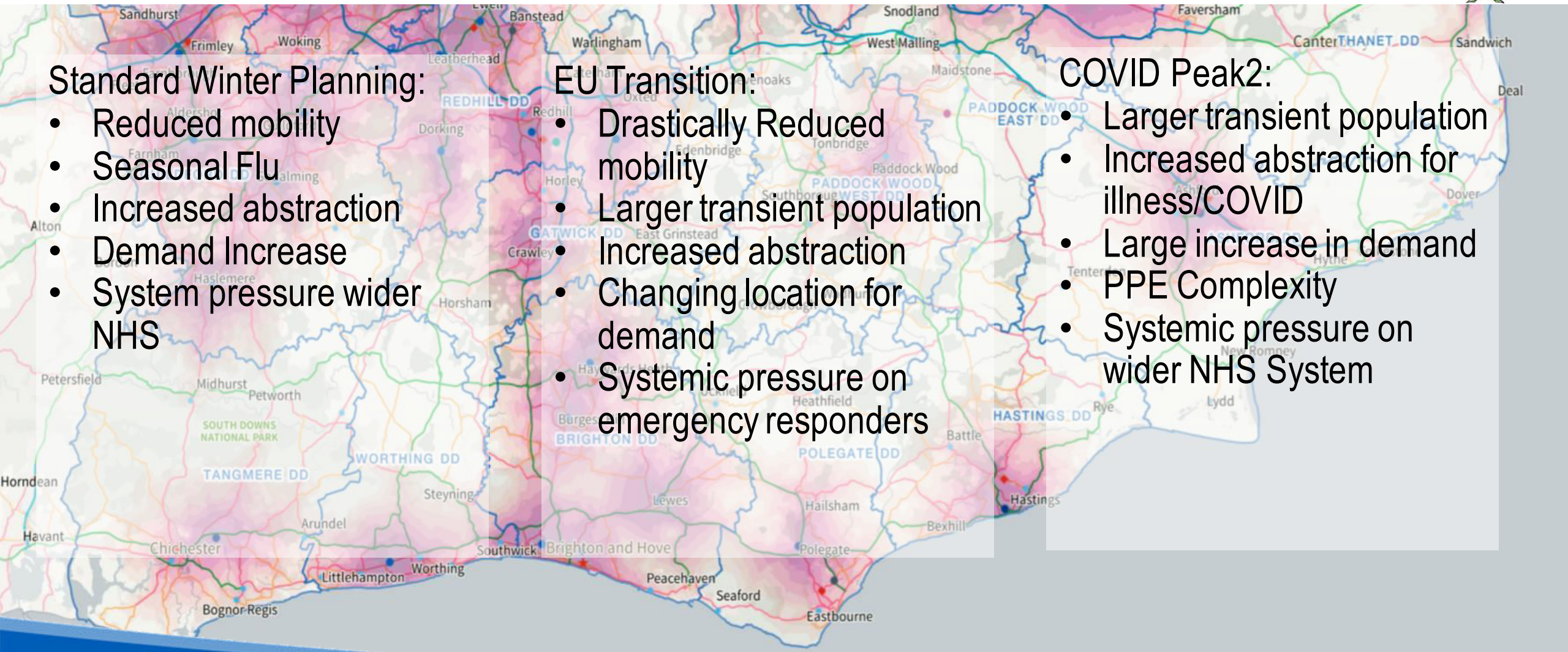
Operational response, consideration from satellite stations to include HART

What are the effects we are trying to achieve?

Traffic Management	Business Continuity	Internal Mutual Aid	Internal Res & Finance	Operational Model

- Operate a resilient service in order to deliver patient care and save life & prevent harm
- Maintain trust in SECAmb and wider NHS partner response

Key Strategic Drivers



Standard Winter Planning:

- Reduced mobility
- Seasonal Flu
- Increased abstraction
- Demand Increase
- System pressure wider NHS

EU Transition:

- Drastically Reduced mobility
- Larger transient population
- Increased abstraction
- Changing location for demand
- Systemic pressure on emergency responders

COVID Peak2:

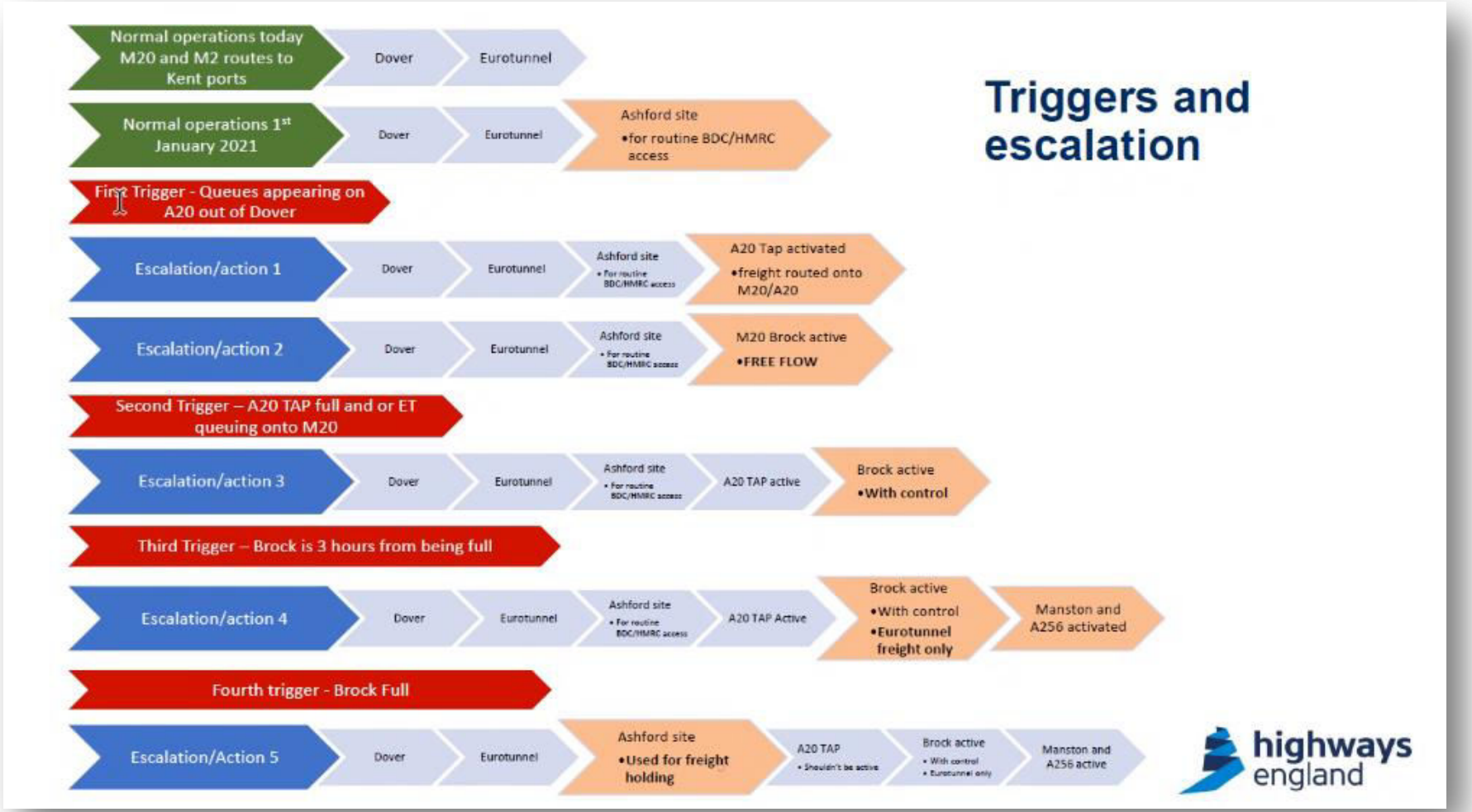
- Larger transient population
- Increased abstraction for illness/COVID
- Large increase in demand
- PPE Complexity
- Systemic pressure on wider NHS System

Terrain Analysis

- Traffic Control System
- COVID Testing and Enabling Locations
- Hospitals, Community Healthcare, GPs etc
- EOCs, 111s, OUs, Logistics & Fleet Hubs, CFRs
- Our Staff Locations
- Military/Fire/Policing Locations
- Predicted demand foci
- Weather effects

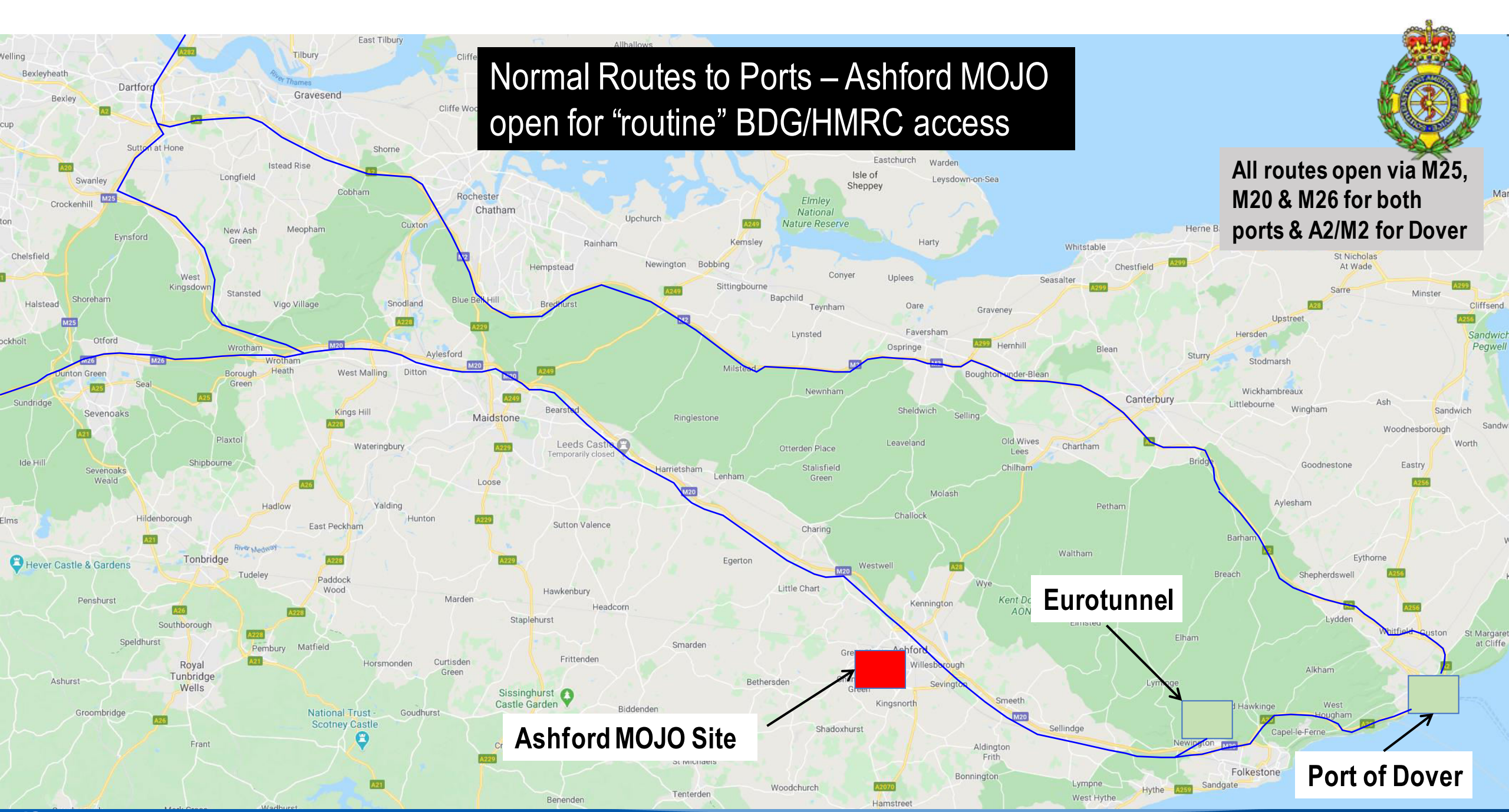
Highways England (provisional plan to be confirmed)

- MOJO
- No M26 Control
- Police considered to have greater enforcement power
- Modelling still scarce
- Learning from 14 Sept




Normal Routes to Ports
All routes open via M25, M20 & M26 for both ports & A2/M2 for Dover
Eurotunnel
Port of Dover
Dartford
Gravesend
Rochester
Chatham
Maidstone
Canterbury
Folkestone
Ashford
Tonbridge
Sevenoaks
Leeds Castle
Temporarily closed
Hever Castle & Gardens
Sissinghurst Castle Garden
National Trust - Scotney Castle
Royal Tunbridge Wells
Elmley National Nature Reserve
Isle of Sheppey
River Thames
River Medway

Normal Routes to Ports – Ashford MOJO open for “routine” BDG/HMRC access

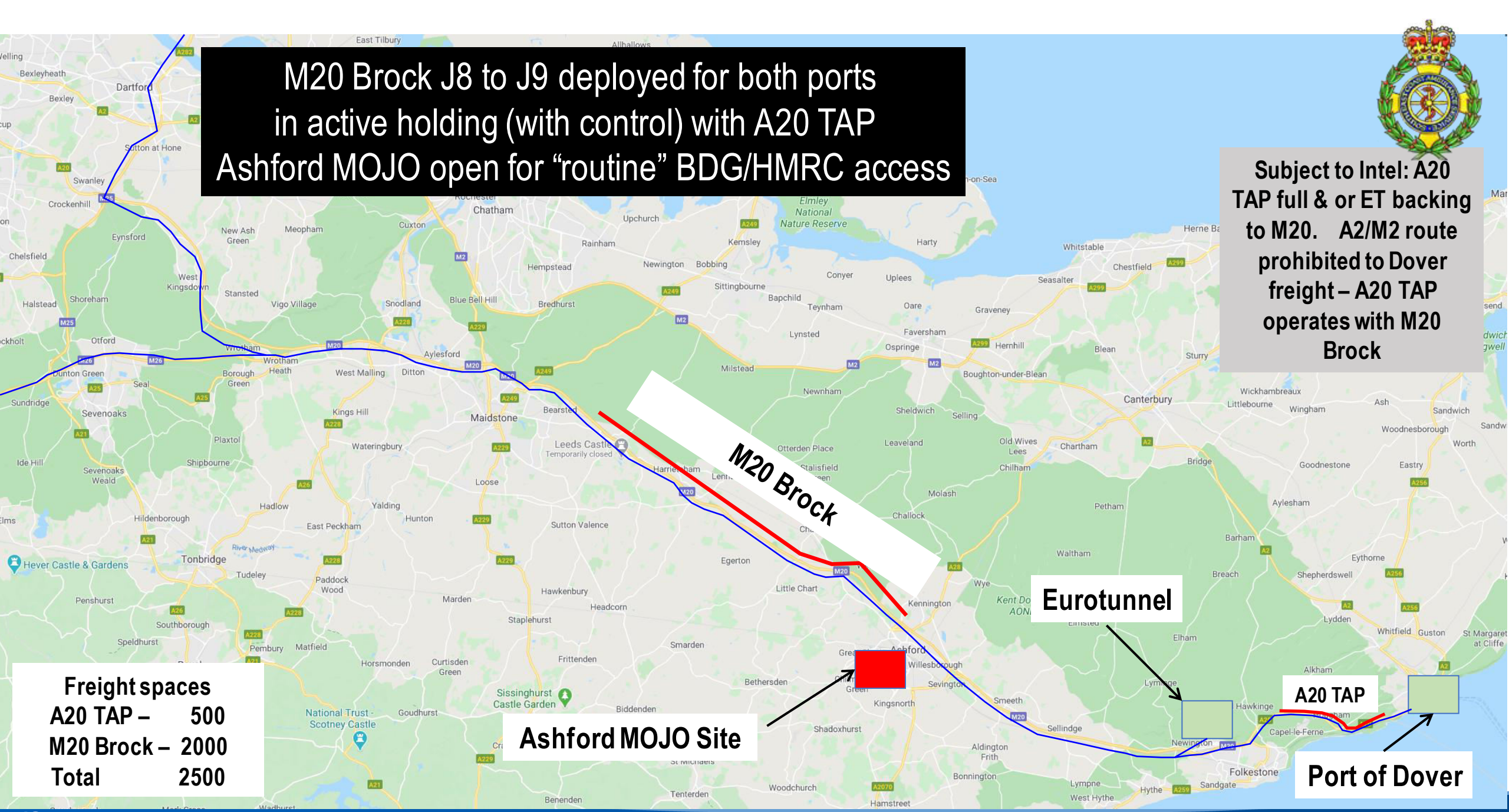


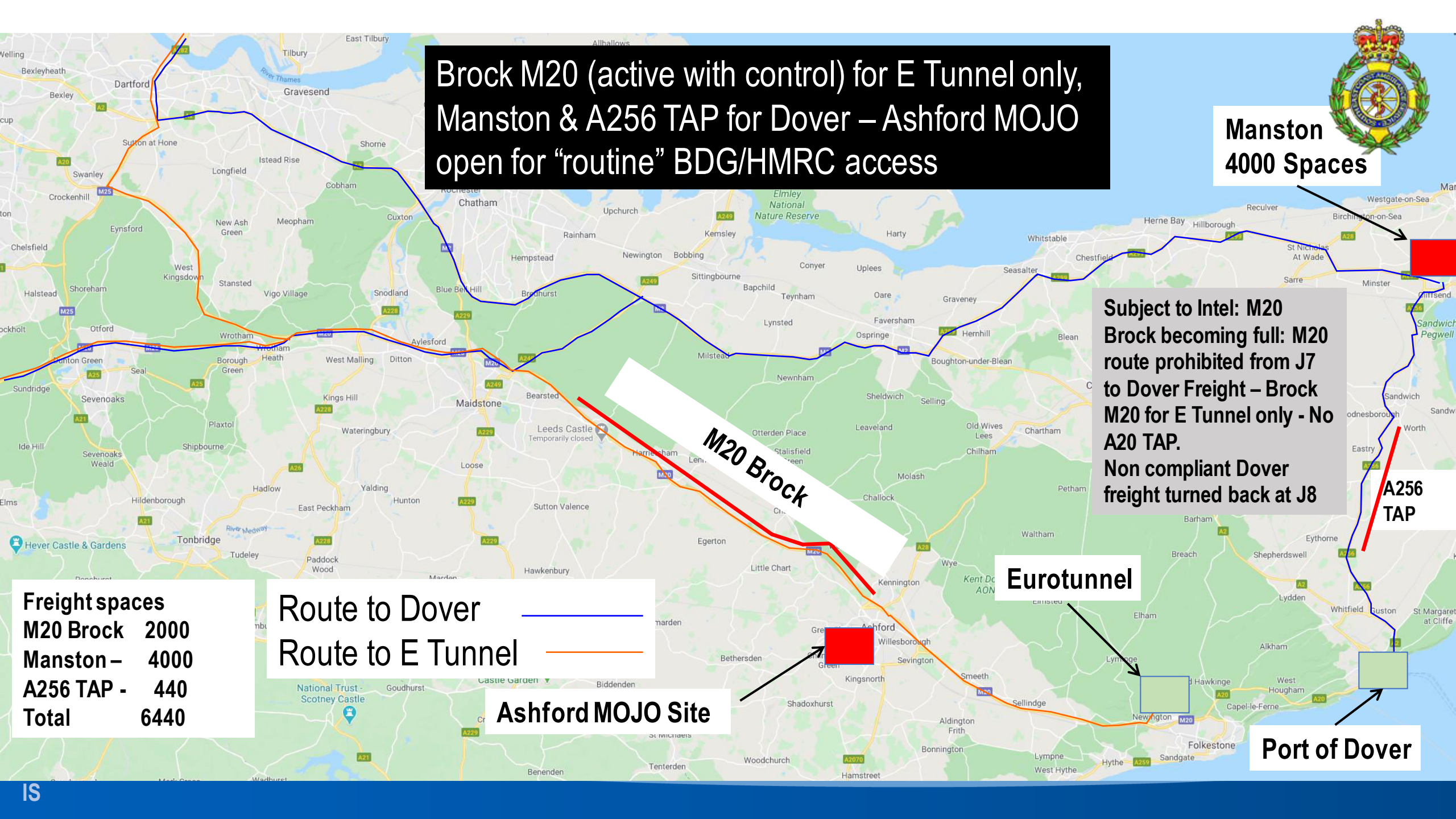
A20 TAP – Ashford MOJO open for “routine” BDG/HMRC access

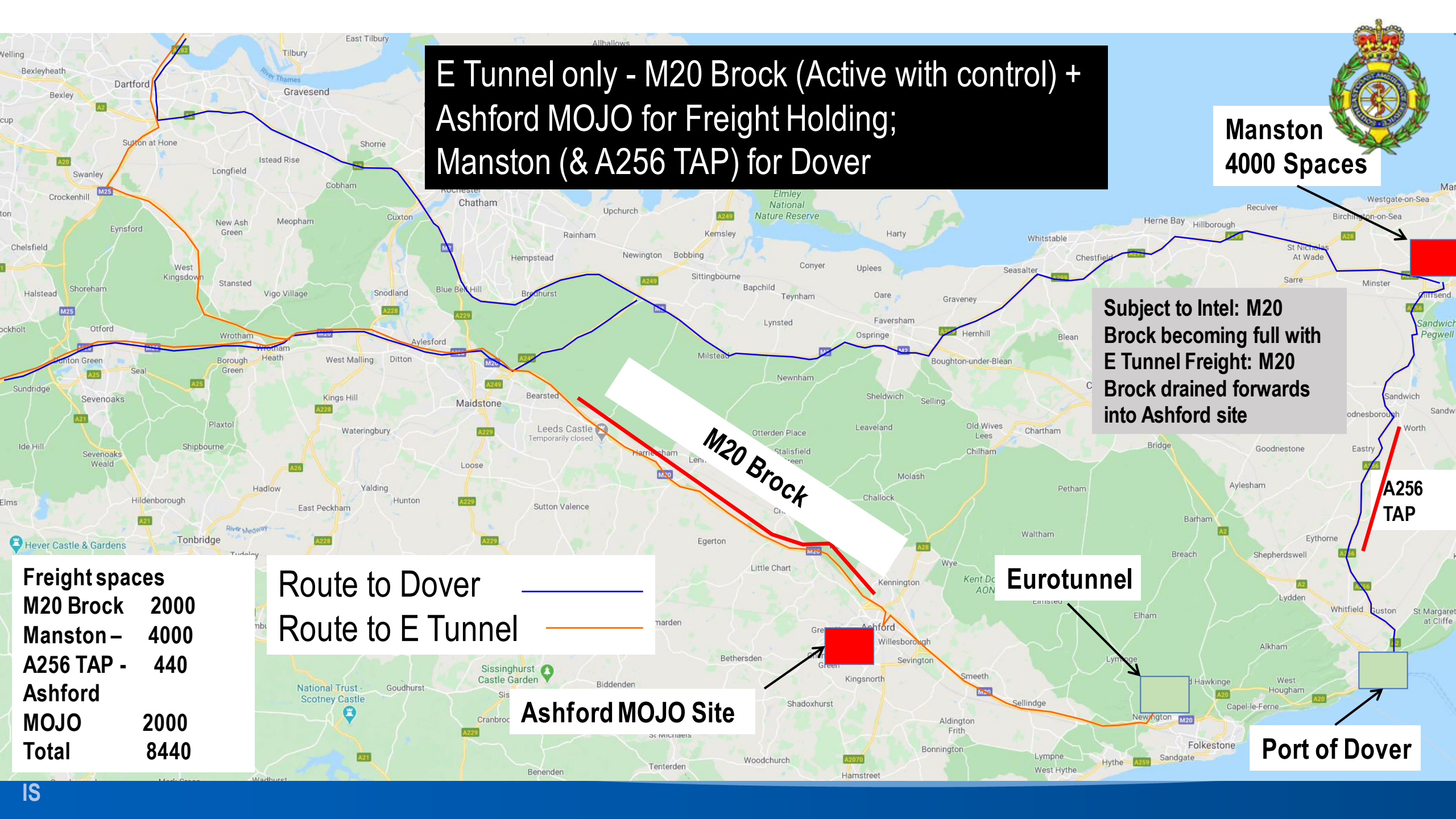
M20 Brock J8 to J9 deployed for both ports in free flow with A20 TAP
Ashford MOJO open for "routine" BDG/HMRC access

Subject to Intel: A20 TAP full & or ET backing to M20. A2/M2 route prohibited to Dover freight – A20 TAP operates with M20 Brock

Freight spaces	
A20 TAP –	500
Total	500

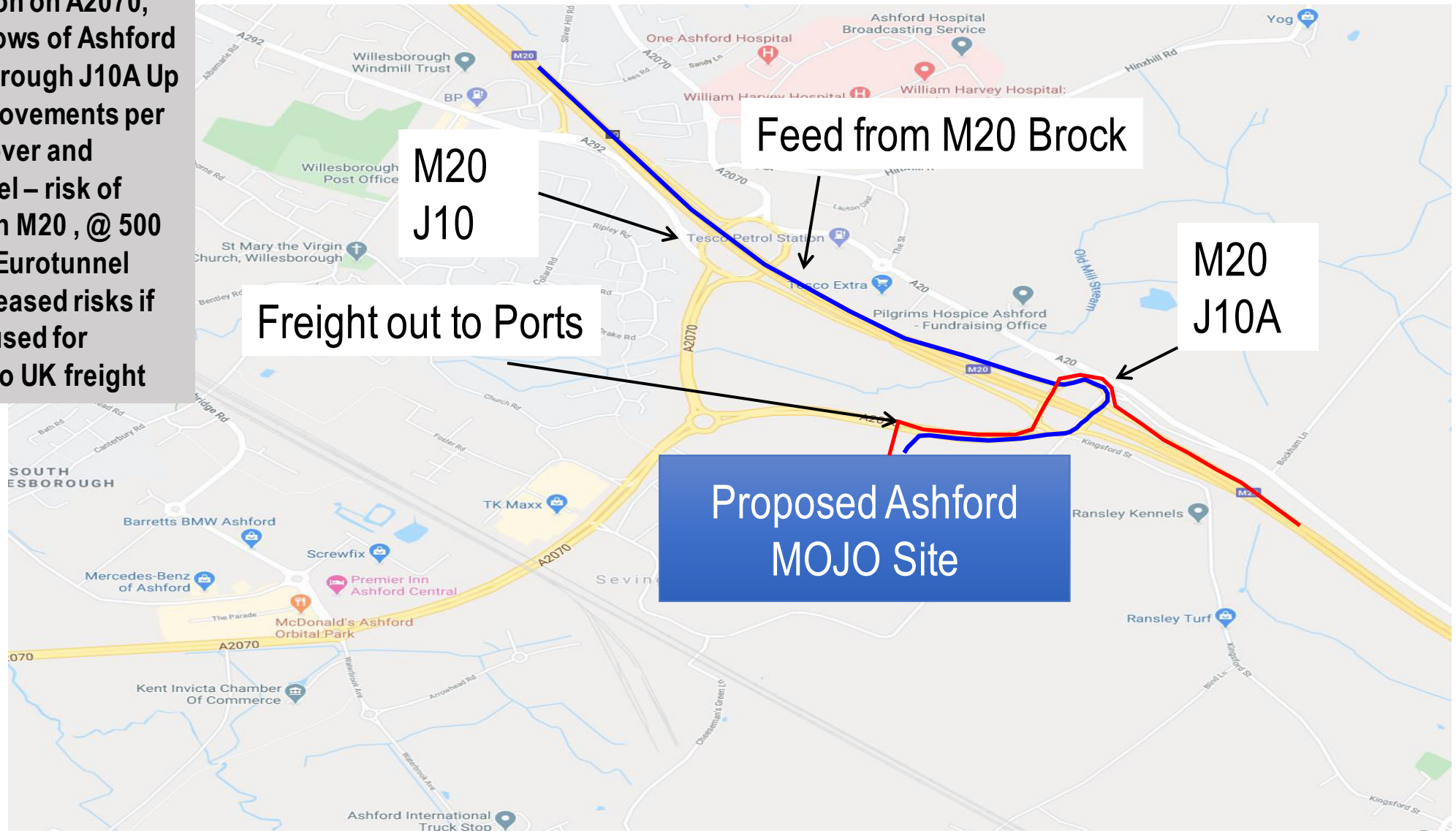

M20 Brock J8 to J9 deployed for both ports
in active holding (with control) with A20 TAP
Ashford MOJO open for "routine" BDG/HMRC access
Subject to Intel: A20 TAP full & or ET backing to M20. A2/M2 route prohibited to Dover freight – A20 TAP operates with M20 Brock
M20 Brock
Eurotunnel
A20 TAP
Ashford MOJO Site
Port of Dover
Freight spaces
A20 TAP – 500
M20 Brock – 2000
Total 2500


Brock M20 (active with control) for E Tunnel only, Manston & A256 TAP for Dover – Ashford MOJO open for "routine" BDG/HMRC access
Manston
4000 Spaces
Subject to Intel: M20 Brock becoming full: M20 route prohibited from J7 to Dover Freight – Brock M20 for E Tunnel only - No A20 TAP.
Non compliant Dover freight turned back at J8
M20 Brock
A256 TAP
Eurotunnel
Port of Dover
Ashford MOJO Site
Freight spaces
M20 Brock 2000
Manston – 4000
A256 TAP - 440
Total 6440
Route to Dover
Route to E Tunnel


E Tunnel only - M20 Brock (Active with control) +
Ashford MOJO for Freight Holding;
Manston (& A256 TAP) for Dover
Manston
4000 Spaces
Subject to Intel: M20 Brock becoming full with E Tunnel Freight: M20 Brock drained forwards into Ashford site
M20 Brock
A256 TAP
Eurotunnel
Ashford MOJO Site
Port of Dover
Freight spaces
M20 Brock 2000
Manston – 4000
A256 TAP - 440
Ashford MOJO 2000
Total 8440
Route to Dover
Route to E Tunnel
Maidstone
Ashford
Folkestone
Dover

Movements to and from Ashford MOJO Site

Congestion on A2070, Double flows of Ashford Freight through J10A Up to 1200 movements per hour if Dover and Eurotunnel – risk of queues on M20 , @ 500 per hour Eurotunnel only. Increased risks if Ashford used for inbound to UK freight



Key Workstreams [for consideration by ORMG]

- Command & Control – NHSE Regional, SCG/TSG, On-Call [IS/ME]
- Clinical Capability – Clinical Route, PPCI, Stroke, Trauma [CH, SMA]
- Scheduling & Production – Abstraction, Illness, Forecasting [JP]
- Sustainment (Fleet & Logistics) – Resilient Stock, Medicines, Assured Supply [RM,AD]
- Operating Model – Dispatch Safety Model, Contra-flow, Staff Safety, CFR [OUMs, DW]
- Operational Finance – Cost Capture, Cost Code, Financial viability [TS]
- Communications – All informed internal/external, single source of truth [JC, LP]
- Internal Mutual Aid & MACA – Augmentation & utilisation, Internal MA, PAP, CFR, MAC(A) [LN]
- Business Intelligence – Link to MAIC, understand context & performance [AC]

Next Steps

- BC to ORMG, reflecting the team required to co-ord this work (previous EUX provision and EPRR BC]
- Revised Winter Plan to incorporate the EU Transition and COVID Peak2 – Draft to be with ORMG (w/c 21 Sep) –with Slide Deck
- Review and revise the Trust Strategic Intent and Objectives and Previous Documentation
- Project Team Established to provide Worst Case/Most Likely Case and Mitigations for each work stream

Questions & Discussion