South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

26 May 2022
10.00-12.45

Sandman Hotel, Crawley

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Administration					
01/22	10.00	Welcome and Apologies for absence	-	-	Chair
02/22	10.01	Declarations of interest	-	-	Chair
03/22	10.02	Minutes of the previous meeting: 31 March 2022	**Y**	Decision	Chair
04/22	10.03	Matters arising (Action log)	**Y**	Decision	PL
Context					
05/22	10.05	Chair & CEO Report	**Y**	Information	Chair
06/22	10.20	Board Assurance Framework Risk Report	**Y**	Assurance	PL
Quality & Performance					
07/22	10.30	Board Story	-	Information	FM
08/22	10.40	2022/23 Priorities	**Y**	Assurance	FM
	11.30	***Break***			
09/22	11.45	Operational Performance	**Y**	Information	EW DR
10/22	12.15	Board Committee Reports	**Y**	Information	Chairs
11/22	12.30	Ockenden Report	**Y**	Assurance	RQ
Closing					
12/22	12.40	Any other business	-	Discussion	Chair
13/22	-	Review of meeting effectiveness	-	Discussion	Chair

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

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 31 March 2022

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

Present:

David Astley	(DA)	Chairman
Philip Astle	(PA)	Chief Executive
David Hammond	(DH)	Chief Operating Officer and Executive Director of Finance
David Ruiz-Celada	(DR)	Executive Director of Planning & Business Development
Emma Williams	(EW)	Executive Director of Operations
Howard Goodbourn	(HG)	Independent Non-Executive Director
Laurie McMahon	(LM)	Independent Non-Executive Director
Liz Sharp	(LS)	Independent Non-Executive Director
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Robert Nicholls	(RN)	Executive Director of Quality & Nursing
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Christopher Gonde	(CG)	Associate NED
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Nicola Brooks	(NB)	Associate Director, Quality and Compliance (Medical)
Jon Porter	(JP)	Deputy Director of HR & OD

Chairman's introductions

DA welcomed members, those in attendance and those observing.

75/21 Apologies for absence

Ali Mohammed	(AM)	Executive Director of HR & OD
Fionna Moore	(FM)	Executive Medical Director

76/21 Declarations of conflicts of interest

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

77/21 Minutes of the meeting held in public 27.01.2022

The minutes were approved as a true and accurate record.

78/21 Action Log [10.02-10.11]

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

DR updated the Board on the green strategy next steps, as outlined in the slide pack, including how we obtain external support to develop the delivery plan. He reinforced the need to get this right within the planning this year, with implementation from next year.

MW asked that the executive ensures we are agile, as is implied in the design, and reinforced that next year is critical as we formulate more detail. He asked that information is provided to the Board to enable it to seek confidence that we are moving in the right direction. The Board agreed that this will affect everyone so is an opportunity to engage our people.

PB referred to the timeline and specifically the pace we are aiming for and asked if we could increase it. DR explained that there are things we are doing, such as electric vehicles, stopping small milk cartons etc., but noted the risk will be in ensuring we target investment in the right things.

HG reminded the Board of a suggestion he has now made a number of time s about ensuring there is an environmental impact assessment as part of the business case process.; he asked that we ensure this happens as part of this strategy. DR confirmed that we will do this.

DA summarised that the Board enthusiastically receives this update. It notes the progress and supports the need for external support to help direct our efforts. This is a significant issue for the Board and so it will need to receive regular updates.

Board Story [10.11-10.21]
The Board Story this month helped to illustrate the management of someone in cardiac arrest; an inspiring story about Mike Ferguson as told by him and the crew that attended. After the video was shown the Board reflected on the skills our people demonstrate every day to help save lives. The video shows the importance of people calling us when they have chest pains and it reminds us of why we do what we do.

79/21 Chair's Report [10.21–10.28]
DA summarised the key issues from his report in order to set the context for this meeting. He referred back to the video just shown which reinforces what we will be discussing today about the need to do all we reasonably can to get to patients as quickly as possible. The IPR sets out the current management of demand and Better by Design later on the agenda is our strategic response.

DA thanked LM for which this is his last meeting, acknowledging his significant contribution to the Board and in particular helping to keep us future focussed.

Reflecting on events of the last few days, such as the national staff survey results and the Okenden Report, DA reinforced with the Board the importance of being able to demonstrate quality of care to patients and support to our people, especially during what continues to be challenging times.

80/21 BAF Risk Report [10.28–10.51]
PL outlined the usual format of this report, with section 3 that outlines for assurance that the BAF risks are integrated with the work of the Board and its committees. One risk related to mandated vaccines has been removed given the change in the legislation in recent weeks. PL then summarised the position with the specific risks and how they link to today's agenda, for example:

- *111 & 999 Performance* - The principal controls and actions are covered by the programme of Better by Design, later on the agenda.

- *Financial Sustainability* - This was a focus of the most recent performance and finance committee meetings, and also one of the programmes within BBD, to ensure the operating model is developed with internal and external stakeholders.

- *Workforce Sustainability* - Work is ongoing at a regional level and taken through our system assurance meeting. There is discussion about a regional workforce plan.

- *Education Training & Development* – A focus of both WWC and Performance committees, with the joint committee meeting held recently, as set out in the escalation report.

- *NHS 111 Single Virtual Contact Centre* - Continue work with national team – focus of the next performance committee meeting, as confirmed in Board's action log.

The Board explored the workforce risk and its link to the integrated plan and asked if this is one aspect of something broader. PA responded that this is not a risk we can solve on our own. We are therefore working closely with the system who recognise this is a system risk. At region, it is accepted that we need a regional workforce plan as gap is circa 500 paramedics over a 3-year period. They will then commission someone to deliver it. PA felt we are having a positive influence over this issue but acknowledged the funding issue remains.

DA reinforced that we must manage what we can control including making the Trust a great place to work, to stop people leaving. This links to training and development (separate BAF risk) and career pathways.

The Board noted that the executive is working to better quantify the risk related to the 111 single virtual contact centre. EW set out the background to this, the work by other 111 providers such as SCAS and PPG, and the risk to our strategic aim to integrate 1s and 9s. EW acknowledged the expectations in the model related to efficiencies and the impact on workforce numbers and commissioning.

HG clarified whether this is more about an implementation / integration risk. EW confirmed it is and has implications for our 999 service, although once in place there is a potential opportunity for patients. However, there is lots to first work through.

TQ asked the executive to clarify the patient safety implications. EW explained that part of the challenge is that the centre initially described this as national call centre, but it has evolved now to region. The patient safety risks are being quantified but they relate to the impact on our ability to flex our workforce between 1s and 9s and also providers may have different processes. There will need to be a regional quality impact assessment to ensure optimal patient safety, but EW confirmed the risks are still to be fully quantified.

MW noted more broadly that while he supports the overall BAF risks, patient safety/quality could be more overt within them. This led to a discussion about how we frame these risks differently.

RN then updated on some of the work to implement a new risk management policy, aimed at making the approach more robust.

DA summarised that this was a good discussion on the BAF risks, and the Board is assured it has visibility on the main strategic risks. He stressed the importance of ensuring clarity on the principal risks and how they link to quality and safety.

81/21 Chief Executive Report [10.51–11.18]

PA started by thanking LM for helping us keep future focussed during the pandemic and welcoming RN to the Trust.

PA highlighted the key national issues, explaining that we are now moving fully into recovery phase of the pandemic, although we still have 300 staff off with COVID. This means a number of things, some clearer than others, for example the national guidance on IPC measures in the NHS is awaited. The long-term plan is to be refreshed and legislation to form ICSs seems to be on track for July 2022. On the COVID inquiry, this is likely to be kept at relatively high level, and we need to make sure we are ready in terms of record keeping; we are in the process of preparedness via the EPRR team.

PA then referred to the ongoing CQC inspection with the findings due to be reported in May for factual accuracy. There has been some useful early feedback which we are working on ensure early action is taken. We are also listening carefully to the feedback from the staff survey some of which is really hard reading. We are working to ensure improvements including on the 'working without fear' campaign. PA acknowledged we need to do more and will bring back more to the Board over the coming weeks.

Lastly, PA confirmed the greatest risk to patient care and safety is the ability to meet ARP, as reflected in the IPR.

DA thanked PA for his summary and opened up to questions.

CG referred to the staff survey results and specifically the section related to recommending SECAmb as a place to work; he asked what we can do to improve this. PA responded that our approach to culture, welfare and wellbeing has to be strategic as these are deep rooted issues that require a sustainable approach. That said there are some hotspots and work locally to do as well; we need to tackle it from all angles.

DA confirmed that we will be bringing back the Board's response to the staff survey.

MW challenged PA, feeling his response was too vague. He asked why staff are saying the Trust is not a good place to work, confirming his expectation that the executive should understand the root cause. Also, while he accepts some of the response is longer term, we need immediate actions too. He reflected that this is a really worrying issue. PA agreed and explained that a fuller response will come back to Board. The executive has agreed a process of understanding this through their teams / line managers. MW reinforced the need to use the full structure not just the executive and PA confirmed this is the plan. DA added that we must empower all leaders to have these discussions.

PL reminded the Board that we have an improving staff experience plan that includes a range of things, using intelligence from the best organisations and so includes the things that make an organisation a good place to work. There is a plan to test this against the recent feedback and the outputs will come back to the Board.

DA summarised that COVID hasn't gone away. We are in charge of this Trust and we need to do what we can to make us a good place to work. It reflects on the entire leadership not just the executive. The Board will shortly expect more detail following the work of the executive, starting at the development meeting in April.

82/21 IPR /Committee Reports (11.18–13.10)

PA introduced the IPR report, referring the Board to his summary. He then handed over to EW.

<u>Operational Performance / Performance Committee</u>

Operations

EW outlined the focus on current challenges in achieving ARP and 111 contractual metrics, all of which is a key element of patient quality and safety. Sickness levels are at the highest levels for some time for both COVID and non-COVID. Annual leave is also still high but this is positive as staff need downtime. Mitigations include dynamic management, robust command structures contributing to what we do to manage hour by

hour and also future planning. We are also optimising resources such as focussing clinicians in EOC on areas with longest waits. And working with emergency departments to manage delays handing patients over, and developing care pathways to manage demand more effectively, ensuring people get the most appropriate care.

The Board noted that our approach to surge management is evolving into a clinical safety plan, using learning from COVID. This supports how, at highest demand, we prioritise those at greatest need, for example asking lower acuity patients to make their own way to hospital. In other words, how we manage risk to optimise safety during these significantly challenging periods, to better match supply with demand.

SS noted the impact of sickness and annual leave and asked how this will affect training and development which is also critical, as this was planned to start from April. EW responded that management training focusses on first line managers, such as OTLs and we have more flexibility with this group. We are committed to this as their development is critical to the overall running of services. The training plan is focussed on front line staff and weighted more to the second half of the year; planning is going ahead but will need to conclude how we schedule this. Statutory and Mandatory training is also ongoing.

MW followed up the question from SS by asking if we are at risk of our current level of abstraction being institutionalised, specifically COVID. He felt that this is a real risk here and across the NHS more widely. EW referred back to the staff survey, and the feedback about finding it difficult to manage with current staffing levels. There is some peer recognition of abstraction / sickness levels and their impact. MW came back to ask if the executive is confident that we have the right level of HR support to manage some of this. EW explained that once COVID sickness can be managed as normal sickness (awaiting national guidance to change) then there might be a capacity issue to work through.

DA asked WWC to keep an eye on this and how we manage the tensions between abstraction and the need for training and development. He summarised that the Board has had a comprehensive discussion, acknowledging that we are under huge pressure. We are listening to the workforce and working with partners to manage safety and risk as best we can at this stage. More detail on impact on patients will come under the quality section of the IPR.

DR then highlighted the work on the look forward and integrated planning for 2022/23 and beyond. The forecast is that activity will rise over the next few weeks but we expect sickness to reduce. We will remain in REAP 4 for a number of weeks. Some weekends, Easter and Queens Jubilee are particular risk periods and part of the mitigation is to use targeted incentivised shifts. Recruitment starts to realise in Q1 and the integrated planning is ongoing, working closely with commissioners. In terms of challenges, DR explained that recruitment and clinical education will be key, and we need to ensure staff are in the right place and right time, through work on rota changes. At present there is some misalignment given changes in the demand profile that our rotas have not kept up with. We are also rebalancing workforce across OUs, which will help reduce out of OU working, to enable breaks and better work experience. All this being developed into specific plans that will inform priorities over the coming year. Delivery will inform an improvement trajectory and financial performance, which we return to later under better by design.

Performance Committee

HG outlined the outcome from the recent meeting, including the areas of assurance and where there are gaps, as set out in the report. He was encouraged by the clear articulation on integrated planning there is better clarity than ever before. However, partial assurance related to the outcome of the scenarios, which draws the distinction between clarity on planning and scenarios that do not deliver ARP / show a funding gap. The committee is encouraged by the good process now for looking ahead and planning for times of greatest risk. There is also improved planning to improve operational performance, but our inability to meet ARP is due to challenges with resources, as discussed.

There were no questions from the performance committee report.

DA summarised that the Board is pleased with the work to better understand the performance issues so we can take forward actions in a measured and evidenced based way.

Quality and Patient Safety / QPS Committee

NB highlighted the information related to the clinical outcomes, including cardiac arrest, confirming a small increase above the mean. In relation to the single witness signature of controlled drugs, reporting has changed which explains the increase. CD audits continue daily. NHS Pathways compliance data is showing normal variation and we are working on all areas of non-compliance through 1:1s, training and coaching.

RN then updated the Board on the harm reviews related to C1, C2 and C3 that EW alluded to earlier. He reminded the Board that there is a high number of reviews of double breaches that showed low harm and so in January we reduced to 15 reviews a week. Then, in light of our move to REAP 4 we started 10% of double breaches and outcomes are reported to EMB and any moderate / high harm escalated to the SI Group that meets weekly. RQ added that we are undertaking a quality assurance review of the process and structure of harm reviews and have asked CCGs for a peer review.

In terms of incidents, the IPR shows an increase which RQ felt is positive. 17,0000 over a 12-month period suggests a good safety reporting culture but we will benchmark with others to confirm the same. The most significant issue aligned to what EW mentioned earlier is the capacity to manage incidents in a timely way, hence there is some back log in investigations and closing actions. We are working to reduce this.

QPS Committee

TQ outlined the outcome from the recent meeting on 17 March, including the areas of assurance and where there are gaps, as set out in the report. The committee did note the increased pressure we are under and agreed to organise extra meetings to continue to assure safety, as required. This will be triggered from outputs of the harm reviews, for example.

DR referred to the Omnicell sign off data, which suggests we are better at reporting and asked NB to explain this. NB confirmed that we only reported previously on adverse incidents but now we show all cases including those we verify as being appropriate; so it would be only one if we were reporting as before. HG noted the single witness Omnicell trend which is moving in the wrong direction and asked why. NB explained that this is linked to abstraction with more staff out on the road (can't counter sign); the assurance we can give though is that they are recorded so are audited and verified as being appropriate.

HG felt that there is balance between reporting incidents and having the capacity to deal with them; he expressed some alarm by the 1595 awaiting managers review. He asked if there any serious incidents within this number. RN agreed it is a high number but added that all incidents are reviewed weekly and any SIs are taken through the SI Group, which ensures immediate learning. He added that we need to get to a point where we don't just follow process but demonstrate real learning.

DR then asked how we use learning from harm reviews to draw conclusions to inform what we might do differently. RN responded that we need to apply this to all we do; the 'so what'. This is why we are reviewing what we are doing to ensure systems and processes are robust to ensure learning, for example the peer review of our harm review process. The output of this will be reported to the Board.

MW asked PA if he is confident that there is an adequate control environment over the use of controlled drugs. He confirmed that he is.

MW then asked about any issues arising from hand hygiene compliance. RN accepted there is concern about this, and we need to ensure improvement. PL reminded the Board that this issue was identified by the Board from the IPR last year and it asked QPS to seek assurance, which it did in January (partial). It is continuing to monitor the improvement plan as set out in its escalation report to the Board. This clarified that this is as much a cultural issue than process and, in answer to MW's question about consequence, a link between hand hygiene and staff sickness was identified.

[break 12.30-12.40]

Workforce and Wellbeing

JP reflected the conversation earlier about wellbeing and drew the link between an engaged workforce and quality. He acknowledged there is much work to do on engagement. In the IPR sickness absence is highlighted and we are working with union colleagues on our absence management policy and awaiting national guidance on the management of COVID sickness.

Made at SECAmb (the 'fundamentals' first line management training programme) is due to be rolled out this year, utilising a range of flexible learning options. The new appraisal process is to be rolled out this year too. Lastly, JP confirmed that we are reviewing the induction process.

Workforce & Wellbeing Committee

LM outlined the outcome from the recent meetings, including the areas of assurance and where there are gaps, as set out in the report. He felt that there is good use of the committee dashboard but perhaps a need to integrate a little deeper any hotspots where management isn't working as well. The committee will need assurance on more focussed development actions / solutions. LM acknowledged the good work on clinical education and wider ETD strategies; there is good links now between clinical education and the wider organisation.

The Board agreed that the extra meeting illustrates how we can use joint committee meetings where there is crossover of spheres of committees.

LM confirmed that while there are several partial assurances, there is confidence in the plans and in the data on which they are based. Due to weight of operational pressures some areas are not progressing as timely as hoped and so the committee will need more assurance on delivery of plans.

MW expressed concern and a lack of assurance about performance appraisals. He challenged the executive (and the committee) to ensure all staff have the opportunity of an appraisal. He supported the new system but wanted to know what percentage completion is expected over the next 12 months and therefore what the performance gap will be. He added that this links closely to cultural change and so we must focus more on this. JP responded that this is fundamental to building workforce engagement and retention. He confirmed the trajectory is 85% by the end of the year. JP also outlined the more conversational approach to the quality of appraisals. MW clarified that the aim by March 2023 is that 85% of staff will have had appraisal. JP confirmed this and MW stated that he will be holding the executive to account for this given its importance. PA supported this and agreed we need to improve significantly, noting this is a two-way process.

On the quality of appraisal, which is of equal importance to completion, TQ asked if we are preparing managers adequately. JP outlined the training in place to support the new process. PA added that feedback has been positive on the quality of appraisals, despite low numbers.

Finance /FIC

DH confirmed we are on track to meet our financial plan for the year. Following on from the integrated planning discussion earlier, the end of this approach is to cost it and then work through how much the system can afford to fund; so the escalation to the Board is that we are working through the scenarios and there is a significant gap which we are working with commissioners on. DH reinforced that this is not about a bottom-line number, but the impact on quality and performance based on what resource we can reasonably provide (such increase in workforce). DA asked if discussions are in the spirit of partnership given the challenges across the NHS. DH confirmed they are explaining it is an open book transparent process.

Finance and Investment Committee

HG summarised the areas covered at the most recent meeting adding in response the point DH made, not only is it clear we are working in partnership but are able to have a well-informed discussion, based on better data / evidence. The committee is assured with the financial plan for the year.

There were no questions.

DA summarised that we are meeting our financial commitments and confident we are where we said we would be and are laying down a marker regarding the challenges going forward.

Audit & Risk Committee

MW summarised his report, with the committee having assurance that coming to the end of the financial year there are no issues arising from the audit of accounts. MW highlighted the Internal Audit on fleet as this was partial assurance; the committee is not concerned as we have good information and this is about how we make proper use of it and progress is being made led by DR.

83/21 Learning from Deaths Q1 Report [13.10-13.12]

DA confirmed this and the following reports have been considered by the relevant committees, as set out in their escalation reports, and are for the Board's information and assurance. NB reiterated the work to ensure more targeted learning from deaths reviews, to ensure better learning. Otherwise, there are no issues to escalate to the Board, which the Board noted.

84/21 IPC BAF [13.12-13.15]

In the context of the earlier discussion on infection prevention and control, the Board noted the report and the improvement work to improve compliance with hand hygiene. RN clarified the gap related to FFP3 masks is mitigated by the investment in powered hoods. DA assured by this and the positive impact of the investment in powered hoods.

85/21 Gender Pay Gap Report [13.15-13.24]

JP outlined the findings of the audit which shows the gender pay gap and disparity in some grades of roles, as described in the report.

The Board noted the report; there are no new actions and the report reinforces the actions previously agreed which are being taken forward.

MW asked if we are confident looking at pipeline of women coming forward in leadership roles; he encouraged the executive to be ambitious. JP gave some examples of supporting female leaders. EW is the chair of the Gender Equality Group and explained the pipeline is not robust; recent vacancies in senior operational roles have had less than 20% female applicants. She added that we are acutely aware of gender imbalance within operations.

DA summarised that there are workstreams in place and reinforced how seriously the Board takes this.

86/21 Better by Design (BBD) [13.24-14.16]

PA introduced this by explaining that BBD arises from our strategy and is about how we care for our patients and staff. From earlier conversations, we can only attract and train a specific number of staff each year so our inflow is not boundless. We are more ambitious each year but the gaps are so big BBD helps to clarify that we need to change the way we provide care in order that we aren't in the place we are now with imbalance of supply and demand. Changing the care delivery model requires engagement across the whole trust, so we all move in unison; hence why we have set up the programme of BBD. What we have is a portfolio of programmes that delivers our strategy; some has started e.g. performance cell that provides key data to inform other areas. Some, such as the operating model has not started. PA handed over then to DH.

DH reflected that this is a design of a programme but does not come up with answers; this is what we do next, engaging with key stakeholders. He then explained the approach and how it is aligned, briefly touching on the six programmes, each led by an executive director. There are three golden threads that underpin each of the programmes; quality (quality improvement); green; and technology. DH outlined the aims, principles and what it will mean for patients and staff, as set out in the paper.

In terms of broad timeline and approach, DH reinforced that the solutions will be driven by the workforce and other stakeholders. These are the structural changes we need to make to ensure we can delivery ARP sustainably. We acknowledge the requirement to engage to get the right answer and this must happen at a programme level and is iterative and continuous.

DR and then EW gave further detail on the performance cell, which is further developed, and the overarching aim of the care delivery model, using the slide deck in the pack.

Lastly, PA summarised that this gives some of detail of two of the programmes, and he explained that we chose these two as the performance cells is the primer for the whole programme, using proper data to forecast impacts of different approaches to determine what will likely work best. And all the other programmes support the care delivery model. Key to this is coordination of the programmes.

DA thanked PA and his team for this, emphasising that this is all about patients and staff. He noted that the Board receives this enthusiastically and reinforced the need for ongoing assurance on engagement and delivery. He then opened up to questions.

HG is very supportive and asked how we intend to make use of big data, e.g. do we have heat map of demand to deliver and organise services.

SS referred to the staff survey feedback and asked about engagement with staff.

MW agreed this is exactly the right approach but expressed how important all stakeholders have confidence in this as there is a resource consequence. We also need to communicate how the governance will work and find a way of talking and engaging with staff to ensure we take them with us.

LS felt that this is the most exciting thing over the next year. From a patient perspective, we need to use evidenced based practice and not try and start from scratch. Learning from the past and working with those already ahead of us.

PB reflected that we have already made some progress such as the performance cell and so we can share this now.

In response to these questions PA started by acknowledging that the Board is united on this. He confirmed that we have used some data from New Zealand, but this is more about how we get patients out of hospital more quickly and prevent people attending before they become more unwell. In response to the staff survey, we will engage on specific areas within the programmes, e.g. DR has already done much and EW has engaged her team about the care delivery model. We have also started engagement with external stakeholders and internally with unions who are supportive. On the question of big data, DR explained we already have this capability, and is part of what we will look at to inform decisions about what we do and how we work as a system at population health level. EW added that there are interesting conversations with AACE in how we support the public health messaging and use of big data such as indices of depravation to understand needs. We are using commissioners who have this data. Overall, this is about how staff can contribute to the future of the organisation, across all directorates and backgrounds.

DA summarised that there have been several months of discussion at Board on the design of this and as a Board we are now behind the delivery, ensuring we are open and engaging, as this will be as much about listening than doing. It is all about giving staff better work experience and better care for patients.

87/21 Investments [14.16-14.28]

a) DCA Replacement

DR explained that this paper is a summary, with a full business case in part 2 due to commercial sensitivities. This asks the Board to approve the investment for the coming year. By 2026/27 all vehicles will be within the current target age profile.

DR confirmed we are offering some old ambulances to the humanitarian effort in Ukraine.

DA commends the approach to our vehicle replacement programme and the Board supports the investment over the next year.

b) OTL Establishment

EW explained that this relates to investment in the operating team leader structure to re-balance and align with the ratio previously agreed. It will provide better support to staff; linked to earlier discussion about how key this level of management is.

The Board approved this business case.

c) Frontline Operations – COVID

EW confirmed that this covers the funding already received, so is a retrospective business case capturing all the additional costs covered centrally.

The Board approved the business case and is assured we are accounting for this appropriately.

88/21 AOB

None

89/21 Review of meeting effectiveness

DA apologised for the meeting overrunning, but felt it was effective and the subject matter has been crucial. Key areas of focus have been patient care and staff welfare / experience. We also heard about the pressure within the NHS and the steps being taken within the local system to make patients safe. And that we are finishing the year within our financial promises.

There being no further business, the Chair closed the meeting at 14.23

DA then asked if there were any questions from the public in attendance, related to today's agenda.

David Romaine – new Governor, asked about plans to move to hybrid/zero emission vehicles. DR responded by explaining that, at present, there is a national trial we are involved with, using three electric (rapid response) vehicles and we are doing a like for like comparison over next few months. Our view is that we will need to move in this direction as we drive 15 million miles each year burning diesel, so to reduce our carbon emissions the focus must be on our vehicles. In terms of hybrid, at COP26 the NHS presented a hybrid vehicle but is still currently a prototype. However, we will be interested in testing these when they come online.

There were no other questions from the public.

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Act

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)
25.11.2021	48 21b	WWC to explore whether we are doing all we can do make SECamb an attractive place for students to want to come and work (and then stay).	LM	Q1 2022/23	WWC	IP
27.01.2022	60 21	The performance committee to explore the risk related to the 111 single virtual contact centre, and a paper will come back to the Board in due course.	PL	Q1 2022/23	PC	C
27.01.2022	63 21	WWC and/or FIC to test that we have allocated adequate resources to ensure education training and development to meet the needs of our workforce.	PL	Q1 2022/23	FIC	IP

Key

	Not yet due
	Due
	Overdue
	Closed

ion Log

Comments / Update
Added to the cycle of business for 2022/23 - and reported back to Board via the escalation report.
Considered by the committee in April - see escalation report
Added to next FIC meeting in consideration of the budgets for 2022/23

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	05-22

Name of meeting	Trust Board
Date	29.05.2022
Name of paper	Chair & Chief Executive Report
Report Author	David Astley, Chairman & Fionna Moore, Interim Chief Executive

Since the last Board meeting in March we have received the feedback from the 2021 staff survey and initial findings from the inspection undertaken by the Care Quality Commission (CQC). The CQC has provided initial feedback (the report is due to be finalised for publication in June), which includes concerns about culture and leadership, reflective of the feedback from the staff survey. It is in light of this that we have decided to provide a joint report this month to provide a commitment on behalf of the Board to our workforce, and to set the context for this meeting.

Many of our staff have essentially told us that for them, SECAmb is not a good place to work, that they have lost faith in leadership (at all levels), and that they do not feel listened to or engaged. The CQC reinforced this and found a disconnect between senior leadership and those directly providing patient care. These are difficult messages to hear. However, as a Board we must commit to really hear this feedback and to take the necessary action.

In the past 6-8 weeks the executive has taken steps to start to re-set its relationship with the senior leadership team and together they have held a dozen or so workshops to work through the recent feedback. The purpose of this was to help agree some priorities including how to ensure we listen and engage our teams over the next period so that we can work together on finding the solutions to the issues that have been highlighted. The Board used some of its development meeting in April to review this and engaged the Council of Governors at the recent joint meeting. The Board Story today includes reflections from some executive colleagues about what they have heard and the steps taken to-date.

The meeting today therefore has a primary focus on how the Board, the executive and the wider leadership team, will be using this opportunity to do things differently, in line with what our workforce have told us. There are some things we can do quickly, and as the Board will hear during the meeting, some actions have already been taken, but most importantly we must ensure the actions we take are sustainable; this is what the Board will be helping to ensure.

One of the areas of Board development is how we use data better to obtain assurance and inform strategic decisions. We had a really helpful session at our last development meeting with a colleague from NHSE who provided some examples of how improve our Integrated Performance Report. As a result of this we agreed a 'data holiday' to provide the capacity the business intelligence team needs to develop this new approach in time for the Board meeting in July. This meeting therefore includes a much shorter IPR showing key operational and clinical data.

To ensure the Board is assured on the progress with the priorities set out by the executive, which will include the action plan in response to the CQC findings, we will be reverting for the time-

being to monthly Board meetings.

Lastly, we have both been visiting a number of sites in recent weeks. It was really good to be able to visit the now operational Banstead Make Ready Centre. It is an impressive development providing our colleagues with excellent changing and mess facilities. There is a state-of-the-art workshop and other excellent supporting facilities for education and administrative purposes.

Joining a shift with one of our ambulance crews in Medway was a great opportunity to witness at first hand the kindness and professionalism of our clinical colleagues in their dealings with patients. A number of the patients had complex needs and had exacerbations of known condition's requiring further hospital care. Fortunately, there were no A&E handover delays that day and the shift was productive with all the patients spending the appropriate time in an ambulance. However that situation changed the next day such is the dynamic nature of our clinical workload. The shift overran by 90 minutes because of the care required by a patient prior to transfer to hospital. Whilst shift overruns can be exhausting and test staff morale the professionalism demonstrated by my clinical colleagues was exemplary.

It was also a real privilege to hand out the Queen's Platinum Jubilee Medals and Covid coins to staff at Chertsey; staff across the trust will have been awarded these over the weeks leading up to the Jubilee celebrations, and I know they will have immense pride in receiving them. They are truly well deserved.

To close, we both recognise the challenges ahead and are determined that we will learn the lessons from the past to ensure SECAmb truly is best placed to care and the best place to work.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	06-22

Name of meeting	Trust Board
Date	26 May 2022
Name of paper	Board Assurance Framework Risk Report
Author	Peter Lee, Company Secretary
Synopsis	The BAF Risk Report includes the principal risks to meeting the Trust's strategic priorities and sets out the controls, assurances, and actions. It is used by the Board and its committees to inform the areas it needs to focus, when setting agendas.
Recommendations, decisions or actions sought	The Board is asked to review the report and seek assurance on how the risks are being managed and considered by the relevant committee.

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

Board Assurance Framework (BAF) Risk Report

1. Introduction

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

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

2. Structure of the BAF Risk Report

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

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

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

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

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

Low	Moderate	High	Extreme

Figure 1

3. Board Committee Review

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

Board / Committee	Agenda Item	BAF Risk
Finance and Investment – March	Financial Planning / Month 11 Position	16
Performance – April	Integrated Plan / Improvement Plan / Performance Cell	13 14 & 17
Quality & Patient Safety – March	SI / Harm Review / Clinical Safety Plan	14
Workforce and Wellbeing – May	Training & Development Plan / Appraisals / Clinical Education Strategy	13 & 15

4. Management Review & Recommendation

As set out in Appendix A, each risk has a nominated scrutinising forum, where the subject matter experts consider the risk, and update accordingly. Where the forum is not EMB, it will make recommendations to EMB about any changes to the risk. When applicable, EMB will recommend removal and / or an addition of a BAF risk(s). Currently, no changes are recommended.

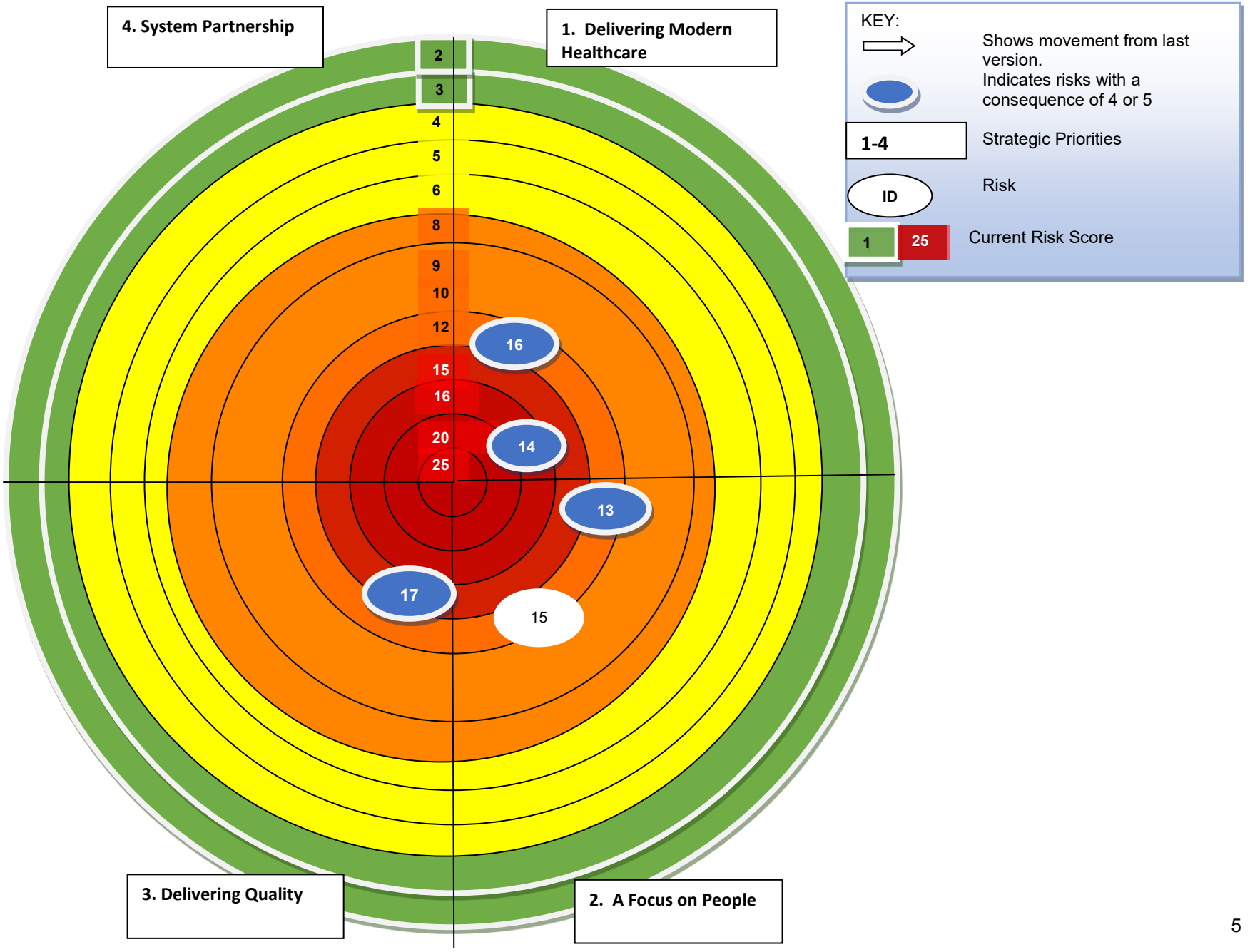
5. Conclusion

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

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

Dashboard

Link to Priorities	Risk ID / Theme	BAF Dashboard	Initial Score	Current Score	Target Score	Target Date	Board Oversight
1 & 3	Risk ID 14 Patient Quality & Safety	Risk that our operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need.	20	16	08	March 2023	Performance /QPS
	Risk ID 17 NHS 111 and Single Virtual Contact Centre	There is a risk that the current and future plans for the 111 and EOC operational models will be affected as a result of Single Virtual Contact Centre plans which are in progress following a mandate from NHS England. This may lead to negative impacts on performance, patient safety, provider agency and strategic direction.	16	16	08	TBC	Performance Committee
1 & 3	Risk ID 16 Financial Sustainability	Risk that we are unable to develop a robust long term financial plan to deliver safe quality and effective services, due to uncertainty over the future with national/regional plans.	16	12	04	Q2 2022/23	FIC
2	Risk ID 13 Workforce Sustainability	Risk that we will lose a significant number of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce.	16	12	08	March 2023	WWC / Performance
2 & 3	Risk ID 15 Education Training & Development	Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development	15	12	06	March 2023	WWC


4. System Partnership
1. Delivering Modern Healthcare
3. Delivering Quality
2. A Focus on People
2
3
4
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6
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9
10
12
15
16
20
25
16
14
13
17
15
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Priorities
ID
Risk
1
25
Current Risk Score

Appendix A

Priority 2	**BAF Risk ID** 13 Workforce Sustainability	**Date risk opened:**

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

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

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

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

Last management review	Executive Management Board	**Last committee review**	21.04.2022 Performance Committee 12.05.2022 Workforce & Wellbeing Committee

Priority 1 & 3	**BAF Risk ID** 14 Patient Quality & Safety	**Date risk opened:**

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

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

Gaps in Control
Establishing the right care delivery model.

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

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

Last management review	Executive Management Board	**Last committee review**	21.04.2022 Performance Committee 19.05.2022 Quality and Patient Safety Committee

Priority 2 & 3	**BAF Risk ID 15** Education Training & Development	**Date risk opened:**

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

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

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

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

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

Last management review	Executive Management Board	**Last committee review**	12.05.2022 Workforce & Wellbeing Committee

Priority 1 & 3	**BAF Risk ID 16** Financial Sustainability	**Date risk opened:**

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

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

Gaps in Control
Funding clarity for 2022/23 / potential funding gap Potential ongoing deficit could result in a cash shortfall that may affect future capital plans ICS capital limits

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

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

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

Priority 1 & 3	**BAF Risk ID 17** NHS 111 and Single Virtual Contact Centre	**Date risk opened: 07.01.2022**

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

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

Continue to engage with NHSE directly to seek responses and answers to the concerns and issues raised to date. The NHSE Integrated Urgent Care (IUC) central team has devolved responsibility for the implementation and communication of SVCC to the NHSE regional leads. As such, KMS 111 Head of Service has been in regular contact with the regional NHS E team (and national NHS E IUC Leads, when necessary, i.e., for telephony, commissioning, clinical and medical).

We have full attendance at the three original NHSE national SVCC engagement sessions, in addition to all local NHSE SVCC meetings covering the three workstreams.

Raised concerns via the AACE national forums.

The Associate Director for IT has escalated his concerns and issues through to the national team. Internally, the Associate Directors for IT and for Integrated Care continue to work closely to ensure that SECAmb is fully compliant with the expectations of NHSE regarding the IT and subsequent operational implementation of SVCC.

Gaps in Control

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) The first region to go live (London) – had to be subsequently switched off due to IT failures.	Regional QIA

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
Continual engagement with NHSE Directly – three workstreams (contracting; workforce; clinical/governance) Current Operating solution has framework to support regional clinical solution (CAS DoS Profiles / DAB etc) Working with AACE and national heads of 111 forum	The Trust is on track to have implemented all requisite IT and telephony changes with the necessary configuration in place to send data to the central SVCC platform. This will enable analysis and modelling to be undertaken with the dataset submitted by SECAmb.

Last management review	Executive Management Board	**Last committee review**	21.04.2022 Performance Committee

Appendix B
Strategic Priorities

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

Appendix C

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

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

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	08-22

Name of meeting	Trust Board
Date	26th May 2022
Name of paper	Improvement Journey – Trust Priorities 22/23
Executive sponsor	Interim CEO, Dr Fionna Moore
Synopsis	Following the receipt of the Staff Survey results and preliminary CQC feedback, the Board, Executive, and Senior Management team have been working together to provide a clear framework for our priorities in 22/23. This is a first step in our Improvement Journey going forward to deliver even better patient care. This framework is designed to provide some clarity around the leadership team's priorities to the rest of the organisation, as well as ensuring that each team can have discussions around what these priorities mean for them, and provide feedback, ideas for improvement, and suggestions, across our 4 key themes: - Culture and People - Quality - Leadership and Engagement - Responsive Care The action plan for the year will also provide a vehicle for delivery against any CQC deliverables and will ensure continuity in the implementation of change approach for the Trust. A core step-change we will do hand in hand with these priorities will be the approach from leadership to becoming more approachable and engaged with staff, ensuring there's a focus on listening and acting on what our people are telling us.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Our Improvement Journey

Trust Priorities for 22/23

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

1. Aim of this document

To outline the key challenges SECAmb faces in the short-term, explain the processes the Leadership Team have undergone to reflect on these challenges, and set a framework for our priority areas over 22/23, alongside the Leadership's action plan for the year within this framework to respond to these challenges.

This plan has been developed proactively before receiving the CQC report, and alongside the Staff Survey feedback, to provide a holistic response to what we believe will be required to sustain improvements over time. We recognise that we will have to directly respond to several CQC actions – the action plan is being developed in parallel and will be a key deliverable for us within the framework of these priorities for 22/23.

2. Background

Over the last two years, everyone at SECAmb has been working hard to deliver the best patient care, whilst keeping each other safe in the context of a pandemic which has thrown unprecedented challenges to the entire NHS.

In April 2022, following a period of reflection following the staff survey result and initial feedback from the CQC visit, several significant areas requiring trust-wide focused attention have become apparent to the Leadership Team. This document outlines the Senior Management Team, Executive, and Board's joint response to these challenges. We are setting out the beginning of the Improvement Journey we must go through to ensure we can continue to deliver the best quality and responsive care for our patients; we must also ensure SECAmb becomes the great place to work we want it to be for our staff.

Despite the challenges this document outlines, everyone should be proud of the work they have done to either directly care for patients, or indirectly support in delivering services. The issues we must address can only be overcome by working in partnership, collaborating across teams, and by ensuring we listen to the significant expertise within SECAmb.

3. Key challenges

The themes that have emerged from our Staff Survey, preliminary CQC report, and our ambitious financial plans to invest in our service in the coming year, inform our key challenges for 22/23. These have then been used to help shape the key priority areas and action plans for the coming months.

Staff Survey:
- SECAmb is not currently the great place to work that we want it to be
- There's a lack of consistent vision and direction of travel, causing confusion and frustration
- The trust in leadership amongst the workforce is currently very low

CQC Preliminary findings:
- It's difficult to see what the consistent quality thread is, across everything we do
- There's a leadership disconnect across the Senior Leadership Team, and with the majority of the Trust
- Significant concerns have been raised over our culture

Financial Plans:
- We have an ambitious investment plan focussed on service improvement and workforce development; however, it means operating at a significant deficit.
- As such we must ensure we utilise our resources in the most effective way to deliver responsive care to patients and ensure staff wellbeing.

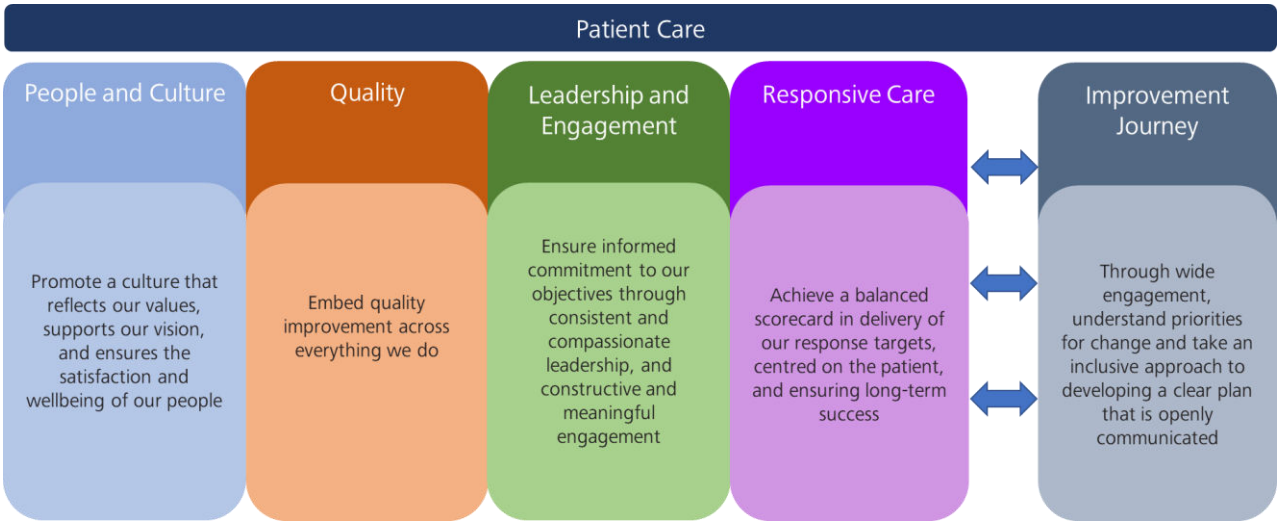
4. Priorities for 22/23

Our framework for establishing priorities in 22/23 are centred around responding to the key challenges and designed for the benefit our of patients and staff.

These priorities have been developed between the Senior Management Group, the Executive, and the Board, to ensure there is strong alignment across the Leadership Team. This has been done over 4 weeks and multiple workshops, and following this work, the Leadership team stands committed to these priorities and this plan going forward.

One of the key messages we have heard is the need to develop more meaningful feedback mechanisms, to listen and act on what staff tell us. As such, this framework is high-level and is being cascaded through teams during May and June, and we will be asking individuals and teams to work together to develop what these priorities mean for them and feeding ideas and suggestions for improvement back.

Meaningful and purposeful engagement, coupled with visible leadership involvement, will be key to ensuring we make the right improvements. As such, a task-and-finish group has been setup to scope out what our improved communication and engagement vehicles will be so that we are better setup to listen to our people. As a starting point, anyone who has an improvement suggestion, feedback, or question, can submit a question following our Improvement Journey – Feedback & Ideas link, and will receive a direct response from the relevant leader in the organisation on how their ideas can be taken forward, how they fit with existing plans, or if we can't consider them now, an explanation on why and when the time might be right.

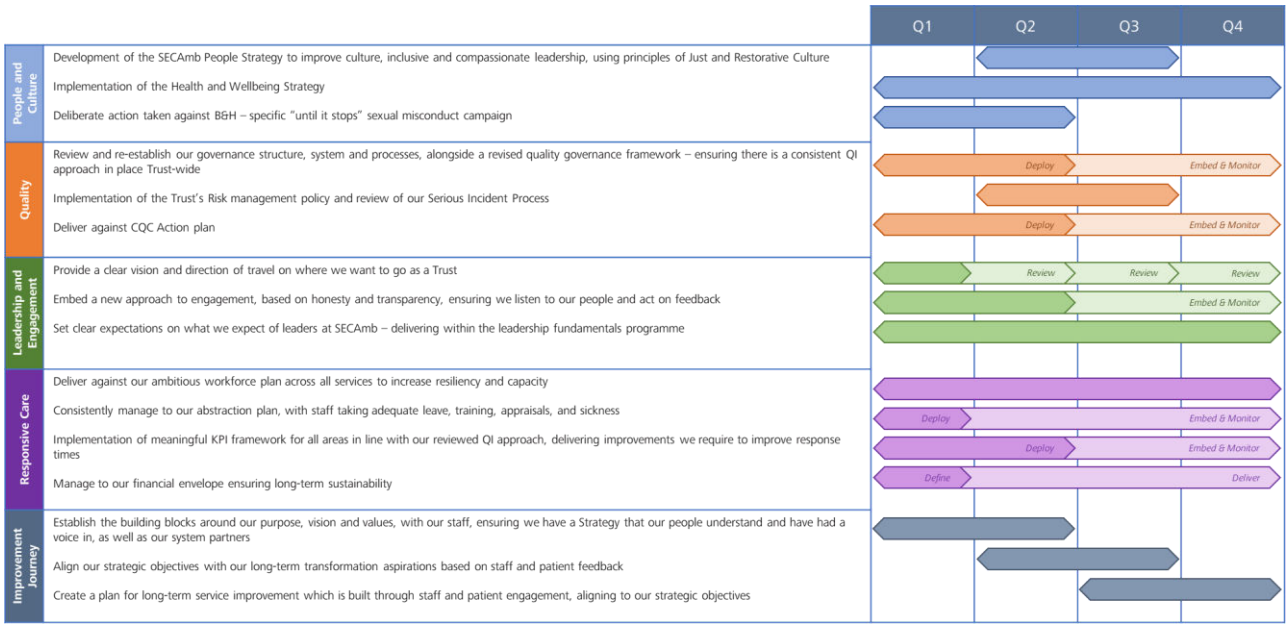


5. Delivery Plan

Fitting the Priorities for 22/23 Framework, the Leadership team have developed a focussed delivery plan, which we will be holding ourselves to account to deliver as a core component of our Trust Plans.

This delivery plan reflects our Leadership objectives and prioritises the top outcomes we want like to see realised through 22/23.

To assure delivery against these plans, and on-going alignment across leadership, we will be stepping up our collaborative approach to monitoring, by having more regular fortnightly SMG (Senior Management Group) and EMB (Executive Management Group) review against progress. We will also use this new joint approach to monitor progress against our eventual CQC Action Plan, which we expect will have strong alignment with our objectives, as well as monitoring our level of leadership engagement both internally with staff as well as externally with key stakeholders and service users.



6. Resource, Governance and Oversight

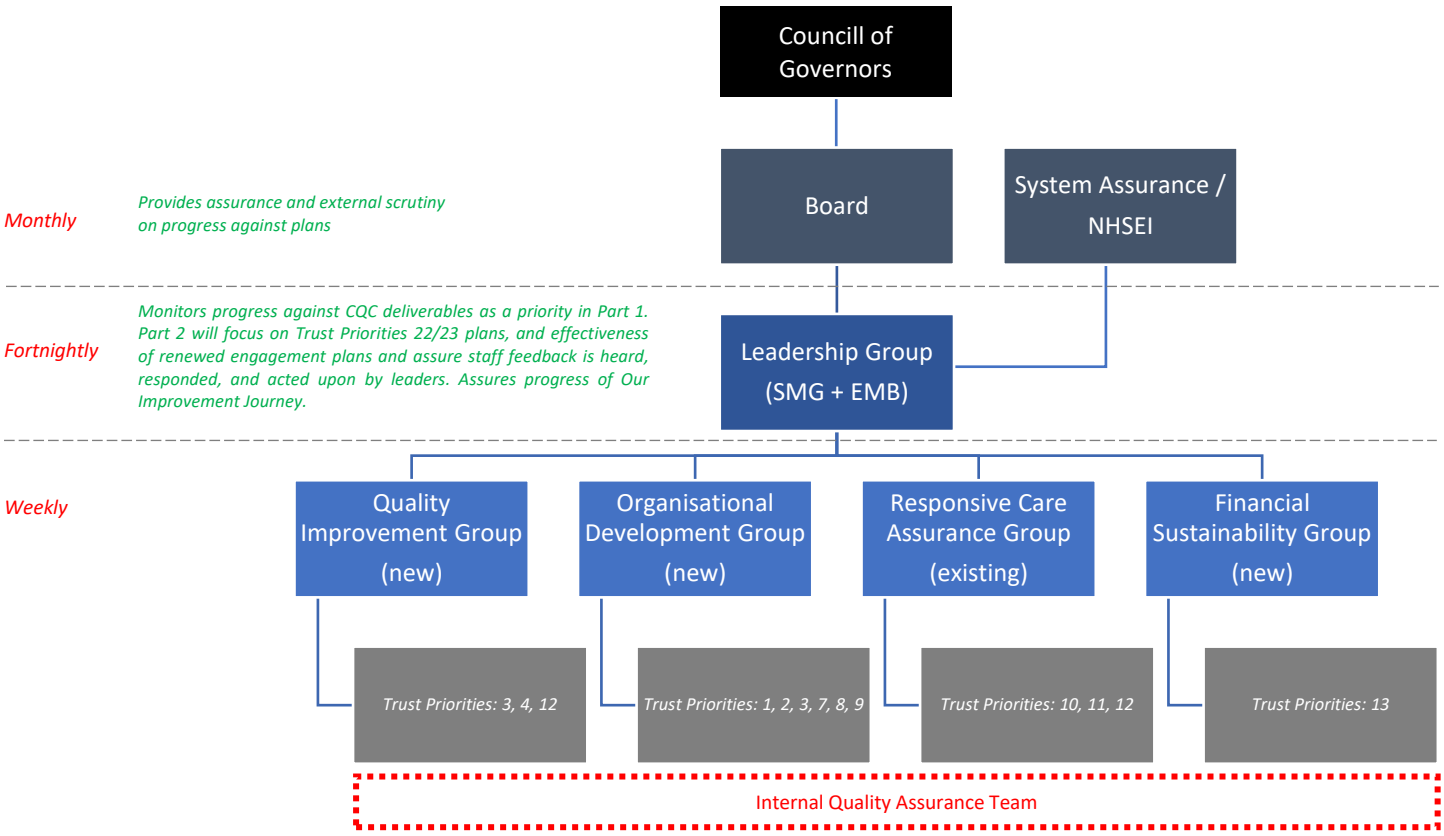
As we go through our Improvement journey, it's important we assure these plans are delivered in a meaningful way, such that we can embed sustainable changes. At the same time, we are conscious of the need to specifically respond to the CQC Actions within a specific timeframe. To that effect, we will be re-focussing from our existing teams and re-prioritising efforts to align with this Delivery Plan, with the CQC Action plan being a critical component of our overall plan.

We have identified the alignment between CQC Actions and our Priorities Delivery Plan for 22/23, and to avoid duplication we will be monitoring progress through a single Leadership-led Improvement Journey Board, which will meet fortnightly. The focus areas will be CQC Action Plan, Trust Priorities (inclusive of financial sustainability), and feedback received through our renewed engagement approach. The Improvement Journey Board will report to the Trust Board and System partners on a monthly basis, and will be informed through 4 core working groups which will have specific deliverables from the CQC assigned and the associated Trust Priorities to deliver.

For further assurance, a small internal Quality Assurance Team will be independent from the working groups and will act as a critical friend by observing progress of each of the groups and proving and challenging. This may include a combination of internal and external resource, and NEDs will be invited to participate in thematic deep dives throughout the process via this Team.

Each Working Group will be formed of a combination of 2 executive leads, with dedicated Project Management resource, and coordinated by an internal Improvement Lead. In addition, each Working Group will have the necessary subject-matter-expert resources to deliver the action plans.

Improvement Journey Governance and Oversight Model



NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Trust Board
May 2022

Data up to and including April 2022

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

Contents

CQC Rating and Oversight Framework

NHSI Oversight Framework*	2
CQC Rating **	GOOD
Information Governance Toolkit Assessment ***	Level 2 Satisfactory
REAP Level ****	3

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

Symbol Key

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

Chief Executive Overview

As part of our continuous improvement drive – we are in the process of migrating our Integrated Reporting to adopt the “Making Data Count”(MDC) methodology which is promoted by NHSEI. This methodology is based on using Statistical Process Control or SPC, and will help us provide better, clearer reporting in the IPR, going forward.

This review will include a bottom-up approach to reviewing our Quality metrics for each service areas, and our Business Intelligence team are busy rolling out MDC training to several teams, as well as reviewing and simplifying the number of KPIs that we have historically report on, making the reporting more succinct, purposeful, and aimed at helping the Board make the right decisions to support our patients and staff.

We will be starting with the IPR for the Board, sub-committees of the Board, our Leadership Group, and the aim is to eventually have a consistent approach to how we use data to improve the service across all of SECAmb. This will be an important enabler to embedding a Quality Improvement methodology throughout our service.

SPC is widely used in the NHS, with over 180 Trusts having already adopted this approach, and there is strong evidence that better decisions are made when using SPC rather than ‘simple’ techniques such as the popular RAG approach and comparing two data point such as performance this month and last or this year and last, which may lead to the wrong conclusions or decisions being made.

To support our team develop the necessary technical reporting, and transition to this new approach, the IPR this month is shorter than usual. You will find core Ambulance Quality Indicators enclosed with associated exception report, our national position in April, as well as a look forward over the next 12 weeks where we have forecasted our expected performance well into the Summer. You will also find as updated workforce position vs plan as we get towards the end of month 2.

Dr Fionna Moore
Interim Chief Executive

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Performance

Best placed to care, the best place to work

Current Performance

- Operational performance across all areas remains significantly challenged – the Trust is not consistently meeting the national ARP standards, although April shows some improvements. Demand remains at approx. 2,400 calls and 1875 incidents with a response per day.

- Staffing is still significantly impacted with elevated levels of sickness, and as summer approaches, increasing levels of annual leave – incentives for overtime shifts remain. Across April front-line total resource hours were 9.0% below required.

- The Trust remained at REAP 4 and with greater proportions of time at higher levels of surge during March & into early/mid-April.

- The overall utilisation levels (proportion of time a front-line resource spends on a call) remain high – usually over 70%, which indicates the balance between demand and resource, and the Trust's ability to meet performance standards. Our target for utilisation is 64%, with lower being better as there is more availability to meet our higher acuity category call targets.

National AQI Position

April 2022

Key

Direction of change in time

Direction of change in position relative to previous

Call Answer Times	Mean
England	28
1	3
2	8
3	12
4	14
5	19
South East Coast	19
7	23
8	24
9	50
10	57
11	80

Call Answer Times	90th centile
England	93
1	5
2	28
3	37
4	49
5	59
South East Coast	72
7	75
8	89
9	174
10	208
11	245

C1	Mean
England	00:09:02
1	00:06:40
2	00:07:16
3	00:08:16
4	00:08:31
South East Coast	00:08:32
6	00:09:23
7	00:09:35
8	00:09:44
9	00:10:17
10	00:10:58
11	00:11:45

C1	90th
England	00:16:07
1	00:11:26
2	00:12:49
3	00:14:26
4	00:14:45
South East Coast	00:15:48
6	00:16:50
7	00:17:04
8	00:17:52
9	00:19:01
10	00:19:46
11	00:21:29

C2	Mean
England	00:51:22
1	00:28:06
South East Coast	00:33:12
3	00:34:01
4	00:37:49
5	00:42:03
6	00:44:49
7	00:47:05
8	00:55:58
9	01:03:50
10	01:09:28
11	01:20:57

C2	90th
England	01:56:34
1	01:01:11
South East Coast	01:08:30
3	01:11:37
4	01:27:46
5	01:36:13
6	01:37:42
7	01:47:46
8	02:10:22
9	02:20:31
10	02:35:52
11	03:12:57

C3	90th
England	06:41:39
1	02:28:56
2	03:52:50
3	04:39:27
4	04:55:58
South East Coast	05:33:53
6	05:48:57
7	07:52:55
8	08:19:08
9	08:52:51
10	09:33:43
11	09:55:11

C4	90th
England	07:41:17
1	03:12:34
2	03:50:31
3	05:03:21
4	05:06:59
5	06:44:37
South East Coast	08:22:07
7	08:26:31
8	09:01:16
9	09:32:58
10	10:57:19
11	12:22:19

Areas of focus

- There continues to be a focus on the appropriate outcomes for both patients and the wider system – looking to manage patients within the community where appropriate.

- Hospital handover time is a key efficiency metric, recognising the fluctuating position seen across a range of sites, however an overall downward trend has been seen over April and into May from a high in mid-March.

- The 111 referral rate to 999 remains in a very good position at an average of 8.3% across April – supporting demand management for the 999 service.

Additional points to note

- Whilst the welfare support and management of staff continues, including the commencement of the 2022-23 plan for ongoing staff training, the Trust is still awaiting formal guidance updates from central government regarding the management of staff with long Covid.

- On-day staff welfare remains a high priority noting that a high proportion of shifts still run over time, but on average with 90% of staff having meal breaks on their base, and with less than 2% of staff not having a meal-break.

- The NHSE additional winter monies finished at the end of March, returning the service to historic budgeted levels for staffing and additional support.

Performance by Domain
Responsive: Exception Report

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

ID	Standard	Background
999-1 to 999-7	Standards: 999 Calls Answered (mean and 90th centile) (999-1) Cat 1 (mean and 90th centile) (999-2,) Cat 1T (mean and 90th centile) (999-3) Cat 2 (mean and 90th centile) (999-4) Cat 3 (90th centile) (999-5) Cat 4 (90th centile) (999-6) HPC 3 & HPC 4 (mean and 90th centile) (999-7)	There are a range of contributory factors which contribute to the poor performance across all metrics. In particular reduced resource provision as a result in of vacancy rates and high levels of abstraction (particularly due to sickness & leave), as well as a reduction in efficiencies such as job cycle time and hospital handover challenges. The ARP performance framework is evidence-based in terms of both the target set, and the clinical implications of each target. • During the 2021-22 financial year, the Trust has consistently failed to deliver against all metrics – this has primarily been as a result of challenges relating to resource provision, coupled with increased unpredictability of demand. • SECAmb performance is scrutinised within the Trust and more widely, including being reported within national ARP league tables for English ambulance services issued each month. In March 2022, overall improvements in performance were seen across all metrics, with relative improvements in 5 of the 8 metrics in the national AQI tables

Action Plan	Accountable Executive
Actions being taken to mitigate issues: <u>Optimising resource levels</u> - A focus on maximising the availability of all resources – call handling, EOC clinicians and field ops crews. In order to achieve this, sub-actions relating to a number of areas are being implemented: • The continued robust management of abstractions such as sickness and annual leave • Continued implementation of a programme of incentives to optimise additional hours • Within the EOC clinical staffing group – improvements in scheduling and utilisation of agile clinicians • Implementation of robust recruitment of staff across all service lines, in-line with workforce plans <u>Dynamic deployment of resources</u> - In live-time Trust resources can be moved between areas/service lines to optimise response and mitigate risk. For example: • Dual-trained call handlers and clinicians in 111 & EOC can work across either service line as required • Private ambulance provision is reviewed daily in terms of the best geographical locations for the crews to work out of dependent on local SECAmb gaps in provision • Cross-border working for SECAmb crews, where they respond to the nearest higher priority call which may be in neighbouring dispatch desk areas	Named person: Executive Director of Operations Complete by date: Ongoing – Metrics are part of the Performance Improvement Plan monitored via weekly Performance Assurance Meetings

Performance by Domain
Effective: Performance Dashboard

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

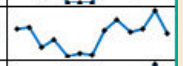
IPRID	Department	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Target	Vs Target	Performance Direction	Sparkline
M-1	Medical	**Cardiac ROSC Utstein %	41.00%	40.50%	48.70%	54.20%	48.70%	57.10%	48.70%	51.30%	40.90%	No Data	No Data	No Data	No Data	45.10%			
M-2	Medical	Cardiac ROSC ALL %	23.00%	24.00%	28.30%	31.00%	24.80%	34.00%	24.80%	23.10%	24.90%	No Data	No Data	No Data	No Data	23.80%			
M-12	Medical	**Sepsis Care Bundle %	85.00%	83.50%	84.00%	81.30%	86.20%	84.50%	85.40%	84.70%	87.00%	No Data	No Data	No Data	No Data	85.00%			
M-3	Medical	Cardiac Survival Utstein %	28.00%	27.30%	No Data	31.30%	30.60%	23.50%	20.00%	36.80%	27.90%	No Data	No Data	No Data	No Data	25.60%			
M-4	Medical	Cardiac Survival ALL %	13.70%	12.30%	No Data	14.00%	10.00%	10.80%	8.00%	11.00%	9.50%	No Data	No Data	No Data	No Data	9.60%			
M-11	Medical	Cardiac Arrest - Post ROSC %	81.00%	78.50%	90.30%	75.80%	68.00%	75.30%	68.00%	75.50%	69.40%	No Data	No Data	No Data	No Data	76.80%			
M-5	Medical	**Acute STEMI Care Bundle Outcome %	69.00%	60.30%	57.30%	60.60%	62.70%	54.00%	55.40%	54.30%	57.50%	No Data	No Data	No Data	No Data	64.70%			
M-6	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	02:20:00	02:19:00	02:21:00	02:36:00	02:33:00	02:31:00	02:32:00	02:23:00	No Data	No Data	No Data	No Data	No Data	02:22:00			
M-7	Medical	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	03:02:00	03:17:00	03:17:00	03:50:00	03:23:00	03:35:00	03:43:00	03:17:00	No Data	No Data	No Data	No Data	No Data	03:14:00			
M-8	Medical	Stroke - Call to Hospital Arrival Mean	01:28:00	01:26:00	01:31:00	01:35:00	01:54:00	01:50:00	01:45:00	01:38:00	No Data	No Data	No Data	No Data	No Data	01:29:00			
M-9	Medical	Stroke - Call to Hospital Arrival 90th Centile	02:07:00	02:14:00	02:15:00	02:21:00	02:56:00	02:52:00	02:44:00	02:36:00	No Data	No Data	No Data	No Data	No Data	02:20:00			
M-10	Medical	**Stroke - Assessed F2F Diagnostic Bundle %	96.00%	95.70%	96.80%	94.10%	97.10%	97.10%	97.90%	97.60%	97.10%	No Data	No Data	No Data	No Data	96.30%			
M-13	Medical	Sensitivity of Cardiac Arrest Detection During Telephone Triage %	82.00%	82.20%	84.10%	91.20%	95.50%	95.20%	95.50%	93.80%	90.40%	No Data	No Data	No Data	No Data	93.80%			
M-14	Medical	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	78.00%	77.30%	80.00%	79.40%	80.30%	85.00%	80.30%	74.10%	81.70%	No Data	No Data	No Data	No Data	77.90%			
M-16	Medical	Proportion of Non-EMS Witnessed Cardiac Arrests with PAD Applied to Patient %	No Data	5.80%	No Data	12.10%	6.40%	8.40%	6.40%	6.90%	9.10%	No Data	No Data	No Data	No Data	7.30%			

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

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Responsive: Performance Dashboard

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

IPRID	Department	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Target	Vs Target	Performance Direction	Sparkline
999-10	Operations 999	999 Calls Answered	61386	77074	71529	85769	77173	81649	86089	76122	78778	71054	67386	86812	72898	N/A	N/A		
999-10	Operations 999	Incidents	62845	65474	67474	65161	62343	60808	64510	62534	63924	62514	56127	62648	60579	N/A	N/A		
999-1	Operations 999	999 Call Answer Mean	00:00:42	00:00:48	00:00:08	00:00:22	00:00:05	00:00:04	00:00:02	00:00:25	00:00:24	00:00:12	00:00:16	00:00:36	00:00:19	00:00:05	-	↑	
999-1	Operations 999	999 Call Answer 90th Centile	00:02:22	00:02:34	00:00:22	00:01:19	00:00:02	00:00:02	00:00:01	00:01:28	00:01:29	00:00:37	00:00:58	00:02:03	00:01:15	00:00:10	-	↑	
999-2	Operations 999	Cat 1 Mean	00:08:45	00:08:49	00:07:57	00:08:18	00:07:32	00:07:37	00:07:33	00:08:42	00:09:09	00:08:36	00:08:43	00:09:35	00:08:34	00:07:00	-	↑	
999-2	Operations 999	Cat 1 90th Centile	00:16:03	00:16:19	00:14:54	00:15:08	00:13:56	00:14:14	00:13:53	00:16:03	00:16:24	00:15:48	00:15:47	00:16:49	00:15:51	00:15:00	-	↑	
999-3	Operations 999	Cat 1T Mean	00:10:51	00:10:54	00:09:36	00:10:24	00:09:20	00:09:02	00:09:01	00:10:43	00:11:06	00:10:25	00:10:43	00:11:35	00:10:20	00:19:00	+	↑	
999-3	Operations 999	Cat 1T 90th Centile	00:20:03	00:20:14	00:17:38	00:19:13	00:17:13	00:16:46	00:16:36	00:20:00	00:19:58	00:19:27	00:20:06	00:20:36	00:19:17	00:30:00	+	↑	
999-4	Operations 999	Cat 2 Mean	00:29:42	00:30:37	00:21:28	00:26:11	00:18:54	00:18:37	00:16:48	00:34:17	00:33:34	00:28:22	00:32:17	00:39:57	00:33:13	00:18:00	-	↑	
999-4	Operations 999	Cat 2 90th Centile	00:58:53	01:00:47	00:40:51	00:50:55	00:34:58	00:34:46	00:31:09	01:10:41	01:08:19	00:56:56	01:06:25	01:22:37	01:08:29	00:40:00	-	↑	
999-5	Operations 999	Cat 3 90th Centile	06:17:02	07:21:23	03:51:24	05:40:07	02:58:41	02:49:03	02:01:52	06:21:14	06:14:03	04:34:42	05:34:49	08:06:49	05:34:57	02:00:00	-	↑	
999-6	Operations 999	Cat 4 90th Centile	05:29:55	06:51:57	04:39:46	07:21:59	04:28:40	03:29:30	02:44:51	08:30:25	08:57:09	05:34:23	06:55:57	08:50:58	07:15:58	03:00:00	-	↑	

\+ Outperformed target
\- Underperformed target
= On target

Performance by Domain
Responsive: Performance Dashboard

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

IPRID	Department	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Target	Vs Target	Performance Direction	Sparkline
999-7	Operations 999	HCP 3 Mean	03:32:39	04:06:19	02:32:00	03:25:11	02:02:40	01:39:18	01:25:11	03:08:40	03:12:01	02:23:50	02:46:40	03:39:59	03:02:30	N/A	N/A	↑	
999-7	Operations 999	HCP 3 90th Centile	08:28:04	08:36:33	05:08:05	06:56:27	04:00:25	03:23:05	02:55:47	07:28:23	07:01:05	05:27:14	05:49:49	09:20:15	07:09:07	N/A	N/A	↑	
999-7	Operations 999	HCP 4 Mean	04:46:11	04:56:09	03:20:43	04:22:49	02:44:10	02:01:07	01:49:46	03:45:42	03:59:08	03:04:42	03:38:42	04:43:01	03:37:18	N/A	N/A	↑	
999-7	Operations 999	HCP 4 90th Centile	10:41:54	09:20:02	06:21:05	08:01:14	05:11:59	04:28:16	04:10:26	08:38:29	09:05:50	06:53:32	07:59:11	10:29:31	08:10:54	N/A	N/A	↑	
999-9	Operations 999	Hear & Treat %	6.90%	9.30%	7.90%	9.60%	9.00%	8.80%	10.30%	9.90%	9.30%	8.60%	9.40%	10.45%	10.02%	10.00%	+	↓	
999-9	Operations 999	See & Treat %	32.10%	31.20%	31.60%	32.00%	32.10%	31.30%	30.50%	31.10%	32.40%	32.00%	31.00%	31.26%	32.16%	35.00%	-	↑	
999-9	Operations 999	See & Convey %	61.00%	59.40%	60.50%	58.40%	59.00%	59.80%	59.10%	58.90%	58.10%	59.30%	59.40%	58.34%	57.86%	55.00%	-	↑	

\+ Outperformed target
\- Underperformed target
= On target

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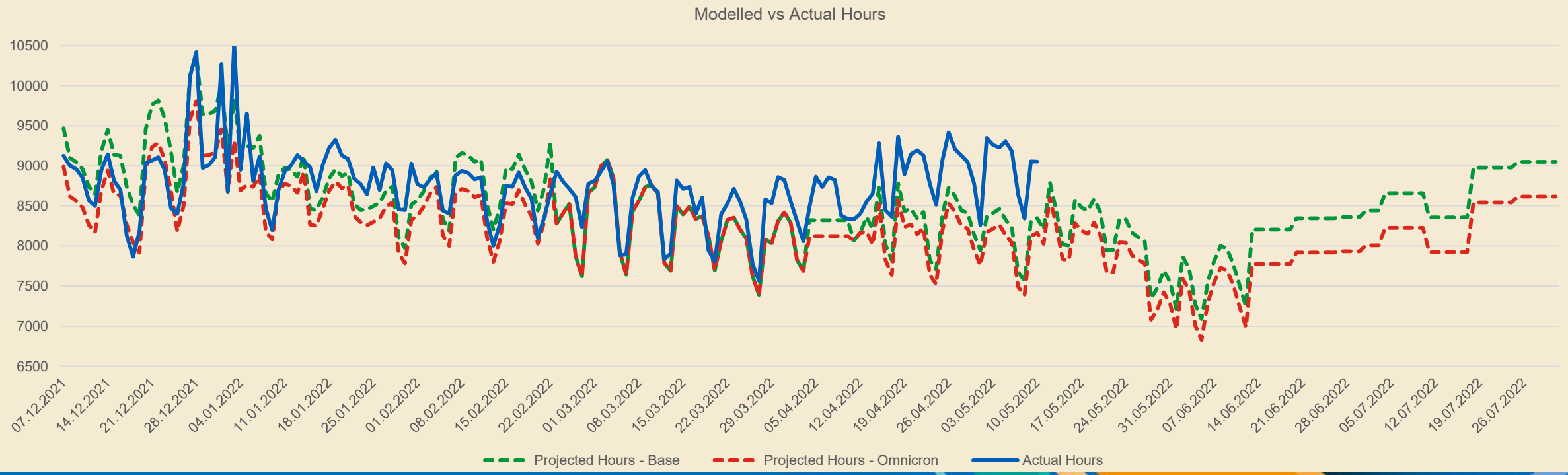
12-Week Look Forward

Best placed to care, the best place to work

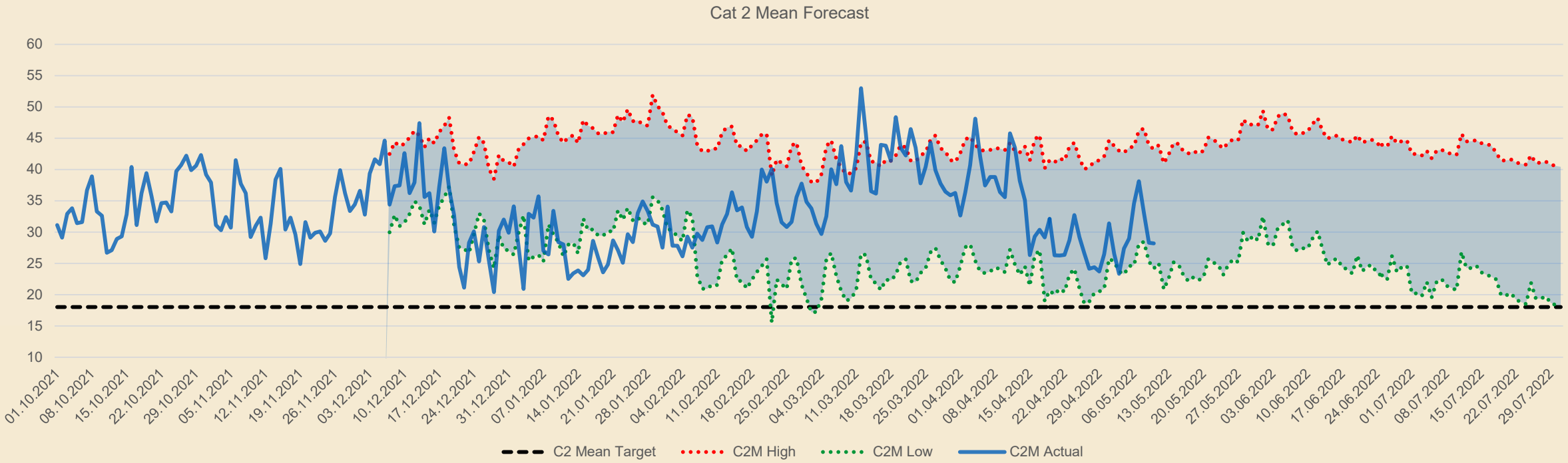
Projected Operational Hours

- Actual hours have exceeded the projections expectations, due to the lower than expected abstraction rates
- Projections show that w/c the 30th[t] of May and 6[th] of June are expected to be a challenge with low resources hours, circa 500 hours lower than the previous weeks.
- After this it is expected that hours increase will due to new ECSWs becoming operational following the March and April intakes



Performance Forecast

- C2 Mean has significantly improved over the previous month due to an improvement in hours, due to lower abstractions and a reduction in demand.
- W/C 30th of May and the 6th of June are the areas of the most risk, however if abstractions continue to be lower than projected, response times should continue to be closer to the low scenario.
- ICS systems are currently reporting OPEL 3 with a number of acute trust at lower levels than that, however at this time it is unclear how stable this position is likely to remain.



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Glossary & Metrics Library

Best placed to care, the best place to work

Appendix 2
Glossary & Metrics Library

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

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

Appendix 2
Glossary & Metrics Library

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

SECAMB Board

Performance Committee Escalation Report to the Board

Date of meeting	21 April 2022
Overview of key issues/areas covered at the meeting:	Under actions arising we heard from the director of operations that we have engaged others ambulance providers on how they better manage 'hear and treat'. This is about how we can ensure more effective use of emergency resources, which may lead to a need for more virtual responses. The committee encouraged the executive to ensure we demonstrate to the system the benefits this will have, e.g. less people taken to emergency departments. The first part of the meeting focussed on planning and forecasting. **Integrated Plan: 2022 – 2023** A really good update was provided on the integrated plan for the year. The Annual Planning Working Group is established with cross-directorate representation and oversight of contracting strategy and scenario development. We have developed a "Plan on a Page" for three commissioning scenarios to determine what is reasonably possible in terms of additional workforce. Each scenario has significant challenges in delivering ARP in 2022/23 and require either significant recruitment or operational efficiency delivery. We have also developed a milestone delivery plan for the next 12 months. There are a number of risks to the plan which the committee explored, in particular the cultural change and how we engage and ensure buy-in from our workforce. The committee asked for more assurance on this. There was also challenge to the executive on ensuring the right balance between front line activity and the right level of overheads to support the right operating model. For example, as we grow our workforce, we need to constantly assess the impact on support services. The executive accepted that there is a gap in understanding this fully at present, but it is part of the immediate next steps acknowledging that without this clarity we will fail to deliver. The committee asked about retention, given that the staff survey indicates a high percentage of staff intend to leave in next 12 months. And also about what assurance there is about filling all training courses for new staff, as some courses have spaces still available. An action was agreed to ask that the workforce and wellbeing committee review how we are delivering against the retention strategy. This is an ambitious programme and the committee supported the need for ongoing dynamic review so that corrective action can be taken proactively, where aspects of the plan are not being met. **12-week look ahead** The committee is assured by the progress we are making in being able to better predict performance levels, and therefore plan ahead. At the meeting challenges were bring forecasted for May and June and the committee explored the mitigating

	actions. The meeting then reviewed **current performance** levels. Performance over the past 12 weeks continued to be challenging. In 999, despite performance across England worsening SECAmb is performing better in comparison with others, which in some way is positive but it is a sobering message for patients across the country. 111 resourcing is showing an improvement over the previous 4-6 weeks from a sustained low level. EMAs remains under the required levels, which is a deterioration from that seen approx. two months ago. EOC clinical staffing has improved. The **Performance Cell Report** highlighted the progress with the implementation of Anaplan. The project closure has been extended to the 09 May to allow for an Internal UAT of the system dashboards prior to the deployment to stakeholders. Stakeholder engagement has been mapped, user stories feedback session will be held in May and wider stakeholder session will be held May-June. A number of future developments have been identified and will be reviewed for inclusion in phase 2. The Optima project is on track and expected to deliver project milestones to the agreed project timelines. Initial solution design document and data analysis report have been received for SECAmb review and approval. A meeting is scheduled with Optima to discuss the solution design document with submission due in April; this does not impact the project timeline. A helpful paper was received setting out the detail of the BAF risk related to the **Single Virtual Contact Centre.** There is significant work still needed to work through how this might be achieved, safely. In the meantime, the committee acknowledged the rationale for this but sought assurance that while this might be a reasonable IT solution, the patient and quality risks must be worked through.
Any other matters the Committee wishes to escalate to the Board	Governors observed this meeting, as part of the approach agreed with the Council of Governors to provide Governors the opportunity to experience how NEDs work at committee-level.

Southeast Coast Ambulance Service NHS Foundation Trust

SECAmb Board

WWC Escalation Report to the Board

Date of meeting	**12 May 2022**
Overview of issues/areas covered at the meeting:	At the start of the meeting the executive raised one issue for **escalation to the committee.** This related to a Crawley College AAP marking issue. The team have been working with the College on marking delays to seek assurance on improvement and has recently commissioned an investigation to understand better the issues, how they can be resolved and the impact on learners. The committee will ask for an update at the next meeting, to include timescales for the related action plan that will include clearing the backlog of marking. There were two Management Responses. This is where the committee has previously identified a gap in assurance and asked for a specific response. **Progress of Ops Trust Learning & Development Plan 2022-25** **Partial Assurance** A new education training and development group has been established by the executive and met for first time recently. There are a number of different portfolios to be taken forward and further detail will be provided in due course. In relation to key skills training, the committee welcomes the development of this programme that has the support from operational colleagues and informed by learning from areas such as serious incidents. It was encouraging to hear that feedback to date has been really positive from staff attending key skills and those delivering the programme. The committee understands there is some scepticism from staff about whether this will continue when operational pressures increase and this was explored in the context of the difficult balance of risk between provision of training and provision of hours. The director of operations gave assurance that there is a robust abstraction plan and this will be kept under close review. The committee then turned to management development and was pleased to learn that we are now in a position to roll the long-awaited fundamental programme for front line managers. This will be delivered in person across three consecutive days, in local areas, and to ensure all first line managers receive this we will need to run 27 cohorts of 15 managers over the next 24 months. We are working with NHS Elect to support us to deliver the programme and looking to use other external resource too. Once this programme is embedded there is a plan to start working on a programme for middle managers. The issue of abstraction was again explored, given the potential challenge for first line

managers within operations in particular, and assurance was received that there is a plan to help manage this.

While the committee is assured training is progressing, it remains concerned about the ongoing abstraction risks.

Operational Sickness Management Plan **Partial Assurance**
The director of HR confirmed that all HR business partner and advisor roles are now filled, which helps the support they can provide local managers manage sickness. The action plan was reviewed and there is still an issue with COVID sickness and the restrictions in our ability to manage sickness in the way we usually would. This will remain until the national guidance changes. The ambulance HRD group agreed to escalate via the regional NHSE teams.

In terms of non-COVID sickness the committee received assurance that managers and HR are working well in partnership, ensuring consistency. However, sickness is still high with mental health / anxiety and stress being a main reason.

In summary, the committee noted that we are seeing a slight decrease in non-COVID sickness and believes the executive is doing all it reasonably can to support staff back to work and ensure provision of wellbeing services.

Following these Management Responses the committee focussed on these areas of scrutiny:

Staff Survey / Improving Staff Experience **Not Assured**
The committee received details of the work in place to improve staff experience (learning from best in class) and how this is informed by the recently published staff survey results. This includes staff survey workshops, to give the opportunity to better understand results and use locally to improve staff experience. Also, there is work to develop a robust staff engagement strategy to ensure the workforce feels engaged. The executive will be using some of the tools from the national pilot on team engagement and development.

The committee acknowledges some of the themes from staff feedback have been consistent for several years. It challenged each other to use this as a watershed moment for the organisation to really listen and change. As part of the work on priorities the committee will focus on the people and culture element, reinforcing that while this will require a long- term change management approach, there are improvement that can and must be implemented quickly.

Appraisals Update **Partial Assurance**
The director of HR confirmed that the appraisal roll out is going to plan, and that the new ESR appraisal process will help deliver what we need to improve both the quality and completion of appraisals. The committee agreed that this is a key lever to changing the

	culture of organisation, because it supports the connection between the trust and individual priorities, informed by shared values and behaviours. Again, on the issue of abstraction, assurance was given by the director of operations that this is factored into the abstraction plan for the year, and so is definitely achievable. This will be one of the key performance metrics tracked by the committee. **Implementation of the Clinical Education Strategy Delivery Plan Assured** An update was provided confirming good progress but with some challenges, including with ensuring better visibility of the dependencies on other priorities / plans. One of the other biggest challenges is resource; a business case has though been developed as part of the restructure needed to deliver the workforce plan. The head of clinical education was therefore confident in delivery. The final section of the meeting was the Forward Look / Horizon Scan. **Priorities / CQC Findings & Action Plan** An update was received on the work of the executive to respond to feedback from CQC and staff survey, as touched on earlier. Leadership priorities for the coming year are in development. Two of the four priority areas are central to the purview of the committee, people and culture, and leadership and engagement. The committee was assured by the work to date and the process to engage / cascade through each directorate to ensure these are translated into individual objectives. A leaders' conference is planned for September, with a focus on management and leadership development. **Wellbeing Update** A service evaluation of the Wellbeing Hub was undertaken by the University of East Anglia, in partnership with Economics by Design. This commenced in September 2021 and was presented to EMB late February. The report concluded that the Hub is an efficient delivery model for the services provided and is likely to be delivering a positive return on investment for the Trust. The wellbeing strategy is being revised in light of this review, engaging with stakeholders.
Any other matters the Committee wishes to escalate to the Board	Two papers expected as part of the cycle of business were deferred to the next meeting: **EOC/111 Culture Action Plan –** to enable the committee to quantify the impact of the actions taken over recent months and to confirm timescales against the actions still to be taken and assurance on how these will ensure the impact needed to prevent recurrence **Incidents of Violence and Aggression Action Plan –** this follows the paper in March when the Head of Health & Safety set out the steps being taken to address violence and aggression, against the NHS Violence Prevention and Reduction Standards. The committee has asked that we show timescales against each of the actions to understand better what is being prioritised. The committee can then monitor the action plan to seek

	assurance on progress.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	11-22

Name of meeting	Trust Board
Date	26.05.2022
Name of paper	Ockenden Final Report response paper
Author	Dawn Kerslake, Consultant Midwife
Executive Lead	Richard Quirk, Acting Medical Director
Synopsis	The Ockenden Report and the review of maternity services in Shrewsbury and Telford was first published on 11th December 2020. The final report, published on 30 March 2022 builds on the first with some new themes to bring positive and essential change that all maternity services must implement. In total this equates to 60 local actions for SATH and 15 areas for national action (with 90 individual points). This has been considered by the Quality and Patient Safety Committee at its extraordinary meeting in April. The link to the report is here: Findings, conclusions and essential actions from the indepedendent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust - final Ockenden report (publishing.service.gov.uk)
Recommendations, decisions or actions sought	The Board should note that the recommendations are far reaching and have wider relevance than the purely maternity focussed actions, including governance, risk management, safe staffing and culture. This paper outlines how the recommendations impact the work of SECAmb.

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

Ockenden Final Report Essential Actions

Initially 23 families escalated concerns, however 1500 families were interviewed and provided feedback between 2000-2019.

After reviewing the report, Trusts should take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

Bill Kickup (Morecombe Bay) is currently leading an independent review into East Kent maternity services and this report is due in autumn 2022

15 New domains

Essential action documented where appropriate

Workforce and sustainability

N/A specifically to ambulance service. Applicable to all Trusts
However, would like the board to consider resourcing some hours to assist consultant midwife to deliver the following.

Safe Staffing

N/A specifically to ambulance service. Applicable to all Trusts

Escalation and accountability

Essential action –

Staff must be able to escalate concerns if necessary

All trusts must develop and maintain a 'conflict of clinical opinion policy' to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. This policy should form part of the training, be adhered to and highlighted. To do

Current process is to escalate concerns to CCD/OTL and potentially Datix. No specific guidance on this.

Clinical Governance – Leadership

Essential action –

Training in civility, human factors and leadership, situational awareness and psychological safety.

All staff must operate a compassionate culture where learning occurs rather than apportioning blame. Staff encouraged to speak out when concerns regarding safe care. This is covered under training

Clinical Governance incident investigation and complaints

Essential action -

Incidents graded correctly and level of harm reflects the harm the patient suffered. In line with the serious incident framework.

Patient and family involvement in investigation, their needs first.

Executives must ensure dedicated time and resources allocated. All investigations have MDT input and never conducted by just one person/individual.

All staff involved in complaints receive training in complaints handling.

Director or consultant midwife must have oversight of complaints before sign off. Consultant midwife believes she has oversight but this may need formalising.

All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.

Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.

Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.

All trusts must ensure that complaints which meet SI threshold must be investigated as such.

All maternity services must involve service users (ideally via their Maternity voices partnership MVP) in developing complaints response processes that are caring, kind, empathetic and transparent. Cons Midwife to reach out to MVP to ask for input.

Learning from maternal deaths

Essential action –

In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings. HSIB and Cons midwife currently do this.

Multidisciplinary Training

Essential action –

Staff who work together must train together. The Consultant Midwife started delivering joint training last year and is now besieged with requests from all our trusts! This is a massive piece of work
The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.
All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.
• Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.
• All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.
• There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient. Pre-Prompt (Prehospital training package recently purchased by SECAmb) will assist in delivering this but the consultant midwife needs colleagues conversant with prehospital midwifery to assist in delivering. Recommendation would be 0.5 of a Paramedic in East and West with an interest in maternity +/- CCP's to assist at all day training events in house.
• There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.
• Systems must be in place in all trusts to ensure that all staff are trained and up to date in ~~CTG and~~ emergency skills. This was covered in part during key skills last year. I had hoped to be on the program again this year to complete it. Recommend including maternity in key skills for 2022/2023.

Complex antenatal care

Already in place. Consultant midwives in South East Coast send list of complex women to 'history marking' for logging on the CAD and cons midwife. Where appropriate senior staff made aware in relevant OU's and develop care plans/pathways for these complex women/babies.

Pre – term birth

Essential action –

There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit. Refer to EOC for IUT pathway. Maidstone case, case in point.

Labour and birth

Essential action –

It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust. Cons midwife to take up with each birth centre. This is not in place currently.

Midwifery-led units must complete yearly operational risk assessments. This would include the above and our responsiveness to emergency calls.

Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. We would need to form part of this at the birth centres and at homebirths.

The importance of ensuring that women undergo a risk assessment at each contact throughout the pregnancy pathway. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.

Findings published from a national cross-sectional survey of all 122 UK maternity services found that 92 per cent of local admission guidelines varied from national guidance. These findings suggest that variation in admission criteria for MLUs exists nationally which presents a potentially confusing and inequitable basis for women making choices about planned place of birth. An earlier study also found that local guidance for transfer of women from MLUs to consultant units were of poor quality. I am assuming we will be asked to assist with this.

Obstetric anaesthesia

N/A

Postnatal care

N/A

Bereavement care

N/A

Neonatal care

Essential action -

• Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU
Preterm pathway was developed in conjunction with the neonatal network last year. We are the only ambulance service doing this, so this is complete for us.

Supporting families

Where appropriate Consultant midwife meets with families following incident/adverse outcome to offer guidance or signpost to appropriate services for ongoing support. This is not necessarily our remit, but we do when women may not be supported by acute trust.
Reaching out to MVPs to ask what women want from us as a service?

Other areas for focus……

Disseminating the learning

Medical directorate page on the zone.

Guidelines

Must be updated annually by an MDT – National Maternity leads for ambulance service developed last year and working through JRCALC guidelines currently, so this is in progress for us.

Audit

Matters arising from clinical incidents must contribute to the annual audit plan.

SECAmb is committed to providing safe, effective and compassionate care to women and their families. We welcome the findings of this report to develop and improve our service to ensure excellence for all.