South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

28 July 2022
10.00-13.00

Tangmere MRC

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Administration					
23/22	10.00	Welcome and Apologies for absence	-	-	Chair
24/22	10.01	Declarations of interest	-	-	Chair
25/22	10.02	Minutes of the previous meeting: 30 June 2022	**Y**	Decision	Chair
26/22	10.03	Matters arising (Action log)	**Y**	Decision	PL
Context					
27/22	10.05	Board Story	-		
28/22	10.20	Chair's Report	**Y**	Information	Chair
29/22	10.25	Chief Executive's Report	**Y**	Information	SM
Quality & Performance					
30/22	10.40	Improvement Journey	**Y**	Assurance	SM
		Integrated Quality Report	**Y**	Information	RN
		Committee Escalation Reports	**Y**	Information	Chair
Governance					
31/22	12.20	Board Development Proposal	**Y**	Decision	PL
32/22	12.30	Board Committee Annual Review / TOR	**Y**	Decision	PL
33/22	12.40	Training Expenses Business Case	**Y**	Decision	EW
Closing					
34/22	12.50	Any other business	-	Discussion	Chair
35/22	-	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, 30 June 2022

Banstead MRC

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Fionna Moore	(FM)	Interim Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
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
Liz Sharp	(LS)	Independent Non-Executive Director
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst*	(PB)	Independent Non-Executive Director
Richard Quirk	(RQ)	Interim Medical 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

*via MS Teams

Chairman's introductions

DA welcomed members, those in attendance and those observing. He explained that these additional Board meetings have been introduced to ensure robust oversight of the Improvement Journey, which has an immediate focus on the findings of the CQC.

The venue today officially opens next week and DA confirmed that this is part of wider strategic estates programme. He thanked DH for his leadership in the delivery of the programme, to-date. DH then updated on progress with Medway, which is due to come online in December with EOC in the Spring of 2023.

14/22 Apologies for absence

None

152/22 Declarations of conflicts of interest

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

16/22 Minutes of the meeting held in public 26.05.2022

The minutes were approved as a true and accurate record.

17/22 Action Log [10.03-10.04]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

18/22 Chair's Report [10.04–10.07]
DA set the context for the meeting which is to review the Improvement Plan. He reflected that it has been a challenging six months or so, with the ongoing service pressures arising from COVID, and the issues highlighted by the CQC.

In terms of leadership changes DA thanked FM for stepping in following the departure of the Chief Executive and to the wider executive team for its work in engaging the workforce to develop the priorities within the Improvement Journey that aim to meet the needs of patients and staff. The new Chief Executive, Siobhan Melia, starts on 12 July.

19/22 Improvement Journey Delivery Plan / Response to CQC [10.07–12.15]
FM introduced the report and set the context to how this has been developed since April, in response initially to the staff survey and early CQC feedback. FM explained that the plan is detailed and challenging; the main risk relates to having the resources/capacity to deliver what is needed. The draft plan was presented to regional and ICS partners and was received positively.

FM then handed to DR who confirmed some of the changes since the earlier version shared with Board, which reinforces the dynamic nature of the plan. He then took the Board through the presentation highlighting in particular the following:

- The plan is framed against the four annual priorities. The CQC final report closely aligned to what we had started to identify as a delivery plan.
- The most immediate focus is delivering against the CQC findings, but in sustainable way. The plan will therefore develop over time to take forward the more transformational plans.
- In terms of engagement, it started with EMB and SMG, which began to address the disconnect at senior level identified by the CQC. The plan was developed initially from some of the issues arising from the Staff Survey feedback.
- EW then engaged 55 leaders from the operations team who took the draft priorities to their teams providing a feedback loop which then fed into the consideration of EMB and SMG. The executive reflected that this has been really positive engagement.
- This plan has however not yet been shared more broadly; this is the next step following Board today to ensure our people help shape the plan and deliver it jointly, so that it is not just the responsibility of the senior leadership.
- The priorities have been shared more widely and staff have been given the opportunity to feedback on these, which many have taken advantage of. Each person feeding back in this way has received a specific response from a member of EMB or SMG. Themes from this engagement will be established.
- The ongoing programme of leadership visits has started.
- One of the workstreams is to develop a strategy for long term engagement. This must ensure sustainability, acknowledging this plan currently has a relatively short-term focus.

DA thanked DR for this overview and opened up to questions.

CG asked about the level of confidence the executive has that the right structures are in place to engage well. DR responded that this would take much effort and the plan draws a distinction between the immediate and longer-term approach. RN added that as we build the engagement platform, we need staff to tell us how they would like to be engaged. We will test this too as part of the leadership visits.

MW reflected that after having read this document, engagement doesn't clearly enough flow from it. Instead, he feels that it is more process and structure. He therefore challenged the executive to ensure engagement is much more prominent. The executive agreed. MW then referred to the way we approach management; he had spoken with some staff recently who felt that the comms from the centre is too target driven, implying there is a missing element about how we manage people in a way that gives them discretion and autonomy to manage and lead their teams. MW believes that more discretion to manage locally will lead to better engagement and management.

HG referred to Better by Design (BBD) and the time the Board has spent in the past year on this and asked if there is anything from BBD that we have left out from this plan. DR responded that this plan has an immediate focus on the CQC findings. However, it will develop over time to incorporate all the programmes under BBD. DR confirmed that we have moved away from the brand of BBD due to the feedback we received from staff about it. FM added that we are still not meeting demand and important elements of BBD was to move to a different model (more virtual) to enable us to get closer to the APR standards.

DA agreed that the important message from this is that while we must focus on the immediate, we should not lose the longer-term structural issues that need to be addressed.

PB noted the number of workstreams and how this needs to be resourced and asked if there are critical success factors and how we will dynamically change as we go. DR confirmed that this will be picked up later in the presentation.

LS asked about the Warning Notice, which is time limited, and whether we have the capacity and capability to achieve the improvement needed. DR responded that at the moment we do not, but we are clear what resource we do need and are working with NHSEI to help with this. AM added that we are constructing the infrastructure we ought to have had in place before. What we are doing therefore is building something that is sustainable for the longer term.

DR then continued with the presentation setting out the framework for delivery of the plan. He reminded the Board of the CQC Warning Notice and the Must and Should Dos, which drives our priorities in the plan. The portfolio approach is therefore designed to deliver the CQC findings. The different workstreams will map across the priorities and CQC findings as illustrated in the matrix in the plan. Each programme has an executive lead, with workstreams with an accountable executive. Responsive Care may not be a CQC Must Do but is central to delivering patient care (quality and safety) and links to the longer-term changes we need to make to our operating model, as referred to earlier. The reporting hierarchy sets out the way we will report internally and externally, using the same reports, via the Board.

DR confirmed that we have engaged Internal Audit to review the plan to provide an additional level of assurance that the objectives align to the CQC findings.

RN updated that the Mock Inspections will be supported externally by ICS / NHSEI partners, and that the Board will have access to all the more detailed weekly reports that are produced. A specific report will also be provided that sets out progress against the Warning Notice to inform the Board's level of assurance.

At this point in the presentation DA asked DR to pause so that the Board could ask questions. He first asked the Board if it is content / assured with the structure of the governance and reporting that has been set out.

MW asked to reserve judgment preferring to first see the outcome of the review being undertaken by Internal Audit. However, as a start he supports the progress being made.

PB asked about the structures below workstream level and how issues and risks are identified. DR responded that the evidence collated will link to the weekly Highlight Reports and the higher-level detail will be provided to Board as part of the overall progress.

MW noted that CQC could come back in October / November at which point some areas within the plan would be more progressed than others. Against this background, he asked what the executive believes would be reasonable evidence to assure the CQC we have made significant enough improvement. RN responded that the principle has to be that we need to deliver what we would expect and want, e.g. good systems and processes, looking at the right information and engaging staff with good learning systems in place, from Board to road. Then more specifically, where the CQC found for example issues with Sis and Incidents, we would expect the backlog to be significantly reduced with systems in place to avoid recurrence. MW thanked RN for this which gives good assurance about the understanding of the success criteria.

DR set out the resource requirements and where we have targeted this, with the majority linked to Quality and People and Culture. He then asked the executive leads to summarise each of the four priorities.

Quality Programme

RN summarised the information provided in the Highlight Report and Quality Programme; this aims to address the findings about quality governance. He felt that some good progress has been made to-date, e.g. review of TOR and quality governance structure and the development of a quality dashboard, which is to be completed by October. In terms of learning, we have a platform to use and incorporate into staff training. We are working hard to reduce the backlog of incidents and use the learning to improve services. The backlog has been halved and we expect this to be reduced to zero by October. And with regards medicines management concerns arose from review of our risk register and we are undertaking a peer review.

DA asked if there were any questions from RB before we move on to Responsive Care.

TQ asked about clinical input and how we get the clinical voice and expertise into our Improvement Journey. RN confirmed that clinicians are involved in the SI Group and are engaged in the development of 72-hour incident reports and in how we manage learning. In addition, we are actively asking clinicians for ideas on development. Most importantly we are working with clinicians on how their voice is better heard and are establishing a clinical senate / advisory body.

SS was pleased to hear about the peer view of medicines management, as she had recently visited Paddock Wood and heard about the challenges there with medicines management. SS sought assurance that the peer review will lead to a short-term plan and then a longer-term strategy for medicines. RN confirmed that it would.

PL referred to the action log related to QI methodology; concern was expressed by the Board in May about the timeliness of this as it is key to underpinning how we approach this improvement plan. He asked about the risk of not having an agreed and/or embedded QI methodology. RN responded that this is a gap in our capability, but we are interviewing next week for a QI lead.

Responsive Care

EW summarised this priority and took the Board through the different workstreams and how each one relates to the CQC findings and / or more broadly how it helps to ensure we better meet patient need.

SS asked whether we have included in the workstreams how we ensure engagement, training and development. EW explained that this week all EOC managers did leadership training and are booked on to the Fundamentals course. SS reinforced that local managers need to own this improvement plan as they will be central to its delivery. EW agreed and felt that the leadership visits will help to test how it is for staff.

TQ referred to job cycle time and how we can better manage the message about the broader picture, e.g. it not just being about the patient in front of clinicians, but also those waiting for a response. He acknowledged it is a difficult balance as we must not restrict time as this won't be good for patients or staff. As a registered paramedic EW agreed that we need to give the right amount of time to staff to provide the right care to patients. We need to think about job cycle time, end to end. Some of this is more about dispatch, some relates to ED delays, and then some is about the time with the patient. FM added that this is an issue and we have to get a better global understanding of the bigger picture and delivering best for everyone. This will require a conversation with clinicians about what the priority is for the patients using the framework we are establishing to listen to our staff.

PB noted the resource gaps, which links to what was said earlier. EW explained that we need additional resource as part of bid we have put in.

Organisational Development

AM explained that this covers people, leadership, culture and engagement, hence why we have framed under the heading of OD. One of the positive findings from CQC was our provision of Health and Wellbeing Services and our work on equalities and inclusion. In terms of lens to view this, AM suggested that much of this is outward looking, and so we need to apply a lens of engagement across all programmes and test all we do against wellbeing and inclusion.

AM outlined each of the different workstreams, noting the resource risks as illustrated in the plan. All parts of the plan are critical to staff experience, not just this programme.

The Until it Stops campaign was launched in June, and the people development workstream includes Board development, but we need a plan for Board, executive and SMG.

DA reflected that the Board needs focus on this, as without content staff we won't have content patients. Therefore the Board needs to be assured this plan will get to heart of our people issues.

SS felt that this is a sea change from where we have been and recognised the overall plan builds infrastructure for sustained improvement while ensuring improvement as we go. She is also pleased to see focus on FTSU and ensuring we learn from this and pleased for a system of cascade related to engagement. However, the key point is our culture and in particular bullying, and core to this is how we develop our managers and leaders.

DA is confident we have got the message about engagement as this comes through in the plan. He asked how we get direct feedback. AM responded that the leadership team discussed this and agreed a light touch approach to the upcoming pulse survey ahead of the September annual staff survey. This is to ensure we mitigate against survey fatigue; what staff need to see is actions taken and changes made that result in better working experience.

AM reinforced the education training and development of management is central to our overall improvement journey; it is the biggest single cultural change.

MW challenged the light touch approach on the pulse survey. He felt that could use this more directly to ask for views on progress / impact. He wants more assurance on the impact we are having. AM agreed and this is what we plan, e.g. do a pulse survey on specific issues. MW wants better information on impact and asked the executive to think about how we provide this.

PB asked that we dig in to more of the detail related to areas not making progress / RAG rated Amber and Red. For example, there is lots of Red on Warning Notice areas. AM reinforced this is due to not having yet reached agreement on resource.

MW then asked about Board development and suggested that the approach we agree needs to specifically relate to some of the concerns expressed by the CQC, such as how is challenge and holds to account. PL outlined some of the areas being considered which will come back to the Board for agreement in due course.

Financial Sustainability

DH clarified that the gap is now closed and we have a breakeven plan for 999; we are working with commissioners on 111. He explained that the Trust delivered its financial plan and the gap the CQC noted wasn't really a gap, but more a negotiating position / point in time. Fundamentally we try and use resources to best meet patient needs. This programme has a short medium and long-term focus, with the short term being this year to meet the integrated plan and improve ARP. Medium term relates to review of the cost base (this year) and establishing the extent to which we are using resources to best effect / most efficiently. Then the long-term needs to move us away from just the supply side, to look at how we influence demand. We are starting these conversations now and need a holistic approach as a health and social care system. Otherwise, we will roll each year with a funding gap. DH summarised that this is the broad direction and more detail is to follow.

HG wondered how the CQC view ARP performance as our plan doesn't meet ARP fully. He asked whether in light of this we are we at risk of doing all this improvement for CQC to come back and conclude we aren't meeting patient need. DH explained that we are on a trajectory to meet ARP, but without looking at demand we are unlikely to ever sustainably meet ARP. This is what we need to work on as a system.

MW challenged the cost allocation and whether this really works to demonstrate every pound. He asked that as we take this forward, we need to relate output and costs; how we allocate; and what our corporate overhead is. He felt that this doesn't seem to be clear within the NHS. DH agreed that reflected that patient level costing in the NHS is still immature.

In terms of the plan, noting it is dynamic and still work in progress, DA asked the Board to confirm if it is content that it will start to address the issues identified by the CQC, noting work on resource and related risks. The Board confirmed it is content with the framework, approach and reporting structure. The caveat it noted was that we need reliable independent feedback from the workforce to test impact. The intention is in the plan, but not yet evidenced.

The Board therefore asked that next time greater assurance is needed on workforce engagement, resources and what are we prioritising in light of the resource gaps.

20/22 Model for Non-Registered Clinicians - AAP Business Case [12.15-12.20]

EW introduced the background to this business case and drivers for amending the model for non-registered clinicians. We have really listened to staff who went through the journey and benchmarked with other trusts. A cross directorate review was undertaken which has led to the proposal in the business case. It is well supported by the BCG, SMG, EMB and FIC. It is also good news for staff and for us related to recruitment and retention, and for patients in terms of scheduling being made easier.

HG confirmed the FIC review and recommendation. AM confirmed unions are supportive.

The Board then approved the business case.

21/22 AOB
None

22/22 Review of meeting effectiveness
DA apologised that there was no break but needed focussed time and concentration.

There being no further business, the Chair closed the meeting at 12.20

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

There were no questions.

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
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	Q2 2022/23	WWC	C	Added to the cycle of business for 2022/23 - and reported back to Board via the escalation report. Subsequently picked up as part of the improvement plan.
28.05.2022	06 22	A revised approach to the BAF risk report to be considered by the Audit and Risk Committee in July, to take account of the feedback provided by the Board at its May meeting. This will refresh how we present the risks and where possible linking to the relevant metrics within the IPR, with narrative describing the 'story' of mitigation and actions planned.	PL	25.08.2022	AUC	IP	The revised BAF will come to the Board meeting in August

Key

Not yet due
Due
Overdue
Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	28-22

Name of meeting	Trust Board
Date	28.07.2022
Name of paper	Chair Board Report
Report Author	David Astley, Chairman

The Board welcomes Siobhan Melia, Interim Chief Executive, who joined earlier in the month. This is Siobhan's first meeting of the Board.

The focus of this meeting is to review progress against the Improvement Journey, particularly against the CQC Warning Notice and Must Do actions. The Board is committed to making significant improvements that are sustained across the four priority areas of quality, organisational development, responsive care, and financial sustainability.

I mentioned last time that one of the areas of Board development is how we use data better to obtain assurance and inform strategic decisions. The development session we had with the making data count team at NHSE has helped guide our development of the Integrated Quality Report. The first version of this new report is on the agenda and we will be using this to help correlate with the Improvement Journey.

I led an online discussion hosted by the Good Governance Institute for Non-Executive Directors on the current pressures facing ambulance services and the importance of eradicating ambulance handover delays. I was able to emphasise the wider role ambulance services could play in managing urgent and emergency care.

I also contributed to a national meeting hosted by NHS Providers on the role of Governors. The Council of Governors are in the process of recruiting to our current NED vacancy and we hope that the new person will be appointed toward the end of the year.

Finally, Siobhan and I met some Sussex MPs to brief them about current pressures on ambulance services and how we managed during the recent heatwave.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	29-22

Name of meeting	Trust Board
Date	28 July 2022
Name of paper	Chief Executive's Report

1 This report provides a summary of the Trust's key activities and the local, regional, and national issues of note in relation to the Trust during June and July 2022 to date. Section 4 identifies management issues I would like to specifically highlight to the Board.

A. Local Issues

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

3 As part of its weekly meeting, the EMB regularly considers quality, operations (999 and 111) and financial performance. It also regularly reviews the Trust's top strategic risks. EMB now also holds two meetings each month as joint sessions with the Trust's Senior Management Group, predominantly to oversee the delivery of the Improvement Journey.

4 The key issues for EMB during this period have remained operational performance (assurance on current and forward planning), patient safety and progress of our Improvement Plan however other issues include:

- Agreeing a 111 Health Advisor hybrid working pilot.
- Approving the Terms of Reference for the new Quality Governance Group and the new Clinical Advisory Group to ensure greater focus on quality and to increase the clinical voice
- Undertaking regular reviews of the Trust's REAP level
- Reviewing the draft Undertakings and Recovery Support Programme exit criteria
- Working on the developing Integrated Quality Report – the first version is on the agenda.

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

- Developing our Green Plan – expertise to establish a baseline and develop a roadmap linked to the Green Strategy approved earlier in the year by the Board.
- Extending the trial of Body Worn Cameras to May 2023

	• Delivery support for the Improvement Journey
6	**Engagement** Since joining SECAmb on 12th July, I have thoroughly enjoyed spending time out and about around the Trust, meeting staff and hearing about the great work they do but also the issues and challenges they are facing.
7	So far, I have spent time with colleagues at Coxheath EOC, Polegate, Tangmere & Brighton Make Ready Centres and our Clinical Education Centre at Haywards Heath and, regardless of role, have been incredibly impressed by the commitment to patient care shown by all colleagues.
8	On 22nd July, the Chair and I met with a number of West Sussex MPs, ahead of the summer parliamentary recess. During a period of political uncertainty, it was a useful opportunity to share our current position and an update on our improvement plans.
9	**Director of Finance to leave SECAmb** On 7th July, we announced that David Hammond, Director of Finance and Chief Operating Officer had decided to leave SECAmb at the end of September after almost 15 years with the Trust to pursue new opportunities.
10	David has been the driving force behind many of SECAmb's key achievements during recent years including the development of the Trust's Make Ready Centres, new Emergency Operations Centre and 111 facilities and we wish him well for the future. The recruitment process for David's replacement will begin shortly.
11	**Official opening of Banstead Make Ready Centre** On 6th July, we were pleased to welcome HM Lord-Lieutenant of Surrey, Michael More-Molyneux to open our tenth and latest Make Ready Centre at Banstead.
12	The centre, which became fully operational in May, sits on the site of the Trust's former headquarters and includes a fleet workshop and the Make Ready vehicle preparation system along with modern office space and rest and wellbeing facilities for staff.
13	Ambulance crews who previously started and ended their shifts at Epsom, Leatherhead, Redhill, Dorking and Godstone ambulance stations now start and finish at the new centre, with service to the surrounding area protected by a network of Ambulance Community Response Posts (ACRP). at both existing ambulance stations and additional sites.
14	It is a fantastic new facility, which I understand is being well received by those teams based there. Well done to all those involved who have worked so hard to get the new Centre up and running.

	B. Regional Issues
15	**SECAmb achieves Armed Forces Silver Award** On 23rd June, I was pleased to see the announcement that SECAmb had achieved an Armed Forces Silver Award.
16	I know that we are rightly proud of our close links with the armed forces, with many staff and volunteers having served in a previous career or continuing to serve as reservist alongside their ambulance role.
17	The Trust had previously signed up to the Armed Forces Covenant in 2018 - a commitment to members of the reserves, armed forces, veterans, or family members, outlining how we will support them, officially, as a military-friendly employer – and this award reaffirms that commitment.
	C. National Issues
18	**Extreme weather** The period of extremely hot weather experienced in our region during the past couple of weeks has put our services under significant pressure but the hard work and effort put in by staff across the Trust has been outstanding.
19	We worked hard, in advance, to prepare as best we could, including increasing our public messaging through broadcast and social media and maximising staffing where possible. It was also good to see our welfare vehicles out and about, providing refreshments for staff where possible.
20	As well impacting on both 999 and 111 demand, the hot weather also contributed to both local and regional infrastructure issues, including water supply/pressure issues at Coxheath EOC, a burst water main at Chertsey Make Ready Centre and the operational and logistical impacts of a number of serious fires in our region. In addition, the traffic congestion and travel delays experienced around the Kent ports in recent days has placed additional pressure on the local teams.
21	I would like to thank all those who have worked so hard during this challenging period.
22	**Continuation of body-worn camera trial** Following feedback from colleagues who are participating in the national trial of Body Worn cameras, we agreed in early July to extend the trial locally and fund the camera licences for a further year.
23	This will allow for further evidence to be gathered to feed into the national evaluation which is taking place into the impact that the cameras can have on violence and aggression towards ambulance staff.
24	The feedback from some of those who have been using the cameras during the past year is that they make them feel safer, especially when working at night and on Single Response Vehicles (SRVs) and that removing them would be seen as a step backwards.

25	We will continue to do all we can to protect our staff and take action against the small minority who think it is acceptable to abuse and assault those who are trying to help them.
26	**COVID-19 outbreak** As we continue in the recovery phase following the COVID pandemic, we have now stood down the Trust's COVID Management Group (CMG), which had been in place for the last two years.
27	Any remaining COVID requirements have transitioned into 'business as usual' within the relevant departments but we continue to closely monitor the number of staff contracting COVID on an on-going basis and the impact this has on our operational resourcing.
28	Our Emergency Planning & Resilience Team are taking the lead on preparing for any requirements and requests to support the national COVID-19 Public Inquiry, announced by the Prime Minister in December 2021.
	D. Escalation to the Board
29	**Improvement Journey** As covered elsewhere in more detail, we continue to work hard to develop and deliver our key priorities for the year through our Improvement Plan, taking on board feedback from a number of sources, including the CQC and the NHS Staff Survey.
30	Recognising the breadth of work required, we are currently reviewing our Plan to ensure it prioritises sufficiently the key CQC requirements, including the Warning Notices and 'must do' actions.
31	We are also working closely with NHS England/Improvement to ensure we have the resources we require to deliver improvements in a timely way.
32	**Operational Performance** It remains a challenging time operationally. We continue to see spikes of high demand at times, which causes operational pressure for us, due to the resources we have available to respond to patients, both on the road and in our control centres.
33	As is evident from the national ambulance response time data, all ambulance services nationally remain under considerable pressure as does the wider NHS system. These pressures have been increased recently by the extreme weather conditions.
34	The impact of staff shortages on many NHS and social care organisations remains a key issue and we know this is impacting on patient flow through hospitals and the ability to discharge patients with social care needs. In turn, this leads to periods when our crews experience significant delays when handing over patients at hospital.
35	We are continuing to work hard to ensure that we provide as responsive a service as possible to our patients, despite the resource constraints we have been experiencing. Although we are not currently meeting the national performance standards, our 999 performance remains stable overall, although we remain concerned about longer

	response times to some patients.
36	As a result of the on-going challenging situation, we remain at REAP Level 4. Our REAP Level is regularly reviewed to enable us to respond to changing operational pressures and take all possible steps to maximise our operational performance. However, we have taken the decision not to suspend essential training for operational staff, recognising the importance of ensuring staff are supported in their clinical practice.
37	Emma Williams, our Executive Director of Operations, continues to lead on the on-going delivery of operational performance and we continue to closely monitor the impact of any delays on our patients and ensure we are taking all steps possible to maintain safety.

Improvement Journey Portfolio Monthly Assurance Update

Reporting Period: July 2022

Contact: matthew.webb@secamb.nhs.uk

Agenda

- Summary of portfolio progress
- Portfolio prioritisation update
- Critical resource update
- Programme updates
  - Quality Improvement Programme – Robert Nicholls
  - Organisational Development Programme – Ali Mohammed
  - Responsive Care Programme – Emma Williams
  - Financial Sustainability – David Hammond
- Example of evidence (QIG)

Improvement Journey Portfolio
Monthly Assurance Report

Completed by: Portfolio Lead, Improvement Journey Portfolio

Oversight group: Trust Board (internal) | System Assurance Meeting (external)

Flash report

RAG status: Previous	Amber
RAG status: Current	Amber
RAG status: Projected	Amber

Portfolio	**Improvement Journey**
Reporting period	July 2022

Code	Programme	Scope	Resource	Time	Cost	Overall progress	Linked CQC actions
QIG	**Quality Improvement Programme**						WN1, WN2, WN3 MD2, MD4, MD5, MD6, MD7, MD8 SD4, SD5, SD6, SD9
RCG	**Responsive Care Programme**						MD4, MD5, MD6, MD7, MD8 SD2, SD3, SD4, SD5, SD6, SD7, SD8, SD11, 111SD1, 111SD2
ODG	**Organisational Development Programme**						WN1, WN2, WN4 MD1, MD2, MD3, MD6, MD7 SD1, SD3, SD4, SD7, SD8, SD10, 111SD2
FSG	**Financial Sustainability Programme**						Not CQC
				Portfolio RAG status		**Amber**	

Progress update (1)

Portfolio | **Improvement Journey**

Summary of progress against plan

- Internal business case approved - BCG 12/07/2022 and EMB 13/07/2022.
- System Assurance Meeting held – SECAmb provided an overview of the portfolio approach, including the journey so far, structure, reporting and evidence collection. Executive leads provided an overview of their programme, with the main focus on QIG where SECAmb employees joined the meeting to provide the group with updates and their perspective of work undertaken.
- Associate Director of Improvement (NHSE) appointed and started 18 July 2022.
- Delivery against the masterplan is going well within each programme. Meeting and reporting frequencies have been established.
- Assurance against the masterplan is becoming more difficult due to resource and capacity issues with the delivery leads, which is likely to become challenging over the next few weeks due to annual leave.
- Recruitment agencies have been contacted to fill these positions but interim resource will take 4-6 weeks to be in post.

Portfolio changes that impact delivery

None

Planned activities completed this period

Portfolio	**IJ** - Internal business case submitted and approved. **IJ** - System Assurance Meeting held 08 July 2022.
QIG	**QIG/1** - SMG ToR agreed in EMB. Joint EMB/SMG to confirm the status of this activity. **QIG/2** - Incidents reduced from 401 to 386. SI actions are down to 47. **QIG/3** - Risk training completion is at 81%. 53 risks have been moved onto Datix Cloud. **QIG/6** - First round of data clinics have been completed to obtain the metrics.
RCG	**RCG/4** - The recommendations from the AACE-facilitated dispatch function review have been reviewed. **RCG/5** – Surrey Heartlands Equality Impact Assessment (EIA) link (Liz Patroe) engaged on the vehicle accessibility issues. **RCG/5** – Completion of Churchill performance issues deep dive (initial session complete).
ODG	**ODG/1** - Thematic analysis of Improvement Journey feedback completed and report submitted to the Joint EMB/SMG. EMB/SMG to ensure feedback is suitably reviewed. **ODG/4 -** FTSU 'follow-up' training provided by e-LFH is active on ESR and communication has been sent to all executives and NEDS for their completion. **ODG/9 -** New workstream created and key deliverables identified (Health & Wellbeing)
FSG	**FSG** - External finance review commenced to define the overall programme **FSG/1** - Commercial Continuous Improvement Assessment Framework (CCIAF) NHSEI Procurement Self Assessment programme introduced and engaged via HoP and Procurement Manager. **FSG/4** - Annual Planning Working Group (APWG) reviewed the integrated strategic 5-year plan framework and approved onward engagement with relevant groups.

Progress update (2)

Portfolio | **Improvement Journey**

Planned activities delayed this period		Ongoing/Upcoming activities in the next period	
Portfolio	No planned activities have been delayed, however, programme delivery resource remains challenged. The Trust has sought support from recruitment agencies, however, this is expected to take 3-4 weeks to resolve.	Portfolio	**IJ** - SECAmb planned outcomes to be defined for all CQC evidence slides for Trust Board and SAM review and agreement. **IJ** - Recruitment activities are underway for key roles to support the Improvement Journey portfolio. **RCG** - Strategic Operations Programme Director has now been appointed and over the coming weeks will be reviewing the programme's plans and governance structure to ensure the infrastructure is in place (including resources).
QIG	QIG/3 - Unable to provide a sample of the new risk register due to issues with utilising the report tool Yellow Fin. QIG/8 - Unable to progress with workstream until the QI role is recruited.	QIG	**QIG/1** - QPSC ToR will go to Board on 28 July 2022 **QIG/4** – Dates to be agreed for PEG bi-monthly meetings. Patient Experience Manager meeting with Director of Participation & Involvement at Kent Community scheduled for 18 July 2022. A meeting is scheduled with the Communications team to discuss patient stories. **QIG/5** – A business case is being developed for Medicines Management following the outcomes of the deep dive.
RCG	None specified.	RCG	**RCG/1** - Rota production by Operating Unit rota groups to be published. **RCG/2 -** Baselining of activity and staffing report continues. **RCG/4** - Plan to be formulated in how the dispatch review recommendations will be addressed. **RCG/7** - The development and implementation of KPIs for Ops, 111 and EOC are in progress.
ODG	ODG - Key personnel are currently unavailable within HR and L&OD due to staff absence or vacant positions. ODG/1 - Some engagement tasks are delayed until the Engagement Coordinator post is filled.	ODG	**ODG/3** - *Dignity at Work* policy consultation is due to close 25 July and feedback is to be analysed. **ODG/4** – FTSU Service draft recommendations paper to be reviewed by Director and Deputy Director of Q&N.. **ODG/5** - NHSE Employee Engagement Strategy document to be shared with the Leadership team (Joint EMB/SMG). **ODG/6** - Appraisal project phases 3 and 4.1 to commence.
FSG	None specified.	FSG	None specified.

Portfolio risks, issues and escalations

Portfolio	Improvement Journey

Key inherent risks (≥ 12) and issues (≥ High)

Description	Type (R/I)	Inherent score (1-25)	Mitigations/Controls	Residual score (1-25)	Latest update	Trend
Resourcing gaps and capacity constraints identified across portfolio programmes, including the capacity of executive, SMG and delivery leads, which could impact progress and delivery.	Issue	High	Programme deputies identified with the development of a business continuity plan and weekly meetings in place to keep to deadlines. Workstreams are currently being prioritised, whilst a plan to address this is progressed.	High	Issue is now impacting assurance reporting. Application for NHSE/I funding in progress, with internal business case final draft due for completion w/e 10/07/2022. Recruitment agencies contacted for Delivery Lead positions	↑
Due to operational demand or unforeseen service pressures, some delivery timeframes could be impacted.	Risk	16	Weekly programme core delivery group meetings are in place to keep to deadlines, with business continuity plans under development.	8	Demand increase is expected during the summer, however, no delays have been noted during the reporting period.	↓
Due to tight timeframes for delivery, some milestones could be delayed.	Risk	16	Weekly portfolio delivery steering group meetings are in place to maintain deadlines, with business continuity plans under development.	8	Key deliverables and milestones have now been defined within the master plan for all programmes.	↓
Additional resources may be required at short notice to aid portfolio delivery.	Risk	12	Early assessment of needs has been undertaken, with key components incorporated within NHSE/I funding request.	6	Internal business case approved, which outline short-notice additional resource required. Recruitment activities can commence	↓
Additional funding is required to support key enablers, such as recruitment, the procurement of systems and training.	Issue	Medium	Early assessment of needs undertaken, with no material impacts identified presently.	Low	Programme core delivery groups are currently determining non-pay enablers that will be key to each programme's success.	↓
Proposal to close ODG/1 Immediate Communication & Engagement plan could result in potential gaps in our communication and engagement.	Risk	16	3-month communications and engagement plan/tracker developed by the Communications team. To be monitored at the portfolio level through Joint EMB/SMG meetings (standing agenda item). Communications Manager attending Delivery Steering Group meetings.	12	The majority of the ODG/1 activities have been delivered and open employee engagement actions will transfer to ODG/5, with communication being managed at a portfolio level. Joint EMB/SMG to agree on proposed communications and engagement plan.	↔

Matters for escalation / information

Portfolio

- Delivery Steering Group meetings have not had consistent representation during the last two weeks due to resourcing constraints and have therefore not been compliant with the agreed ToRs.
- Trust planned outcomes for each CQC deliverable are outstanding and need to be defined by the relevant programme core delivery group before the next SAM and agreed on by the Trust Board.
- NHSE/I funding approved – EMB/SMG to discuss recruitment prioritisation and administration.

QIG

- New programme issue relating to risk reports and the complexities in utilising the report tool 'Yellow Fin'. Unable to pull detailed risk reports in the short term on DCIQ which may result in poor visibility of the Trusts risk picture, Support being provided by RL Datix in report building. Trust BI team investigating the ability to extract data from DCIQ to Power BI.

ODG

- Proposal to close ODG/1 Immediate Communication & Engagement plan.
- New workstream created – Health & Wellbeing ODG/9.

Highlight report sign-off for reporting period

Programme Manager	Date created
Claire Webster	18/07/2022
Portfolio Lead	**Date approved**
Matt Webb	19/07/2022
Oversight group	**Meeting date**
Leadership Team (Joint EMB/SMG)	20/07/2022

Improvement Journey Portfolio
Critical resource update

Improvement Journey Resources

Critical resources funded in BC1

Improvement Journey – Portfolio

- Associate Director / Portfolio Lead (B8d) – backfill capacity (B8c)
- Improvement Director (NHSEI) (£86k for year 1)
- Portfolio Delivery Manager (B8a)

Quality Improvement

- Programme Delivery Lead (PM) (B7)
- Interim Deputy Director – QI (B8d)
- Medicines Project Manager (B8a)
- Data Analyst (*B7 - no additional cost*)
- Violence and Aggression Prevention Trainer (B7)
- Safeguarding Officer (B7)
- Violence Reduction Officer (B7)
- Making Data Count – *no additional cost*
- Incident and harm HF training – *no additional cost*
- NHSEI Patient experience Team – *no additional cost*

Responsive Care

- Ops Programmes Director (*B8d – no additional cost*)
- Programme Delivery Manager (B8a)
- Delivery Team (3xB7 – *1 at no additional cost*)
- Ops Support Delivery M. (*B8a – no additional cost*)
- Administrative Support (B4)
- Rota Implementation Leads (*2xB7 – no additional cost*)
- Surrey ICS EIA Team Support – *no additional cost*

Org. Development

- Programme Delivery Lead (PM) (B7)
- Engagement Coordinator (B5)
- Policy & Proc. Manager (2xB8a)
- EDI Programme Lead (B8a)
- FTSU Coordinator (2xB4)
- E-Learning Lead (1xB7)
- Board/Senior Mgmt. Development (75k/yr. x 3yr)
- Long-term engagement (inc. NHSEI sup.) (£100k)
- Civility and Respect NHSEI – *no additional cost*
- e-Learning Development Support (£15k)

Financial Sustainability

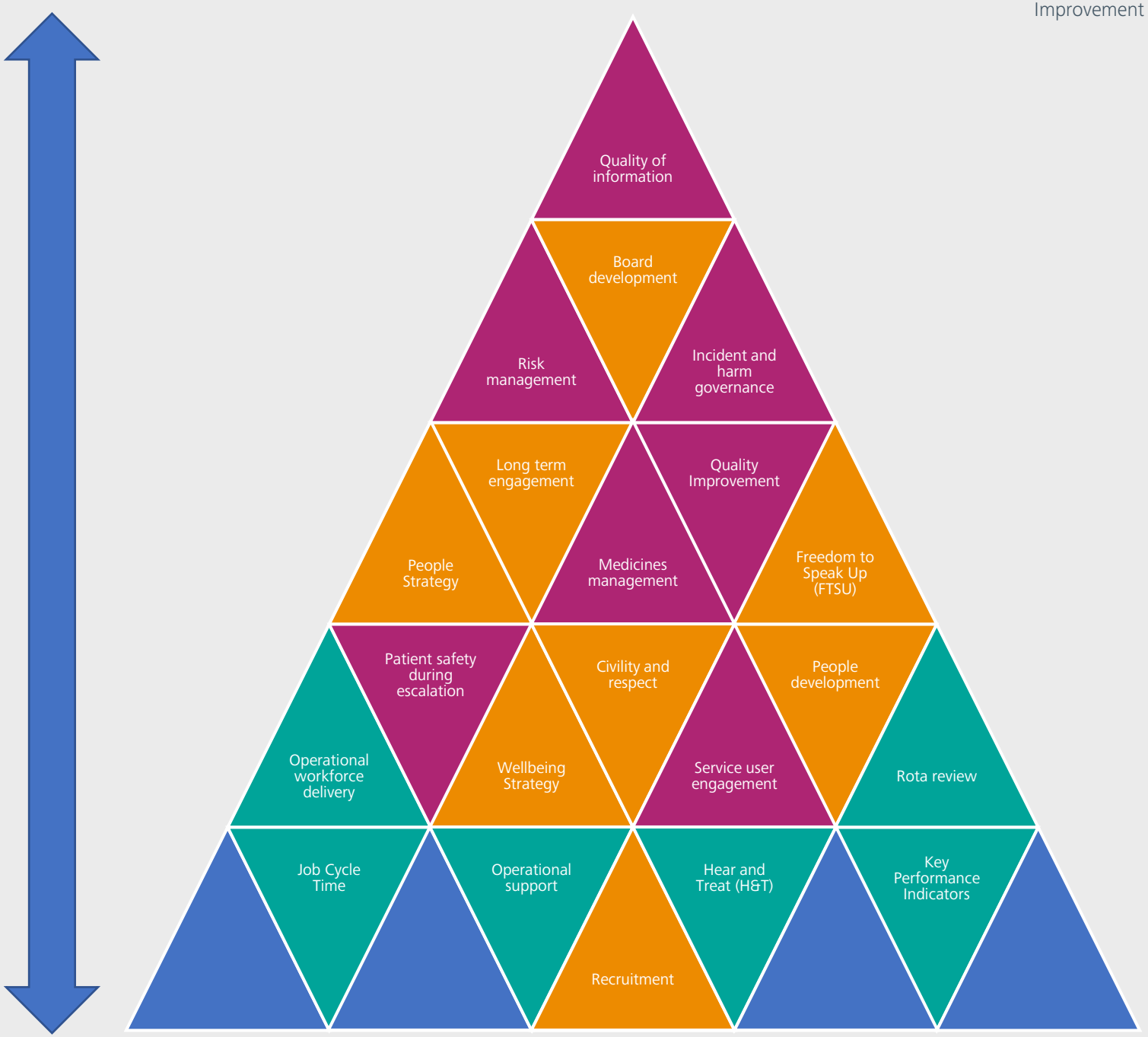
- Programme Delivery Lead (PM) (B7)
- External Finance Review – RC (£17k)
- NHSEI Proc. Self Assessment – *no additional cost*

Improvement Journey Portfolio
Workstream prioritisation update

Portfolio prioritisation matrix

		Quality Improvement								Organisational Development									Responsive Care								FS	
		QIG1	QIG2	QIG3	QIG4	QIG5	QIG6	QIG7	QIG8	ODG1	ODG2	ODG3	ODG4	ODG5	ODG6	ODG7	ODG8	ODG9	RCG1	RCG2	RCG3	RCG4	RCG5	RCG6	RCG7	RCG8	FS	
Code	**CQC deliverable**	Quality of information	Incident and harm governance	Risk management	Service user engagement	Medicines management	Making data count	Patient safety during escalation	Quality Improvement	Immediate engagement	Board development	Civility and respect	Freedom to Speak Up (FTSU)	Long term engagement	People development	Recruitment	People Strategy	Wellbeing Strategy	Rota implementation	Job Cycle Time (JCT)	Hear and Treat (H&T)	Dispatch review	Operational support	Operational workforce	Key Performance Indicators	Additional operational support	Financial Sustainability	Lead programme
WN1	There was a disconnect between the board and the wider organisation and the board was not working effectively together to achieve its full potential.	•		•					ODG2		•			•			•										•	ODG
WN2	The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge.	•	•	•		•		QIG2	•		•																	QIG
WN3	Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements.	•	•	•		•		•	•																		QIG1	QIG
WN4	There was a culture of bullying across the organisation. There was a failure to act swiftly to address staff concerns. There was a dismissive culture where staff raising serious concerns did not have their concerns acted upon.		ODG4						ODG3		•	•	•	•			•											ODG
MD1	The trust must ensure all staff complete mandatory, safeguarding and any additional role specific training in line with the trust target.		ODG6	ODG6					ODG6		ODG4				•	ODG6								ODG6				ODG
MD2	The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and improve the quality of care.			ODG4					•		•	•	•	•	•		•	•										ODG
MD3	The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns.			ODG4							ODG4	•	•	•	•		•	•										ODG
MD4	The trust must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly.		•												QIG2									•				QIG
MD5	The trust must ensure it works collaboratively with system partners to improve category 2, 3 ,4 response times.		•	FSG				•								RCG6			FSG	•	FSG	FSG	FSG	•			•	FSG
MD6	The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided.	•	•	•	•	•		•	•		•										QIG6	QIG7							QIG
MD7	The trust must ensure it seeks and acts on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving services.		•	ODG5	•			QIG2	•				•	•					•	FSG	QIG8	•	•				•	QIG
MD8	The trust must collect and analyse the End of Life (EoL) calls and share the analysis with ICS stakeholders, with the objective of reducing the needs for unanticipated EoL care by emergency and urgent care services.	•							QIG1																			QIG
SD1	The trust should ensure it provides appraisals and continuous professional development to all staff.														•		ODG6								ODG6			ODG
SD2	The trust should ensure blood glucose (sugar) machines are calibrated.																						•					RCG
SD3	The trust should consider how to recruit to staff vacancies.															•	ODG7							•				ODG
SD4	The trust should consider how to improve communication and relationships between staff and senior leaders.	•		ODG5					•		ODG5			•			•											ODG
SD5	The trust should consider a consistent approach in the management of ambulance response to categories 2, 3 and 4 calls.		RCG	RCG				•											•	•	•	•						RCG
SD6	The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.							•													•				•			RCG
SD7	The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale.											•		•		•	•	•	•	•	•	•	•	•	•			RCG
SD8	The trust should consider how to improve engagement with staff (trustwide)	ODG5							ODG5					•			ODG5		•	•	•	•	•	ODG5	ODG5			ODG
SD9	The trust should consider how to improve engagement with patients.				•				QIG4																			QIG
SD10	The trust should better understand the role of the FTSUG to improve the speak up culture.	x	ODG4								•		•															ODG
SD11	The trust should consider how to drive the improvements needed to achieve key performance indicators on clinical call back times, call abandonment rates and call response times in 111.							RCG7																	•			RCG
111SD1	Continue to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.							RCG7																	•			RCG
111SD2	Continue working towards supporting the workforce in order to reduce the pressure and improve staff morale.											•		•		•	•	•						•				ODG

Higher priority



Lower priority

Immediate, Short, Medium and Long-Term Planning

Immediate

- Quality of information
- Board development (BAF)
- Risk management
- Incident and harm governance
- Long term engagement
- Quality Improvement
- People Strategy
- Medicines management
- Freedom to Speak Up (FTSU)
- Patient safety during escalation
- Civility and respect

Short-medium term

- People development
- Operational workforce
- Wellbeing Strategy
- Service user engagement
- Rota implementation
- Job Cycle Time
- Dispatch review
- Operational support
- Hear and Treat
- Key Performance Indicators
- Recruitment

Long-term (Sustainability)

- Culture change programme
- Board and senior leadership development
- QI methodology
- Governance & assurance
- Financial sustainability
- Care delivery model
- Demand management

Quality Improvement Programme
Monthly Assurance Report

Flash report

RAG status: Previous	Amber
RAG status: Current	Red
RAG status: Projected	Amber

Programme	**Quality Improvement**
Lead Executive	Robert Nicholls

Code	Workstream	Scope	Resource	Time	Cost	Overall progress	Linked CQC actions	Expected outcome
QIG/1	**Quality of information**						WN1, WN2, WN3, MD6, MD8, SD4	Information is of high quality and presented in a standardised, consistent format trust-wide, with clear professional challenge which achieves assurance and improved decision-making regarding **staff** and **patients**. **Monitored** through framework developed through workstream.
QIG/2	**Incident and harm governance**						WN2, WN3, MD4, MD5, MD6, MD7	Improved and consistent incident management processes for **patients** and **staff**, including a new learning strategy, together with the elimination of backlog in Datix and SI reporting and associated actions. **Measured** through independent harm review and Integrated Performance Report.
QIG/3	**Risk management**						WN1, WN2, WN3, MD6	New related risks identified and managed consistently following implementation of a robust structure and associated processes, focussed on early recognition, allocation and control or mitigating measures **Monitored** through a revised Risk Management Policy, developed through this workstream, and the Integrated Performance Report.
QIG/4	**Service user engagement**						MD6, MD7, SD9	Opportunities are improved for **service-user** involvement within quality improvement programmes and relevant governance groups, ensuring patient stories and learning is communicated and acted upon appropriately. **Measured** through the Friends and Family Test (FFT) and locally defined feedback processes within this workstream.
QIG/5	**Medicines management**						WN2, WN3, MD6	Clear recommendations and actions determined, with clarity regarding reporting and escalatory processes for **staff**, following review of Medicines Management systems and processes. **Measured** through locally defined framework as produced within this workstream.
QIG/6	**Making data count**						WN2, WN3	Improved use of data trust-wide, through the implementation of a consistent approach to reading and analysing **patient** and clinical data to enhance decision-making and its consistency. **Monitored** against Making data count practical guide, Integrated Performance Report and contractual Data Quality Improvement Plan.
QIG/7	**Ensuring patient safety during periods of escalation**						WN3, MD5, MD6, SD5, SD6	Improvement in **patient** safety events during periods of extreme pressure, identified, shared and reported on through a visible framework embedded within the Trust. **Monitored** through Integrated Performance Report, SI and harm reviews.
QIG/8	**Quality Improvement**						WN2, WN3, MD2, MD6, MD7, SD4	Improved service delivery and quality for **patients**, which also meets the needs of the Trust and **staff** through the implementation of a quality improvement programme. **Measured** through a locally defined framework as produced within this workstream.

Risks, issues and escalations

Programme	Quality Improvement

Key inherent risks (≥ 12) and issues (≥ High)

Description	Type (R/I)	Inherent score (1-25)	Mitigations/Controls	Residual score (1-25)	Latest update	Trend
Risk regarding the take up of risk training and that there could be a large uptake of staff seeking to complete this at the same time which may cause a delay with certificates and onboarding.	Risk	12	The Risk and Incident Lead is monitoring the uptake daily and will report any issues with this to the QIG.	3	The QIG is monitoring training uptake very closely, which seems to be increasing rapidly, currently with 72% completed.	↓
Capacity concerns remain within the SI team. Admin support would be beneficial, although is not critical at present.	Risk	12	Progress is being monitored weekly by the QIG and the SI team is making good progress, expected to meet the deadline for reducing SI actions down to 40 by the end of July.	3	The SI team is currently progressing well with their assigned workstream and is expected to reduce open SI actions to the target by the deadline.	↓
Gap in processes relating to MDC work taking place. Unable to access data from certain areas like fleet, Estates & HR, therefore metrics cannot be built around these departments. We can report on the basic areas but there would still be areas which require information systems in place	Issue	Medium	IT data manager to be invited to QIG meetings to understand what systems the Trust needs to adopt/adapt. Reporting can still be provided in some areas but there are still others which require information systems in place.	Low	The action owner is to provide a list of the quality indicators which will be presented within the first iteration of the quality dashboard	↔
Not able to progress with the Quality Improvement actions as post remains unfilled	Risk	16	No mitigations in place	16	Recruitment continues, with ISCS funding requested.	↔
There is a risk that the Trust will be unable to export detailed risk reports in the short term from DCIQ due to complexities in utilising the report tool Yellow Fin, which may result in poor visibility of the Trust's risk picture.	Risk	12	Support is provided by the Risk and Incident Lead in report building. Trust BI team is investigating the ability to export data from DCIQ to Power BI. Scope of reports required sent to Risk and Incident Lead and awaiting a completion date.	6	As per mitigations.	↔

Matters for escalation / information

New risk added above relating to risk reports and the complexities in utilising the report tool 'Yellow Fin'.

Highlight report sign-off for reporting period

Executive Lead	Date approved
Robert Nicholls, Executive Director of Quality and Nursing	20/07/2022
Delivery Lead	**Date created**
Victoria Baldock, Quality Improvement Core Delivery Group	18/07/2022
Oversight group	**Meeting date**
Improvement Journey Steering Delivery Group	-

Organisational Development Programme
Monthly Assurance Report

Flash report

RAG status: Previous	Amber
RAG status: Current	Amber
RAG status: Projected	Amber

Programme	Organisational Development
Lead Executive	Ali Mohammed

Code	Workstream	Scope	Resource	Time	Cost	Overall progress	Linked CQC actions	Expected outcome
ODG/1	**Immediate engagement**							Joint SMG/EMB approval to close workstream. Remaining open employee engagement actions will transfer to ODG/5 and Communication actions will transfer to portfolio level. Closure governance process currently underway.
ODG/2	**Board development**		↓			↓	WN1, WN2, WN4, MD2, MD6, SD10	Effective Board in operation, as **measured** through the agreed framework from the Board Development Plan.
ODG/3	**Civility and respect**						WN4, MD2, MD3, SD7, 111SD2	Significant reduction in **staff** bullying and harassment prevalence, as **monitored** through the Integrated Performance Dashboard and NHS Staff Survey.
ODG/4	**Freedom to Speak Up (FTSU)**		↓		↓	↓	WN4, MD2, MD3, MD7, SD10	**Staff** are empowered and supported, through a safe mechanism, to raise concerns, promoting changes and learning as a result of speaking up, and this informs more effective decision-making at Board-level. **Monitored** through the Integrated Performance Dashboard and NHS Staff Survey.
ODG/5	**Employee engagement**						WN1, WN4, MD2, MD3, MD7, SD4, SD7, SD8, 111SD2	**Staff** are aligned with the Trust's values, and feel appreciated and informed through the implementation of the Trust Employee Engagement Strategy. **Measured** through NHS Staff Survey and local feedback mechanisms.
ODG/6	**People development**						MD1, MD2, MD3, SD1	Opportunities for education, training and CPD are identified and accessible through a fair and equitable process, with improvement in **staff** retention and wellbeing rates, as **measured** through the NHS Staff Survey and national pulse surveys.
ODG/7	**Recruitment**						SD3, SD7, 111SD2	Achievement of recruitment plan, including diversity targets, with a significant reduction in **staff** bullying, harassment and discrimination, provision of a workforce that is representative of the communities served, and improved inclusivity increasing retention over time. **Monitored** through the Integrated Performance Dashboard and NHS Staff Survey.
ODG/8	**People strategy** (including NHS People Plan)	↓					WN1, WN4, MD2, MD3, SD4, SD7, 111SD2	Improvement of the **staff** experience, with a particular focus on health and wellbeing, staff feeling valued, retention, and development of the workforce through a clear People Strategy. **Monitored** through the Integrated Performance Dashboard and NHS Staff Survey.
ODG/9	**Health & Wellbeing**						MD2, MD3, 111SD2	Improvement health and wellbeing of **staff** through newly procured occupational health service; completed value for money review of our wellbeing services and a refreshed Heath & Wellbeing strategy. **Monitored** through the Integrated Performance Dashboard, KPI's in Occupational Health contract and NHS Staff Survey.

Risks, issues and escalations

Programme	Organisational Development

Key inherent risks (≥ 12) and issues (≥ High)

Description	Type (R/I)	Inherent score (1-25)	Mitigations/Controls	Residual score (1-25)	Latest update	Trend
Delivery Lead is not currently in place due to changes within the portfolio delivery team.	Issue	High	Leadership team to review on 20/07/2022. Internal business case includes delivery lead roles. Position currently being covered by the IJ Programme Lead.	Low	Recruitment process started, agencies are actively looking for candidates and sending through suitable CV's Long term the delivery lead is not on place	↔
Within the HR and L&OD department, there are key personnel missing either through absence or vacant positions which could impact some elements of programme delivery.	Risk	20	Recruitment activities are ongoing for vacant posts and a request for additional resource funding has been supported by NHSE/I.	16	No changes currently	↔
There is not a robust assurance process for CSTF completion which will mean that non-completion could remain high.	Risk	20	The CSTF dashboard is being reviewed with directorate reporting to SMG monthly.	12	Audit of mandatory & statutory training due in August After group review it was felt that the residual score previously under reflected the level of controls in place, score adjusted.	↔
There is a demonstrable lack of commitment or action on EDI issues or completion of actions identified in Board strategies.	Issue	High	All managers at B7 and above have EDI smart objectives set at appraisal. EDI is also a regular agenda item for reporting by each directorate	Low	The actions set out in the IEAP require a review to ensure validity and realism. Scoring of issue to then be reviewed following this.	↔
The Speak Up agenda is not taken with sufficient seriousness below board-level.	Issue	High	Communication and commitment from EMB and SMG is a priority to support the Speak Up agenda, with regular reviews and updates on FTSU being undertaken.	Low	FTSU 'follow-up' training provided by e-LFH is active on ESR and communication has been sent to all executives and NEDS for their completion.	↔

Matters for escalation / information

Highlight report sign-off for reporting period

Executive Lead	Date approved
Ali Mohammed, Executive Director of HR & Organisational Development	25/07/2022
Delivery Lead	**Date created**
Claire Webster, Performance & Planning Delivery Manager	25/07/2022
Oversight group	**Meeting date**
Improvement Journey Steering Delivery Group	-

Responsive Care Programme
Monthly Assurance Report

Flash report

RAG status: Previous	Amber
RAG status: Current	Amber
RAG status: Projected	Amber

Programme	Responsive Care
Lead Executive	Emma Williams

Code	Workstream	Scope	Resource	Time	Cost	Overall progress	Linked CQC actions	Expected outcome
RCG/1	**Rota implementation**	↑		↑			MD7, SD5, SD7, SD8	Improved staffing allocations delivered through new rotas by day/hour according to demand/activity, delivering improved **staff** experience, more efficient utilisation of limited resources, timely responses to the highest-acuity calls, and improved **patient** outcomes and experience. **Monitored** through Ambulance Quality Indicators.
RCG/2	**Job Cycle Time (JCT)**	↑		↑			MD5, SD5, SD7, SD8	Improved overall ambulance availability through a reduction in job cycle time providing timely responses to the highest-acuity calls, improved **patient** outcomes and experience, and improved **staff** experience. **Monitored** through the Integrated Performance Report.
RCG/3	**Hear and Treat (H&T)**	↑					MD7, SD5, SD6, SD7, SD8	Increased number of incidents where 999 calls are successfully completed without dispatching a physical resource, resulting in improved **patient** outcomes and experience, and improved **staff** experience, i.e., dispatching staff to the most appropriate calls. **Monitored** through Ambulance Quality Indicators.
RCG/4	**Dispatch review**	↑		↑			MD7, SD5, SD7, SD8	Efficiency and effectiveness of dispatch function improved, contributing to greater **patient** outcomes, experience and ARP performance across all categories. **Monitored** through Ambulance Quality Indicators.
RCG/5	**Operational support**			↑			MD7, SD2, SD7, SD8	Improvement in efficiency in the delivery of operational support functions, particularly where these interface directly with operational delivery, improving **staff** experience, wellbeing and service responsiveness. **Monitored** through the Integrated Performance Report.
RCG/6	**Operational workforce delivery**	↑		↑	TBC		MD4, MD5, SD3, SD7, 111SD2	Delivery of all components of the 2022-23 workforce plan, including recruitment, retention and abstraction management, ensuring resource availability, and improving **patient** and **staff** experience. **Monitored** through the Integrated Performance Dashboard.
RCG/7	**Key Performance Indicator delivery**	↑		↑			SD6, SD7, SD11, 111SD1	Service and **staff** development and capability are supported in order to improve overall trust performance and responsiveness through the implementation of a KPI framework. **Monitored** through the Integrated Performance Dashboard
RCG/8	**Additional operational improvement (End-of-Life Care)**	↑		↑			MD8	Improvement in the response to and management of End of Life Care patients, working in partnership with health & care system partners to reduce the need for unanticipated care, resulting in improved **patient** experience and outcomes. **Monitored** through feedback from systems and framework developed within the workstream.

Risks, issues and escalations

Programme	Responsive Care

Key inherent risks (≥ 12) and issues (≥ High)

Description	Type (R/I)	Inherent score (1-25)	Mitigations/Controls	Residual score (1-25)	Latest update	Trend
Additional resources to enable key programme workstreams will likely be required (e.g. RCG5 and RCG7)	Risk	12	Job descriptions to be reviewed and evaluated.	6	20/07/22 – CW and JG to discuss recruitment into the Delivery Lead role.	↔
There is a risk that the momentum of the programme may be slightly delayed due to a lack of project resources and the transition from the existing Delivery Lead to the Strategic Operations Programme Director.	Risk	12	Business case to seek funding for NHSE/I funding completed. Portfolio Manager, Business Change Manager and Administrator job descriptions have now been evaluated.	8	20/07/22 – Job roles are now advertised, closing mid August 2022.	↔

Matters for escalation / information

Risks and issues to be reviewed in detail.

Highlight report sign-off for reporting period

Executive Lead	Date approved
Emma Williams, Executive Director of Operations	20/07/2022
Delivery Lead	**Date created**
Eileen Sanderson, Responsive Care Core Delivery Group	20/07/2022
Oversight group	**Meeting date**
Improvement Journey Steering Delivery Group	TBC

Financial Sustainability Programme
Monthly Assurance Report

Placeholder - Financial Sustainability flash report

Quality Improvement Programme
Example of supporting evidence

Improvement Journey Portfolio
Reporting & assurance guidance

Portfolio flash report RAG status key

RAG status key	Scope	Resource / Capacity	Time	Cost/Budget	Individual programme progress	Overall portfolio progress
Red (Off-track, significant risks identified)	• Requirements are unclear • Significant uncertainty in scope and deliverables	• Resource not in place/unavailable • Roles/responsibilities unclear	• Timelines are unclear • Critical path not identified • Completion date unachievable unless intervention	• Costs not understood • Budget not available • Actual or high risk of overspend >10%	• One or more red sub-category • Significant risk or issue without appropriate treatment plan • Ability to deliver programme impacted	• Serious issue or risk that portfolio is unlikely to meet expected outcomes within agreed time constraints
Amber (Risks identified but still on track)	• Requirements lack clarity • Only key deliverables are identified • Scope still lacking clarity • Plan in place to address	• Gaps in resourcing • Lack of clarity regarding roles/responsibilities • Plan in place to address	• Timelines lack clarity • Critical path not identified • Programme slippage, but not expected to impact planned completion date • Plan in place to address	• Uncertainty about costs • Budget identified but not approved • Programme will result in overspend ≤10%	• No red sub-categories • More than one amber sub-category • Risk and issues exist with plans to manage them • Programme delivery at risk but manageable	• Portfolio delivery is at risk but still manageable within agreed constraints
Green (On track and expected to deliver on time)	• Requirements are clear • All deliverables are identified • Scope (what is in/out) is clear	• Delivery team in place • Clear roles/responsibilities • No significant gaps in resourcing	• Clear on timelines • Critical path identified • On track to deliver milestones	• Costs clearly defined • Budget allocated to programme • Programme forecast as on track / under budget	• No red sub-categories • No more than one amber sub-category with clear path to return to Green • No risk or issue material to programme success • No risk to programme delivery	• Portfolio is on track and scheduled to deliver the expected outcomes within agreed constraints
Blue	Programme and associated workstreams completed					
Grey	*Not applicable to programme*					

Programme flash report RAG status key

RAG status key	Scope	Resource / Capacity	Time	Cost/Budget	Individual workstream progress	Overall programme progress
Red (Off-track, significant risks identified)	• Requirements are unclear • Significant uncertainty in scope and deliverables	• Resource not in place/unavailable • Roles/responsibilities unclear	• Timelines are unclear • Critical path not identified • Completion date unachievable unless intervention	• Costs not understood • Budget not available • Actual or high risk of overspend >10%	• One or more red sub-category • Significant risk or issue without appropriate treatment plan • Ability to deliver workstream impacted	• Serious issue or risk that programme is unlikely to meet expected outcomes within agreed time constraints
Amber (Risks identified but still on track)	• Requirements lack clarity • Only key deliverables are identified • Scope still lacking clarity • Plan in place to address	• Gaps in resourcing • Lack of clarity regarding roles/responsibilities • Plan in place to address	• Timelines lack clarity • Critical path not identified • Slippage against plan, but not expected to impact completion date • Plan in place to address	• Uncertainty about costs • Budget identified but not approved • Workstream will result in overspend ≤10%	• No red sub-categories • More than one amber sub-category • Risk and issues exist with plans to manage them • Workstream delivery at risk but manageable	• Programme delivery is at risk but still manageable within agreed constraints.
Green (On track and expected to deliver on time)	• Requirements are clear • All deliverables are identified • Scope (what is in/out) is clear	• Delivery team in place • Clear roles/responsibilities • No significant gaps in resourcing	• Clear on timelines • Critical path identified • On track to deliver milestones	• Costs clearly defined • Budget allocated to workstream • Workstream forecast as on track / under budget	• No red sub-categories • No more than one amber sub-category with clear path to return to Green • No risk or issue material to workstreams success • No risk to workstream delivery	• Programme is on track and scheduled to deliver the expected outcomes within agreed constraints
Blue	Workstream and associated tasks completed					
Grey	*Not applicable to workstream*					

CQC deliverables

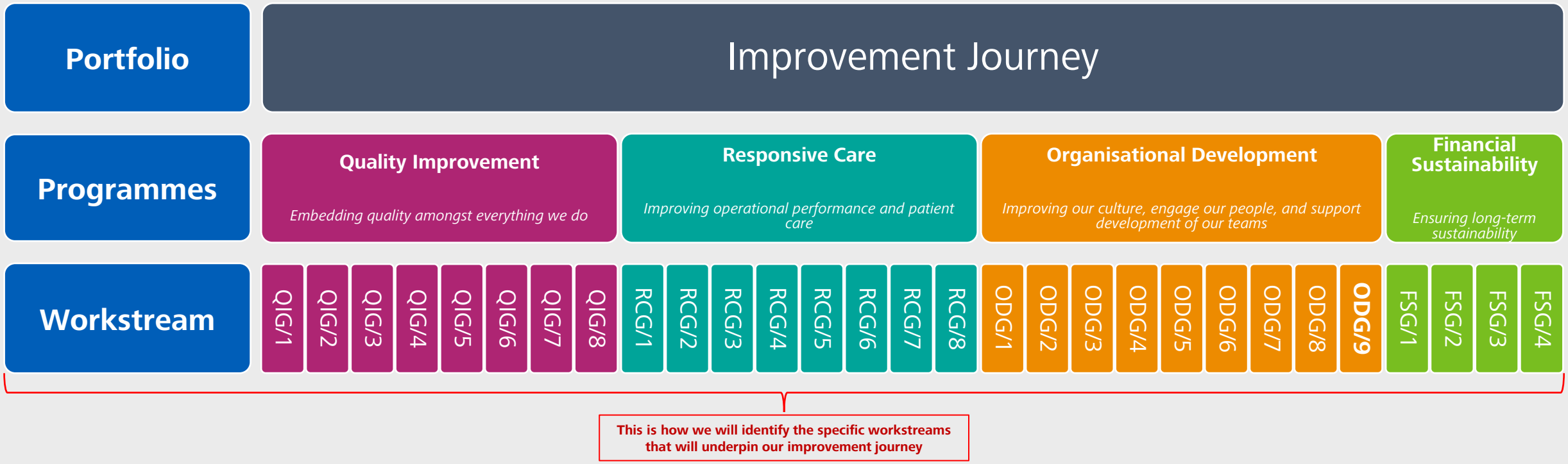
ID	Warning Notice - S29A
WN1	There was a disconnect between the board and the wider organisation and the board was not working effectively together to achieve its full potential.
WN2	The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge.
WN3	Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements.
WN4	There was a culture of bullying across the organisation. There was a failure to act swiftly to address staff concerns. There was a dismissive culture where staff raising serious concerns did not have their concerns acted upon.

ID	Must-do action
MD1	The trust must ensure all staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).
MD2	The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and improve the quality of care. (Regulation 12 (1) (2i)).
MD3	The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. Regulation 17 (2)(b).
MD4	The trust must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b) (e)).
MD5	The trust must ensure it works collaboratively with system partners to improve category 2, 3 ,4 response times. (Regulation 12, (1) (2) (a) (I)).
MD6	The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. (Regulation 17, (1) (2) (a) (b)).
MD7	The trust must ensure it seeks and acts on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving services. (Regulation 17, (2) (e)).
MD8	The trust must collect and analyse the End of Life (EoL) calls and share the analysis with ICS stakeholders, with the objective of reducing the needs for unanticipated EoL care by emergency and urgent care services (Regulation 17, (1) (2) (a) (b) (c)).

ID	Should-do action
SD1	The trust should ensure it provides appraisals and continuous professional development to all staff.
SD2	The trust should ensure blood glucose (sugar) machines are calibrated.
SD3	The trust should consider how to recruit to staff vacancies.
SD4	The trust should consider how to improve communication and relationships between staff and senior leaders.
SD5	The trust should consider a consistent approach in the management of ambulance response to categories 2, 3 and 4 calls.
SD6	The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
SD7	The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale.
SD8	The trust should consider how to improve engagement with staff.
SD9	The trust should consider how to improve engagement with patients.
SD10	The trust should better understand the role of the FTSUG to improve the speak up culture.
SD11	The trust should consider how to drive the improvements needed to achieve key performance indicators on clinical call back times, call abandonment rates and call response times in 111.
111SD1	Continue to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
111SD2	Continue working towards supporting the workforce in order to reduce the pressure and improve staff morale.

Improvement Journey Portfolio

- We have set up an Improvement Journey Portfolio approach that aligns to:
  - Our Trust Priorities
  - Staff Feedback
  - CQC Deliverables
- This portfolio approach will take us beyond November, with future workstreams able to be added or removed, responding dynamically to the needs of the service
- This will ensure we are being consistent across our delivery approach and ensure sustainable long-term improvement.



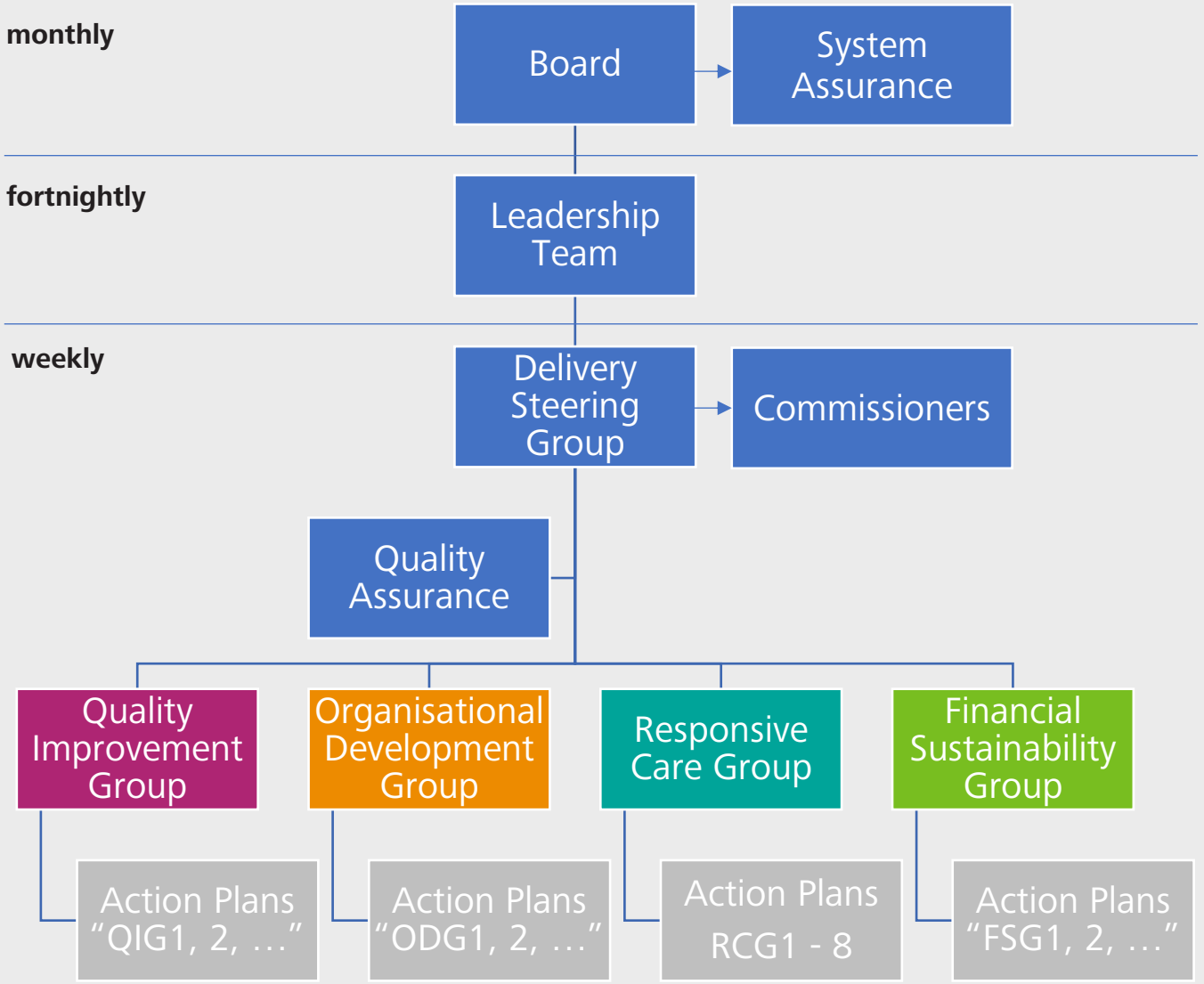
Reporting hierarchy

Monthly progress report

Fortnightly progress report

Weekly progress report

Weekly monitoring



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South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – July 2022

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

Contents

Chief Executive Overview

Siobhan Melia
Interim Chief Executive

I am pleased to introduce our Integrated Quality Report for July 2022, and to explain the rationale for development of this new report.

In May, the Board approved our priorities for 22/23. These priorities were based on the preliminary feedback that we received through the CQC inspection earlier in the year, as well as on the feedback our colleagues gave us through the staff survey. Through the month of June, we developed our Improvement Journey framework, ensuring there was a robust delivery plan to meet our priorities for 22/23, and address the Must do and Should do actions from the CQC, following the publication of the report late in June. Through July, our focus has been to start making progress across the improvement journey programmes, whilst rapidly resourcing the programme to ensure we can make the improvements our patients, colleagues and partners, expect of us.

A critical finding from the CQC was around the quality of the information that was being provided at the Board. I am pleased to report that as part of our Improvement Journey, the Board undertook a development session and adopted the "Make Data Count" system, to help us increase visibility of the issues and make our reporting more conducive of meaningful and effective challenge at the Board. "Make Data Count" is based on providing Statistically Process Controlled (SPC) data to the Board. The benefits come from looking at trends over time and drawing conclusions of improvement or concern based on a statistically sound methodology. We have also strengthened our narrative around the key areas we are focussing on to improve the service we provide to our patients, as well as how we are supporting our to help deliver exceptional and responsive care.

This is the first iteration of our new Integrated Quality Report, and we will continue to gather feedback from system partners on how we can improve on our reporting to make sure we continuously improve this critical element of assurance to our the Board.

We have also separated the reporting into the four component parts of our Improvement Journey: **Quality Improvement**, **Organisational Development**, **Responsive Care**, and **Financial Sustainability**. We expect this approach will allow us to better triangulate the work we are doing on our Improvement Journey with the impact it is having on our patients and colleagues, further strengthening the alignment between the quality of information the Board sees, and the comprehensive improvement plans we have put in place. We are also for the first time providing live links to our quality dashboards, so that you can explore the data in more detail should you wish to. We look forward to further improving the quality of information we provide to the Board over the coming weeks and months.

Siobhan Melia, Interim Chief Executive

Alignment Framework

Improvement Journey

Quality Improvement	Responsive Care	Organisational Development	Financial Sustainability
Embedding quality amongst everything we do	*Improving operational performance and patient care*	*Improving our culture, engage our people, and support development of our teams*	*Ensuring long-term sustainability*
 ***Patients***	 ***Service***	 ***People***	 ***Sustainable***
- *Incident Management* - *Medicines Management* - *Patient Experience* - *Safeguarding* - *Safety in the workplace* - *Impact on Patient Care*	- *Ambulance Quality Indicators* - *Call Handling* - *Utilisation* - *999 Frontline Efficiency* - *Supporting the system* - *111 Operation*	- *Employee Experience* - *Workforce* - *Wellbeing*	- *Delivery against Plan*

IQR Themes

Icon Descriptions

				
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently **HIT OR MISS** the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.

				Special cause variation where **UP** is neither improvement nor concern.
				Special cause variation where **DOWN** is neither improvement nor concern.
				Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

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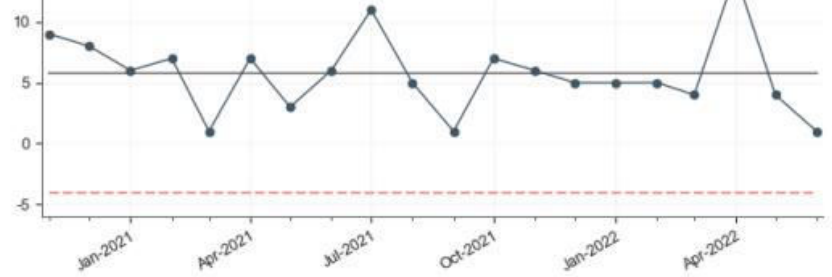
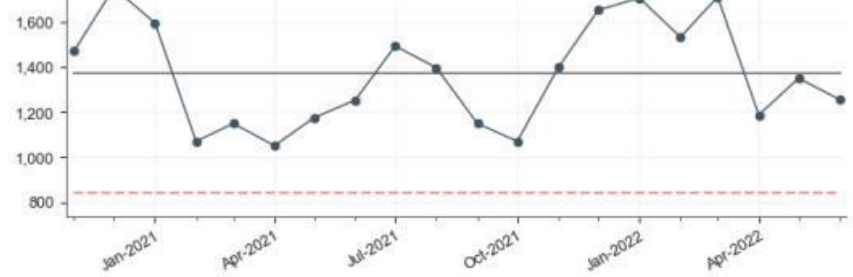
Quality Improvement

Patients

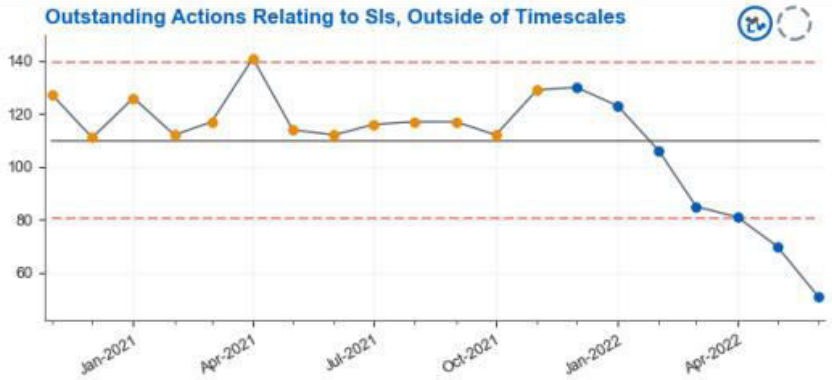
Quality Improvement – Sis & Incidents



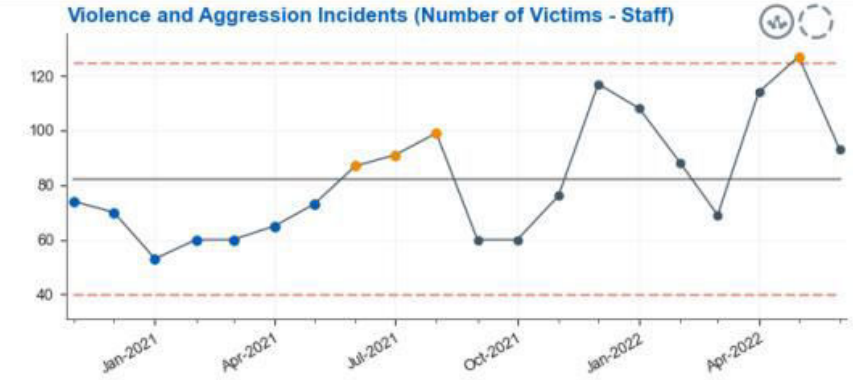
QS-2
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1



QS-1
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1255



QS-17
Dept: Quality & Safety
IP: Quality Improvement
Latest: 51



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 93

What is the information telling us?

The variability on these graphs correlate with the periods SECAMB has experienced times of surge in demand and a depletion of capacity due to internal and external factors related to the pandemic, and system pressures. An increase in reporting is an indicator of a good reporting culture and so is encouraged. However, it is evident that at times of extreme pressure on the service, reporting reduces in the no/low harm and near miss events, though tend to remain constant in those incidents perceived as more severe.

Quality improvement measures put in place to reduce the number of outstanding actions are having the desired outcome as the graph above illustrates the continual decrease to a target of zero by Dec 2022.

The introduction of the Violence Reduction Support Officer resulted in a rise in reporting as staff became more confident in reporting instances. We expect this to continue to rise over this first year.

What actions are we taking?

Work is underway to raise awareness of incident reporting and to include frontline staff with the development and build of the new reporting system so they can identify and report incidents easily.

Continue with drive to close outstanding Datix, SIs and actions maximising change and learning. Setting out a sustainable process to mitigate this situation re-occurring.

Violence Reduction Support officer in post for 1 year initially and full plan in place being implemented in phased approach Body-cam cameras in 7 locations have been extended for a further year as a pilot that is being measured.

Establishing a Violence Reduction Working Group to develop a trust strategy and review current policies. The group will review violence data and develop the violence reduction plan, and establish a meeting structure to enable oversight and scrutiny of violence reduction plans and standards.

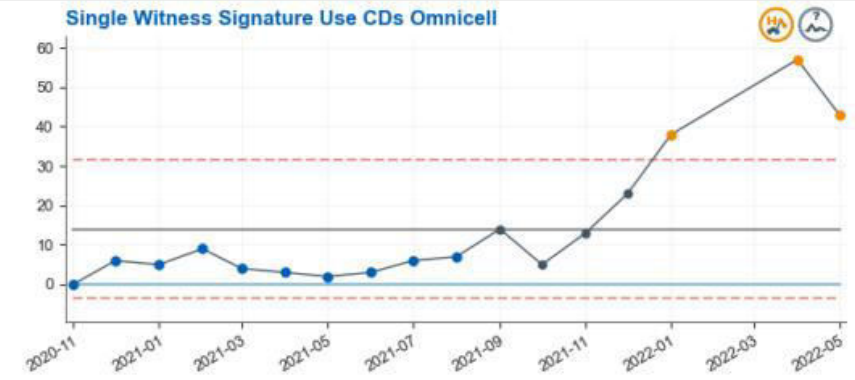
Patients

Quality Improvement – Medicines Management

MM-1
Dept: Medicines Management
IP: Quality Improvement
Latest: 121

MM-7
Dept: Medicines Management
IP: Quality Improvement
Latest: 75.7%
Target: 100%

MM-5
Dept: Medicines Management
IP: Quality Improvement
Latest: 17



MM-3
Dept: Medicines Management
IP: Quality Improvement
Latest: 43
Target: 0

What is the information telling us?

Our staff continue to report around medicines activity in particular around Controlled Drugs (CDs) which is mandatory. There has been an increase in incidents from our Medicines Distribution Centre (MDC) due to increasing clinical risk in this area. Medicines pouch incidents remain consistently high

CD breakage volumes have remained consistent over the reporting period with no identifiable trends.

Medicines Management Audit is currently showing a decreasing trend due to closed stations being included within the reports that no longer require an audit check to be completed.

The Trusts Chief Pharmacist has requested that all **single witness CD signatures** are captured, which has driven the recent increasing trend seen on the chart.

What actions are we taking?

Additional resource for the medicines team is currently being reviewed as an option to support and reduce the number of medicines incidents, alongside the relocation of the MDC.

The **Medicines Management Audit** dataset will be adjusted for the next IQR to ensure all closed stations are removed from the dataset to ensure accurate reporting.

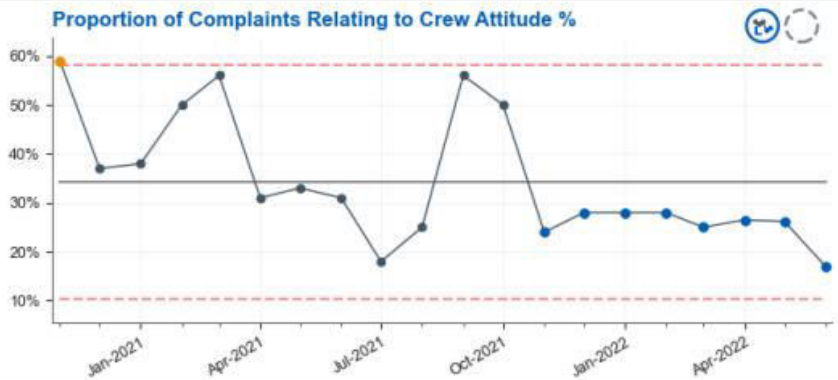
Medicines team is working with OTLs to ascertain whether any of the **single witness signatures** for CDs were inappropriate which will be included within the narrative of future IQRs.

Patients

Quality Improvement – Patient Experience

QS-5
Dept: Quality & Safety
IP: Quality Improvement
Latest: 78

QS-4
Dept: Quality & Safety
IP: Quality Improvement
Latest: 77%
Target: 95%



QS-10
Dept: Quality & Safety
IP: Quality Improvement
Latest: 17%

QS-3
Dept: Quality & Safety
IP: Quality Improvement
Latest: 100%
Target: 100%

What is the information telling us?

The overall number of **complaints** has risen overall over this period, again reflecting the rise in demand on our services. However the themes from the complaints remain as prior to this period which are timelines of response, staff conduct, pathways, inappropriate treatment and not transported to hospital. There is sustained improvement in reducing the number of complaints relating to **crew attitude** reflecting work undertaken across the organisation to support stressed staff facing the pandemic system pressures.

Capacity has been an issue within the corporate teams as it has across all staff groups evident in the slight variations in **timeliness** of response, but this is on an improved trajectory.

Duty of Candour has been variable month to month that reflects the pressures of allocating SI investigations to staff to investigate. This is quickly rectified but is an element of the improvement journey in order to retain 100% at all times.

What actions are we taking?

Patient experience teams are working closely with OUs to improve response rates but, as importantly achieve meaningful responses.

The Quality Improvement Group has a comprehensive programme for improvement in responsiveness and sustainable processes for managing the incident management process.

Patients

Quality Improvement – Safeguarding

QS-8
Dept: Quality & Safety
IP: Quality Improvement
Latest: 84.6%
Target: 85%

What is the information telling us?
There has been a stable delivery of Level 2 training for all new starters consistently achieving the target of 85%.

What actions are we taking?
Level 2 training will be included in the 2023/24 safeguarding training requirement.
Level 3 training will recommence in Sept 2022.

Patients

Quality Improvement – Safety in the Workplace

QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 29

QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 91%
Target: 90%

QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 21

QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 68%
Target: 95%

What is the information telling us?

Variation in incidents aligns with times of surge and pressure in Q1 21/22 within the service though this has since reduced consistently to average figures for H&S incidents and lower levels for manual handing incidents. H&S visits were ceased over the Covid-pandemic period removing physical presence and support from the team to the OUs

The drop in compliance to hand hygiene correlates with times of ongoing high demand on our services and limited access into the OUs due to the pandemic.

There has been a decrease in RIDDOR incidents (Q1 22/23 were 23 with 17 incidents reported on time to the Health and Safety Executive; Q1 2021 35 reported to the HSE with 30 incidents reported on time).

What actions are we taking?

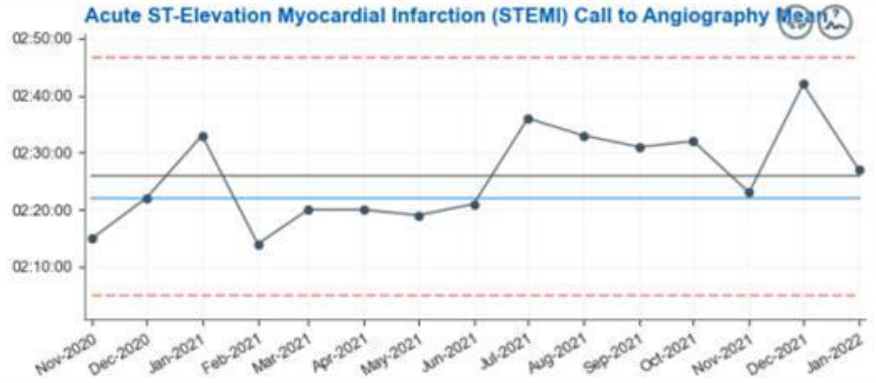
H&S and IPC visits have recommenced on a regular schedule with intense support, training and challenge being offered through the teams.

Following a drop in local audits providing assurance of hand hygiene compliance during Q3/4 the IPC Team have actively engaged with the auditors to ensure they understand the audit tool. This is already showing an improvement in compliance levels. The next round of IPC Quality Assurance visits will focus on audit completion and training for the auditors.

Patients

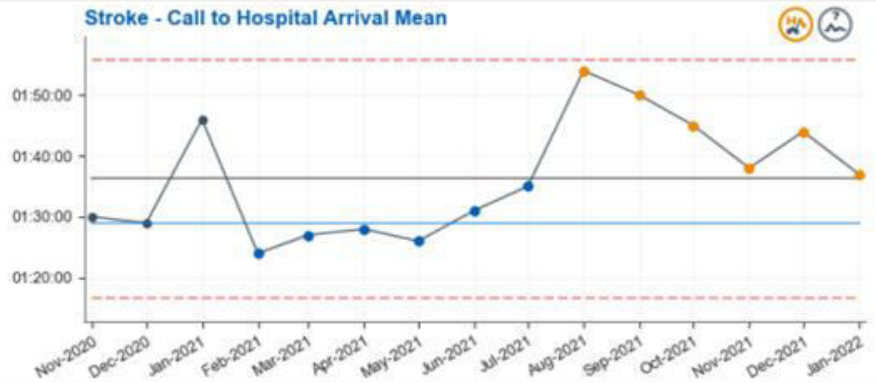
Quality Improvement – Impact on Patient Care

M-4
Dept: Medical
IP: Quality Improvement
Latest: 8.3%
Target: 9.6%



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:27:00
Target: 02:22:00

M-3
Dept: Medical
IP: Quality Improvement
Latest: 26.7%
Target: 25.6%



M-8
Dept: Medical
IP: Quality Improvement
Latest: 01:37:00
Target: 01:29:00

What is the information telling us?

Cardiac Survival All: Due to the small sample size (denominator remained below 295 incidents) involved in this measure, performance shows a higher degree of fluctuation than other COI elements. Whilst there is month on month fluctuation, the Trust mean is inline with the target. Performance fluctuates between of low of 5% in December 2020 to highs of 14% in April and July 2021. The target figure is the annual average for a previous 12 month period. The latest Trust performance published by NHSE was 2nd nationally.

Cardiac Survival Utstein: Due to the small sample size involved (denominator remained below 50 incidents) in this measure, performance shows a higher degree of fluctuation than other COI elements and is particularly relevant for the Utstein group. Performance fluctuates between a low of 15% (Dec 20) to a high of 38% (Nov 21). The target figure is the annual average for a previous 12 month period. The latest Trust performance published by NHSE was 6th nationally.

STEMI Call to Angio Mean: Whilst the Trust can focus on improving At Scene to At Hospital times, it has no control over the time taken between Arrival at Hospital and Angiography. These vary considerably throughout the area. Unlike most graphs the lower the time, the better the performance. The target figure is the annual average for a previous 12 month period.

Stroke Call to Hospital Arrival Mean: Call to Scene times and Time on Scene are dependant on operational pressures. The lower the time, the better the performance. The target figure is the annual average for a previous 12 month period. In areas where there is Telemedicine, on scene time increases by about 6 minutes, however, there is evidence that this is more than gained back by decreased door to needle time after arrival.

What actions are we taking?

Cardiac Survival All: An audit into Cardiac Arrest Skills is currently being undertaken, for reporting in September 2022. The Trusts Cardiac Arrest Outcomes Improvement Programme continues to review all aspects of cardiac care from first contact through to handover. Delivery of the Trust wide Key Skills Programme for 22/23.

Cardiac Survival Utstein: Actions as per Cardiac Survival All above.

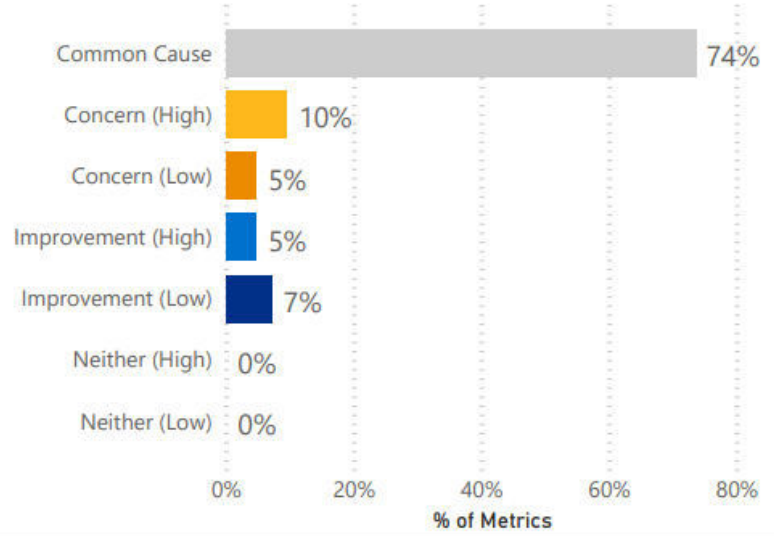
STEMI Call to Angio Mean: Wider communications to include a STEMI 'Time-bomb' poster is being drafted for publication during August 2022 to encourage reduced time on scene. There is a focus on this in the 22/23 Key Skills programme. Dashboard COI feedback to individual OUs is being developed - average call times are to be included in this piece of work and will be published during end July/August 2022.

Stroke Call to Hospital Arrival Mean: Dashboard COI feedback to individual OUs is being developed - average call times are to be included in this piece of work during end July/August 2022. There is a two year study (to 2024) underway with LAS to analysis impacts of telemedicine, including time on scene.

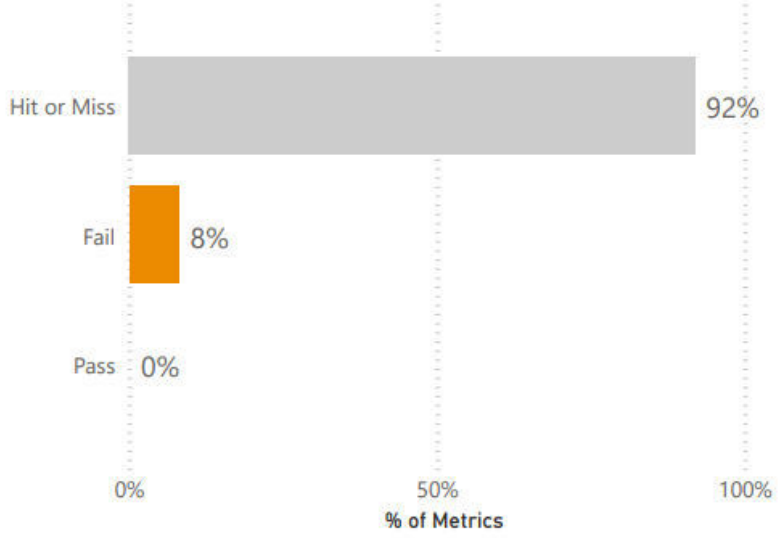
Patients

Quality Improvement – Summary (1 of 2)

Variation Icon Summary



Assurance Icon Summary

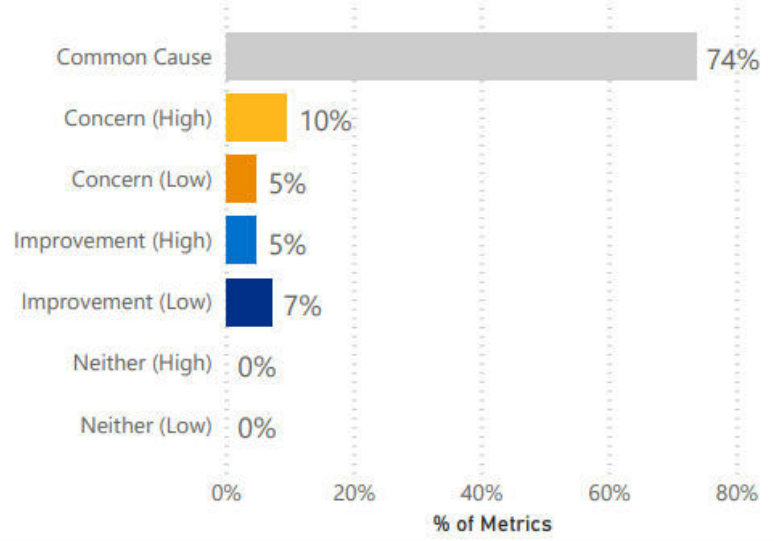


Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Mar-2022	52.2%	45.1%	31.64%	47.55%	63.46%		
Cardiac ROSC ALL %	Quality Improvement	Mar-2022	25.8%	23.8%	14.74%	24.56%	34.39%		
**Sepsis Care Bundle %	Quality Improvement	Mar-2022	83.8%	85%	79.51%	84.86%	90.22%		
Cardiac Survival Utstein %	Quality Improvement	Mar-2022	26.7%	25.6%	6.63%	26.79%	46.96%		
Cardiac Survival ALL %	Quality Improvement	Mar-2022	8.3%	9.6%	3.1%	9.68%	16.25%		
Cardiac Arrest - Post ROSC %	Quality Improvement	Mar-2022	66.3%	76.8%	54.01%	74.96%	95.91%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Mar-2022	58.7%	64.7%	50.38%	60.54%	70.69%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Jan-2022	02:27:00	02:22:00	02:04:58	02:25:52	02:46:46		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Jan-2022	03:39:00	03:14:00	02:40:34	03:22:56	04:05:18		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Jan-2022	01:37:00	01:29:00	01:16:41	01:36:16	01:55:51		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Jan-2022	02:41:00	02:20:00	01:57:02	02:30:28	03:03:54		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Mar-2022	96.7%	96.3%	94.33%	96.57%	98.81%		
Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Mar-2022	95.7%	93.8%	80.75%	90.46%	100.17%		
Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Mar-2022	78.7%	77.9%	69.14%	77.85%	86.56%		
Number of Medicines Incidents	Quality Improvement	Jun-2022	121		79.27	142.55	205.83		
Single Witness Signature Use CDs Omnicell	Quality Improvement	May-2022	43	0	-3.46	14	31.46		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	May-2022	108	0	-27.17	21.71	70.58		
Number of CD Breakages	Quality Improvement	Jun-2022	17		-1.47	17.85	37.17		
Medicines Management % of Audits Completed	Quality Improvement	Jun-2022	75.7%	100%	81.44%	92.49%	103.54%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Jun-2022	104%		56.03%	93.55%	131.07%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Jun-2022	88%	100%	74.57%	86.05%	97.53%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Jun-2022	96%		82.65%	92.45%	102.25%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Jun-2022	100%		83.67%	97.95%	112.23%		
Number of Datix Incidents	Quality Improvement	Jun-2022	1255		842.2	1370.7	1899.2		
Number of Incidents Reported as SIs	Quality Improvement	Jun-2022	1		-4.05	5.75	15.55		
Duty of Candour Compliance %	Quality Improvement	Jun-2022	100%	100%	46.81%	89.65%	132.49%		

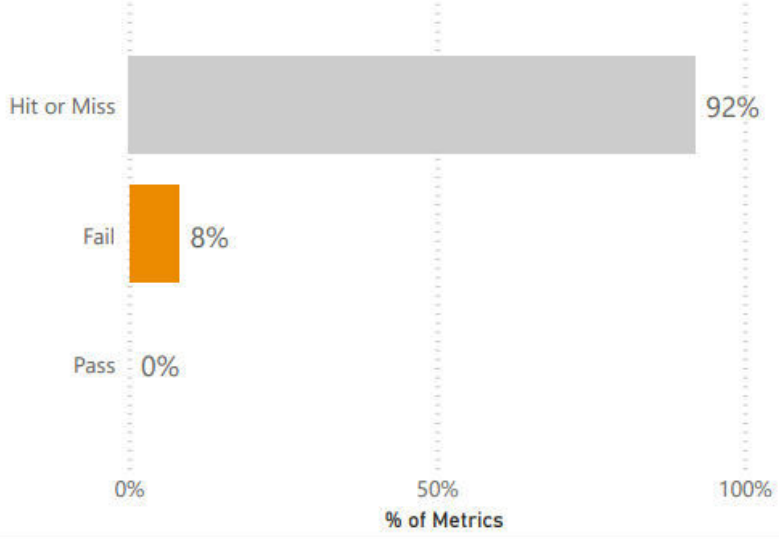
Patients

Quality Improvement – Summary (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Jun-2022	91%	90%	82.19%	91.15%	100.11%		
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Jun-2022	84.6%	85%	78.89%	84.36%	89.83%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Jun-2022	93		39.78	82.2	124.62		
Number of RIDDOR Reports	Quality Improvement	Jun-2022	6		0.05	10.55	21.05		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Jun-2022	51		80.45	109.85	139.25		
Deep Clean Compliance %	Quality Improvement	Jun-2022	68%	95%	44.04%	79.51%	114.97%		
Health & Safety Incidents	Quality Improvement	Jun-2022	29		9.66	31.5	53.34		
Manual Handling Incidents	Quality Improvement	Jun-2022	21		9.96	26.9	43.84		
Complaints relating to privacy and respect %	Quality Improvement	Jun-2022	0.1%		-0.16%	0.04%	0.24%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Jun-2022	17%		10.4%	34.34%	58.28%		
Complaints Reporting Timeliness %	Quality Improvement	Jun-2022	77%	95%	38.82%	80.82%	122.82%		
Number of Complaints	Quality Improvement	Jun-2022	78		32.25	79.15	126.05		
Complaints per 1000 999 Calls Answered	Quality Improvement	Jun-2022	0.01		-0.33	0.48	1.3		
Organisational Risks Outstanding Review %	Quality Improvement	Jun-2022	78%	30%	20.22%	53.01%	85.8%		
Number of Wellbeing Hub Referrals	Quality Improvement	Jun-2022	77	0	35.98	103.6	171.22		
Time Spent in SMP 3 or Higher %	Quality Improvement	Jun-2022	73%		3.8%	57.47%	111.13%		

NHS
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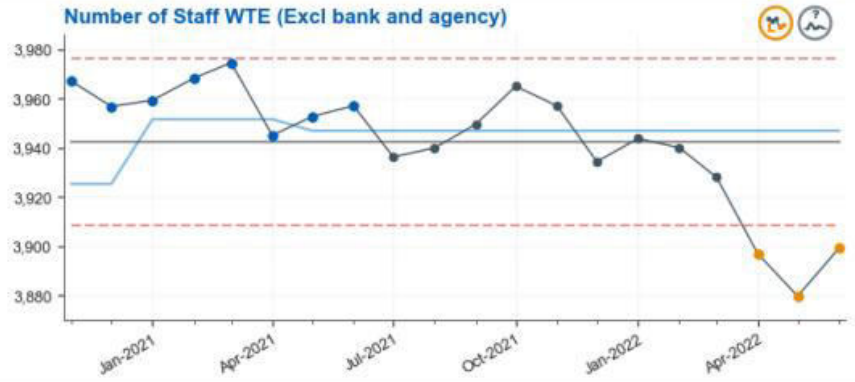
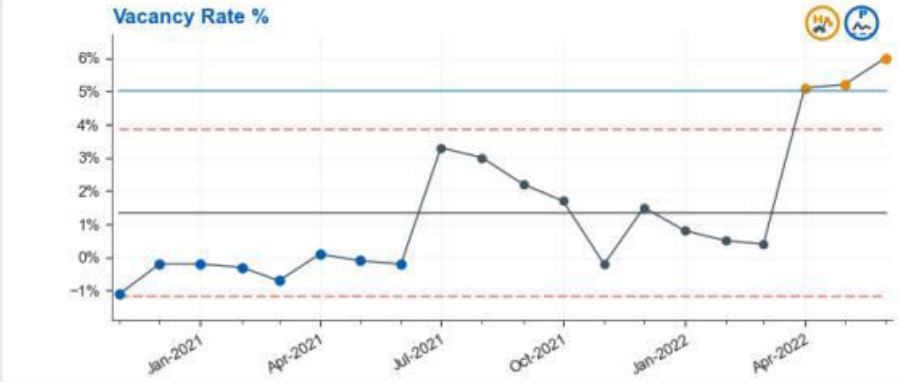
Organisational Development

People

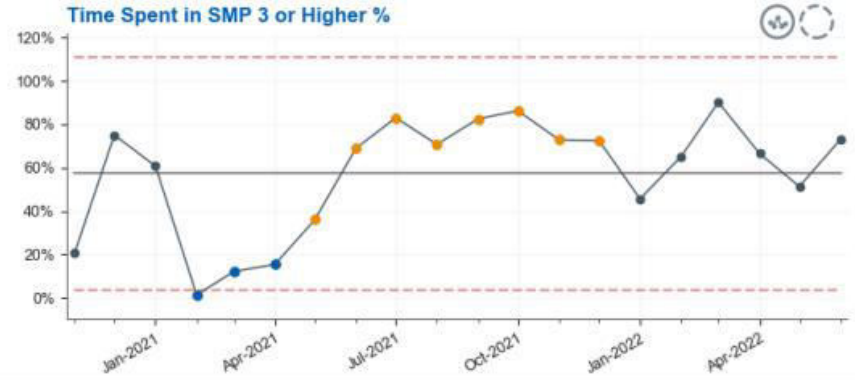
Organisational Development – Workforce



WF-1
Dept: Workforce HR
IP: Organisational Development
Latest: 3899.24
Target: 3946.96



WF-4
Dept: Workforce HR
IP: Organisational Development
Latest: 6%
Target: 5%



999-14
Dept: Operations 999
IP: Quality Improvement
Latest: 73%

WF-7
Dept: Workforce HR
IP: Organisational Development
Latest: 18.1%
Target: 15%

What is the information telling us?

Targeted recruitment campaigns continue, filling courses but with turnover still high the vacancy rate is not reducing.

Data shows that over the past year 27% of new starters have left within the first 6 months of joining the Trust. 10% of leavers in the last 12 months have stayed within the NHS.

What actions are we taking?

Responding to the staff survey to improve the employee experience will encourage stability of the workforce. The Trust retention strategy will need review to ensure that progress is maintained towards the target of 30% reduction in turnover by 2023/24.

People

Organisational Development – Employee Experience

QS-27
Dept: Quality & Safety
IP: Organisational Development
Latest: 28

WF-10
Dept: Workforce HR
IP: Organisational Development
Latest: 10

999-27
Dept: Operations 999
IP: Organisational Development
Latest: 98.1%

999-15
Dept: Operations 999
IP: Organisational Development
Latest: 52.6%
Target: 5%

What is the information telling us?

Since 2020 we have seen a 23% reduction in all Employee Relations cases but an increase within these of Grievances by 28%. Therefore these figures could be masking the issues.

The most frequent three reasons for opening cases are for Unfair Treatment, B&H and Inappropriate/Unprofessional Behaviour.

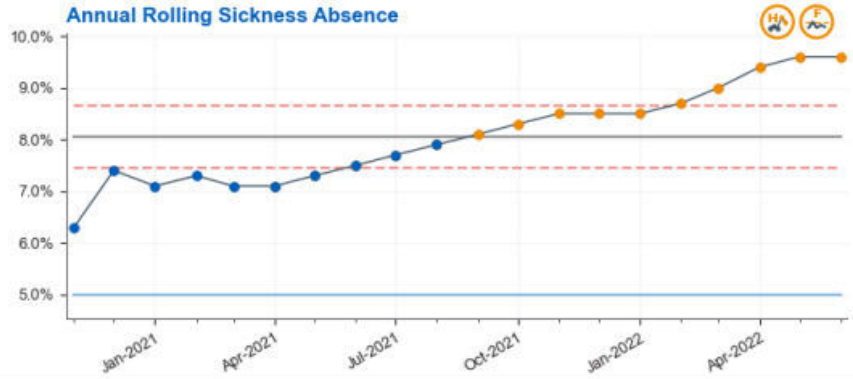
What actions are we taking?

First Line Management Training is a critical factor in resolving issues early. Our Fundamentals programme restarts on 19.7.22.

Early Resolution & mediation training have also started as key strategies to help reduce ER cases.

People

Organisational Development – Employee Sickness



WF-8
Dept: Workforce HR
IP: Organisational Development
Latest: 9.6%
Target: 5%

WF-25
Dept: Workforce Wellbeing
IP: Quality Improvement
Latest: 77
Target: 0

What is the information telling us?

The Trust has seen an increase in our absence for both Covid and non Covid sickness absences. New national guidance has been distributed to the Trust. The wellbeing hub continues to experience high referral volumes and this is impacting on response times for service access.

Operational pressures and increasing sickness are factors affecting overall achievement of the Trust's target for mandatory training.

What actions are we taking?

We have started work with our union colleagues to put this into place by 1st October 2022. Weekly review meetings between HR and Ops continue to actively manage sickness in line with our absence policy and agreed sickness improvement programme.

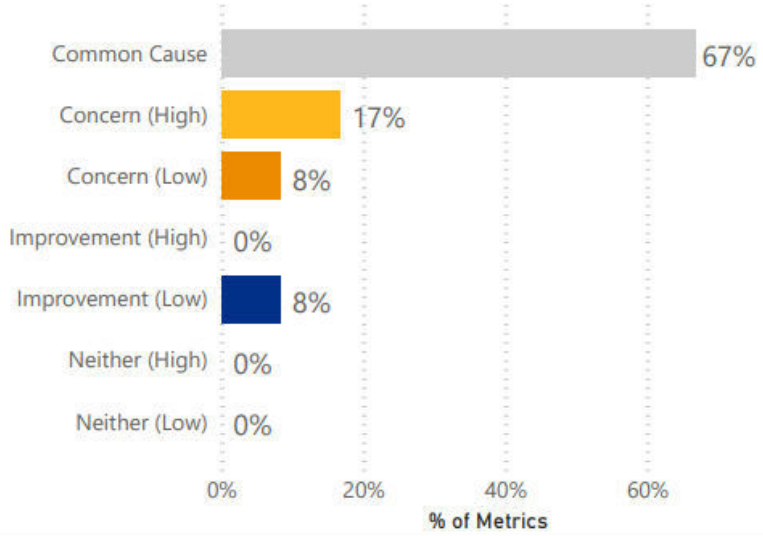
Further inquiry is required to understand any additional barriers to colleagues completing mandatory training. Ensuring all staff complete mandatory, safeguarding and any additional training is a 'must do' in the Trust's improvement journey.

An Appraisal Tracker in Power BI has been launched for all managers to achieve the appraisal targets in line with the roll out plan for the new appraisal system. Phase 3 (Ops) commences 18.7.22. First line managers programme, Fundamentals commences 19.7.22. The aim of the programme is to develop our first line managers equipping them with knowledge and skills to be highly effective in their roles and contributing effectively towards the growth and development of a safe and well-led organisation.

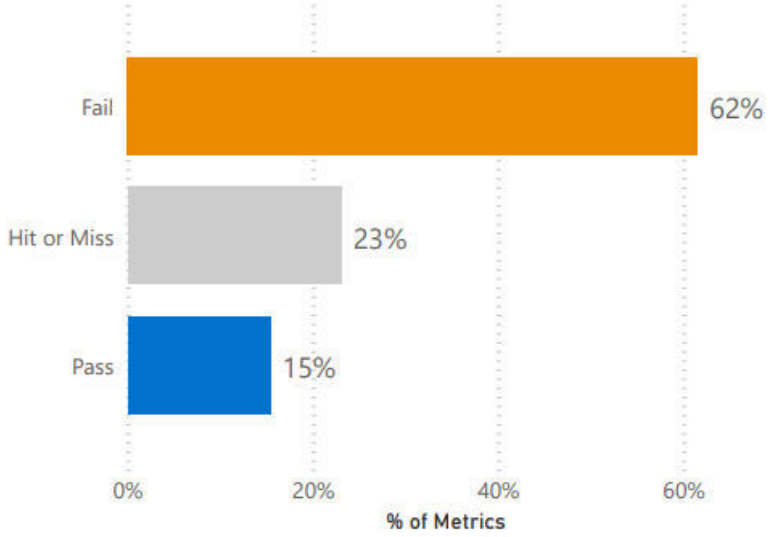
People

Organisational Development – Summary

Variation Icon Summary



Assurance Icon Summary



Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	Organisational Development	Jun-2022	3899.24	3946.96	3908.62	3942.55	3976.49		
Number of Staff Headcount (Exc bank and agency)	Organisational Development	Jun-2022	4310		4301.02	4339.1	4377.18		
Vacancy Rate %	Organisational Development	Jun-2022	6%	5%	-1.17%	1.34%	3.85%		
Annual Rolling Turnover Rate	Organisational Development	Jun-2022	18.1%	15%	12.61%	13.84%	15.07%		
Annual Rolling Sickness Absence	Organisational Development	Jun-2022	9.6%	5%	7.44%	8.05%	8.65%		
Statutory & Mandatory Training % Year to Date	Organisational Development	Jun-2022	36.1%	95%	16.93%	51.33%	85.72%		
Statutory & Mandatory Training Rolling Year %	Organisational Development	Jun-2022	62%	95%	58.95%	69.21%	79.47%		
Appraisals Rolling Year %	Organisational Development	Jun-2022	40%	80%	28.96%	37.22%	45.48%		
Appraisals YTD	Organisational Development	Jun-2022	8.7%	85%	0.92%	22.09%	43.25%		
Individual Grievances	Organisational Development	Jun-2022	10		0.39	7.95	15.51		
Collective Grievances	Organisational Development	Jun-2022	1		-1.07	0.75	2.57		
Bullying & Harrassment Internal	Organisational Development	Jun-2022	1	0	-3.15	2.45	8.05		
Whistleblowing	Organisational Development	Jun-2022	0		-0.69	0.15	0.99		
DBS Compliance %	Organisational Development	Jun-2022	100%	100%	100%	100%	100%		
Disciplinary Cases	Organisational Development	Jun-2022	8		-3.31	3.55	10.41		
999 Frontline Late Finishes/Over-Runs %	Organisational Development	Jun-2022	52.6%	5%	43.8%	52.27%	60.74%		
Average Late Finish/Over-Run Time	Organisational Development	Jun-2022	00:40:00		00:35:37	00:41:54	00:48:11		
% of Meal Breaks Taken	Organisational Development	Jun-2022	98.1%		93.98%	97.73%	101.47%		
% of Meal Breaks Outside of Window	Organisational Development	Jun-2022	58.4%		32.94%	54.63%	76.31%		
Current licence details held for Operational Staff %	Organisational Development	Jun-2022	92.6%	100%	85.37%	91.86%	98.35%		
Freedom to Speak Up: Total Open Cases	Organisational Development	Jun-2022	28		0.4	26	51.6		
Freedom to Speak up: Cases Opened in Month	Organisational Development	Jun-2022	11		-3.48	5.28	14.04		
Freedom to Speak up: Cases Closed in Month	Organisational Development	Jun-2022	11		-5.53	3.44	12.42		
Policies & Procedures Outstanding Review %	Organisational Development	Feb-2022	44.8%	0%	20.61%	27.13%	33.66%		

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

Service

Responsive Care – Response Times

999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:09:04
Target: 00:07:00

999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:35:28
Target: 00:18:00

999-5
Dept: Operations 999
IP: Responsive Care
Latest: 06:30:41
Target: 02:00:00

999-6
Dept: Operations 999
IP: Responsive Care
Latest: 07:55:28
Target: 03:00:00

What is the information telling us?

As can be seen from the graphs above, the Trust is failing to meet the national ARP standards for all categories of call and has been in this position reasonably consistently over the past 2 years. This performance has been strongly impacted by the fluctuating demand and resource availability – in the most recent couple of months, the resource hours produced has been very significantly impacted by an elevated level of sickness (including increased Covid rates) and high levels of annual leave.

Whilst a similar trend is being seen across all ambulance services, recognising that for the C2 performance in particular, SECAmb performs favourably, fundamentally, poor performance such as this results in worse clinical outcomes for some patients – this is monitored through quality & harm review routes. In addition, through discussions with staff, and a review of reported incidents, this poorer performance is affecting our staff and how they feel about the potential additional harm that is bring caused.

What actions are we taking?

Maintenance of high proportions of revalidation of C3 & C4 calls from 111 and within 999 EOC to ensure that all calls requiring attendance have been appropriately assessed

Optimising hear and treat outcomes within EOC to provide care in an appropriate way through remote/virtual consultation

Continued focus on optimising resources through maintain overtime and abstraction management

Continued engagement on a local and strategic level regarding hospital handover process to minimise lost hours where possible

Service

Responsive Care – EOC Emergency Medical Advisors

999-10
Dept: Operations 999
IP: Responsive Care
Latest: 77366

999-33
Dept: Operations 999
IP: Responsive Care
Latest: 26%

999-9
Dept: Operations 999
IP: Responsive Care
Latest: 10.5%
Target: 10%

What is the information telling us?

This narrative relates to the overall efficiency and effectiveness of the call-taking functions within EOC.
Over the time period from November 2020 to present, the total **number of EMAs** has increased significantly, primarily due to the increased need (& funding) during Covid and through the 2021 winter pressures. With these additional staff, the number of calls being answered has increased, however partially due to the numbers of staff in training, the **overall efficiency** (Aux time) has decreased. This has resulted in fewer calls being answered first time, which in turn has created an increase in duplicate calls, all of which has contributed to a poorer call answering performance. **Hear and Treat** performance is on an improving trajectory, however SECAmb remains lower in the league tables for English ambulance services

What actions are we taking?

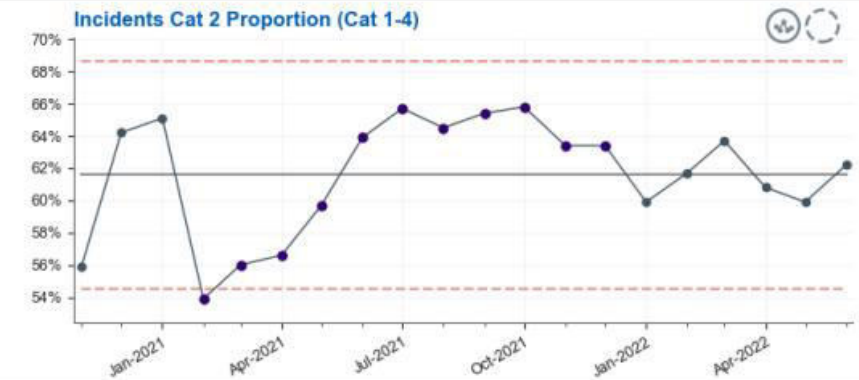
Continued recruitment of EMAs in line with trajectory, recognising increasing recruitment challenges in the Crawley area
Focus on improving aux time – close monitoring via EMA Team Leaders
Hear & Treat is a specific workstream within the Improvement Journey Programme – supported by a detailed action plan including learning from other Trusts

Service

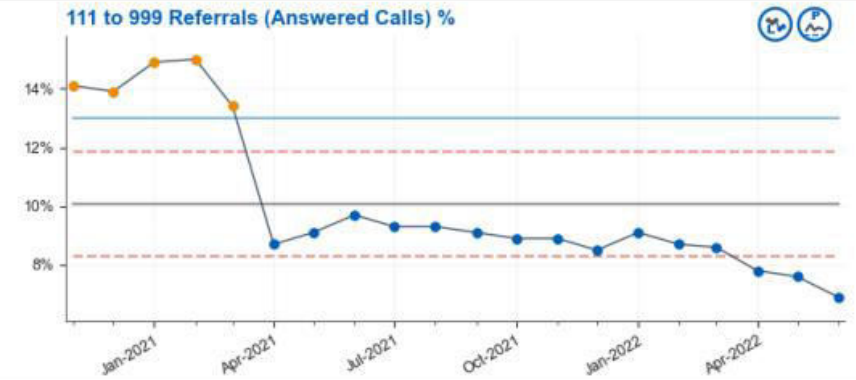
Responsive Care – Utilisation

999-10
Dept: Operations 999
IP: Responsive Care
Latest: 60253

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 89.7%
Target: 100%



999-32
Dept: Operations 999
IP: Responsive Care
Latest: 62.2%



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.9%
Target: 13%

What is the information telling us?

There are multiple contributors to 999 demand, and where possible actions are taken to reduce inappropriate call volumes arriving in the 999 service line – this is demonstrated by the **111 to 999 referral rate** being consistently under the 10% target due to focused attention on revalidation of relevant calls. In addition, it can be seen that the overall proportion of the greatest proportion of 999 calls (the C2 category) has remained relatively consistent around the 62-63% level.

From the above it can be seen that since May 2021, there has been very significant fluctuations in **frontline hours** provided – this has directly impacted on the Trust's ability to respond physically to incidents, hence the trend seen of a slow reduction in total number of incidents managed.

Frontline hours impacted by high abstraction levels, mainly driven through sickness. In particular, for Q1 the **attrition** has been double that planned, further creating a gap between planned resources and available resources.

The recruitment plans remain c.30 WTE short of target, efforts continue through the international recruitment.

What actions are we taking?

Continued revalidation of appropriate 111 calls, in line with contractual agreements

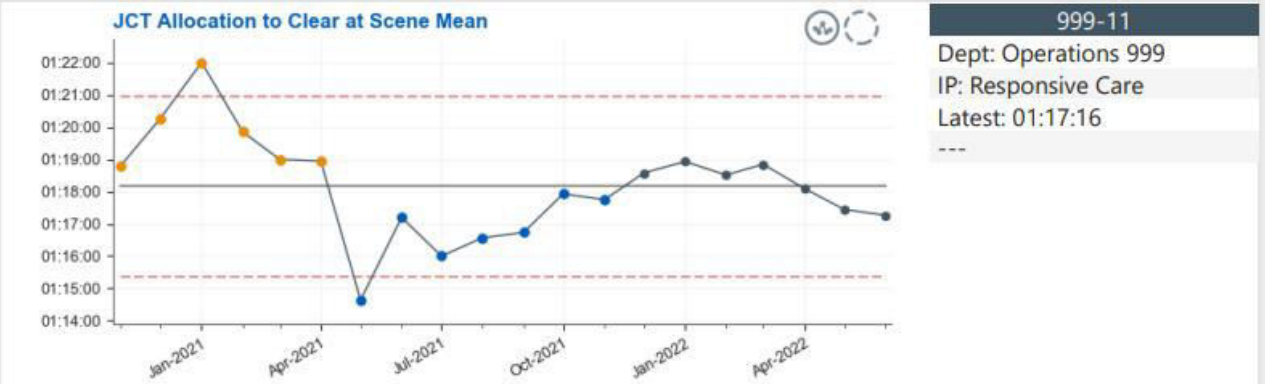
Continued focus on optimising resources through maintain overtime and abstraction management

Service

Responsive Care – 999 Frontline

999-17
Dept: Operations 999
IP: Responsive Care
Latest: 1.09
Target: 1.09

999-13
Dept: Operations 999
IP: Responsive Care
Latest: 00:23:49



999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:17:16

999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:55:21

What is the information telling us?

The efficiency of front-line clinical staff whilst on scene directly contributes to the ability of the Trust to respond to incidents.

The data within this summary is designed to provide a coordinated suite of indicators demonstrating a number of metric trends. For example, the Paramedic Practitioner hubs are available for front-line staff to be able to reach out for supportive decision-making discussions, and as can be seen, there has been a slowly improving trend in terms of response time to **ECAL** request.

Job cycle time (JCT) provides clues as to how the time between allocation and patient discharge functions – the metrics above are influenced by a range of internal and external functions including proportion of cross-border working, the requirement to wear additional PPE as a result of the Covid Pandemic, and hospital handover times.

There is a significant influx of new starters expected in the Autumn, driving a risk of increased JCT up due to a higher mix on inexperienced colleagues.

What actions are we taking?

Dispatch review with recommendations that will improve dispatch efficiencies including RPI

Continued focus on delivery of Paramedic Practitioner hubs to ensure optimal response to ECALs from crew staff, also support to work with OOH GP/primary care call-backs

Increased focus on JCT, linked to outcomes and on-scene decision-making including delivery of appropriate care bundles, ePCR use etc

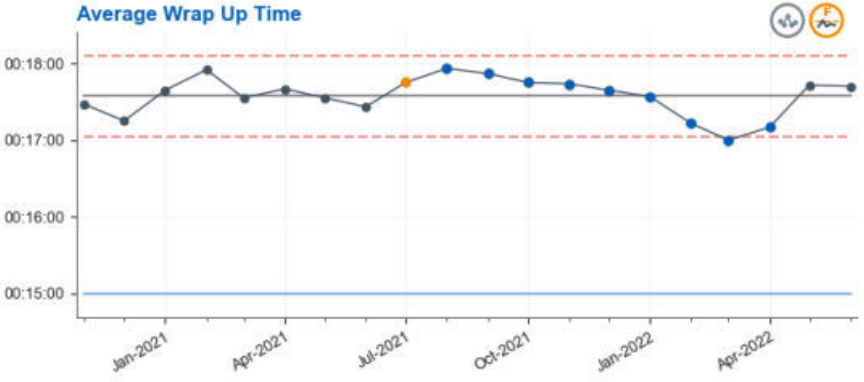
Service

Responsive Care – 111/999 System Impacts

111-5
Dept: Operations 111
IP: Responsive Care
Latest: 8.7%
Target: 9%

999-9
Dept: Operations 999
IP: Responsive Care
Latest: 31.4%
Target: 35%

999-24
Dept: Operations 999
IP: Responsive Care
Latest: 4131.08



999-31
Dept: Operations 999
IP: Responsive Care
Latest: 00:17:42
Target: 00:15:00

What is the information telling us?

SECAmb is a key component of the emergency and urgent care health system in the SE region – this narrative provides an overview of the metrics which describe this component

The **111 to ED dispositions** have been maintained at a good level since the introduction of ED disposition revalidation, supported by direct booking. In comparison, the level of **see & treat** provided has decreased since the start of the Covid Pandemic, below the 35% ultimate target, however further work is ongoing regarding promoting and recording of the use of care pathways as an alternative to Emergency Departments.

Whilst there was a period where **wrap-up times** improved, this has not been sustained, and at the same time the overall trend in hours lost at Hospital Handover, continues to increase.

What actions are we taking?

Maintain 111 to ED revalidation, to support improved outcomes for system partners, particularly when they are under pressure through appropriate DOS management

Monitoring of see & treat to optimise use or appropriate pathways as alternatives to Emergency Departments as well as completing definitive care episodes on scene

Continued partnership working with hospitals relating to hand over time, both on a local and strategic level

Service

Responsive Care – 111

111-1
Dept: Operations 111
IP: Responsive Care
Latest: 116972

111-3
Dept: Operations 111
IP: Responsive Care
Latest: 22.3%
Target: 5%

111-2
Dept: Operations 111
IP: Responsive Care
Latest: 29.2%
Target: 95%

111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.9%
Target: 13%

What is the information telling us?

The call activity and demand in 111 continues to rise and remains significantly above that which SECAmb is contractually commissioned and remunerated for

The service's responsiveness remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds

The percentage of 111 calls abandoned remains high, causing potential pressure on the wider urgent and emergency care system

The 111 referral rate to 999 continues on an improving trajectory, supporting the Trust's delivery of 999

What actions are we taking?

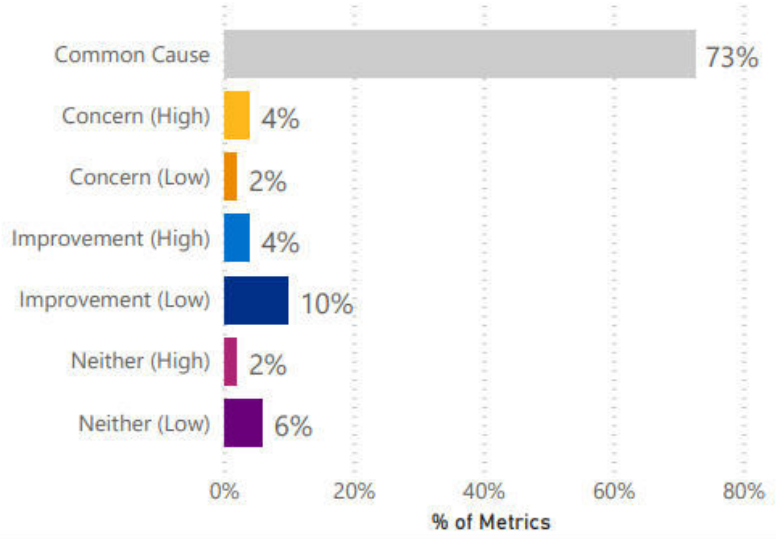
The service has suspended its recruitment (June 2022) as the ongoing issue of the 111 contract being under-funded continues. Until appropriate funding is in place, the Trust is compromised in its endeavours to have enough call handlers, consistently to reduce call abandonment and the increase the speed to answer calls. Dialogue continues at an executive level with NHS E and commissioners, to address the issue of 111 service funding for 22/23

The service continues to protect the wider healthcare economy by being a benchmark nationally for 999 and ED validation, in addition to Direct Appointment Booking (DAB). If the delta between staffing required and actual call handlers (operational and clinical) continues to grow, service performance will deteriorate further, leading to rising clinical risk

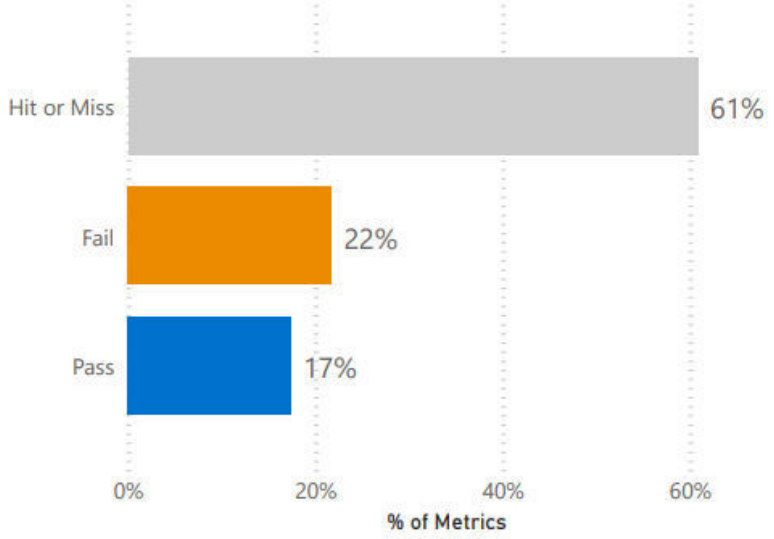
Service

Responsive Care – Summary (1 of 3)

Variation Icon Summary



Assurance Icon Summary

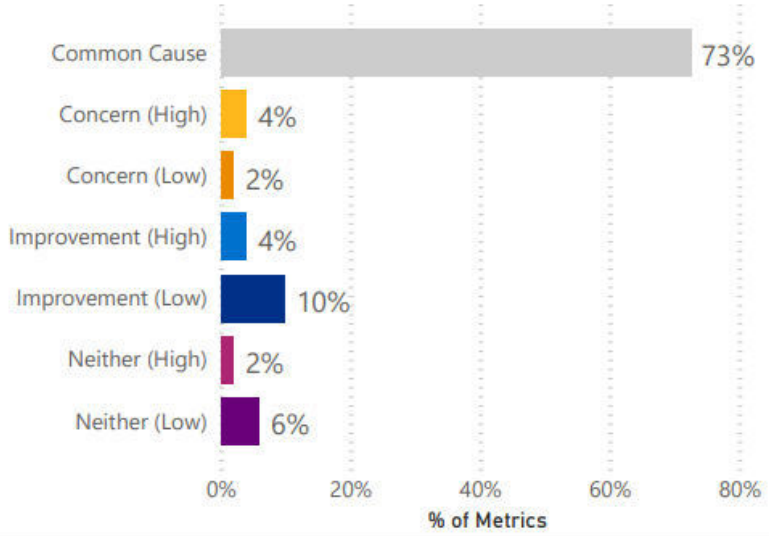


Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Jun-2022	89.7%	100%	85.49%	93.29%	101.08%		
Provided Bank Hours %	Responsive Care	Jun-2022	0.6%		-0.76%	1.11%	2.97%		
Provided Overtime Hours %	Responsive Care	Jun-2022	11.6%		6.48%	11.04%	15.6%		
Provided PAP Hours %	Responsive Care	Jun-2022	6%		4.21%	5.61%	7.01%		
999 Operational Abstraction Rate %	Responsive Care	Feb-2022	36.2%	28%	23.83%	32.08%	40.32%		
JCT Allocation to Clear at Scene Mean	Responsive Care	Jun-2022	01:17:16		01:15:22	01:18:10	01:20:58		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Jun-2022	01:55:21		01:49:21	01:54:01	01:58:41		
Hear & Treat %	Responsive Care	Jun-2022	10.5%	10%	6.06%	8.76%	11.46%		
See & Treat %	Responsive Care	Jun-2022	31.4%	35%	29.99%	32.44%	34.89%		
See & Convey %	Responsive Care	Jun-2022	58%	55%	55.26%	58.75%	62.23%		
Responses Per Incident	Responsive Care	Jun-2022	1.09	1.09	1.08	1.09	1.1		
Section 135 Mean Response Time	Responsive Care	Apr-2022							
Section 136 Mean Response Time	Responsive Care	Jun-2022	00:28:57		00:10:49	00:26:07	00:41:26		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Jun-2022	1.5%		0.79%	1.37%	1.94%		
Number of Hours Lost at Hospital Handover	Responsive Care	Jun-2022	4131.08		2017.31	3809.85	5602.39		
CFR Attendances	Responsive Care	Jun-2022	1319		704.63	1179.65	1654.67		
FFR Attendances	Responsive Care	Jun-2022	264		113.62	293.1	472.58		
ECAL Mean Response Time	Responsive Care	Jun-2022	00:23:49		00:21:39	00:23:35	00:25:31		
999 Remaining Annual Leave FY	Responsive Care	Feb-2022	31%			44.88%			
Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	Responsive Care	Jan-2022	30.2%		29.79%	30.95%	32.11%		
Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	Responsive Care	Jan-2022	17.9%		40.74%	48.31%	55.87%		
Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	Responsive Care	Jan-2022	51.8%		13.82%	20.73%	27.65%		
Vehicles Off Road (VOR) %	Responsive Care	May-2022	10.5%		6.82%	10.59%	14.35%		
% of DCA vehicles off road (VOR)	Responsive Care	Jun-2022	14%			11.75%			
% of SRV vehicles off road (VOR)	Responsive Care	Jun-2022	5%			6.75%			
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Jun-2022	166		105.89	229.31	352.74		

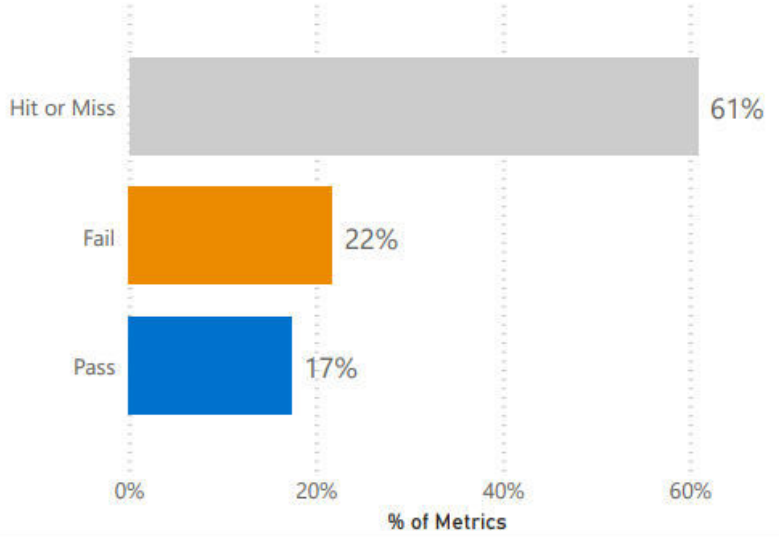
Service

Responsive Care – Summary (2 of 3)

Variation Icon Summary



Assurance Icon Summary

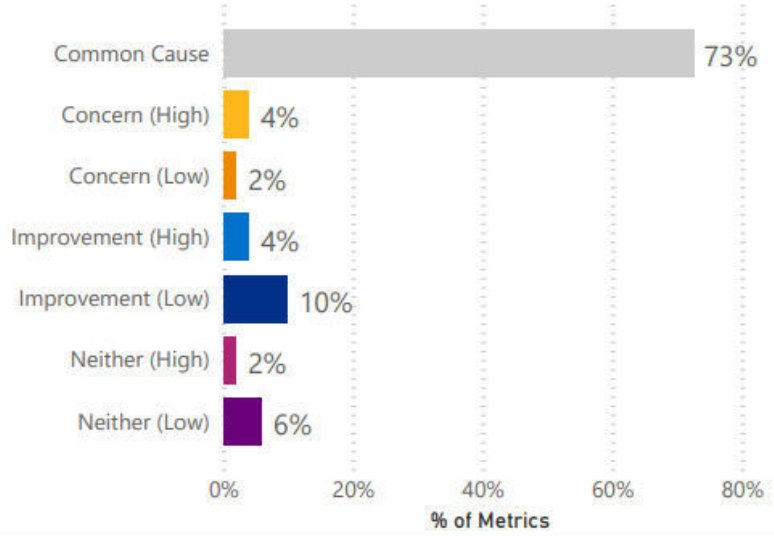


Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of RTCs per 10k miles travelled	Responsive Care	Jun-2022	0.82			0.7			
% of planned vehicle services completed	Responsive Care	Jun-2022	69%			75%			
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	May-2022	95%	95%		94.71%			
Average Wrap Up Time	Responsive Care	Jun-2022	00:17:42	00:15:00	00:17:03	00:17:35	00:18:06		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Jun-2022	49.6%		47.12%	51.31%	55.49%		
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Jun-2022	62.2%		54.52%	61.59%	68.66%		
Duplicate Calls %	Responsive Care	Jun-2022	26%		17.37%	24.11%	30.84%		
111 Calls Offered	Responsive Care	Jun-2022	116972		84772.25	117583.35	150394.45		
111 Calls Answered in 60 Seconds %	Responsive Care	Jun-2022	29.2%	95%	16.07%	40.04%	64.01%		
111 Calls Abandoned - (Offered) %	Responsive Care	Jun-2022	22.3%	5%	3.34%	15.49%	27.64%		
111 to 999 Referrals (Answered Calls) %	Responsive Care	Jun-2022	6.9%	13%	8.31%	10.08%	11.84%		
999 Referrals	Responsive Care	Jun-2022	5733		6946.93	8672.15	10397.37		
A&E Dispositions %	Responsive Care	Jun-2022	8.7%	9%	8.82%	11.19%	13.56%		
A&E Dispositions	Responsive Care	Jun-2022	7244		7481.57	9695.25	11908.93		
Clinical Contact %	Responsive Care	Jun-2022	49.7%	50%	45.88%	48.61%	51.34%		
Ambulance Validation %	Responsive Care	Jun-2022	97.3%	85%	91.57%	95.34%	99.12%		
999 Calls Answered	Responsive Care	Jun-2022	77366		49964.58	73305.1	96645.62		
Incidents	Responsive Care	Jun-2022	60253		54102.43	62693.25	71284.07		
999 Call Answer Mean	Responsive Care	Jun-2022	00:00:19	00:00:05	00:00:11	00:00:23	00:00:56		
999 Call Answer 90th Centile	Responsive Care	Jun-2022	00:01:11	00:00:10	00:00:40	00:01:15	00:03:11		
Cat 1 Mean	Responsive Care	Jun-2022	00:09:03	00:07:00	00:07:10	00:08:33	00:09:56		
Cat 1 90th Centile	Responsive Care	Jun-2022	00:16:27	00:15:00	00:13:41	00:15:36	00:17:32		
Cat 1T Mean	Responsive Care	Jun-2022	00:10:50	00:19:00	00:08:39	00:10:25	00:12:12		
Cat 1T 90th Centile	Responsive Care	Jun-2022	00:19:59	00:30:00	00:16:24	00:19:09	00:21:54		
Cat 2 Mean	Responsive Care	Jun-2022	00:35:31	00:18:00	00:15:00	00:28:58	00:42:57		
Cat 2 90th Centile	Responsive Care	Jun-2022	01:14:10	00:40:00	00:26:53	00:58:01	01:29:10		
Cat 3 90th Centile	Responsive Care	Jun-2022	06:32:04	02:00:00	01:00:14	05:28:22	09:56:30		

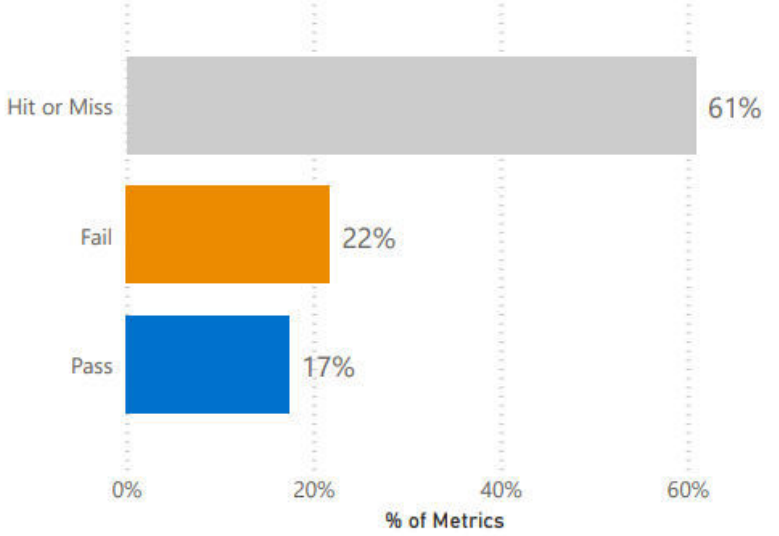
Service

Responsive Care – Summary (3 of 3)

Variation Icon Summary



Assurance Icon Summary



Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Cat 4 90th Centile	Responsive Care	Jun-2022	08:06:48	03:00:00	01:16:01	06:46:58	12:17:55		
HCP 3 Mean	Responsive Care	Jun-2022	03:04:14		00:58:50	02:56:27	04:54:04		
HCP 3 90th Centile	Responsive Care	Jun-2022	06:44:49		01:53:29	06:32:16	11:11:04		
HCP 4 Mean	Responsive Care	Jun-2022	04:12:07		01:22:53	03:44:00	06:05:07		
HCP 4 90th Centile	Responsive Care	Jun-2022	10:51:21		02:34:48	08:09:43	13:44:38		

NHS
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Financial Sustainability

Sustainable

Financial Sustainability – Delivery against our plan

ID	Metric	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£23325.10	£23415.40	£23521.20	£29157.60	£23450.50	£24049.10	£25088.10	£24865.50	£24640.50	£28750.10	£22741.10	£23107.80	£29732.80	£27847.00	£1885.80		
F-9	Income (£000s) YTD	£69907.20	£93332.60	£116853.80	£146011.40	£169461.90	£193511.00	£218599.10	£243464.60	£268105.10	£296855.20	£22741.10	£45848.90	£75581.70	£73267.00	£2314.70	£303937.80	£230670.80
F-2	Operating Expenditure (£000s) Month	£24345.40	£24929.90	£25040.50	£27981.60	£24300.60	£24785.10	£26396.10	£25269.10	£24949.00	£25280.70	£25308.00	£25680.00	£24694.40	£22809.00	£1885.40		
F-10	Operating Expenditure (£000s) YTD	£72849.00	£97787.90	£122828.40	£150810.00	£175110.60	£199895.70	£226291.80	£251560.90	£276509.90	£301790.60	£25308.00	£50988.00	£75682.40	£73717.00	£1965.40	£303601.90	£229884.90
F-3	Capital Expenditure (£000s) Month	£983.67	£1252.68	£412.32	£655.48	£395.11	£2905.10	£2476.90	£2428.81	£0.00	£11423.73	£1055.46	£1769.56	£1629.39	£2011.00	£-381.61		
F-14	Capital Expenditure (£000s) YTD	£3589.58	£4842.26	£5254.58	£5910.07	£6305.18	£9210.27	£11687.18	£14115.98	£14115.98	£25539.71	£1055.46	£2825.02	£4454.41	£6098.00	£-1643.59	£19774.18	£13676.18
F-4	Cost Improvement Plan (CIP) (£000s) Month	£150.00	£430.00	£250.00	£238.00	£161.00	£250.84	£181.32	£963.31	£392.69	£1676.00	£83.87	£124.50	£160.00	£319.00	£-159.00		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£150.00	£580.00	£830.00	£1068.00	£1229.00	£1479.84	£1661.16	£2624.31	£3017.00	£4693.00	£83.87	£208.37	£368.37	£513.00	£-144.63	£5598.00	£5085.00
F-6	Surplus/Deficit (£000s) Month	£-1020.30	£-1514.50	£-1519.30	£1176.00	£-850.10	£-736.00	£-1308.00	£-403.60	£-308.50	£3469.40	£-2566.90	£-2572.20	£5038.40	£5038.00	£0.40		
F-7	Cash Position (£000s) Month	£35923.00	£36684.00	£38289.00	£40507.00	£46592.00	£45791.00	£43638.00	£47832.00	£53937.00	£62555.00	£52948.00	£45599.00	£44224.00	£39388.00	£4836.00	£39388.00	£0.00
F-8	Agency Spend (£000s) Month	£107.24	£347.61	£234.08	£168.06	£154.98	£192.19	£255.95	£284.74	£170.08	£445.27	£352.65	£338.74	£597.00	£448.00	£149.00		
F-16	Agency Spend (£000s) YTD	£526.14	£873.76	£1107.84	£1275.89	£1430.87	£1623.06	£1879.01	£2265.41	£2435.49	£2880.75	£352.65	£691.39	£1288.39	£1344.00	£-55.61	£5498.00	£4154.00

What is the information telling us?

The Trust's financial performance was virtually as planned as at 30 June 2022, with a deficit of £0.4m compared to a plan of £0.5m.

The forecast for the year is in line with the planned breakeven position. This assumes that commissioners will fund costs incurred in delivering 111.

What actions are we taking?

The Trust continues to engage with commissioners to secure recurrent funding for the 111 service in response to the increased demand placed on it. This is due to be concluded by the end of the second quarter.

In addition, the Trust has an efficiency target of £5.6m being 1.9 per cent of planned operating expenditure. Engagement of stakeholders to achieve this efficiency target will be enabled through the Financial Sustainability Group as part of the Trust's improvement journey.

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Appendix

Appendix 1: Glossary

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

SECamb Board

Summary Report on the Audit & Risk Committee

Date of meeting	**14 July 2022**
Overview of issues/areas covered at the meeting:	
Internal Audit	Two **Internal Audit Reviews** were considered at this meeting. Reasonable Assurance was provided for Community Resilience and Financial Services. There was also a review of the Data Security Protection Toolkit which provided Moderate Assurance. In the review of the annual audit plan, the committee explored the increasing concern about HR and management issues. It asked for an independent view of these issues and the Chief Executive will discuss with Internal Audit how this can be sought. Linked to this was concern about a management action arising from a HR IA review last year, which has been pushed back by 12 months. The committee did not accept this and asked the Chief Executive to pick this up and report back next time.
Counter Fraud	The committee continues to be assured we are in a strong position and the annual assessment does not identify any significant gaps. However, concern was expressed about the extent to which we are tolerating the high number of incidents where staff are found to be working while on sick leave. It challenged the executive to ensure we apply policy consistently and fairly.
IPR	There was a review of the development of the IPR – now framed as an Integrated *Quality* Report. The committee supports the good progress that has been made and discussed how the Board could better use this report, reflecting that in the past it has been too formulaic, rather than using it as a tool to inform how the Board seeks assurance / makes decisions.
Risk Management	This is an area of focus within the Improvement Journey. While the committee is assured that the new policy will help support effective risk management, it asked for clarity on how the executive will be testing its implementation. The committee suggested holding an externally facilitated risk seminar with the full Board early next year.
Serious Incident	The committee received the outcome of a SI concerning the internal controls relating to areas such as information governance and medicines management. It noted the recommendations that have been taken forward.

SECAMB Board

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

Date of meeting	30 May 2022
Overview of key issues/areas covered at the meeting:	**End of year Financial Summary 2021/22** There was a detailed review of the end of year accounts which show a deficit of £4.9m, which include a £1.5m gain on property disposals and a £1.2m impairment reversal as a result of a revaluation. Therefore, after excluding these items the deficit for the year was £7.6m, which was £2.0m better than the planned deficit of £9.6m. An external Audit of the financial accounts is presently underway by KPMG. The cash balance at year end was £62.6m, significantly above plan due to property sales and a large value of capital accruals. The Committee requested this needs to be articulated clearly in the financial reporting, noting that although this is a timing issue, it impacts hugely on the cash position and could result in a perception that cash is not being effectively managed. CIPS were £4.7m against a target of £5.9m (27% of these savings delivered were non-recurrent). **Month 1 – Financial Performance** There was a detailed review of month 1 performance summary: - Month 1 is reporting a deficit of £2.6m in line with plan - both income and expenditure are in line to plan - Planned hours in the month were 7% below the planned trajectory towards 2670 WTE – overtime represented 10.5% of the total hours provided. - Cash fell from £62.6m to £52.9m due partly to the deficit and partly to due to the settlement of capital creditors. - Capital spend in the month was £1.1m against a plan of £1.9m The initial five-year Capital Plan was submitted to NHSE&I on 17 March 2022, a final submission is due on 20 June. Members agreed the Capital Plan remains at risk with proposed changes in the financial regime meaning that limits on ICS capital spending could be enforced on Foundation Trusts. The plan will need to be closely monitored and expenditure appropriately prioritised. More work is required to align the Vehicle Fleet spend. **Financial Planning and Commissioned Contracts** A long stop has been agreed with Commissioners until funding discussions are completed, this includes certain specifics still being worked on such as service specification, data quality impacts and the service development improvement plan. Results have been compared to the latest submitted plan, with a deficit of £39m, although a further planning submission is due on 20 June 2022. No account has yet been taken in the plan of the recently announced funding boost which is estimated to reduce the planned deficit in 999 by c£14m. Discussions continue with Commissioners and NHSE/I on drivers and potential funding of the remaining gap. Concern was raised around the 111-funding gap, currently 7% below trajectory, which unless urgently addressed will continue to rollover and increase. Mitigations are being developed in discussions with the ICS to scrutinize on a more granular level. The proposal will be to negotiate further income for 111 or not to resource up to the planned level unless the additional funding is received. It is anticipated there will be a 20% rise in 111 calls for the next

	year, which technically the Trust will be unable to respond to. There is a considerable risk to not only finances but patient safety and quality. The committee is partially assured with the approach and process of planning until we are clearer about outcomes, and particularly in relation to Capital funding. A verbal update was received around the Trust's NHS commissioned contracts, it was noted that the Paediatric Transfer initiative ceased on 31 March, along with the Adult Critical Care Contract. CQUIN funding will commence again this year (this equates to 1.25% of the 999-contract figure). Requests for the Trust to support individual events are being reviewed on a case-by-case basis to ensure they align with Trust Strategy and do not divert resources away. **Private Ambulance Providers (PAP's)** The Committee received a helpful paper containing the current contractual arrangements for PAP's which included legacy background, current contract status/plans for 2022/23 and PAP governance arrangements. It was noted that for the past two years PAP DCA's have accounted for approximately 5% of total operational resource. PAP provision is contracted to 31 March 2023, and the current PAP Procurement Framework expires on 31 August 2022. The Committee were assured by the management of the contract and steps being taken to enhance and extend the PAP contract, and aligning it to the longer workforce strategic plan, noting it needs to be a five-year outlook with some assurance of funding longer term. **Fleet Strategy** Members were pleased to receive a progress report on the Fleet Strategy refresh, and noted the positive steps being made to understand and align the different elements involved in refreshing the Strategy to ensure it is more future proof and data driven. Detailed discussion took place around the FIAT issues, and the Committee were assured that everything that could be done was being done to ensure resolution safely and at pace, including the support of an external forensic engineer, and including Union, HR and Legal colleagues. It was clear that more work is need around understanding the fleet requirement, and in particular the DCA requirements and how they align to the Capital Plan. The Committee requested more detailed work around this to establish any gaps in lease costs against potential capital costs, particularly in light of some additional DCA funding available centrally (although match funded). **Green Strategy** Members noted that the Business Case to commission an external company to help implement the Green Strategy is due to be reviewed at the Business Case Group Meeting in mid-June. FIC will continue to track progress, as work is expected to be completed on the Delivery Plan by Q4.
Any other matters the Committee wishes to escalate to the Board	This was another good meeting with constructive debate and exploration of important issues. On reviewing the effectiveness of the meeting members discussed the thread of Quality evidenced throughout and agreed that all future FIC papers and slides will include a statement around their impact on quality and patient care. Whilst aspects of Quality were being captured verbally, this needed to be evidenced robustly in written papers.

SECAMB Board

Performance Committee Escalation Report to the Board

Date of meeting	23 June 2022
Overview of key issues/areas covered at the meeting:	Under **escalation**, an update was given on the work on the *improvement journey*, in particular the Responsive Care priority. The Director of Operations took the committee through the highlight (flash) report, setting out the structure and aim. Progress to-date was noted including the risks and issues. The committee reinforced the need for the golden thread to patient care and challenged the executive to refrain from describing aims in managerial speak, for example the objective related to rotas is really about being able to provide more timely quality care and supporting the workforce. There was also challenged about the comms plan that sits alongside the improvement journey; this must be more strategic to ensure coherent top line messages that has the golden thread of people and quality. And ensuring we engage continually to ensure we continue to focus on the right things. The committee noted the capacity risks to deliver this and asked the executive to ensure it is really open with Board on what the support gaps are. The first part of the meeting focussed on **planning and forecasting**. **Integrated Plan: 2022 – 2023** This looked at the workforce plan at month 2. The Trust is aiming to deliver a total frontline workforce of at least 2555 WTE, comprising a combination of substantive staff, overtime, and private ambulance providers. The substantive staff was planned to be 2228 WTE as of May 2022. However, the Trust is currently 78 WTE below this target position, at 2150 WTE. The executive confirmed that to mitigate this, additional courses have been created later in the year to catch up to the original recruitment plan, which sees the Trust back on track by August 2022. By August therefore, if the plan is not back on track, we will know whether the mitigating plans are working. The committee requires a greater level of assurance about the balance between road staff and staff in the EOC, i.e. the nature of our operating model. This remains the longer-term plan. Initial workstreams within the Responsive priority of the improvement plan helps to establish the baseline and then the evidence we need to inform a new operating model. There was also a helpful discussion about this one-year plan being heavily focussed on the supply-side. The strategic solution will be to drive demand issues and how we reduce / redirect system demand. Unless this is done as a system trying to meet demand (patient need) will be a constant challenge. **12-week look ahead** The committee noted in March we exceeded the projected performance levels but this would be unlikely to continue; the projections for C2 mean is around the 35min

	range. The meeting then reviewed **current performance** levels. In May ARP improved and we compare well relative to other ambulance services. ARP though in past few weeks has seen a noticeable deterioration linked to staffing issues. 111 performance challenges continue also. The **performance improvement plan** was reviewed using SPC charts (linked to the work on the IPR) to show true trends and variation. This helped to identify a number of gaps in assurance and specific hotpots. The committee noted a number of areas failing, requiring process redesign. While the committee needs greater assurance with the actions being taken it is assured there is executive focus. In future it has asked for clearer timelines for resolution along with more specific plans, which will be provided via the Improvement Journey. **Performance & Patient Harm / Colleague Wellbeing Correlation Analysis** Analysis was completed to help support discussions with commissioners related to funding and link between resources and performance (quality and safety). ▪ Using Category 2 Mean as a proxy for overall performance – we can describe with some certainty the relationship between delayed responses and patient harm. ▪ Where we have seen C2 Mean exceed 30 minutes, we see between a 2.5x and a 3x in verified patient harm, taking us to the region between 15 and 18 reported incidents of harm every 5 days. ▪ In addition, overall incident reporting has doubled in volume in Q4 of 21/22 versus the 2019 baseline. This is putting a significant strain on our ability to process incidents, in turn creating significant backlogs in our investigation processes and is an indication of the level of strain and moral injury staff who report the incidents are under. Weekly reported incidents involving a patient death has increased by 10. This reinforces that ARP standards directly links to patient quality and safety.
Any other matters the Committee wishes to escalate to the Board	In terms of overall assurance, there is more assurance on the Integrated Plan (to reach the commissioned 2555 WTE) but this position will be clearer in August. The committee welcomes the increasing ability to forecast and plan, but even the best-case improvement trajectory (linked to the 2555 WTE) still falls short of achieving the ARP standards.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	31-22

Name of meeting	Trust Board
Date	28.07.2022
Name of paper	Board Development
Report Author	Peter Lee, Company Secretary

Within the Improvement Journey, the OD programme includes a workstream (ODG 2) on Board development, which aims to address the areas of development highlighted by the CQC. The issues included:

- *There being a disconnect between the Board and the wider organisation / Separation between the Board and the core services*
- *Poor relationships between certain members of the Board*
- *The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge.*
- *Limited triangulation of information for example - quality, workforce and finance, to assist effective understanding and mitigation of risk.*
- *Limited evidence of effective and timely actions being taken when risks had been identified or holding to account for such actions.*

In March the Board concluded the work it started in November 2021 with an external facilitator, where it explored the issue of Board leadership and effectiveness through the lens of the organisation's aspiration of making SECAmb 'the best place to work'. Central to this were concerns about the culture of the organisation, and perspectives relating to the Board's leadership and effectiveness, including tensions between executive and non-executive Board members and the impact of this on the effectiveness of the Board. During the time between November and March there were changes in the composition of the Board and focused attention was given to the CQC Well Led Inspection's highlight of concerns relating in particular to culture. This helped inform the development of the Trust's priorities that subsequently reflected the final CQC findings.

Acknowledging the importance of how data can inform better decision making, the Board held a development session in April, supported by NHS England's Making Data Count Team. The focus of this was in improving the information the Board receives to ensure the right focus and enable better triangulation. Arising from this was the development of a new Integrated Quality Report, the first version of which is on the agenda, linking the information with the priorities within the Improvement Journey.

Then in June, the Board held a development session where it invited the National Freedom to Speak Up Guardian to talk about the role the Board has in ensuring a robust speak up culture.

Building on this, the following areas of Board development for the coming year are proposed with timings to be agreed in the coming days, but using the development sessions scheduled

between now and March 2023:

Effective Challenge / Holding to Account	The company secretary is meeting with NHS Providers on 29 July to arrange a bespoke development session with the following objectives: ▪ Clarify the respective roles and responsibilities of the unitary board, along with exploring the common problem areas relating to accountability ▪ Explore the key elements and enablers of effective challenge including evidence-based assurance, triangulation and creating a safe space to have constructive conversations ▪ Develop an understanding of the relationship between challenge and support in effective decision making ▪ Discuss the benefits of, and barriers to, effective challenge in the Trust and how these can impact culture ▪ Deliver practical exercises to explore and compare different approaches to questioning and challenge
NHSE Board Development Programme	Through the Trust's Improvement Director we can access support from the programme led by NHSE. This consists of two distinct parts: 1. Analyse how the Board functions using a diagnostic tool such as the Affina Seven Dimensions of an Effective Team, which includes coaching for the Chair and CEO to help them improve the effectiveness of their team; 2. Appraise and support improvement in the core areas of Board delivery. We will work with NHSE to establish the modules within the Programme that will be most effective. A summary of these are listed in Appendix 1.
Making Data Count	NHSE will return in August to review the development of our Integrated Quality Report and how it was used by the Board at its July meeting. They will provide feedback to help inform the ongoing development and use of this report.
NHS Employee Engagement Strategy	Employee Engagement is key for harnessing the creativity and enthusiasm of colleagues, leading to the creation of a high performing and supportive culture. A workshop is scheduled for August on how SECAmb can implement the NHS Employee Engagement Strategy, which is a blueprint for NHS trusts to implement and encompasses research into best practice. This Board workshop is one of the proposed initials actions to developing the strategy.
Quality Improvement	One of the underlying issues highlighted by the CQC related to a gap in an effective quality improvement system. It is a key priority within the Improvement Journey and a seminar-type event will be scheduled

	either in August or September, on how we intend to apply QI over the coming months.

The Board is asked to consider the approach outlined here and provide any feedback to inform the next step of confirming the schedule for the remainder of 2022/23.

Board Development Programme

NHS England and NHS Improvement

Board cohesion and effectiveness

Purpose

To provide Boards with an objective assessment of their strengths and weaknesses against the 7 domains of an effective team and offer a structured, evidence based methodology to support Boards to become a 'real team' as defined by Affina. The alternative would be to work with the organisation and regional leadership academy to enlist support to run a diagnostic and develop a tailored OD programme, delivered by the LA. (Add contact details for academy leads).

Content

Minimum Offer:

Modules 1, 2 and 10 of the Affina Team Journey

- Provide engagement materials to the Chair
- Contract with the Chair (and CEO) to run the ATAAP diagnostic
- Analyse the results
- Discuss results with the Chair
- Facilitate discussion and action planning event with Board members
- Re-run the diagnostic at agreed interval (usually not less than 6 months later)

Medium Offer:

Modules 1,2,3, 4,5,8 and 10 of Affina Team Journey

- Provide engagement materials to the Chair
- Contract with the Chair (and CEO) to run the ATAAP diagnostic
- Analyse the results
- Discuss results with the Chair
- Facilitate discussion and action planning event with Board members
- Provide Coaching to the Chair on running the 3 modules with greatest influence on team effectiveness (Team Identity, Team Objectives, Increase Role Clarity, Increase Constructive Debate).
- Re-run the diagnostic at agreed interval

Comprehensive Offer:

Modules 1- 10 of the Affina Team Journey:

- Provide engagement materials to the Chair
- Contract with the Chair (and CEO) to run the ATAAP diagnostic
- Analyse the results
- Discuss results with the Chair
- Facilitate discussion and action planning event with Board members
- Coach Chair to run monthly / bi monthly sessions for each of the 7 elements of effective teams
- Re-run the diagnostic at agreed interval

Skills assessment: administration and collation of questionnaires to gather information on knowledge skills and experience of Board members

Well led Self Assessment

Purpose
To ensure the Board understands the scope of the well led framework (current and future) and has taken a considered view of where they stand against each Key Line of Enquiry. To facilitate a discussion about relative priorities for the Board's development and agree a plan for delivery.

Content
The allocated ID will work with Board members to understand and document evidence of delivery against each of the CQC Well Led KLOES. Once all evidence is collated each Board member will rate the Trust using the Outstanding to Inadequate CQC ratings. This will then be collated by the ID and a Confirm and Challenge Board Development session held to discuss evidence and identify gaps and potential quick wins for improvement. By the end of the session, all Board members will have the same evidence base for Well Led and will all be aware of gaps in this evidence base. There will be a short plan of improvement agreed to address gaps. NB- This work will be refreshed following the publication of the CQC Single Assessment Framework

Strategy

Purpose
To assess the Board's approach to developing strategy, setting strategic goals and measuring progress against the strategic goals. To support the Board to identify positive changes it can take to strengthen the approach.

Content

Offer

- Table top review of Evidence to review, including:
  - ✓ Trust 5 year strategy + supporting strategies (clinical, workforce, estates, IT)
  - ✓ ICS 5 year strategy
  - ✓ Trust objectives
  - ✓ Last national staff survey feedback results on strategy
  - ✓ Interviews with Board members, selection of staff, ICS partners, patient bodies
  - ✓ CQC feedback on strategy
  - ✓ Board forward plan and last 3 papers showing how strategy is monitored
- Interviews with key board members and stakeholders
- Observation of Board
- Facilitate Board session to discuss strategy
- Re-check progress at an agreed interval
- Bring in external specialist support where needed
- Re-run the diagnostic at agreed interval (usually not less than 6-12 months later)

Culture and Leadership

Purpose
To support Boards to reflect on the organisation's culture and develop their approach to diagnosing, designing and implementing a programme of culture change based on Michael West's research.

Content

Core Offer:

- Introduce the NHSEI Culture and Leadership Programme, the evidence base and requirements for running a successful programme
- Broker support from National C&L Team to use the programme tools
- Support the Board to establish the internal support and oversight systems to monitor progress and address risks including metrics and intelligence

Additional Offer:

- **Board Session on Creating Psychologically Safe Workspaces (in progress)**
- **Review the Trust arrangements for Freedom to Speak Up,** including
  - Review of strategy, policy and reporting to Board against National Guardian's Office recommendations
  - Test infrastructure and support for the FTSU Guardian and champions against National Guardian's Office recommendations
  - Synthesis of intelligence on culture and psychological safety in the organisations
  - Improving approachability of leaders from Band 6 up
  - Interviews with members of staff
  - Broker support from national Whistleblowing team where needed

Governance

Purpose

To review the Board's systems and processes in place to ensure key strategic and corporate quality, financial and operational risks are proactively identified and mitigated and robust intelligence is available to inform Board decision making.

Content

This is a set of offers that will allow NHS board members to understand and shape the:

- Collective role of the board.
- Governance role within the wider health system.
- Activities and approaches that are most likely to improve board effectiveness.
- Contribution expected of them as individual board members.
- The intelligence which provides trend and comparative information on how the organisation is performing together with an understanding of local people's needs, market and stakeholder analyses.

There are 6 offers available:

Offer 1:

To review BAF, Risk appetite, corporate risk register, board and sub-committee functioning to ensure that the board has identified the appropriate strategic risks, has focused its agenda appropriately around monitoring and managing risks and has effective processes in place at Board and -sub-committee level.

Evidence reviewed

- Strategy & objectives
- Risk management policy/strategy
- BAF
- Risk appetite statement
- Significant risk register
- Last 3 sets Board papers
- Board forward plan
- Last 3 sets of papers for each sub-committee and their forward plan

Observation undertaken

- 1x board sub committees – Audit Committee; People and OD Committee; Quality Governance Committee; Finance and Performance Committee. If an Organisation has specific requests for other committees to be observed, this can be factored in.
- Board – both Public and Private (at discretion of the chair)

Interviews with Board Non Executive and Executive members

Governance

Offer 2:

Better Tomorrow – Board role

This will be a 90-minute workshop on understanding mortality metrics and general data interpretation run by Dr Jean McLeod and Tracey Sparkes. This may be run in conjunction with the Making Data Count session, so offering the Board a 3-hour package.

In addition to the above session, Jean and Tracey plan to run Master classes for 20-30 people with Professor Mohammed. There will be 3 x Masterclasses during 21/22 and 4 run in 22/23.

Offer 3:

Making Data Count (see also offer under Quality Improvement)

Offer 4

Writing for and gaining Assurance

Facilitate board discussion of what constitutes good assurance and how that should be reflected in a board report. Critique examples which come regularly to board and sub-committee. Discuss and agree what guidance the Board can give authors to improve standards of assurance papers.

Offer 5

Deep-dives and independent assurance

Facilitate a discussion about the importance of evidence and particularly independent evidence in gaining robust assurance and how to add rigour to use of deep dives where assurance is lacking

Offer 6

Board role in the Patient Safety Incident Response Framework (due in 2022)

A board session on board responsibilities, monitoring processes and information for assurance.

Quality improvement (Delivered by Colleagues within Improvement Directorate)

Purpose
To appraise the organisation/system's approach to leading for improvement, set out what good looks like and support the Board to identify how best to strengthen its approach to total quality management.

Content

Core Session:

1. Welcome and introductions led by the Chair and Chief Executive
   - Our shared purpose
   - Aims for the day
2. What does good look like in terms of board leadership of quality and quality improvement and why does it matter?
   - Review and reflection on survey responses
   - Identification of key assets to build upon and areas for further development
3. What are the local assets in place to support achievement of local vision and ambitions?
   - Local teams outline progress, plans, ambitions, and support
4. Developing a shared action plan
5. **Optional session(s)**

   a) Quality management systems and creating the culture for improvement to flourish – influencing mindset shifts.

   (b) 'Making Data Count', this session focuses on supporting boards to understand the value and importance of using time-series analytical tools for board and operational reporting

   (c) The role of the Board and individual leaders in supporting and championing the improvement mindset and culture
6. Capturing additional actions and commitments and introductions led by the Chair and Chief Executive
7. Summary and close led by Chief Executive and Chair

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	32/22

Name of meeting	Board of Directors
Date	28 July 2022
Name of paper	Board Committee Annual Review
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of Board Committees' membership (Appendix 1) and the terms of reference for the Audit, Quality & Patient Safety, Workforce and Wellbeing, Performance, and Finance and Investment committees. The annual plan (cycle of business) for each committee is included, and these will continue to ensure appropriate focus.
Recommendations, decisions or actions sought	The Board is asked to agree the Board Committee membership and revised Terms of Reference.

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**

Appendix 1
(Membership of Board Committees)

	Appointments and Remuneration	Audit & Risk Committee	Quality & Patient Safety	Finance & Investment	Performance Committee	Workforce & Wellbeing	Charitable Funds
David Astley Chairman	**√**		**√**				
Michael Whitehouse Non-Executive Director	**√**	**Chair**		**√**	**√**		**Chair**
Liz Sharp Non-Executive Director	**√**		**√**	**√**		**√**	
Subo Shanmuganathan Non-Executive Director	**√**		**√**		**√**	**√**	**√**
Howard Goodbourn Non-Executive Director	**Chair**	**√**		**Chair**	**Chair**		
Tom Quinn Non-Executive Director	**√**	**√**	**Chair**			**√**	
Paul Brocklehurst Non-Executive Director	**√**			**√**	**√**		
Christopher Gonde NEXT Director	**√**					**√**	
Chief Executive	**√**	**A**					
Executive Director of Quality & Nursing		A	**√***	**√**			**√**
Executive Medical Director			**√***			**√**	
Executive Director of Operations			**√**		**√***	**√**	
COO / Finance Director		**A***		**√***	**√**		**√***
Executive Director of HR	**A**				**√**	**√***	**√**
Executive Director of Planning & BD				**√**	**√**	**√**	

√ Member
A – Attends
*denotes committee Executive-Lead

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Quality and Patient Safety Committee ('QPS') referred to in this document as 'the committee'.

2. Role & Purpose

To enable the Board to obtain assurance that high standards of care is provided by and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the trust to:

- promote safety and excellence in patient care
- identify, prioritise and manage risk arising from clinical care
- ensure the effective and efficient use of resources through evidence-based clinical practice
- ensure compliance with legal, regulatory and other obligations

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three Independent Non-Executive Directors and at least three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Tom Quinn, Independent Non-Executive Director (Chair)
- Liz Sharp, Independent Non-Executive Director
- Subo Shanmuganathan, Independent Non-Executive Director
- David Astley, Chairman
- Executive Director of Nursing & Quality (Joint Executive Lead)
- Executive Medical Director (Joint Executive Lead)
- Executive Director of Operations

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are being reviewed.

6. Frequency
The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority & Duties
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of governance and internal control in relation to the areas with its purview are designed well and operating effectively.

In particular, in respect of general governance arrangements:

- to ensure that all statutory elements of clinical governance are adhered to within the trust

- to review and approve the trust's annual clinical governance / patient safety / quality reports before submission to the board

- to consider matters referred to the committee by the Board

- to review and approve the annual clinical audit programme

- to make recommendations to the audit committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference

In respect of safety and excellence in patient care, to ensure that internal standards are set and monitored, including (without limitation):

- to ensure the registration criteria of the Care Quality Commission continue to be met

- to support the Board to promote within the trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy

- to ensure that robust arrangements are in place for the review of patient safety incidents (including near-misses, complaints, reports from HM Coroner) from within the trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning

- to ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed

- to identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey / PALS and ensure appropriate action is taken

- to ensure that risks to patients are minimised through the application of a comprehensive risk management

- to ensure the trust incorporates the recommendations from external bodies, as well as those made internally e.g. in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery

- to assure that there are processes in place that safeguard children and adults within the trust

- to escalate to the Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the trust

- to assure that the trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the trust, so as to identify areas for improvement and ensure that these improvements are affected. In particular, in respect of efficient and effective use of resources through evidence-based clinical practice

In particular, in respect of efficient and effective use of resources through evidence-based clinical practice:

- to review and recommend for approval by the Board the annual quality plan/account and to monitor progress

- to review proposals for cost improvement programmes and other significant service changes and to monitor their impact on the trust's quality of care (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the committee) and report any concern relating to an adverse impact on quality to the board of directors

- to ensure that care is based on evidence of best practice/national guidance

- to ensure that there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance

- to monitor trends in complaints received by the trust and commission actions in response to adverse trends where appropriate

- to monitor the development of quality indicators throughout the trust

- to identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas

- to ensure the research programme is implemented and monitored

- to ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission)

- to ensure that where practice is of high quality, that practice is recognised and propagated across the trust

- to ensure the trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board:

Quality & Patient Safety Committee	Executive Lead	19 May 2022	21 July 2022	15 Sept 2022	17 Nov 2022	12 January 2023	16 March 2023
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
ESCALATION							
Committee (IPR) Dashboard	Executive Director of Quality & Nursing	√	√	√	√	√	√
Executive Escalation (verbal)	Executive Director of Quality & Nursing	√	√	√	√	√	√
MANAGEMENT RESPONSES (As required)							
NHS Pathways Audits	Executive Medical Director	√					
NHS Pathways Audits			√				
SCRUTINY							
Serious Incidents	Executive Director of Quality & Nursing	√	√	√	√	√	√
Harm Reviews	Executive Director of Quality & Nursing	√	√	√	√	√	√
Integrated Learning (complaints, incidents, claims, inquests etc.)	Executive Director of Quality & Nursing		√	√	√	√	√
Key Skills	Executive Medical Director						
Patient Experience	Executive Director of Quality & Nursing	√		√		√	
Quality Improvement	Executive Director of Quality & Nursing	√		√			√
Quality Impact Assessment	Executive Director of Quality & Nursing						
Clinical Audit	Executive Medical Director						
Research & Development	Executive Medical Director						
Medicines Management	Executive Medical Director		√				
Infection Prevention and Control	Executive Director of Quality & Nursing	√		√		√	
Safeguarding	Executive Director of Quality & Nursing		√		√		√
Patient Records	Executive Medical Director						
Medical Equipment	Executive Director of Planning and Business Development						
Consent to Treatment	Executive Medical Director						
National Guidance: JRCALAC / NICE etc.	Executive Medical Director						
Clinical / Professional Scope of Practice	Executive Medical Director						
PAP Quality Governance & Safety	Executive Director of Operations						
CFRs	Executive Director of Operations						
Clinical Outcomes	Executive Medical Director						
Mental Health	Executive Medical Director						
Bariatric Care	Executive Medical Director						
Dementia Care	Executive Medical Director						
Maternity services (linked to Ockenden)	Executive Medical Director						
End of Life Care	Executive Medical Director						
Frequent Callers	Executive Medical Director						
Management of Acute Behavioural Distrubance	Executive Medical Director						

PAD sites/Defibs	Executive Director of Operations						
NHS Pathways Licence Compliance	Executive Director of Operations						
Quarterly / Annual Reports							
Clinical Audit	Executive Medical Director			√			
Controlled Drugs Accountable Officer (CDAO)	Executive Medical Director				√		
Complaints (Patient Experience)	Executive Director of Quality & Nursing			√			
Freedom to Speak Up	Executive Director of Quality & Nursing			√			
IPC	Executive Director of Quality & Nursing						
Learning from Deaths	Executive Medical Director		√		√		√
Safeguarding	Executive Director of Quality & Nursing		√				
Quality Account	Executive Director of Quality & Nursing	√					
Research	Executive Medical Director		√				
Cardiac Arrest	Executive Medical Director		√			√	
Enabling Strategies							
Clinical & Quality	Executive Director of Quality & Nursing						
Dementia Care	Executive Medical Director						
End of Life Care	Executive Medical Director						
Infection Prevention and Control	Executive Director of Quality & Nursing						
Medicines Optimisation	Executive Medical Director						
Patient Experience	Executive Director of Quality & Nursing	√		√		√	
Research & Development	Executive Medical Director						
Improvement Journey							
Quality Improvement - Workstreams 1-7	Executive Director of Quality & Nursing			√	√	√	√
Internal Audit							
Station Visits				√			
Horizon Scan / Forward Look							
TBC	Responsible Exec	√	√	√	√	√	√
Governance							
Committee Annual Self-Assessment	Company Secretary		√				√
Cycle of Business	Company Secretary	√					√
Terms of Reference	Company Secretary	√					√

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'the Committee'.

2. Role & Purpose

The Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the board of directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions.

The Committee shall provide the board of directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the foundation trust's activities (clinical and non-clinical) both generally and in support of the annual governance statement.

In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have at least three members, to include the Chairs of the other Board committees appointed by the Board from amongst the independent Non-Executive Directors of the Trust.

3.2. The Chairman of the Trust shall not be a member.

3.3. One of the members with recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.4. Current members**:**

- Michael Whitehouse, SID and Deputy Chair (Chair)
- Howard Goodbourn, Independent Non-Executive Director – FIC/PC/ARC
- Subo Shanmuganathan, Independent Non-Executive Director - WWC
- Tom Quinn, Independent Non-Executive Director - QPS

In addition, each Independent Non-Executive Director (save the Chairman) will be an ex-officio member of the Committee.

4. Quorum
The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance
5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Executive Director of Finance & Corporate Services
- Executive Director of Quality & Nursing
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5.3. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

5.4. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency
6.1. The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least four times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Authority
7.1. The Committee has no executive powers. It is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

7.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

7.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

8. Duties

8.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

8.2. Governance, Risk Management and Internal Control

8.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

8.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

8.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing policy(s) so test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

8.3. Internal Audit

8.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

8.4. External Audit

8.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

8.5. Financial Reporting

8.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

8.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

8.6. Other Assurance Functions

8.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

8.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

8.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

9. Purview
The purview of the Committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

10. Reporting
The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

12. Review
12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board:

Audit & Risk Committee	Executive Lead	19 May 2022	14 July 2022	22 Sep 2022	01 Dec 2022	09 March 2023
ADMINISTRATION						
Apologies	Chair	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√
Minutes	Chair	√	√	√	√	√
Action Log	Chair	√	√	√	√	√
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√
FINANCIAL STATEMENTS & THE ANNUAL REPORT						
Annual Report & Accounts -External Audit Report -ISA260 Report (Audit Hilights Memo) -Management Representations Letter on the financial statements -Management Representations Letter on the quality report	Exec Director of Finance KPMG	√				
Plan for the production of the Annual Report & Accounts	Chief Executive				√	
Annual Governance Statement	Company Secretary	√				√Draft
Accounting Policies	Exec Director of Finance				√	
Accounting and Reporting Systems	Exec Director of Finance					√
Financial statements - integrity / judgments	Exec Director of Finance				√	
Single Tender Waivers	Exec Director of Finance		√			
Losses and Special Payments [incl. baseline numbers / % as per action 164-19 04.03.2019]	Exec Director of Finance					√
INTERNAL AUDIT						
Counter Fraud Progress Report	RSM		√	√		√
Counter Fraud Work Plan	RSM					√
Counter Fraud Annual Report incl. SRT	RSM					√
Internal Audit Progress Report	RSM		√	√	√	√
Internal Audit Annual Plan	RSM					√
Annual Report to include Internal Audit Opinion	RSM	√				√Draft
EXTERNAL AUDIT						
External Audit Finding Report	KPMG	√				
Report to Governors on Quality Report	KPMG	√				
Limited Assutance opinion on Qualiry Report Indicators	KPMG	√				
Progress Report / Technical Update	KPMG					√
Audit Plan	KPMG				√	
GOVERNANCE & RISK MANAGEMENT						
Business Continiuty	Exec Director of Operations			√		
Records Storage and Security				√		
Data Quality	Exec Director of Strategy				√	
Whistleblowing / FTSU [Improvement Journey Workstream]	Exec Director of Nursing			√		
Decl. of Interests	Company Secretary			√		
Policy Matrix - Annual Review	Company Secretary	√				√
Assurance Map - Annual Review	Company Secretary	√				√
Board Assurance Framework Review	Company Secretary				√	
Risk Review, incl. BAF Risk Report	Executive Director of Nursing / Company Secretary		√	√	√	√
Risk Management System / effectivess of the policy and procedure	Exec Director of Nursing				√	√
Annual Review of SO's/SFI's	Exec Director of Finance					√
Annual Self Certification GC6/COS 7	Company Secretary	√				
Corporate Governance Statement	Company Secretary	√				√Draft
Integrated Performance Report Annual Review	Exec Director of Strategy				√	
Information Governance (incl. *Annual Report)	Exec Director of Nursing		√*			√
Annual Review of Cycle of Business	Company Secretary					√
Annual Self-Assessment	Company Secretary					√
Review of Terms of Reference	Company Secretary					√
Review Purview / TOR of other Board Committees	Company Secretary					√
MANAGEMENT RESPONSE (delete once received)						
Internal Audit Plan						
BAF / Risk Management						√
Data Security Protection Toolkit			√			
FTSU / Whistleblowing				√		

South East Coast Ambulance Service NHS Foundation Trust

Performance Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Performance Committee referred to in this document as 'the Committee'.

2. Role & Purpose

The purpose of the Committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the delivery of operational performance are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the Committee shall constitute at least three Independent Non-Executive Directors and at least three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Howard Goodbourn, Independent Non-Executive Director (Chair)
- Michael Whitehouse, SID & Deputy Chair
- Paul Brocklehurst, Independent Non-Executive Director
- Subo Shanmuganathan, Independent Non-Executive Director
- Executive Director of Operations [Executive Lead]
- Executive Director of Planning & Business Development
- Chief Operating Officer
- Executive Director of HR

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are being reviewed.

6. Frequency

The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board:

Performance Committee	Lead	21 April 2022	23 June 2022	11 August 2022	13 October 2022	08 December 2022	09 February 2023	
ADMINISTRATION								
Apologies	Chair	√	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	√	
PLANNING & FORECASTING								
Use of operational resource / impact on performance 111 & 999	Executive Director of Operations	√	√	√	√	√	√	
999 Operational efficiencies, e.g. job cycle time / unit costs	Executive Director of Operations	√	√	√	√	√	√	
Integrated Plan	Executive Director of Planning & BD		√	√	√	√	√	
Seasonal Planning (12 week look ahead)	Executive Director of Operations	√	√	√	√	√	√	
MONITORING PERFORMANCE								
111 / CAS & 999 Operational Performance	Executive Director of Operations	√	√	√	√			
Operational Performance and Sustainability Plan	Executive Director of Operations	√	√	√				
IMPROVEMENT JOURNEY								
Responsive Care - Workstreams 1-8				√	√	√		
INTERNAL AUDIT								
Performance & Data Quality	Executive Director of Operations			√				
GOVERNANCE & RISK								
Risk Summary Report	Executive Director of Quality & Nursing		√	√	√	√	√	
Committee Annual Self-Assessment	Company Secretary				√	√	√	
Cycle of Business	Company Secretary	√						
Terms of Reference	Company Secretary	√						

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the Committee'.

2. Purpose

The purpose of the Committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, investments and corporate services, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Howard Goodbourn, Independent Non-Executive Director (Chair)
- Michael Whitehouse, SID and Deputy Chair
- Paul Brocklehurst, Independent Non-Executive Director
- Liz Sharp, Independent Non-Executive Director
- Executive Director of Finance (Executive Lead)
- Executive Director of Quality & Nursing
- Executive Director of Planning & Business Development

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- Deputy Director of Finance

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

6. Frequency
The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board:

Finance and Investment Committee	Executive Lead	16 June 2022	08 Sept 2022	19 January 2023	23 March 2023
ADMINISTRATION					
Apologies	Chair	√	√	√	√
Declarations of Interests	Chair	√	√	√	√
Minutes	Chair	√	√	√	√
Action Log	Chair	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√
ESCALATION					
Committee (IPR) Dashboard	Executive Director of Finance	√	√	√	√
Executive Escalation (verbal)	Executive Director of Finance	√	√	√	√
MANAGEMENT RESPONSES					
As required					
SCRUTINY					
Financial Planning - annual plan / budgets	Executive Director of Finance			√	√
Financial Long Term Plan (3 - 5 years)	Executive Director of Finance	√	√	√	√
Financial Performance (Pack) / Forecast	Executive Director of Finance	√			
Financial Governance	Executive Director of Finance	√			
Commissioning Updates including ICS Boards/Financials	Executive Director of Finance	√	√	√	√
Capital Programme Plan - development* and delivery**	Executive Director of Finance	√	√	√	
Patient Level Costing - Submission/Feedback	Executive Director of Finance		√		
Cost Improvement Programme / Overview of Schemes	Executive Director of Finance	√	√	√	√
Environmental Sustainability Delivery Plan	Executive Director of Planning & Bus Dev	√		√	
Procurement (Governance / Effectiveness)	Executive Director of Planning & Bus Dev		√		
Legal Costs Update	Company Secretary		√		√
IT/ Digital	Executive Director of Finance		√	√	
Fleet	Executive Director of Planning & Bus Dev		√		√
Estates - Maintenance / Quality	Executive Director of Planning & Bus Dev		√		√
PAP Contract - Governance Review	Executive Directors Ops/Finance	√			
Disposals and Acquisitions	Executive Director of Planning & Bus Dev		√		√
Risk Summary Report	Executive Director of Quality & Nursing	√	√	√	√
IMPROVEMENT JOURNEY					

Financial Sustainability - Workstreams 1-3	Executive Director of Finance		√	√	√
INTERNAL AUDIT					
Procurement & Contract Management	Executive Director of Planning			√	
Financial Planning	Executive Director of Finance				√
Fleet Management	Executive Director of Planning			√	
Business Cases					
Business Case Schedule / Tracker	Executive Director of Finance	√			√
Business Cases for Recommendation	Responsible Exec	√	√	√	√
Business Case Post Project Implementation Review	Responsible Exec		111/CAS		Brighton MRC
Benefits Realisation	Responsible Exec			Performance Cell	
Enabling Strategies					
Digital Strategy	Executive Director of Finance		√		
Estates Strategy	Executive Director of Planning & Bus Dev			√	
Fleet Strategy	Executive Director of Planning & Bus Dev	√			
Procurement Strategy	Executive Director of Planning & Bus Dev		√		
Environmental Sustainability Strategy	Executive Director of Planning & Bus Dev		√		
Horizon Scan / Forward Look					
TBC	Responsible Exec	√	√	√	√
Governance					
Committee Annual Self-Assessment	Company Secretary				√
Cycle of Business	Company Secretary				√
Terms of Reference	Company Secretary				√

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) referred to in this document as 'the Committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the workforce, encompassing resourcing, staff wellbeing and HR processes, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and at least two Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Subo Shanmuganathan, Independent Non-Executive Director (Chair)
- Tom Quinn, Independent Non-Executive Director
- Liz Sharp Independent Non-Executive Director
- Chris Gonde, Associate Non-Executive Director
- Executive Director of HR & OD (Executive Lead)
- Executive Director of Operations
- Executive Medical Director
- Executive Director of Planning & Business Development

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are being reviewed.

6. Frequency

The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board:

Workforce & Wellbeing Committee	Executive Lead	12 May 2022	18 August 2022	10 Nov 2022	16 Feb 2023
ADMINISTRATION					
Apologies	Chair	√	√	√	√
Declarations of Interests	Chair	√	√	√	√
Minutes	Chair	√	√	√	√
Action Log	Chair	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√
ESCALATION					
Committee (IPR) Dashboard	Executive Director of HR & OD	√	√	√	√
Executive Escalation (verbal)	Executive Director of HR & OD	√	√	√	√
MANAGEMENT RESPONSES (As required)					
EOC/111 Culture Action Plan	Executive Director of Operations	√			
Progress of Ops Trust Learning & Development Plan 2022-25	Executive Director of HR & OD	√			
Operational Sickness Management Plan	Executive Director of HR & OD	√			
Incidents of Violence and Aggression Action Plan	Executive Director of Quality & Nursing	√			
SCRUTINY					
Wellbeing / Welfare					
Appraisals	Executive Director of HR & OD	√			
Staff Survey / Improving Staff Experience Plan	Executive Director of HR & OD	√			
Pulse Surveys	Executive Director of HR & OD				
Occupational Health	Executive Director of HR & OD				
Health & Safety					
Health & Safety Management systems	Executive Director of Quality & Nursing				
Management of violence and aggression	Executive Director of Quality & Nursing	√			
ETD					
External Compliance (Ofsted; Fquals; ESFA)	Executive Medical Director				
Annual Training Plan	Executive Director of HR & OD				
Continuous Professional Development	Executive Director of HR & OD				
Driving Standards	Executive Medical Director				
Apprenticeship Governance	Executive Medical Director				
Higher Education Institution - partnerships with Universities	Executive Medical Director				
Management Training & Development - Fundamentals	Executive Director of HR & OD				
Staff Induction Programme	Executive Director of HR & OD				

Succession Planning & Talent Management	Executive Director of HR & OD				
Workforce Planning / Recruitment					
Workforce Plan 2022/23	Executive Director of HR & OD				
Student Paramedics - recruitment and support	Executive Director of HR & OD				
Retention	Executive Director of HR & OD				
Regional Workforce Planning [how we align with ICS plans]	Executive Director of HR & OD				
Employee Relations					
Bullying & Harassment	Executive Director of HR & OD				
Until it Stops Campaign (Sexualised Behaviours)	Executive Director of HR & OD				
Grievances	Executive Director of HR & OD				
Unions - Relations / Joint Working	Executive Director of HR & OD				
Equality, Diversity, Inclusion & Wellbeing					
Equality Delivery System - EDS2 Goals, Delivery on the WRES, DES, Equality Objectives, Gender Pay gap.	Executive Director of HR & OD				
Governance & Controls					
Payroll Discrepancy - effectiveness of policy	Executive Director of HR & OD				
Payroll Contract	Executive Director of HR & OD				
Pre-Employment Checks	Executive Director of HR & OD				
People & Culture					
Cultural Issues - Hot Spots	Lead Director				
People & Culture Priority / Action Plan	Executive Director of HR & OD				
Improvement Journey					
Organisational Development - Workstreams 1-8	Executive Director of HR		√	√	√
Quarterly / Annual Reports					
Staff Survey Results / Next Steps	Executive Director of HR & OD	√			
Annual H&S Audits	Executive Director of Quality & Nursing				
Annual Wellbeing report	Executive Director of HR & OD			√	
Annual Inclusion report (including an overview of stat and legislative requirements: Equality Delivery System (EDS2), Delivery on the WRES, DES, Equality Objectives, Gender Pay gap, etc)	Executive Director of HR & OD			√	

Enabling Strategies					
People Strategy	Executive Director of HR & OD				
ETD Strategy	Executive Director of HR & OD				
Clinical Education Strategy	Executive Medical Director	√			
Inclusion Strategy (includes E&D and membership)	Executive Director of HR & OD				
Retention Strategy	Executive Director of HR & OD		√ PC April		
Health and Wellbeing Strategy	Executive Director of HR & OD				
Internal Audit Plan 2022/23					
Modernisation of HR September 2022	Executive Director of HR & OD			√	
Stat Man Training September 2022	Executive Director of HR & OD			√	
Payroll January 2023	Executive Director of HR & OD				√
Station Visits July 2022	TBC		√		
Horizon Scan / Forward Look					
TBC	Responsible Exec	√	√	√	√
Annual Reviews					
Committee Annual Self-Assessment	Company Secretary		√		
Cycle of Business	Company Secretary	√			
Terms of Reference	Company Secretary	√			

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Appointments and Remuneration Committee (ARC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Appointments and Remuneration Committee (ARC).

2. Role & Purpose

2.1. The Committee is responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

2.2. The Committee is also responsible for determining the remuneration and terms of service for any other senior employee appointed on terms outside of the Agenda for Change framework, i.e. where their remuneration exceeds Band 9.

2. Membership

3.1. The Committee shall be composed of all the independent Non-Executive Directors. However, when appointing or removing executive directors (other than the Chief Executive) the Chief Executive will also be a member, as described in Schedule 7, 17 (3) of the NHS Act 2006, as amended by the Health & Social Care Act 2012.

3.2. The Trust Chair will determine who should be Chair of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be three members.

5. Attendance

5.1. Only members of the committee have the right to attend committee meetings.

5.2. The trust secretary shall be secretary to the committee.

5.3. At the invitation of the committee, meetings shall normally be attended by the director of human resources.

5.4. Other persons may be invited by the committee to attend a meeting so as to assist in deliberations.

5.5. Any non-member, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

6. Frequency
Meetings shall be called as required, but at least twice in each financial year.

7. Authority
7.1. The Committee is constituted as a standing committee of the trust's board of directors (the board). Its constitution and terms of reference are as set out in these terms of reference, which are subject to amendment at future board meetings.

7.2. The Committee is authorised by the board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the committee

7.3. The Committee is authorised by the board to instruct professional advisors and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

7.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

8. Duties

8.1. Appointments – the committee will;

i. regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the council of governors, with regard to any changes;

ii. give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future;

iii. keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy;

iv. be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise;

v. when a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search;

consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria;

vi. ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation;

vii. ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise;

viii. ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

ix. carefully consider what compensation commitments (including pension contributions) the directors' terms of appointment would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw back provisions should be considered in case of a director returning to the NHS within the period of any putative notice;

x. consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract

8.2. Remuneration – the committee will

i. establish and keep under review a remuneration policy in respect of executive board directors [and senior managers on locally-determined pay];

ii. consult the chairperson and/or chief executive about proposals relating to the remuneration of the other executive directors.

iii. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors [and senior managers on locally-determined pay], including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars;
- allowances;
- payable expenses;
- compensation payments.

In adhering to all relevant laws, regulations and trust policies:

iv. establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

v. decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

vi. make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the foundation trust, and take as a baseline for performance any competencies required and specified within the job description for the post;

vii. consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements;

viii. use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors [and senior managers on locally-determined pay], while ensuring that increases are not made where trust or individual performance do not justify them;

ix. be sensitive to pay and employment conditions elsewhere in the trust, especially when determining annual salary increases;

x. monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

xi. monitor procedures to ensure that existing directors are and remain 'fit and proper' persons as defined in law and regulation.

8.7 In accordance with the Standing Financial Instructions, the Committee will consider and approve individual redundancy payments that fall outside of the employees' contract / standard AfC terms and conditions

8.8 The Committee will also consider and approve large scale redundancies, e.g. as a result of re-organisation.

8.9 The Committee will consider any other workforce issue referred to it by either the Chief Executive, the Chairman or a Committee member, where the nature of the

discussion is considered to be sensitive and not appropriate for more general discussion at one of the other Board Committees.

9. Reporting

9.1. Formal minutes shall be taken of all committee meetings

9.2. The Chair of the Committee shall report a summary of the proceedings of each meeting to the Board and draw to the attention of the Board any significant issues that require disclosure.

10. Support

10.1. The secretary to the committee shall support the committee by:

- Agreeing meeting agendas with the Chair of the Committee;
- Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings;
- Recording formal minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Advising the Chair and the Committee about fulfilment of the Committee's Terms of Reference and related governance matters.

11. Review

11.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

11.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

11.3. These Terms of Reference shall be approved by the Board and formally reviewed at intervals not exceeding two years.

Date Approved by the Board:

ARC ANNUAL CYCLE OF BUSINESS 2020-21

Appointments & Remuneration Committee	Executive Lead	26 May 2022	20 October 2022	09 February 2023			
ADMINISTRATION							
Apologies	Chair	√	√	√			
Declarations of Interests	Chair	√	√	√			
Minutes	Chair	√	√	√			
Action Log	Chair	√	√	√			
Next Meeting Agenda / Forward Look	Chair	√	√	√			
APPOINTMENTS / GOVERNANCE							
Executive Succession Planning / Skills Gap Analysis / Diversity	Chief Executive		√				
Annual Review of structure, size and composition of the Board	Trust Chair		√				
Fit and Proper Persons Test Annual Review	Company Secretary		√				
Committee Annual Review / TOR	Company Secretary			√			
REMUNERATION / APPRAISALS							
Executive Director Remuneration Framework	Chief Executive	√					
National VSM Cost of Living Pay Recommendation				√			
Annual Review of Executive Remuneration	Chief Executive		√				
Executive Director Appraisals	Chief Executive		√				
Chief Executive Appraisal / Objectives	Chair	√ **A**					
Executive Remuneration Benchmarking Review (every 3 years)			√				
*Staff Remuneration Outside of AfC / Interims & Consultants to be Approved	Chief Executive						
*Redundancy / Exit Packages to be Approved	Chief Executive						

*AS REQUIRED