South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

25 August 2022
10.00-12.00

Banstead MRC

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Administration					
36/22	10.00	Welcome and Apologies for absence	**-**	-	Chair
37/22	10.01	Declarations of interest	**-**	-	Chair
38/22	10.02	Minutes of the previous meeting: 28 July 2022	**Y**	Decision	Chair
39/22	10.03	Matters arising (Action log)	**Y**	Decision	PL
Context					
40/22	10.05	Board Story	**-**		
41/22	10.15	Chair's Report	**Y**	Information	Chair
42/22	10.20	Chief Executive's Report	**Y**	Information	SM
		CQC Initial Feedback – Inspection of UEC & Resilience			
Quality & Performance					
43/22	10.40	Board Assurance Framework	**Y**	Assurance	PL
44/22	10.50	Improvement Journey	**Y**	Assurance	DR
Closing					
45/22	11.50	Any other business	**-**	Discussion	Chair
46/22	-	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, 28 July 2022

Tangmere MRC

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Siobhan Melia	(SM)	Interim Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
Emma Williams	(EW)	Executive Director of Operations
Fionna Moore	(FM)	Medical Director
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
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
Matt Webb	(MWe)	Associate Director of Strategic Partnerships
Steve Lennox	(SL)	Improvement Director

Chairman's introductions

DA welcomed members, those in attendance and those observing.

23/22 Apologies for absence

David Hammond	(DH)	Chief Operating Officer and Executive Director of Finance
David Ruiz-Celada	(DR)	Executive Director of Planning & Business Development

24/22 Declarations of conflicts of interest

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

25/22 Minutes of the meeting held in public 30.06.2022

The minutes were approved as a true and accurate record.

26/22 Action Log [10.02-10.02]

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

27/22 Board Story [10.02-10.31]

FM introduced this Board Story, which relates to our paramedic practitioners (PPs) and the development work they are doing. Andy Collen and Sean Edwards attended and gave a short presentation to the Board

outlining the role of PPs and work ongoing to better retain this group of staff who have historically left for other parts of the system, e.g. primary care. And then how they use their skills to meet patient need and support clinical professional development. They reinforced with the Board the benefits of portfolio working, which will help retain staff, and the work of the PP hubs to support patients remotely who do not require an emergency ambulance.

DA thanked Andy and Sean open to questions.

SS asked about losing PPs and why this happens, and also asked about clinical supervision discussed at the quality committee last week, and timescales for delivery. Sean confirmed we have retention issues, hence the need to embrace the portfolio approach. Andy added that there is a risk o. the risk register relating to a gap in prescribing supervisors and one way of closing this gap is to bring back PPs who have these skills. On supervision, which is a CQUIN and one of the priorities in the Quality Account, Andy confirmed there is a road map in development over Q2 and 3, testing a pilot with a wider roll out in Q4.

MW asked how demand for caseload is changing for PPs and whether we are doing enough to encourage cross regional planning, to ensure the system works together. Sean responded that end of life care provision increased through COVID and additional training was provided and we now have more knowledge and experience in dealing with end-of-life patients. Staff look to PPs for support with this patient group. In response to the question of joining up workforce planning, EW explained that this has to involve ICSs and related to pharmacists and physiotherapists, not just paramedics. MW suggested a need to hold the ICS to account for proper workforce planning.

TQ challenged the Executive to resolve the prescribing issue as it seems to have been placed in the 'too difficult box'. Andy confirmed that he and the Chief Pharmacist are doing a gap analysis.

DA thanked Andy, Sean and the wider team. He reflected that it is helpful to focus on roles and celebrate what PPs are doing and that the examples of remote working align with the Trust strategy. We will pick up some of the issues through the relevant board committees.

28/22 Chair's Report [10.31–10.35]
DA welcomed SM to her first meeting, and set the context for the meeting, with the focus today on the improvement plan and the significant work by the Executive team, and on the development of the IQR.

29/22 CEO Report [10.35–10.52]
SM highlighted aspects of her Board report. From her visits to various sites the subject of engagement was a consistent theme of feedback. SM reinforced the need to have meaningful dialogue acting on what our people tell us.

SM outlined a constructive meeting with MPs who were asking how they can support, as well as seeking assurance on our improvement journey. She also acknowledged how impressed she is with our Make Ready Centres, and how efficiencies are delivered through the make ready process, arising from the strategic estates programme.

With regards operational challenges, SM reflected that there is a good level of understanding about the delays with this being a symptom of wider health and social care system pressures. That said, in our improvement plan, there are a number of things within our control to ensure we are as efficient and effective as we can be.

DA thanked SM for this update and opened up for questions.

HG referred to REAP 4 and the related strain on the organisation, asking when we expect to move out of Reap 4. EW outlined the context of REAP which is designed for short period of time, not prolonged as we are seeing across England. In the SW for example, the ambulance service has been at REAL level 4 for over a year. REAP includes things like placing all clinical staff in operational roles and stopping training. However, we have taken a risk-based view and decided not to implement all these measures. In particular, learning from before, we are continuing with training and development. REAP is reviewed weekly. HG asked if this is an indication of being under resourced. EW explained the work we are doing with commissioners on this and also on our operating model to manage demand differently, element of which are part of the Improvement Journey.

TQ reflected that the decision of the Executive to continue training and development despite being in REAP 4 has gone down really well with staff and encouraged the Executive to retain this courage, which will be good for both staff wellbeing and patient safety.

30/22 Improvement Journey [10.52-12.53]
SM introduced the report, acknowledging some of feedback from external partners that this is a big programme of work and therefore we need to prioritise. Some of what is in the report sets out how we are prioritising, with a renewed focus on the CQC Warning Notice and Must Dos. SM confirmed the importance of holding to the overall timeframe, reflecting that while each element is important, we need to distinguish between the immediate and short term. SM then handed over to MWe to give an overview of the programme.

MWe took the Board through slides. He reinforced that it is developing at pace, e.g. there was a meeting with NHSE / ICS yesterday on the Recovery Support Programme (RSP) exit criteria which we are now linking to the plan. MWe reminded the Board about how the plan builds on the priorities for the Trust, ensuring an immediate focus on the CQC findings. The plan will however extend beyond this, in due course. MWe then confirmed some amendments since this version was published, e.g. FS is now Green; OD –has a clearer scope and enabling resources; Responsive is Amber across the board and now has a delivery lead. Finally, QI is on track but there is an outstanding QI resource which RN will talk to shortly, and we recognise the Flash Reports provide assurance against delivery but not impact on people / patients; this is the development for next time to show this more clearly.

MW then handed over to the executive leads for each priority.

<u>Quality Improvement</u>
RN provided a summary of progress reminding the Board of the aim of ensuring quality is at the heart of all we do. There are challenges with delivering all the actions within the timeframe. However, colleagues have worked really well to deliver our ambitions. We need to test how we make the impact and this must be through our clinicians and patients.

RN took the Board through the Flash Report and risks and issues as set out on slides 15 and 16. He outlined some of the actions taken against each of the workstreams, confirming for example the establishment of the clinical senate and work to reshape the quality governance structure, reviewing TOR etc. Plus the work to reduce the SI backlog and revise the approach to harm reviews. He explained that we have made good improvement on risk management, with a new policy in place and over 80% of training completed to-date. The aim is for 100% in the next couple of weeks. In addition to training, we have invested in Datix Cloud to help better analysis of information and have transitioned 60% of the risks from the old Datix system; the aim here is to complete this work by the end of August.

RN then set out some of the other work being progressed, including the Patient Experience Group relaunch, with a revised approach aligned to the strategy; Medicines Management, where we reviewed the risks on

the risk register to establish a need for a peer review by lead commissioners, with several actions being taken forward, overseen by the Quality Governance Group. RN also explained the work to ensure patients are kept safe during high demand and the mapping exercise and quality summit with key partners planned for September, reflecting this is not just about us but a system approach to keeping patients safe.

With regards the QI programme, RN explained that this will give clinicians the framework to influence and make dynamic changes to improve patient care. The interviews for the QI lead are next week; this person will lead the implementation of this.

DA then opened up to questions.

SS referred to SIs and asked about the impact of capacity for staff to undertake investigations and ensure learning. RN confirmed it is not an issue of capacity of investigators as we have circa 200, but rather demand and capacity. EW added that we have done some pre-emptive planning, so we can proactively allocate investigators therefore preparing OUMs who can plan workplans for their teams better. This enables balance too, so we share the workload better. RN added that we have good relationship with lead commissioners who support grouping of common cause incidents, so we do 72-hour report which streamlines the process significantly.

HG asked if there is a risk of not raising incidents while trying to get numbers down. RN does not think there is a correlation. He explained that we are trying to improve reporting and reduce moderate and serious harm events, embedding good practice which will take time to achieve.

TQ asked for assurance that the SI process ensured consistent quality of investigations and a clinical voice. RN responded that we have the SI Group with professional /clinical challenge and good relations with commissioners who quality check reports too.

PB asked how we are tracking progress made. RN responded that we have evidence folders that includes how we demonstrate progress, which must be sufficient before we close an action, e.g. the impact on people and patients including how we communicate and receive feedback on the same. PB came back to ask how we assess we are meeting the aims. MW responded to this by confirming the Flash Reports are exported from the master plan and should set this out.

[break 11.42-11.56]

<u>Organisational Development</u>
AM confirmed that we have plans in place to ensure the resources needed to deliver the workstreams. On bullying and harassment, the outcome measure has been refocussed on the specific point about whether we are responding to concerns quickly enough and in an effective way. There is good progress on FTSU; there was a Board session last month time and an e-learning module for Board members to complete. Additional roles are being advertised to support the FTSU Guardian.

In terms of People Development, AM confirmed we have launched the management development programme and the new appraisal system. On Engagement, the culture and leadership programme is being provided by NHSE. We need to be thoughtful about how we engage our people in this in a coordinated way.

AM reflected that on Recruitment we now have in place the most advanced recruitment tracker he has seen, which allows tracking of every stage by; we have not had this before.

Lastly, AM confirmed the launch of the Sexual Safety Campaign, with positive feedback to-date. The plan is to implement an SPC chart to show the impact of the campaign on reported cases.

DA opened up for questions.

CG referred to employee engagement and noting the plan to use the staff survey as a measure, asked what else we can use to measure this. AM explained that we will be using pulse surveys and the feedback from leadership visits. He warned about a risk over engagement and so need to be careful we coordinate properly.

MW referred to some of the staff feedback about nothing ever changing when issues are raised and he suggested that one way to tackle this in relation to the Improvement Journey is to tell staff what we have done, noting the Improvement Journey responds as much to the staff survey than the CQC. MW asked if we are doing this in a way that demonstrates impact. AM agreed and felt we can use data to understand how we engage and publicise for example closure times of grievances.

SM reflected that we have a Warning Notice that says we have culture of bullying and she doesn't think our messaging is clear enough about our work on civility and respect. Therefore, SM will be working with comms on how we get this message out more clearly. We need to create a better comms and engagement approach to demonstrate that it is no longer acceptable and that this is top of our agenda. SM added that this is about simple human behaviours that we need to talk about more. One thing is to say it then as AM mentioned we back it up with data. This will help to demonstrate we listen and take action.

MW came back to his original point and when we go out to see staff, we should be expecting them to start saying that they have raised an issue and it was sorted; this is difference MW is looking for.

DA supported the approach outlined by SM, confirming that if people can't live to our standards in line with our established values, they must leave.

LS outlined a conversation she had with a trainee about what it is like for a young female coming to SECAmb. They fed back that banter is not always acceptable, from a minority few and they are worried about reporting it. This was countered with a feeling of being looked after. DA reinforced how we must call this out.

The Board acknowledged that there are examples where staff fed back and robust action has been taken as a direct consequence, such as Fiats and Rotas (12-hour shifts). EW confirmed that with the rota review over 1,000 staff responded to the consultation and this will inform the review.

SS challenged the Executive to ensure people do not self-select for sexualised training so that we ensure those that really need it, receive it. AM confirmed that this training is being delivered externally (so not reliant on internal resource) and that the workshops are compulsory for managers. It will then be rolled out to all staff. A proposal for compulsion is being developed.

<u>Responsive Care</u>
EW outlined some of the key parts of the programme some of which is longer term. She referred to the dispatch review and the external support we have. This was started in February and the rota review was also started earlier in the year informed by feedback of staff.

LS asked how we plan to manage the integrated governance across workstreams. EW confirmed that we have two executive directors for each workstream to ensure cross thinking. MWe added we are mapping interdependencies and the purpose of the Steering Group is to ensure alignment.

MW added to the challenge of LS, by reflecting that he has heard lots today from the Executive but is not assured. He asked that we need to show more impact, and also asked where we are with developing a targeted operating model, to ensure we make significant improvement with the Must Dos while getting clarity about the type of organisation we want to be. MW felt that we need to have better clarity on what it will look like and we can then all focus on the direction of travel; Better by Design started to get close to this.

SM asked that we capture the following action:

Action
The reports showing progress against the Improvement Journey must include outcomes and impact, specifically what is different since the last report to Board. This should articulate where progress is made and how this has made an improvement for patients and staff.

As the Improvement Journey develops, the Board will need time to discuss the timing of the aspects of Better by Design relating to the operating /care delivery model that currently have a placeholder in the 'sustainable' (longer term) part of the Improvement Journey.

Financial Sustainability
PA confirmed that this programme is not yet clearly defined. We have a financial Improvement Director currently undertaking a diagnostic of our underlying financial position. Workstreams will therefore be defined following this review, currently planned for the end of August. In the meantime, we will develop what we think the programme will look like then use outcome of diagnostic.

MW referred to the Trust moving from a potential significant deficit (circa £39 as previously reported) to a breakeven position; to avoid this being seen as smoke and mirrors he asked that the Executive ensures this is properly explained. MW added that we have efficiency assumptions in the plan and so assurance is needed too that we won't approach this in a transactional way as it could demotivate staff. Instead we need a more transformational approach.

HG added that while from his perspective (as chair of the finance committee) the step down from the deficit is mostly explained he agrees on the point about messaging and supports the approach from CIP to 'reducing waste'. He added that financial messaging can't undermine the improvement journey.

DA reflected that the key theme here is good clinical care is cost effective so should be about waste reduction / efficiency. It is our duty to reduce waste.

PA agreed with the need for a different approach to sustainability and efficiency, noting that we have already signalled this as HG says, to make better use of resources. Most will improve care and staff moral and some will provide financial savings.

SM confirmed that the report to the Board next time will not be as long or in as much detail and will focus more on actions and impact.

DA agreed with this approach, and reinforced that the feedback today acknowledges the amount of work being done and is in the spirit of learning.

31/22 Integrated Quality Report [12.53-13.20]
SM introduced this new report which continues the theme of being a learning organisation. It is now framed as an integrated 'quality' report. This is a result of the engagement with the NHSE making data count team and introduces SPC charts to improve board assurance, and lead to the right focus and challenge. SM added

that we have aligned the IQR with the four priorities of the Improvement Journey, using feedback from partners to improve assurance against delivery. In the future it may not be structured in this way.

SM asked the Board for feedback on how it helps generate the right conversation, confirming that in the coming months the focus will be on the Warning Notice, Must Dos, and our cultural issues.

RN then highlighted aspects of the quality section, noting some positive movements e.g. violence and aggression and SIs. FM then highlighted the medicines management slide and decrease in audits, which is due to closing some stations. FM added that we are being tighter on single witness signatures. With regards impact on patient outcomes, FM summarised the work on STEMI which reflects the speed we get this group of patients to the right treatment centre, same with Stroke patients. We can now inform each OU on performance and the link between timeliness and outcomes.

AM highlighted that the issue of turnover rates and the fact we have recruited 1000 staff in the past year, and also sickness absence, which is a big issue for us.

On responsive care EW explained that the report is set out to help tell the story of how we are trying to use resources to meet patient need and demand. It includes the system impacts too.

Lastly, related to financial sustainability, PA confirmed that at Q1 we are on plan for the £0.5m deficit and expect to deliver the breakeven target for the year. Moving from a large deficit to breakeven increases the level of risk in the plan. There is a significant risk relating to 111 funding. We started the year with a level of resource with a higher level of funding last year that was non recurrent. The funding did not continue and so we have a cost pressure. We assumed in the reporting that we will receive funding for these costs, but this hasn't yet been confirmed. PA expressed a degree of confidence with the progress being made to receive this funding, albeit not all and likely to be non-recurrent. PA added that the ICS want us to join the 111 Single Virtual Contact Centre but this is predicated on being funded to an appropriate level. Lastly, PA confirmed that break-even is largely supported by non-recurrent income and we need to ensure longer term planning with commissioners going forward.

DA then opened to questions.

SS felt that this is a much better way to present data so we can see trends over time and the margin of variation. Related to training, SS asked that we keep track of management training completion and also sexualised / bullying training to demonstrate we are on track. SS then referred to the 27% new starters that left within 6 months and asked why this was. AM responded that this relates to all staff, including 111 / EOC where there is more naturally fast turnover.

Action
In response to a question about 27% new starters leaving within 6 months (as confirmed in the IQR) AM to explain to the Board the reasons / breakdown for this to include plans to reduce this level of turnover.

HG suggested that the SPC charts confirm where the Board needs to focus, i.e. the areas failing. There is currently a long list. On C1 mean we say we fail but we don't say we fail for C2, and so HG questions this analysis. He added that if we know we can't meet targets then we should instead plot what we can achieve and measure performance against this instead. Likewise with 999 hours provided, SPC shows a year of failure yet doesn't come up as a failure so need to check this. HG asked that when providing commentary we need honesty, for example, for sickness and turnover, the trend line is staggering so good we have focus on this.

Action
IQR – where there are metrics we know we cannot achieve, such as ARP, the IQR should show the improvement trajectory.

MW suggested that where there is an emerging trend it would be good to know whether this is a cross trust issue or related to specific area / OU. Visibility of this will improve assurance. SM agreed and asked that this needs to be in the narrative to include the actions being taken.

32/22 Board Committee Reports [13.26-13.30]
The Board noted the reports. There was nothing specific the chairs wished to escalate not already covered, save for HG who noted the risk to the integrated plan and the expectation of the Executive that this will be back on track by August.

Action
Arising from the Performance Committee report to Board in July, DR to confirm to the Board if the Integrated Plan (recruitment) is back on track.

33/22 Board Development [13.30-13.32]
PL introduced the paper, confirming that the Board is being asked to support the approach. The paper includes some of the development work the Board has done over the past 9 months or so and sets this into the context of the development needs the Board identified previously and that highlighted by the CQC during its inspection in February / March. PL explained that a number of areas are to be prioritised over the coming months using the existing board development schedule.

The Board supported the approach.

34/22 Board Committee TOR [13.32-13.35]
PL summarised the work to update the committee TOR and related annual plans, which will be used to guide the focus of each committee over the coming months.

The Board approved the TOR and supported the approach to each committee for the coming year as set out in the annual plans.

35/22 Training Expenses Business Case [13.35-13.40]
EW introduced the business case which EMB supports. It aligns costs and budgets and takes us to the end of 2023/24 by which time we will have agreed a better solution. The Board noted that due to timing it did not go to the finance committee, and HG confirmed that he was consulted on this and supports its route direct to Board.

The Board approved the business case noting the proactive approach to training.

36/22 AOB
None

37/22 Review of meeting effectiveness
DA apologised for over running but it was important discussion.

There being no further business, the Chair closed the meeting at 13.40

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

Q1 – time on scene with patients has increased significantly over the past 10 years. Over the same period there has been no corresponding number of patients treated on scene nor improvement in outcomes at scene. Reducing scene times will give more time between calls and improve staff wellbeing and patient care.

EW responded that this is within the JCT workstream in the Improvement Journey. It has increased for different reasons e.g. EPCR / PPE / shared decision-making with GPs. But we do need to be more efficient on scene. This workstream will aim to understand this more clearly and where there are outliers to understand what is driving behaviours. And how we create additional capacity with on scene time, ED delays etc.

FM added that in terms of stroke and STEMI we are working on on-scene time. Many of these patients require specialist centres and we are using more drugs on scene. We also wait to talk to GPs and are reviewing the pathways available to accept patients.

There were no other 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
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	C	On agenda 25.08.2022
28.07.2022	30 22	The reports showing progress against the Improvement Journey must include outcomes and impact, specifically what is different since the last report to Board. This should articulate where progress is made and how this has made an improvement for patients and staff. As the Improvement Journey develops, the Board will need time to discuss the timing of the aspects of Better by Design relating to the operating /care delivery model that currently have a placeholder in the 'sustainable' (longer term) part of the Improvement Journey.	DR	25.08.2022	Board	IP	On agenda.
28.07.2022	31 22a	In response to a question about 27% new starters leaving within 6 months (as confirmed in the IQR) AM to explain to the Board the reasons / breakdown for this to include plans to reduce this level of turnover	AM	25.08.2022	Board	IP	
28.07.2022	31 22b	IQR – where there are metrics we know we cannot achieve, such as ARP, the IQR should show the improvement trajectory.	DR	25.08.2022	Board	IP	
28.07.2022	32 22	Arising from the Performance Committee report to Board in July, DR to confirm to the Board if the Integrated Plan (recruitment) is back on track.	DR	25.08.2022	Board	IP	On agenda - see Performance Committee escalation within the Chair's Board Report

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	25.05.2022
Name of paper	Chair Board Report
Report Author	David Astley, Chairman

This is one of the additional Board meetings we introduced following the CQC report in June, with a narrower focus on progress against the Improvement Journey, which includes our response to the CQC findings.

On the agenda we have the draft Board Assurance Framework Risk Report, which is being redeveloped to take account of both the Board's feedback and that of CQC. The finalised version will be received in September and then at every other Board meeting, along with the Improvement Journey and the new Integrated Quality Report; these will be main reports the Board receives at each of its 'full' meetings to help enable triangulation of risks and issues. In the intervening months, the focus will be more narrowly on progress with the Improvement Journey.

As the Board noted last month, in light of the depth of the Improvement Journey, the Executive has re-prioritised the workstreams to ensure sufficient attention to the areas most closely linked to the Warning Notice and Must Dos. There is also now alignment to the five main Board committees, which will allow the committees to test the evidence and impact of the actions more deeply, providing assurance to the Board.

One Board committee has met since the last Board meeting on 28 July. The Performance Committee's usual report will be received next month. In the meantime, there is one escalation to the Board related to the integrated plan and, specifically, the risk that the recruitment plan to increase our clinical workforce will be undermined by high attrition. The committee challenged the Executive about the extent to which our retention strategy is effective and also whether we are managing sickness effectively; sickness and attrition the main drivers for our inability to provide sufficient hours. This is an area within the Responsive Care Programme of the Improvement Journey and at the meeting I will be asking the Executive to respond to this gap in assurance highlighted by the committee.

At the last Board meeting we received a paper on Board development, which is also an area within the Improvement Journey. I am looking forward the development session after the Board meeting, where we will have scheduled time to continue our review of the IQR, supported by the NHSE Making Data Count team, and also on preparation for the Board engagement with the NHSE Culture and Leadership Programme.

As part of the programme of leadership visits, non-executive colleagues continue to be out and about meeting and talking to our people in operating units and support services. I visited Polegate Make Ready Centre on 2nd August and held a number of informal meetings with staff. That morning I met with the Chair of the Royal Sussex University Hospitals Trust, at their Royal Sussex County site. I was introduced to their A&E team and given a tour of their Emergency Department. I was briefed on the steps they had

taken to reduce ambulance handover delays. SECAmb staff I spoke to confirmed that was the case. The conditions for patients and staff in the A&E Department were challenging. However, the commitment to safe patient care was evident. They reported there was good working relations with the SECAmb team.

The NHS locally is facing many challenges. However, in spite of that, the commitment of staff is exemplary with many examples of selfless care to patients and families. As we discuss our agenda items today, I ask Board colleagues to be particularly mindful of how difficult it is for the people needing our services and the pressures on our staff, their moral and what we as a Board are going to do to sustain our workforce to ensure safe services through the challenging period ahead.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	42-22

Name of meeting	Trust Board
Date	25.08.2022
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 July and August 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.

4 The key issues for EMB during this period have remained operational performance (including patient safety and the impact on staff) and progress of our Improvement Journey, however other issues covered include:

- Receiving updates on Emergency Preparedness, Resilience & Response (EPRR) standards and seeking further assurance ahead of the annual assessment due later in the year
- Reviewing and then recommending to the Board the NHS Culture & Leadership Programme
- Agreeing the establishment of and Terms of Reference for a new Clinical Advisory Group, recognising the need to strengthen the clinical voice' within the Trust. Once established, this group will provide an important forum to review and test ideas, as well as making recommendations of areas for action or development

5 EMB continues to hold two meetings each month as joint sessions with the Trust's Senior Management Group to oversee the delivery of the Improvement Journey and the approach to and feedback from the on-going programme of leadership visits.

6 At a recent meeting, EMB and SMG jointly considered the current financial challenges facing the Trust, including how we assess the question of affordability in light of the cost pressures and investments needed, as well as work on developing a

framework for a multi-year Integrated Plan.

7 During this period, EMB have also agreed a number of key investment decisions including:

- Extension to the lease of the Clinical Education Centre at Haywards Heath College
- Creation of a new senior role – Deputy Director for Quality Improvement - to drive our organic approach to quality improvement

Engagement

8 I continue to enjoy spending time out and about around the Trust, meeting and listening to staff. During the past couple of weeks, I have spent time at Worthing, Brighton, Paddock Wood and Hastings, as well as with the Clinical Education team at Haywards Heath.

9 On 18th August, I met with Daniel Elkeles, Chief Executive of London Ambulance Service at our new Make Ready Centre at Banstead. It was pleasure, together with the local operational managers, to show Daniel around the great facilities there but also to have the opportunity to discuss the very real challenges facing ambulance services across the country at present.

10 I continue to be impressed with the commitment shown by our teams but recognise that we need to continue to do more to listen to their concerns and their ideas on how we can accelerate our improvement journey.

Welcome to our new international recruits

11 On 16th August, I was very pleased to welcome our six new international paramedic colleagues to SECAmb at a special reception held at HQ, ahead of them joining their operational teams later that week.

12 Our new colleagues – from Nigeria, the USA, India and Australia - will be with us for a minimum of three years and are the first of more than 30 international paramedics due to join us over coming months, as part of our wider recruitment plan to recruit to all clinical grades and increase our front-line capacity.

13 It was great to meet our new colleagues and with growing national and international demand for paramedics, I'm absolutely delighted that they've chosen to continue their careers in the UK with SECAmb.

Medical Director to step down

14 On 9th August, we announced that Dr Fionna Moore had decided to stand down as Executive Medical Director in January 2023, after an impressive 50 years' NHS service.

15 Fionna has enjoyed a distinguished and lengthy career in the ambulance service spanning more than 20 years and has played an important role at SECAmb since joining in March 2017.
I know that Fionna is held in the highest regard by our staff and the wider ambulance service, both nationally and internationally and so am very pleased that she and I are

16	in discussion about various options for alternative roles with SECAmb once she steps down.
17	**Clinical Education Centre to remain at Haywards Heath** Having seen first-hand the excellent facilities enjoyed by students and the Clinical Education team at Haywards Heath College, I'm very pleased that the Leadership Team have approved the investment required to extend the current lease for a further three years. It is imperative for us to invest, as an organisation, in learning and development for all staff and having access to great facilities such as these is a key part of this.
18	
	B. Regional Issues
19	**Initial feedback following CQC visit** On 26th July, the Care Quality Commission (CQC) undertook an unannounced inspection of our Urgent & Emergency Care and Resilience services, following their inspection earlier in the year into Well Led, our Emergency Operations Centres and 111. As part of their inspection, the CQC team visited a number of Make Ready Centres across our patch, as well as observing crews at A&E departments.
20	We are awaiting the detailed report following their inspection, however we have received initial feedback from the inspection team. This feedback is in line with the CQC's report published on 22nd June 2022, with key issues highlighted including communication and engagement with staff, leadership visibility and risk management processes.
21	This feedback aligns with the plans we have developed as part of our Improvement Journey but we will ensure that, once the full report is received, all issues are properly addressed in our plans.
22	**Brighton Pride returns** On 6th August, I was pleased to join more than 80 colleagues taking part in Brighton Pride after an absence of two years due to the pandemic. It was fantastic to see the great reception the team received from the local community and see, so obviously, how much everyone enjoyed taking part.
23	With thousands of additional visitors to Brighton during Pride, I know it's also a very busy weekend operationally, so thank you to all those involved in planning for and responding to such a popular and high profile event.
	C. National Issues
24	**Extreme weather** We have continued to experience periods of extremely hot weather during recent weeks, which continue to put both our services and those in primary and secondary care under considerable pressure, which in turn has a knock-on impact on demand for both 999 and 111 services.
25	The hard work and effort put in by staff across the Trust continues to be outstanding and I'm pleased to see our staff welfare vehicles out and about, providing refreshments for staff where possible. Thank you to the team of volunteers for giving up their time to support colleagues – it is very much appreciated.

26	**Go-live of documentary following the Joint Response Unit** On 17th August, the first episode was screened of Channel 5's '999 Emergency Call Out', which follows the work of the Joint Response Unit (JRU), run jointly with Kent Police. Filming has been underway for the past few months and the 10-part series will cover the wide variety of calls that the JRU are dispatched to.
27	It was great to see the team in action and I'm really proud that we're able to showcase not only the work of the JRU but also of the wider SECAmb team.
	D. Escalation to the Board
28	**Improvement Journey** Our Improvement Journey is covered elsewhere on the agenda, however I wanted to highlight here the emphasis that we are placing on delivering our Improvement Plan, which focusses on our key priorities for the year and which takes account of the key CQC requirements, especially the Warning Notices and 'must do' actions.
30	**Operational Performance** As is evident from the national ambulance response time data, all ambulance services remain under considerable pressure as does the wider NHS system. These pressures have been increased recently by the extreme weather conditions.
31	We are continuing to work hard to ensure that we provide as responsive a service as possible to our patients with the resources available to us, although we recognise that some patients, especially those in Categories 3 and 4, are waiting longer at times than they should. We have raised this with system colleagues to ensure that alternative pathways are developed for some of these patients ahead of winter.
32	We continue to closely monitor the impact of these delays and ensure we are taking all steps possible keep patients safe when there are longer response times, although this remains a challenge.
33	We also know that 999 call answer times remain longer than we would like at times, due to the availability of staff in our Emergency Operations Centres. This is a problem for many ambulance services nationally and is an area that we will continue to monitor closely.
34	Our REAP Level is regularly reviewed and at present, we remain at REAP Level 4, the highest level of escalation. We have, however, taken the decision not to suspend essential training for operational staff, recognising the importance of ensuring staff are supported in their clinical practice.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Improvement Journey Update

Board Paper – 25th August 2022

Best placed to care, the best place to work

Executive Summary – Progress since last update

- The Trust approved the critical delivery resource required on 13/07/22
- We have struggled to recruit to key posts during the Summer
- As a result and despite significant internal movements – we have not met the quality of reporting or required assurance by evidence we expected by August
- Second CQC inspection and further information requests in late July and early August have created additional capacity bottlenecks
- However – noticeable progress has been achieved in:
  - Key staff engagement areas, both in change areas, and increased leadership visibility
  - Reduction of outstanding investigations and strengthening of incident and harm process
  - Development of a new IQR, replacing the old IPR, alongside a developing Data Strategy

- Key areas of focus over the next month:
  - Fully resource project delivery team and complete re-baselining of programme.
  - Deliberate focus on outcomes required to satisfy "significant improvement" against WNs 1-4 by 1st November 2022 – inclusive of Board sub-committee alignment
  - Strengthen internal engagement and communications around the CQC action plan in preparedness for review date of November.

Support Offer – critical resources required to enable programme

Portfolio	
Associate Director / Portfolio Lead (B8d)	Matt Webb in post
Improvement Director (NHSEI)	Steve Lennox in post
Portfolio Delivery Manager (B8a)	Claire Webster in post
Quality Improvement	
Programme Delivery Lead (B7)	Nicola Brooks providing interim support
Interim Deputy Director – QI (B8d)	Recruitment ongoing. Post offered - planned start date 10/2022.
Medicines Project Manager (B8a)	Katie Spendiff in post
Responsive Care	
Strategic Operations Programme Director (B8d)	Eileen Sanderson in post
Programme Delivery Lead (2xB7)	Recruitment ongoing
Operations Support Delivery Manager (B8a)	Recruitment ongoing
Administrative Support (B4)	Recruitment ongoing
Organisational Development	
Programme Delivery Lead (PM) (B7)	Post vacant – interim support provided by Claire Webster and NHSE/I x2 days per week
Financial Sustainability	
Improvement Director (External review)	Finance ID in post
Programme Delivery Lead (B7) - unfunded	Post vacant

Key Messages:

1. Programme significantly at risk of not being able to evidence progress adequately or provide necessary assurance and scrutiny over issues due to lack of project resource
2. **Escalation to SAM:** System support required to identify skilled project management resources who can support in particular on Quality Improvement and People and Culture

Internal Audit recommendations – linked IJ programmes

ID	RSM consideration	Linked IJ programme	Current Status (16.08.22)
RSM1	Ensure there is an easy way to slice the reporting so that if required it can easily report back against the specific actions stipulated by the CQC without having to extract these individually from the Improvement Journey workstreams	Portfolio	Tracker produced
RSM2	Consider giving higher profile to help show more clearly the role of the secondary director and to help evidence this joined-up approach, e.g., within associated governance documents and reporting	Portfolio	QIG revised. Will also clarify in supporting documentation
RSM3	It will be important to identify an assigned action owner for the actions within QIG8 where the action owner is currently shown as "to be recruited".	Quality Improvement	Will resolve end of October
RSM4	Ongoing review of the individual action owners and associated progress towards delivery should be undertaken to ensure that where there are leavers or known changes of responsibility that these can quickly be reflected in the plan and, if necessary, formal handover to the new action owner undertaken in a timely manner.	Portfolio	Plan is to change names to roles
RSM5	It will be important to determine whether the specified resource funding is available, as well as the source of the funding, and to progress towards appointing to the "critically" identified posts to help prevent a loss of momentum or delay in delivery of the action plan.	Portfolio	Critical resourcing is identified
RSM6	We understand that in some instances funding for critical posts may only be available non-recurrently, up to for instance 31 March 2023. In such instances it will be important to understand the requirements of the Trust and the Improvement Journey beyond that point in time and whether there will be a need for ongoing resource or an opportunity to absorb within existing funded structures	Financial Sustainability	Also dependent on RSP status
RSM7	A walk through of the specific CQC actions should be conducted to ensure that all of these can be accurately reconciled to clear outcomes. Embedding the actions within the Improvement Journey workstreams is good but it is important there are no gaps in confirming that CQC actions are being met and that the Trust knows and can evidence when this has taken place.	Portfolio	Metrics identified
RSM8	It is good that it has been recognised that there may not yet be a suitable form of measurement in all instances and that this remains to be defined but it will be important that these measurements are developed and then built into the reports so that improvement or successful achievement of actions can be demonstrated.	Portfolio	Metrics identified
RSM9	Review how the existing sub-committees, Executive team and Board can link into the governance arrangements as set out for the Improvement Journey. Consider whether the sub-committees of the Trust Board could be used to deep-dive into specific actions and to focus on the assurance around the outcomes, for instance on key workstreams. Consider how the Board agenda is set out to link business as usual with the oversight required of the Improvement Journey	Portfolio	Currently being mapped
RSM10	As work is undertaken to develop, refresh and engage on the Trust's strategy it will be important to sense-check back against the Improvement Journey to ensure that actions being implemented are geared towards a sustainable and medium to long term future.	Financial Sustainability	Not yet required
RSM11	Whilst recognising that the time of Non-Executives is comparatively limited it would be good to ensure some of that time is allocated to active engagement through visits and listening and observation exercises. It may be beneficial to review Non-Executive portfolios so that a suitable balance of time can be shared between engagement, governance and leadership tasks	Organisational Development	Visits being planned. Non exec champion being considered

Key Messages:

1. SECAmb Board commissioned Internal Audit to conduct a review of the Improvement Journey Framework.
2. Majority of considerations incorporated - expectation that all will be incorporated by October

Assurance Against Warning Notices

WN1 – Board disconnect

CQC requirement	CQC Finding	Action type
There was a disconnect between the board and the wider organisation and the board was not working effectively together to achieve its full potential.	*There was a disconnect between the board and the wider organisation. We were told there was not collective leadership at executive board level and that there were poor relationships between certain members of the board and that there was separation between the board and the core services. Staff told us there was lack of visibility of senior leaders in clinical areas.*	***Warning notice (Section 29A) WN1***

SECAmb Planned Outcome by November
Effective Board in operation as measured by the "Healthy NHS Board" framework and CQC Well-led. The Board will be following a programme of development that is informed by a training needs analysis, supported by CQC, Staff and NHSEI feedback. The Board meetings are regularly being conducted and checked in alignment to the Trust's values. The Board and senior leadership team have a programme of structured leadership visits and effective mechanisms to review trends of feedback and close the loop where issues, concerns, or ideas for improvement are identified.

Summary of progress since CQC inspection
✓ Between March and May, the Senior Management Group and the Executive have worked together to shape the Trust Priorities for 22/23, followed by cascade across the organisation.
✓ The senior leadership team have implemented a programme of visits focussed on listening with structured reporting, and shaping weekly feedback into core messages for internal communications.
✓ There's an acknowledgment that internal communications and engagement requires an overhaul throughout all levels of the organisation.
✓ SMG/EMB now meet fortnightly with a strong agenda based on joint ownership of the Improvement Plans and staff feedback.
✓ Board Development committed to NHSE Culture and Leadership Programme, starting in August, and building on Board Development work done in Q1 of 2022.

WN1 - Leadership visit activity

Location	*Times visited*
Banstead MRC	10
Paddock Wood MRC	8
Guildford VPP	8
Brighton MRC	8
Polegate MRC	5
Chertsey VPP	5
Gatwick MRC	4
Medway VPP	4
Crawley EOC	4
Thanet MRC	3
Tangmere MRC	3
Ashford MRC	3
Dartford VPP	3
Haywards Heath	3
Coxheath EOC	2
Other - Virtual meeting	2
Telford Place	1
Other - Clin Ed Away Day	1
Worthing MRC	1
Hastings MRC	1
Ashford HART	1
Other - Crawley	1
Other - National meeting	1
Other - NARU @ Winterbourne Gunner	1
Grand Total	**83**

What Staff are telling us:

- Improve internal communications and engagement mechanisms
- Don't understand what the plan is to fix the pressures, the model is broken
- Be more compassionate – we feel like a number and expendable, especially in high SMP, and we keep on getting sent to the "wrong" jobs (NHS pathways dispositions, impacts on working out of area, and impacts on shift overrun)
- The FIATs are not fit for purpose

What we are doing:

- Overhaul of e-bulletin, weekly CEO messages. Long-term engagement embedded into IJ, session with 50 colleagues to develop stakeholder map and make recommendations of alternative moderated social media engagement means
- SMG / EMB escalation to the Board: there's a need to review our strategy and plans, and how we engage our clinicians in the development of the future plans
- Development of managers under Made@SECAmb – review of Dispatch function completed
- Fit and Risk assessments developed for colleagues with accessibility challenges, started 15th August, 57 vehicles paused from build, 8 vehicles to be road-shown during Autumn to improve functional design of the Saloon

WN1- Engagement for Improvement

Improvement Journey Briefing to share progress in an impactful way – based on staff feedback

Meeting with staff to explore their concerns and ideas, and learning from other Trusts

NHS South East Coast Ambulance Service NHS Foundation Trust

IMPROVEMENT JOURNEY BRIEFING

Case Study
Fiat Ambulances

- Fiat Ducato ambulances first introduced to SECAmb in 2018 and now form 30% of our total fleet.
- They are van conversions, in line with the national requirements of Lord Carter's review into unwarranted variation in NHS ambulance trusts (2018).
- Vehicles imposed on us by national NHS contract.

Challenges

- Fiats unpopular with some staff since introduction.
- Issues raised regarding seatbelts, driving position, space availability and layout of patient area.
- **November 2021:** Safety concerns escalated internally and externally by unions.

It was clear that staff did not feel their concerns were being listened to.

Action

- **November 2021:** Red Bulletin issued to ensure the safety of staff while investigations took place.
- Engagement with unions and staff over next six months, including work with manufactures and specialist advisers.
- **February 2022:** Commissioned a full safety review with NHSEI and Fiat to investigate concerns raised
- **25 May 2022:** Visit by team of 12 (fleet/unions/frontline staff) to West Midlands Ambulance Service to review 'new spec' vehicles
- **10 June 2022:** Joint Partnership Forum to review work so far and discuss and agree next steps with unions BUT significant HR issue raised during meeting.

Tensions heightened following JPF meeting.

- **13 June 2022:** Exec issued an apology to all staff – 'we got it wrong' – and shared recording of JPF
- **21 June 2022:** Engagement session led by Exec with unions and staff at Gatwick MRC
- **1 July 2022:** All staff webinar - 130 staff join live/recording viewed over 100 times
- **7 July 2022:** Answers to all questions raised by staff published on Intranet – viewed 200 times

Listening

- Layout of eight trial vehicles (currently in build) amended to take on board staff feedback – Lifepak re-positioned; clear-fronted cupboards introduced.
- Roadshows planned for every MRC during October so staff can see the trial vehicles and give feedback. This will then be incorporated into future builds.

Work continues to listen to and act on the issues raised by staff and unions.

Next Steps

- Progress personal risk assessments for colleagues who've raised issues - helping us gather evidence to present to our commissioners and NHSEI.
- Delay building 57 vehicles for the year, until we have collected feedback from the eight trial vehicles.

WN2 – Quality of Information and Board Assurance

CQC requirement	CQC Finding	Action type
The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge.	*The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge. A read of the executive board and sub board committee papers showed limited triangulation of information for example; quality, workforce and finance, to assist effective understanding and mitigation of risk. There was limited evidence of effective and timely actions being taken when risks had been identified or holding to account for such actions.*	***Warning notice (Section 29A) WN2***

SECAmb Planned Outcome by November

Information to Board is of high quality and presented in a standardised, consistent format trust-wide, with clear professional challenge which achieves assurance and improved decision-making, supported by the improved use of data trust-wide.

Summary of progress since CQC inspection

- ✓ The Terms of Reference and Annual Plans (Cycle of Business) for each of the five main Board committees have been updated, using the model TOR as a guide, as set out in The Foundations of Good Governance. These were approved by the Board in July 2022.
- ✓ A process has been established by each committee where the Chair, Executive Lead and Company Secretary meet in advance of every meeting to agree the agenda, using the Cycle of Business as a guide, and then establish the specific purpose and assurance questions for each item.
- ✓ This will help paper/report authors better understand what assurance the committee needs, to improve the quality of information provided, and also help the committee ensure it is focussed in its challenge and holding to account.
- ✓ Data clinics have been held to inform the development of the Integrated Quality Report (IQR); this followed a Board development session with NHSE making data count team who are returning in August / September to follow up.
- ✓ Together with a revised Board Assurance Framework Risk Report (BAF) and the Improvement Journey Report, these three main reports will help the Board to better triangulate quality, people and finance.
- ✓ To support this further, and in particular helping the Board to improve how it challenges and holds to account, a Board development session has been scheduled for October with the well-established training package run by NHS Providers – Effective Challenge.

WN2 - Board Reporting Alignment and IQR

Improvement Journey

Quality Improvement	Responsive Care	People and Culture	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***

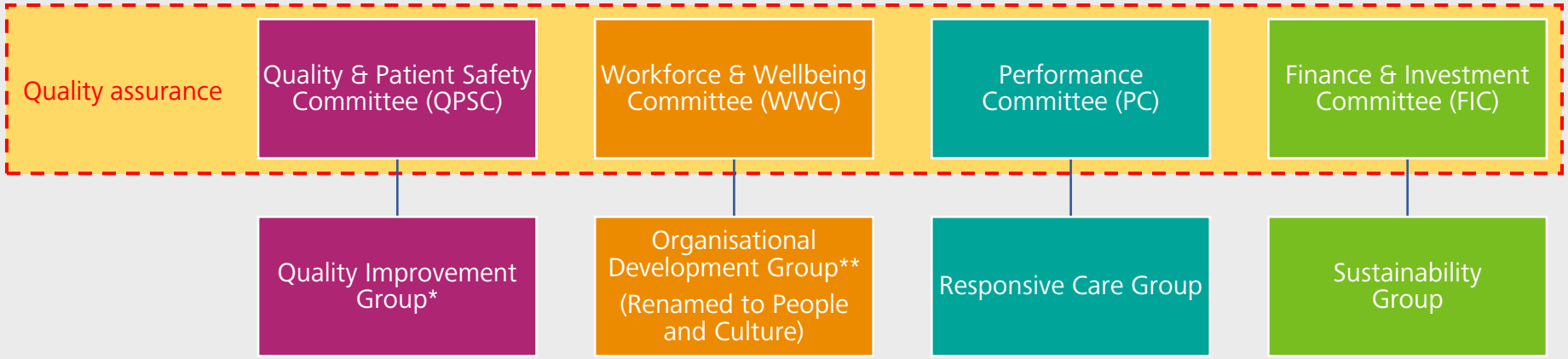
IQR Themes				
	- *Incident Management* - *Medicines Management* - *Patient Experience* - *Safeguarding* - *Safety in the workplace* - *Impact on Patient Care*	- *Ambulance Quality Indicators* - *Call Handling* - *Utilisation* - *999 Frontline Efficiency* - *Supporting the system* - *111 Operation*	- *Employee Experience* - *Workforce* - *Wellbeing*	- *Delivery against Plan*

Key Messages:

1. Significantly improved Quality of information enabling triangulation of workforce, finance, culture, performance data
2. Positive feedback received from NHS MDC Team – further development planned in August and September with targeted Board Development from MDC
3. Focus now to develop a framework that expands beyond Board and to all levels of the organisation

WN2 - Integrated Quality Report

WN2 - Board sub-committee alignment and assurance



Key Messages:

1. Alignment of the Sub-committees of the Board, with the Improvement Journey "pillars", Trust Priorities, and the IQR, enables for the first time a structure that allows full line of sight of the effectiveness of the plans in place to deliver improvements
2. Sub-committees to conduct 2x targeted deep dives per session going forward in alignment with Improvement journey plan

WN3 – Effectiveness of risk management and QI

CQC requirement	CQC Finding	Action type
Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements.	*Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements in health care. We were told, as of 15th March 2022 there was a backlog of open DATIX incidents (1,500). We were told that there had been no risk stratification of these as yet to understand any risk. There was a concern that harm was not being appropriately assessed when undertaking harm, death, SIs and Datix reviews.*	***Warning notice (Section 29A) WN3***

SECAmb Planned Outcome by November

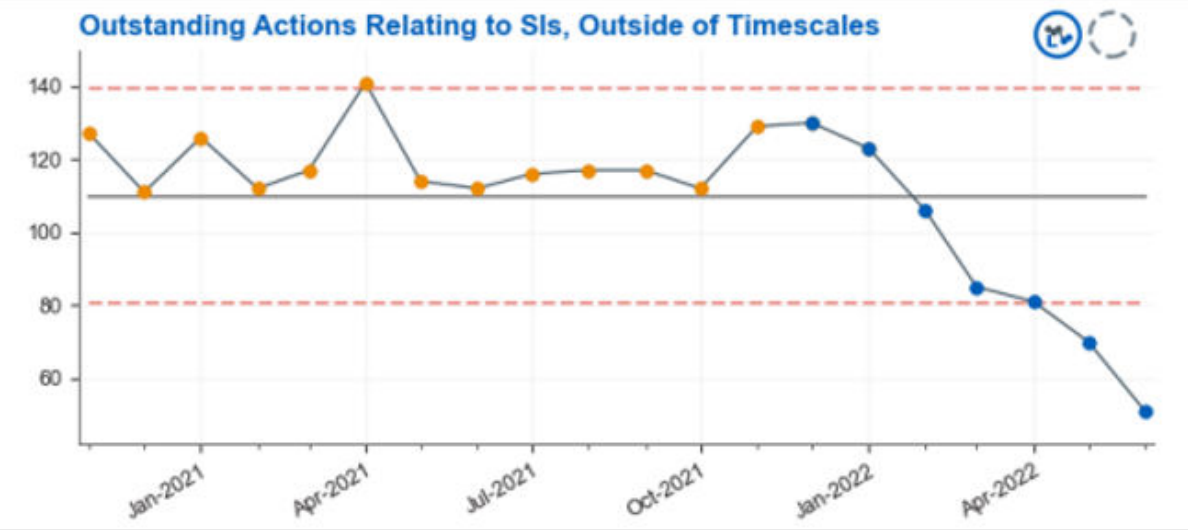
Greater oversight of clinical risks and issues through an integrated governance framework, supporting the consistent use of high-quality information and improved incident management and harm review processes, which drive improvements for patients and staff.

Summary of progress since CQC inspection

- ✓ Significant progress has been made with regards to the reduction of breached SI actions, SIs and Datix incidents.
- ✓ All trajectories to reduce overall breached numbers by 50% by end of July met, and trajectories being met to reduce to zero for SIs and SI actions, and by 90% for Datix on track.
- ✓ Workshops undertaken to map out refreshed incident management process, articulating immediate and short term actions to be undertaken by November to ensure assurance of risk stratification, quality of approach and investigations, feedback and learning is achieved.
- ✓ Operational Governance groups refreshed to provide two-way feedback of information on incidents, harm and risks to inform decisions and future models of support.
- ✓ A new model for Harm Reviews has been developed to address 5 types of harm typically encountered in pre-hospital services, and methodology to be applied to each type is now being developed.
- ✓ In the meantime, a systematic harm review was undertaken following the July Heatwave and discussed with commissioners at weekly forum.
- ✓ All SI reports submitted to Clinical Education and reformatted for use as case studies or teaching slides for dissemination to all accessing training tools and key skills curriculum.
- ✓ All policies are with appropriate Directors and plans being finalised for reviews and updates to be completed.
- ✓ Datix Cloud implementation is on track with over 80% of risk leads trained and on the system. Transfer of risks underway, updating and closing as appropriate.
- ✓ Mapping of the full patient journey has taken place (12/08/22) and 6 risk points identified.

WN3 - Achievements so far

- **Quality Improvement:**
  - Significant **reduction in outstanding incident backlog** in line with submitted trajectories.
  - Approval and appointment to **Deputy QI Director**.
  - Completed review of risk and harm governance, **migration to cloud system**.
  - Medicines management deep dive completed with system peer review. Programme fully resourced aiming for full business case in October.
  - A facilitated review of **how we keep patients safe** underway – Internal workshop in August and system review in September 2022
  - Learning from SIs



	Total open incidents	Breached	Within timeframe	Number still outstanding from original 1020
01/03/2022		1020		
23/05/2022	1427	622	805	334
14/06/2022	1404	633	771	242
21/06/2022	1459	601	858	234
29/06/2022	1304	462	842	178
04/07/2022	1262	409	853	149
12/07/2022	1328	386	942	145
19/07/2022	1265	358	907	110
26/07/2022	1218	353	865	77
02/08/2022	1194	313	881	69

WN3 - Understanding our biggest areas of risk – Patient Journey Mapping, preparation for Quality Summit

WN4 – Culture and addressing staff concerns

CQC requirement	CQC Finding	Action type
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.	*There was a culture of bullying across the organisation. Our interviews with staff and CQC staff survey and number of contacts with whistle blowers indicated a culture of bullying occurring across the trust with a 'lack' of ability to hear, address or resolve incidents in a timely fashion in line with trust policies.*	***Warning notice (Section 29A) WN4***

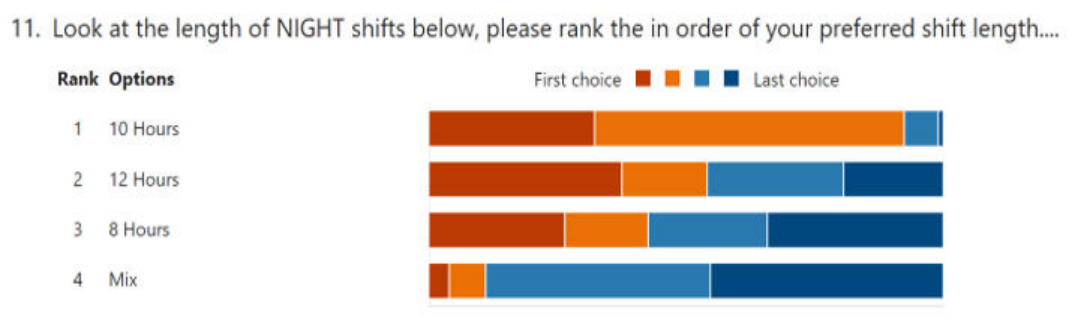
SECAmb Planned Outcome by November
Significant reduction in bullying and harassment prevalence, with staff feeling empowered and supported, through a safe mechanism, to raise concerns, promoting changes and learning as a result of speaking up in a timely manner

Summary of progress since CQC inspection
✓ An ER PowerBi Dashboards that monitors case completion has been made available to the Senior Management Group and Executive Team.
✓ This has been refreshed and re-implemented w/c August 22.
✓ Data from these dashboards shows that in August 2022, the average time to complete a grievance case was 85 days against a policy expectation of 93 days.
✓ Existing FTSU data is being be validated (quality and format) to be added to these dashboards.
✓ The new Fundamentals training programme aimed at middle managers has commenced; it is a five module programme of 24 cohorts that has specific content aimed at inclusive leadership.

WN4 - Achievements so far

- **Responsive Care:**
  - Progress towards our workforce targets for the year continues, expecting to be on target for recruitment, with attrition being the biggest risk to the plan.
  - On track for delivery of a full rota review in field operations including an engagement programme which has resulted in 978 responses to a questionnaire on rota preferences supporting improved patient response and staff welfare.
  - Completion of external dispatch review – undertaken in collaboration with AACE subject matter expert, also lessons learned from other Trusts.
  - Focus on listening to staff concerns: extensive consultation undertaken through the rota review programme for the year (over 900 responses in consultation), and development of a supportive risk-assessment process to support colleagues who have raised concerns with the FIAT DCA, supported by national NHS procurement, manufacturer, commissioners and through an independent expert. 57 FIAT DCA's build paused until new configuration engagement on-station can happen in the Autumn.

Shift length has been a key aspect of rota planning with strong links to staff welfare. We asked for staff preferences for inclusion in the rota requirements.

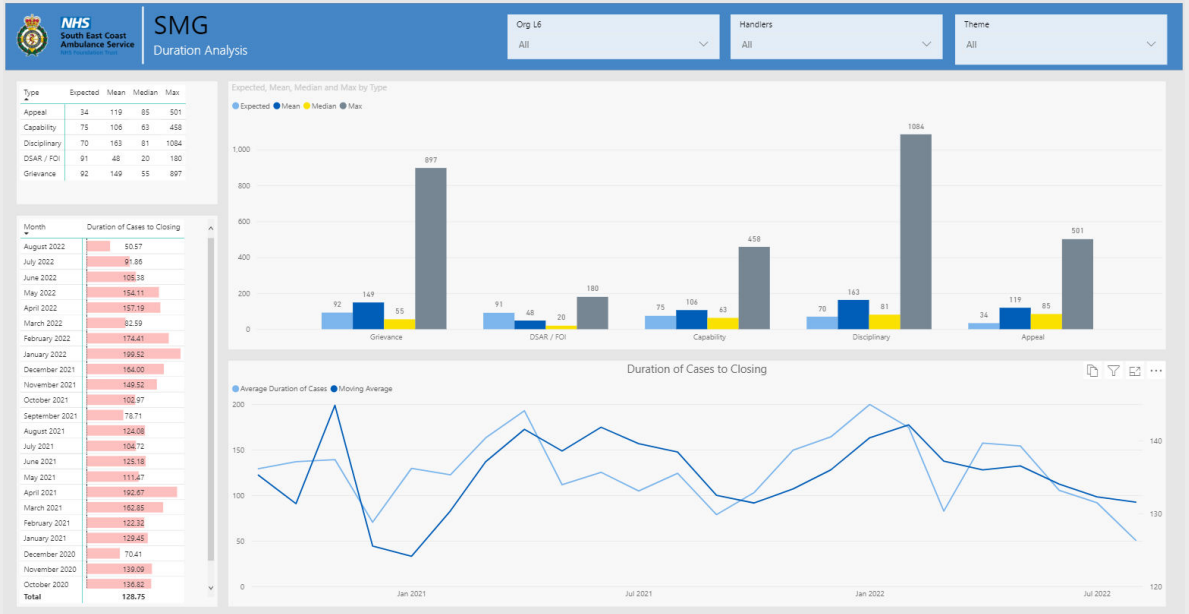


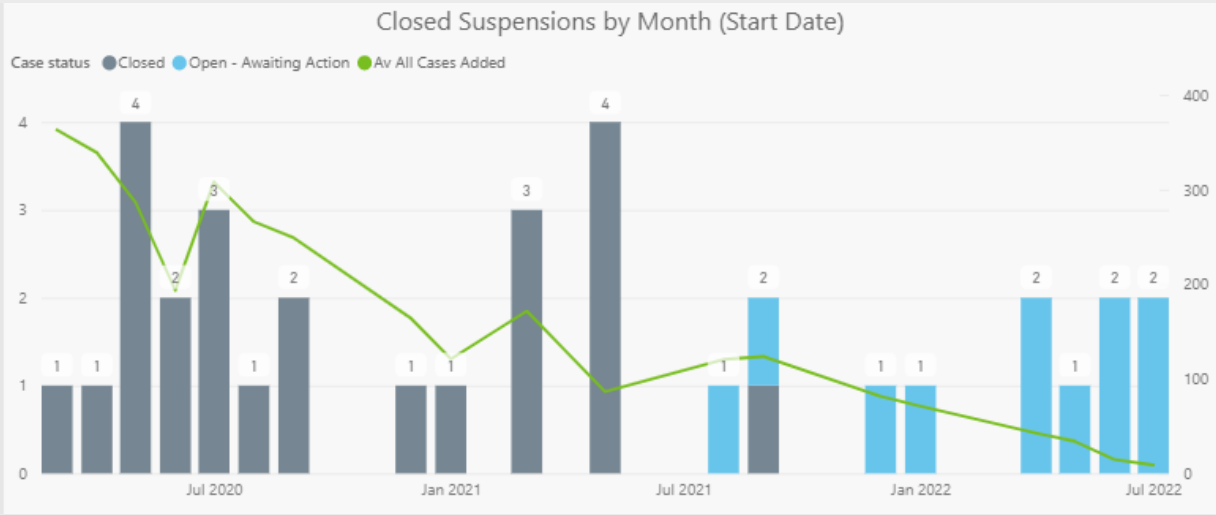
Measure	Q1 Trajectory	Q1 Actual
C1 Mean	08:30 - 09:30	08:43
C1 90th	16:00 - 17:00	15:52
C2 Mean	30:00 - 35:00	32:36
C2 90th	59:00 - 71:00	66:50

WN4 - Achievements so far

People and Culture

- Re-alignment of senior leadership behind the Trust Priorities for 22/23 and alignment to BAF, quality reporting, and Improvement and CQC Action plan. Over 200 feedback from staff sent directly to online portal with leadership personal response
- Trust has **committed to starting the NHSE Culture and Leadership Programme** and held two planning meetings. Programme formally commences on 25 August with a Board development session to affirm commitment and commence Stage 1 – Scoping.
- New **Civility and Respect Policy has completed consultation** and will now move to approval. CEO issued personal video message to all staff reinforcing message.
- **Civility and respect** programme started with the rollout of **sexual safety** workshops; four courses have been run (57 attendees) and a further four (72 attendees) are planned, with a total of **30 courses over the next two years**.
- **Leadership visibility programme** put in place with structured leadership visits on a rotational basis **– >90 visits/listening session conducted to date**
- Key additional roles to support FTSU progressed and open recruitment commenced. Improvement work **jointly approached with NGO**.
- **Made @ SECAmb management development programmes started** in line with plans – investing in leadership, and announcement of leadership conference in September – keynote speaker, Sydney Dekker, founder of Just and Restorative Culture philosophy.
- New interim CEO in place. Appointment of interim CFO awaiting HMT approval, with appointment of substantive CFO commenced.





Sustainability

- NHSEI Finance Improvement Director **completed finance review** – report due by end of August and workstream to formally commence in September.
- **National peer-reviewed** procurement improvement programme started through the CCIAF framework – scheduled peer review starts on 1st of October.
- **Green Plan** development started with 3rd Party consultant SME, focus on 3-10 year roadmap to 80% scope 1 reduction, inclusive of De-carbonisation Board Assurance Framework with yearly milestones expected by end of Q4 22/23.
- Emerging need for the development of a refreshed **strategy** and **5-year planning** framework to address the structural issues with the current model of care, and to shape the Improvement Journey beyond 31st March 2023 – formal escalation to August Board in public

Appendix

Portfolio risks, issues and escalations

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 and internal business case approved with recruitment ongoing. Interim Delivery Lead arrangements introduced for QIG and NHSE support offered for ODG.	↔
Due to operational demand or unforeseen service pressures, some delivery timeframes could be impacted.	Issue	High	Weekly programme core delivery group meetings are in place to keep to deadlines.	Medium	Demand increase is expected during the summer and reporting delays have been observed due to unforeseen operational pressures and annual leave.	↑
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. A full review of the master plan has been completed.	↔
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 outlines short-notice additional resource required. Recruitment activities have commenced.	↔
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 Portfolio Steering Group meetings.	12	The majority of the ODG/1 activities have been delivered and open employee engagement actions are being transferred to ODG/5, with communication being managed at a portfolio level. Joint EMB/SMG to agree on proposed communications and engagement plan.	↔

WN1 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion by
WN1-1	Strenghtening of SMG/EMB leadership relationships	**Descriptor:** SMG and EMB are working closer together now, with clear alignment behind direction of travel, regular joint meetings, and with a standing agenda item that is focused on engagement feedback from our staff. The SMG and EMB now have a clear DOR. **Evidence:** 1) Agenda and minutes of fortnightly Joint SMG/EMB meetings 2) Evidence of workshops conducted between EMB and SMG to define Trust priorities 3) Feedback on improved communications between SMG/EMB from core members	Gap to be covered in re-baseline	ODG	-
WN1-2	Trust priorities	**Descriptor:** SMG, EMB, Board and COG worked together through April and May to develop the Trust Priorities for the year, with a strong focus on people, engagement and leadership and built on the 200 Staff written feedback. These have supported the organisation to prepare to respond to CQC preliminary findings on a sustainable basis. The priorities have been used to engage all teams, empowering managers and local teams to develop action plans for the year in line with the Trust priorities for 22/23. **Evidence:** 1) Outcomes from facilitated workshops in April and May 2022 2) Communications plan for the Trust priorities 3) Examples of presentations where local teams have set their plans for the year in accordance with the priorities (including Teams F) 4) Examples of open feedback questions and answers (from staff to the senior leadership team)	ODG1.1	ODG	Completed
WN1-3	Leadership Engagement Plans	**Descriptor:** Rotational engagement plan for senior leadership team (SMG/EMB/NEDs/Governors) to have planned visits at stations, with structured feedback forms systematically collecting soft intelligence and feedback from staff. Leadership Engagement Coordinator recruited, ensuring even coverage of leadership visits across extensive patch, and providing summarised trend analysis on the feedback collected to the joint SMG and EMB meetings for consideration. **Evidence:** 1) Visit tracker presented, demonstrating greater leadership visibility 2) Raw and summarised leadership visit feedback forms 3) Minuted discussions and actions at SMG/EMB meetings to address issues and concerns raised 4) Adapted engagement approach with a greater social media presence demonstrated 5) Enhancements to communications with use of short videos and easily accessible updates (based on feedback received) 6) Case studies / specific evidence where the Trust has taken action based on feedback received	ODG5.1	ODG	14-Apr
WN1-4	Board reporting aligment to Trust priorities	**Descriptor:** The Board now meets monthly, with a focus on our Improvement Journey as the main conduit for measuring delivery against the Trust priorities as well as the CQC deliverables. The IQR has been re-developed with support from NHS Futures and now contains more relevant narrative focussed around each of the 4 pillars of our programme: People and Culture, Quality Care, Responsive Care and Sustainability, such to ensure there's better triangulation between the data, the discussion at the board, the improvement journey plans, and the impact it's having on patients and colleagues. **Evidence:** 1) BAF and reporting of the new IQR re-aligned to Trust priorities 2) Regular updates/reports to Board regarding the Improvement Journey 3) Board minutes	Gap to be covered in re-baseline	ODG	-
WN1-5	Board Development Plan	**Descriptor:** Our comprehensive Board development plan, and training needs analysis, identifying the needs for the Board to operate in line with NHS Leadership Academy "Healthy Board". **Evidence:** 1) Summary of all Board development sessions completed to date 2) Statement of impact from individual members of the Board 3) 12-month Board development plan - started with the work done with David Weaver from November 2021 - March 2022 4) Evidence of TNA to support development plan 5) Completion of minimum training relating to sexual misconduct and FTSU by all Board members 6) Phased plan for regular "Well-led" self-assessments in line with the KLOE as identified by CQC	ODG2	ODG	31-Mar
WN1-6	Colleague wellbeing reporting at Board	**Descriptor:** Strengthening of the people-focussed reporting and narrative at the Board and WWC sub-committee through the IQR. **Evidence:** 1) A new quality dashboard has been created to strengthen triangulation of colleague wellbeing with operational pressures and patient harm through the Integrated Quality Report (IQR) 2) Minutes of Board meetings 3) Action logs	QIG1.1 QIG1.4	QIG	20-Sep

WN2 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion
WN2-1	Re-structure of the quality governance structure	**Descriptor:** Complete overhaul of our Quality Governance Structures	QIG1.1	QIG	28-Jul
		Evidence: 1) Updated ToR and annual plans (Cycle of Business) for each of the five main Board committees			
		2) Standard templates and cover sheet for all governance groups			
		3) Example of good quality reports being presented at Board level, inc. risk summaries			
		4) Governance framework established by each Board committee outlining how the Chair, Executive Lead and Company Secretary will meet in advance of each meeting to agree agenda (using the Cycle of Business) and on specific purpose and assurance questions			
		5) Triangulation of quality, people and finance evidenced through joined up BAF, IQR and IJ reporting			
		6) Minutes which evidence how information in the IQR is being discussed			
		7) Evidence of key messages and escalations clearly being captured			
		8) Review of cycle of business and presentation of new governance approach to effectively answer the "so what" questions			
		9) Clear reporting framework that outlines how to record and report on BAF risks			
WN2-2	Closing the loop from escalations to groups and committees	**Descriptor:** Actions and escalations to committees have clear feedback look mechanisms embedded in the way they conduct business, with clearly linked actions from escalations being taken and fed back to origin (closing the loop).	QIG1.1	QIG	28-Jul
		Evidence: 1) Minutes of relevant meetings			
		2) Action logs			
		3) Examples of subsequent feedback to origination of issues			
WN2-3	Make Data Count	**Descriptor:** Re-structured approach to quality metrics reporting, following the MDC framework as supported by NHSE. This will ensure consistency and relevancy of metrics presented at the Board, supporting triangulation by design between workforce, finance, quality, and fully aligning to the Improvement Journey plans to provide assurance to Board. As part of this programme, there will be further Board Development provided by Sam Riley and her team at NHSE to ensure the Board is being professional in it's challenge based on evidence, improving quality of the narrative to the Board, and developed roadmap if there are any quality metrics missing from the current reporting systems.	QIG1.4	QIG	21-Jul
		Evidence: 1) Trust IPR converted to IQR			
		2) Board Development session on MDC and decisions (i.e. data holiday) to support development and implementation of SPC			
		3) Updated Data Strategy supporting implementation of quality metrics within the warehouse			
		4) Gap analysis undertaken linked to data strategy			
		5) Evidence of data clinics held to inform development of the Integrated Quality Report (IQR)			
WN2-4	Performance and Quality Assurance Framework	**Descriptor:** Development of a written Performance and Quality Assurance Framework that covers from Road to Board. This will include effective parameters for escalation through the operational structure and up to EMB/Board.	Gap to be covered in re-baseline	RCG / QIG	-
		Evidence: 1) Written Performance and Quality Assurance Framework			
		2) Regional (OU) and trust-wide level quality metric reports inclusive of workforce information, operational performance, quality data, and financial, as a minimum, clearly supporting written framework			
		3) Ammended TORs for a minimum of Teams B, Teams A, SMG, EMB, enabling clear escalation of issues.			
WN2-5	Promoting curiosity, constructive challenge, and holding to account	**Descriptor:** Promoting an environment of professional curiosity, with Board members and senior leaders feeling empowered to ask direct questions, check out and reflect on information received.	Gap to be covered in re-baseline	ODG	-
		Evidence: 1) Training records for committee chairs/EMB evidencing training on how to constructively challenge non-compliance			
		2) Training records for committee chairs/EMB evidencing training on how to use information within the IQR to drive challenge			
		3) Feedback from wider leadership team indicating what has changed (i.e., evidence of curiosity and challenge)			
WN1-5	Board Development Plan	Refer to WN1-5	-	ODG	-

WN3 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion
WN3-1	Key metrics: Reduction in outstanding incidents, breached SI and outstanding SI actions	**Descriptor:** Demonstrated reduction in outstanding incidents, breached SIs and outstanding SI actions in line with planned trajectories. **Evidence:** 1) Reduction in outstanding DATIX incidents to no more than 10% of overall count 2) Closure of all open SIs and associated actions 3) Planned trajectories to reduce breached SIs and to maintain this state.	QIG2.1 QIG2.3	QIG	30/12/2022
WN3-2	New incident and harm process	**Descriptor:** New process that demonstrates systematisation of the improvements achieved under WN3-1, ensuring improvements are sustained and mitigating against future backlogs. **Evidence:** 1) New policy, standardising quantification of harm across the Trust 2) Timeline of a phased approach demonstrating monitors of effectiveness 3) Evidence of learning being fed back into decision making (i.e., captured through minutes and actions of governance groups) 4) Evidence of workshop/s undertaken, outlining immediate and short-term actions to be undertaken 5) New framework for harm reviews founded on best-practice evidence 6) Evidence of ad-hoc harm reviews undertaken to respond dynamically to increased risk (i.e., heat wave) 7) Evidence of feedback to staff following incident submission 8) Evidence of triangulation between surge management/ARP and levels of harm (via Performance Cell) 9) Evidence of learning to prevent recurrence of backlog and to promote best practice - i.e., via case studies or teaching content produced by clinical education	QIG2.1	QIG	11/05/2023
WN3-3	All governance policies in date	**Descriptor:** All governance policies are in date, and there is a plan for addressing the backlog of outstanding policies and procedures which are out of date. This will ensure Trust governance is working as effectively and as up-to-date as possible. **Evidence:** 1) Risk assessment supporting prioritisation of governance policies to be updated and rationale/mitigation for those out-of-date 2) Timeline and trajectory with dates for updating all out-of-date policies (policies reviewed by accountable executive) 3) Operational governance groups refreshed to provide two-way feedback and information on incidents, harm and risks	Gap to be covered in re-baseline	QIG	-
WN3-4	Updated risk process, inc. new system	**Descriptor:** Reviewed risk management policy, reflecting changes in the TOR of meetings and clearly articulating how we manage and oversee risks at all levels of the organisation with identified accountable and appropriate owners. **Evidence:** 1) Updated risk management strategy articulating how SECAmb manages and escalates risk 2) TORs for all governance meetings where risks are discussed in line with risk management policy 3) Clear alignment of BAF risks to Improvement Journey with Board oversight 4) New Datix risk management platform in place (Datix Cloud) 5) Targets for training of risk leads, with 100% risk leads trained and target date by which >90% appropriate persons will be trained 6) Full review of all risks and evidence no risk has been "left behind" when transferring to Datix Cloud 7) Comprehensive risk report evidencing dynamic management and presenting trends, movement of ratings and stratification 8) Internal audit reports and clearly articulated process on how we are tracking recommendations and actions from internal audit.	QIG3.1 QIG3.2	QIG	10/08/2022
WN3-5	Patient journey mapping	**Descriptor:** In-depth review of the full end-to-end patient journey mapping, highlighting greatest areas of patient risk and potential harm. Learnings from this exercise will help define the Quality Summit in September, and learnings shared with key governance groups, EMB, and Board, and informing strategy going forward. **Evidence:** 1) Outcomes from patient journey mapping workshop 2) Quality Summit feedback and learning 3) Evidence of how learning has been embedded in risk and harm management processes 4) Evidence of how the outputs are used to influence future strategy.	Gap to be covered in re-baseline	QIG	-

WN4 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion
WN4-1	Key metrics: Workforce, culture and wellbeing	**Descriptor:** Key metrics that will be used to measure this requirement. **Evidence:** 1) Response time to issues raised for B&H allegations or grievances 2) Time from allegation raised to closure 3) Proportion and total amount of staff suffering from detriment when raising concerns 4) Total open grievances, and monthly new and closed 5) ER trendline of cases over time for sexualised behaviours and bullying and harassment 6) Reduction if sexualised behaviours, bullying and harassment and FTSU cases resulting in formal disciplinary action	ODG8.2	ODG	31-Mar
WN4-2	Resource plan to support caseload	**Descriptor:** A resource plan for the next 12 months to demonstrate an understanding of the requirements to adress grievances in a timely fashion and within policy timelines. **Evidence:** 1) Resource plan (e.g., FTSU) 2) Evidence to support resource plan is on track to meeting trajectory of resources required 3) Options appraisal undertaken considering longer-term resource requirements. To include Professional Standards functionality	Gap to be covered in re-baseline	ODG	-
WN4-3	Suspensions management process	**Descriptor:** Provide the evidence for safeguarding / risk assessments and weekly review of suspensions with fortnightly letters. **Evidence:** 1) Evidence of process being followed 2) Timeliness of issue identified vs outcome issued 3) Trajectory demonstrating improvement in timeliness of investigation outcomes etc.	Gap to be covered in re-baseline	ODG	-
WN4-4	Development of a "listening strategy"	**Descriptor:** A listening strategy that enable the Trust to improve it's ability to listen, hear and feedback when issues or concerns are raised. **Evidence:** 1) Written listening strategy	ODG5.1	ODG	16-Sep
WN4-5	Training and development of managers	**Descriptor:** Evidence that under the training plans for the year we are following our planned trajectories for developing leadership and managers under the Made@Secamb programme. **Evidence:** 1) Trajectories for completion of sexual safety workshops, mediation and management fundamentals courses 2) Evidence that trajectories are being met with completion summary 3) Feedback from persons who have undertaken or benefited from the training 4) Learning and outputs from the Leadership Conference	ODG6.2	ODG	03-Apr
WN4-6	Zero-tolerance stance	**Descriptor:** Visible communications from the executive and leaders across the organisation on our zero-tolerance approach to B&H and sexualised behaviours, supporting a visible zero-tolerance approach from the Trust's leadership. **Evidence:** 1) CEO weekly message reiterating Trust values and zero-tolerance stance 2) Communications plan to address a zero-tolerance stance on sexualised behaviours and B&H, including progress to date 3) Evidence of communications cascaded against plan 4) Timeline of phased approach to #UntilItStops training	Gap to be covered in re-baseline	ODG	-
WN4-7	Review of process for logging of concerns raised	**Descriptor:** Review of the process for raising concerns at SECAmb, ensuring there are effective communications and emphasis on the routes for raising concerns and supporting the FTSU function. **Evidence:** 1) External review of HR function, i.e., processes for raising and handling staff concerns 2) Full review of Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy undertaken 3) Alternative processes for raising and logging concerns mapped across the Trust, demonstrating multiple routes 4) Staff survey evidences of staff feeling heard with appropriate action undertaken and results demonstrated	ODG4.2	ODG	31-Mar
WN4-8	FTSU Board Development	**Descriptor:** Evidence that the Trust Board is supporting our FTSU function by actively engaging in Board Development based on the Board Development plan. This will increase awareness and robustness of the scrutiny at Board. **Evidence:** 1) Board Development plan with FTSU as core component 2) FTSU training undertaken led by FTSU leads 3) Feedback on impact from Board members on the Board Development	ODG4.1	ODG	08-Sep
WN4-9	Review of engagement approach through social media - in particular the FB Community Page	**Descriptor:** Feedback from colleagues is that the FB community page is not properly moderated and is systematically described as "toxic and negative". Visibly changing our approach and creating a values-based platform for social media engagement amongst colleagues. **Evidence:** 1) Options appraisal undertaken to consider staff engagement platforms 2) Where agreed, change in approach to alternative platform conducted 3) Social Media Policy reviewed and updated, with moderation process outlined	Gap to be covered in re-baseline	ODG	-

RSP exit criteria – linked IJ programmes

ID	SOF domain	Outline RSP exit criteria	Linked IJ programme	Linked IJ workstreams
L1	Leadership & capability	Interim CEO appointed and the Trust's Board-level leadership seen as stable.	Organisational Development	QIG3, ODG2
L2	Leadership & capability	Clear lines of responsibility and accountability for individual executives.	Organisational Development	QIG3, ODG2
L3	Leadership & capability	Trust Board sighted on all key risks through an effective Board Assurance Framework and improved quality reporting aligned to the BAF and the comprehensive improvement plans.	Quality Improvement	QIG1, QIG2, QIG3, QIG8, ODG2
L4	Leadership & capability	There was a culture of bullying across the organisation and 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.	Organisational Development	QIG8, ODG2, ODG3, ODG4, ODG6, ODG8
L5	Leadership & capability	Improved communication and engagement channels between the frontline and the Board, inclusive of routes of escalation for risks and concerns.	Organisational Development	QIG1, QIG3, QIG8, ODG2, ODG5, ODG8, RCG6
L6	Leadership & capability	Evidence of improved transparency and timeliness of reporting and information sharing with ICS partners. The level of desired transparency will be agreed between the ICS partners and SECAmb as part of the improvement journey evidence framework to avoid duplication.	Quality Improvement	QIG1, QIG2, QIG3, FSG
L7	Leadership & capability	External Well-Led review co-commissioned and all key recommendations acted on effectively.	Organisational Development	QIG1, QIG3, ODG2, ODG5, ODG6, ODG8, FSG
L8	Leadership & capability	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	Organisational Development	QIG1, QIG3, ODG2, ODG5, ODG8, FSG
L9	Leadership & capability	CQC reinspection has taken place and significant improvement found against all Warning Notice and Must Do findings/recommendations.	Portfolio	All
Q1	Quality, access & outcomes	Comprehensive improvement plan developed to deliver the Trust's improvement priorities including CQC's May 2022 findings and recommendations and the areas for improvement highlighted in the 2021 Staff Survey.	Portfolio	QIG1, QIG8, FSG
Q2	Quality, access & outcomes	Improved Board oversight and clarity on safety and quality metrics, ensuring there is good triangulation between demand and capacity issues driving ARP challenges, and the impact on patients and staff.	Quality Improvement	QIG1, QIG2, QIG3, QIG7, QIG8, ODG2, ODG9, RCG2, RCG3, RCG5, RCG6,
Q3	Quality, access & outcomes	Trust F2SU policy/process has received board assurance and oversight and has been appropriately resourced.	Organisational Development	ODG2, ODG4
P1	People	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	Organisational Development	ODG5
P2	People	Workforce plan developed to address capacity gaps in 111 and 999 services with evidence of delivery against agreed recruitment trajectories. Subject to funding and signed contracts to support required levels of resources.	Responsive Care	ODG7, RCG5, RCG6, FSG
P3	People	Trust career development and career pathways strengthened in line with the Board-approved clinical education strategy.	Organisational Development	ODG2, ODG6
P4	People	Trust not an outlier with ambulance service peers for staff retention or sickness absence.	Organisational Development	ODG7, ODG8, ODG9, RCG6
P5	People	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	Organisational Development	QIG1, QIG8, ODG3, ODG4, ODG6, ODG7, ODG8, RCG6
F1	Finance and use of resources	Comprehensive financial sustainability plan in place supported by diagnostic of deficit drivers, Quality Impact Assessment, robust efficiency plans and agreed levels of ICS investment.	Financial Sustainability	QIG1, FSG
F2	Finance and use of resources	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.	Financial Sustainability	QIG1, QIG3, FSG
F3	Finance and use of resources	Trust can evidence delivery of financial trajectories for at least two most recent quarters.	Financial Sustainability	QIG1, FSG

Key Messages:

1. RSP exit criteria workshop completed on the 27th July
2. Exit criteria deliverables have been mapped and incorporated within the relevant workstreams within the Improvement Journey