South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

29 September 2022
10.00-13.30

Banstead MRC

Agenda

Item No.	Time	Item	Paper	Lead
Board Governance				
47/22	10.00	Welcome and Apologies for absence		Chair
48/22	10.01	Declarations of interest		Chair
49/22	10.02	Minutes of the previous meeting: 25 August 2022		Chair
50/22	10.03	Matters arising (Action log)		PL
51/22	10.05	Chair's Report		DA
		Themes from Board Leadership Visits		DA
52/22	10.15	Audit & Risk Committee Report		MW
53/22	10.25	Chief Executive's Report		SM
Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report** c) **Improvement Journey**		
Delivering Quality				
55/22	10.35	**Keeping patients safe**	Board Story	EW
			BAF Risks 13, 16 & 256 Improvement Journey IQR	FM RN EW
			Safeguarding Annual Report	RN
			Quality & Patient Safety Committee Report	TQ
Focus on People				
56/22	11.15	**Improving Culture**	FTSU Guardian Report	FTSUG
			BAF Risks 13, 15 & 255 Improvement Journey IQR	AM
			Workforce & Wellbeing Committee Report	SS
	11.50	Break		
Delivering Modern Healthcare				
57/22	12.00	**Operational Performance & Efficiency**	BAF Risks 14 & 17 Improvement Journey IQR	EW
			Winter Planning	
			Performance Committee Report	HG

Delivering Sustainability & Partnerships				
58/22	12.30	**Achieving Sustainability / Working with Partners**	BAF Risks 14, 16 & 17 Improvement Journey IQR	DH
			Finance & Investment Committee Report	HG
Our Improvement Journey				
59/22	12.50	**Warning Notice Progress**	BAF Risk 257	DR
			Improvement Journey	
Board Effectiveness				
60/22	13.05	▪ Improving quality of information to the Board ▪ Improving professional curiosity and triangulation		Chair
Closing				
61/22	13.10	Any other business		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, 25 August 2022

Banstead 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
David Hammond	(DH)	Chief Operating Officer and Executive Director of Finance
David Ruiz-Celada	(DR)	Executive Director of Planning & Business Development
Emma Williams	(EW)	Executive Director of Operations
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
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
Margaret Dalziel	(MD)	Deputy Director of Quality

Chairman's introductions

DA welcomed members, those in attendance and those observing this meeting which is being streamed live for staff and members of the pubic to also join via MS Teams.

36/22 Apologies for absence

Robert Nicholls (RN) Executive Director of Quality & Nursing

37/22 Declarations of conflicts of interest

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

38/22 Minutes of the meeting held in public 28.07.2022

The minutes were approved as a true and accurate record.

39/22 Action Log [10.01-10.02]

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

40/22 Board Story [10.02-10.06]
Due to a technical issue the video was not able to be shown. It will instead be shown at the next meeting in September.

41/22 Chair's Report [10.06–10.10]
DA set out his report, highlighting his visit to a local hospital and the challenges faced by our staff and patients. He acknowledged the significant pressure everyone is working under. He asked from the Board today that there is robust and respectful challenge from both executive and non-executive given we are a unitary Board, collectively working together for patients and staff. He asked that we aim to get to the heart of issues with focus on what is in our control.

42/22 CEO Report [10.10–10.49]
SM drew out a number of points from her report, including a summary of the business the Executive Management Board (EMB) transacted in the last few weeks. The Board is encouraged by the increasingly positive way in which EMB and the Senior Management Group (SMG) is working together, with regular meetings; this is a really positive step forward. SM explained how as a leadership group we are working jointly to problem solve rather than just transacting business; SM reflected that the group has real potential to add real value.

SM then outlined the approaches being taken to better communicate and engage the workforce. There is also a focus on operational performance, acknowledging the concern staff are expressing about not being able to always respond to patients in a timely way. More positively, international recruitment is showing a strong pipeline and we are entering arrangements with the Republic of Ireland, which is a positive step.

Section B of SM's report confirms the receipt of verbal feedback from CQC following its inspection of urgent and emergency care, and Resilience. SM confirmed that we have reviewed this feedback against the priorities within the Improvement Journey and much aligns to the actions in train. At this point therefore, we are not suggesting deviation from the existing priorities.

SM reinforced how committed we are to leadership visibility. The Improvement Journey update later on the agenda will focus on the Warning Notice including the triangulation of what we have heard from these visits.

SM was really pleased by the televised documentary about our Joint Response Unit. She thanked the great work of those involved; it is good to have this platform to show the dedication of staff working in partnership with the Police to the benefit of patients.

Lastly, SM noted that the whole of the health and social care system remain under sustained levels of pressure. We remain at REAP level 4 (highest level), and most of our systems are at the equivalent level, which demonstrates the stress this puts on our staff and the impact on patients. We continue to work hard to be as efficient as we can be.

DA thanked SM for her report and opened to questions.

CG referred to the work on engagement and asked how soon we think we will be able to demonstrate that the voice of our people have really been heard. SM felt that by the end of September we will be able to see tangible differences, albeit with incremental changes. We are looking at different platforms to engage with our people and to gather insights from outside of the organisation, for example we are engaging with a very experienced director of comms and engagement to help support our improvement.

HG expressed a little concern about being clear what we mean by engagement; he reflected that the leadership visits are really positive, but by themselves not enough. Instead, HG suggested that real

engagement is when we engage staff in solutions to problems. Not just being asked what they think but working together through solutions. SM responded that there is not one definition or a textbook approach to engagement. What we do know is that staff have told us they feel disconnected. SM agrees there are multiple routes and we don't yet have an established QI culture, hence why the next part of the journey is to establish this. SM acknowledged that we need to move fast with examples of collective problem solving and devolved accountability; our immediate focus is to connect leaders in two-way dialogue and helping to support local decision-making.

TQ has met a number of staff as part of the visits he has undertaken and noted that the best place to engage and interact with staff is outside emergency departments. He therefore asked for permission to engage in this way as a Board, i.e. on the sites of other NHS trusts. DA confirmed that all we need to do is let the Trusts know; he will write to the Chairs to say Board members will be visiting emergency departments in this way.

Action
DA to write to the Chairs of local NHS Trusts to confirm that Board members will be visiting emergency departments to engage staff as part of the programme of leadership visits.

LS referred to what SM had outlined related to engagement and wondered if we could keep it simpler, e.g. "you said we did". LS does not think we have yet been able to effectively communicate the changes we have made recently. SM noted this and confirmed she is happy to take this on board as part of the overall thinking. She added that we discussed yesterday what improvements we have made and when we get to this under the Improvement Journey item, we will need to manage expectations, as we aren't as far forward as we need to be, but SM accepted we can definitely simplify messages.

MW noted the Integrated Care Boards' objectives impact our services, and he asked for assurance that because of our footprint we are relaying back to the four ICBs where the pinch points are related to patient care, such as primary care and community support. SM responded that she has monthly meetings with ICB CEOs on the sit rep; there was one yesterday where SM fed back that the System Assurance Meeting is not effective to fulfil the duty MW described. For example, at the last meeting we had an agenda item on system issues but did not then have the discussion we needed, so SM is not able to give this assurance MW is seeking. It has however been escalated as a concern and SM intends also to escalate via NHS England. The System Assurance Meeting needs a reset with more senior people to ensure we as a system are doing all the best we can for patients.

PB asked if we are collecting enough data to support the system issues MW refers to. SM confirmed that we have a lot of information and we are data rich, but there is probably variability in how effectively we are using it. We need to work with the system to develop new access points / pathways as alternatives to an emergency ambulance. PB felt that we should be data driven all the time. SM agreed and while we have some good live dashboards, we need to explore further about this is used. EMB is in discussion about how it will use data differently to drive its oversight.

HG reflected that when he joined SECAmb one of the ideas he wanted to explore was to seek international experience on how to do things. International recruitment presents an opportunity to get ideas from these staff coming from other countries and HG asked if we could use this to establish learning. AM confirmed that we have recruited six but this is just the start as we aim to recruit 75 by the end of the year. AM met one from America and part of the design is to cohort and this will be an opportunity to seek views in the way HG suggests.

DA thanked SM again for her frank reflections. He summarised that we must not promise what we can't deliver. There has been some false starts in recent years and so when we do promise we need to deliver with openness and integrity. We have the Improvement Journey and this needs to help us get the basics

right and then improvement that is sustained. As an organisation we are the experts in urgency and emergency care and so need to show system leadership to drive improvements for our people and patients.

43/22 Board Assurance Framework Risk Report [10.49-11.17]

PL set out the revisions to the new Board Assurance Framework (BAF) highlighting the following:

- This BAF report is in development in response to the Board's feedback in May and that of the CQC. We will be continuing this development through September.
- We have put in additional Board meetings, such as today's, to focus primarily on the Improvement Journey. The plan is that for the full Board meetings (every other month), the Improvement Journey will be received alongside the BAF & Integrated Quality Report as the main sources of information to confirm progress against the priorities; how these relate to the metrics in the IQR; and the strategic risks and how these are being managed.
- The focus of the development has been to improve the BAF's link to the strategic goals / priorities, and to provide more detail especially in relation to the controls and the actions. This predominately relates to Appendix A where we detail each risk.
- The dashboard has been revised, illustrating the link to the strategic goals, and shows the changes in risk score over a 12-month period.
- The aim of section 4 in the narrative section is to try and provide a brief description of why we have included these risks and how they inter-relate.
- There are three new BAF risks:
    1. A second workforce risk related to the Integrated Plan, which links to the Performance Committee's escalation to the Board, set out in the Chair's report.
    2. The risk related to a lack of approach to establishing Quality Improvement
    3. The Improvement Journey risk and not being able to demonstrate timely significant improvement against the Warning Notice, in particular.

HG set out the concern from the recent Performance Committee, noting that while recruitment is catching up against the plan, it is being undermined by huge attrition rates. AM responded by referencing the separate BAF risk on retention. He explained that we are taking a full paper to EMB on 14 September to set out how we intend to improve retention, outlining some of the thinking, including a need to engage staff earlier after starting and ensuring ongoing development. In addition, there are some more structural issues, such as pay for call handlers which is a national issue.

EW responded to the issue raised last time which is recorded on the action log (31 22) related to the high percentage of new starters leaving. EW confirmed that some of this is call handlers moving to ECSW roles; this presents as a loss of staff from call centres. Also, it is more difficult to recruit in Crawley as airports re open, and there is an impact of the Medway move on staff at Coxheath and Ashford.

TQ asked about the steps we are taking to ensure we recruit the right people and ensure they really know what the role is, rather than just chasing numbers. EW explained that we invite potential staff to visit beforehand to give exposure and insight. Also, we learnt much via lockdown when we employed people from airlines and they helped create a different environment. However, call handlers is the lowest paid job and so attracts certain groups of people. It is a complex issue and despite the exposure we try to give it isn't until you are in the job that you really know what it involves.

DA acknowledged that retention is a material risk and has the Board's attention.

Action
The Board to receive an update on the retention (BAF) risk to seek assurance our mitigating actions are having a positive impact.

SS warned against over complicating things; what we need is to have basics like training and one-to-ones and appraisals, too often these do not happen. Notwithstanding the challenges, 111 / EOC has the highest referral rate to the Wellbeing Hub, and SS suggested that this can't all be down to the type of work; she felt this has to relate at least in part to cultural issues. SS confirmed that we have asked before at Board for focussed action on hotpots and this hasn't been forthcoming; she challenged what middle management are doing as the executive can only do so much. They must also be held to account for delivery.

DA noted that the BAF has done its job in bringing out these risks and issues. Clearly, there are some environmental issues but things also that we can control, such as engagement and development. DA asked the Workforce and Wellbeing Committee (WWC) to report back outputs of its discussion tomorrow.

MW expressed surprised we aren't looking at the recruitment and retention strategies; he asked if we have these and who is accountable. SM confirmed this is AM. AM responded that we do have a retention strategy, which an update is coming to WWC tomorrow. We don't have a recruitment strategy but instead a workforce plan. MW challenged this. Not to have recruitment strategy is a gap and the systemic issue is that the Trust needs to think more medium to longer term to check we have things in place to ensure we are resilient going forward.

SS asked about the ETD risk and controls, suggesting they should be more about abstraction than ETD. EW responded that we have a plan but agreed the controls need to be more overtly how we control abstraction. This will be picked up in the next review.

44/22 Improvement Journey [11.17-12.15]

SM introduced this, confirming that the focus today is on the Warning Notice (WN) and reinforcing that WN1 is owned by the full Board. SM acknowledged we are a unitary Board and in looking at the evidence to demonstrate progress reinforced the need to own this together. DA completely agreed and on behalf of the Board acknowledged that we are part of the problem; it starts with us. We therefore need to be clear we are the Board, accountable for the performance of the Trust.

DR then took the Board through the report reflecting on each WN, asking that every Board member ensures they are clear what the WN is and what we have done / need to do. DR explained that we have struggled with delivery managers recruitment, so have moved several people internally to close the gaps. This means however we aren't as far forward as we would like demonstrated by the gaps in evidence. The focus of the next four weeks is to ensure we collect this evidence. DR chairs the Steering Group (PB attends as NED champion) and its focus is on outcomes / evidence. DR referred to slide 2 which shows the gaps in critical resources which we are asking the system for support with.

HG asked about the People and Culture gap. DR explained that have no dedicated delivery lead but have an NHSE expert to take a look at programme as part of intensive support, which was escalated to EMB yesterday. Sustainability is Red as we are still to formalise this programme, awaiting the output of the NHSE finance review.

HG expressed concern we don't have a delivery lead for the programme we most worried about (P&C). DR reinforced that we have moved this into intensive support and working urgently to identify resource.

<u>WNI & 2 – Board disconnect / information</u>

The Board reviewed what it has done since March and what can reasonably be evidenced by November, accepting the need to challenge ourselves. MW reflected that we have engaged and talked to people and heard what they are saying. We are doing some things to address concerns but whether they know this / there is buy, MW is not sure.

DA noted that it is not just Board meeting effectiveness, but committees too. He has asked for external peer review of how effective the committees are.

There were other reflections about the need to develop a direction of travel that engages people and living and breathing the trust values. Also about some of the Board development, such as improving information flows (IQR and BAF) and FTSU (leading to an increase in resources).

In summary, the Board accepted the broad exam question that the Board is not working together to achieve its potential. There was acceptance that as part of the improvement work there are some basics such as ensuring the papers and agendas drive the right conversations leading to informed decisions. What have we done is to improve papers / triangulate, which links then to WN2. The Board also agreed that a really powerful story is that the Board lives the values; this must include how we consider reports/papers (no matter the topic) always in the context of impact for our people and patients. Part of this is ensuring good preparation; having read and understood the information prior to meetings so that we can ensure curiosity and challenge. The making data count session later this afternoon relates specifically to this.

DR referred to slide 22 that sets out the evidence we think we need and took the Board through each line, reinforcing that despite work to do we have done tangible things. The test will be in how effective the Board and committees (including EMB SMG) are.

TQ asked if the leadership conference on 13 September an opportunity to take some feedback from the leadership about how different / better it is for them. AM agreed this be an opportunity to explore the question of connectivity.

DR then took the Board through the slides setting out the evidence expected to demonstrate significant improvement for WN2. SM added that the learning from the Board committee effectiveness reviews will help inform actions / deliverables. The process itself is good development, and there is also external validation from the making data count team at NHSE who are supporting us.

<u>WN3 – risk management / QI</u>
The Board noted some of the progress made against this WN, such as the reduction in backlog of incidents. However, work still to do to reduce further and also to implement QI. MD explained that we need to address the cause for the incident backlog so this does not recur. She felt that there has been good work to-date and the challenge will be to sustain this, although engagement across operations has been positive in breaking down barriers to ensure collective focus on patient safety. MD added that there is work to develop the harm review model; first for ambulance services. Many SIs relate to demand and capacity so more system issues and we are working as part of the system to manage these differently.

HG asked how we disseminate learning from harm reviews. SM was not able to give assurance but did give some examples of how this works well, but accepting it is not consistent. There is no coordinated approach and relies on local OUs. However, we are working to ensure systems are in place to get this at organisational level and starting to establish systems in conjunction with the medical directorate.

On risk management and corporate governance, SM explained that there is more to do. There is a role for the Audit & Risk Committee and Board, and we are currently looking at EMB oversight of corporate risks. We need the golden thread of quality to demonstrate risk is appropriately discussed and managed, but SM reflected we are not quite there yet.

WN4 – culture and bullying

DR then went through the slides setting out the gaps in evidence. AM added that on FTSU, the question now is do Board better understand the role of FTSU following its session in July. On the employee relations side AM explained that we have done some work to reduce the backlog but cases are continuing to come through. DA asked that we have better clarity on why the cases continue to come through in such high numbers. AM agreed, and confirmed that we are doing some analytical work, but there is an issues with capacity to complete this as staff are prioritising the response to the cases.

SS is unclear where we are with FTSU. SM felt that this starts at Board and challenged directors on whether we have done enough to explore the data re sexualised and B&H cases to understand progress and how it feels for staff.

Action
Greater focus at the Board meeting in September on how much progress we are making in improving culture, using the data on bullying and harassment / ER cases to inform the level of assurance the Board can take.

There was then a discussion about how we use the IQR to have the discussion on bullying and sexualised behaviour. MW reinforced that we need to be clear on action being taking, not just the data. DA agreed, and we want to know where bullying is happening and why and what we are doing to address this.

DA summarised that there is much work still to do, and we must be clear on where the gaps are and how we will close these and by when. The Board needs to hold itself to account and be self-critical. There are lots of actions being taken. As a Board we need to raise our game to coordinate what we do so we have more focussed discussions at Board, agreeing clear actions. We all need the same picture of what we have done collectively and what we are doing going forward in terms of priorities and expected impact. That said, we must also acknowledge the huge efforts of many. This must be properly resourced to ensure the pace of improvement needed.

45/22 AOB

None

46/22 Review of meeting effectiveness

The Board reflected that when it discussed the BAF risk related to recruitment / retention it didn't link enough to patient safety clearly.

There being no further business, the Chair closed the meeting at 12.32

DA then asked if there were any questions from the public in attendance, related to today's agenda. There were none.

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
28.07.2022	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	C	25.08.2022: Agreed to pick up on the agenda as part of the escalation related to the integrated plan. See minute
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	C	25.08.2022: DR confirmed this has been reflected in the current version which we will be reviewing later as part of the development session.
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	C	25.08.2022: On agenda - see Performance Committee escalation within the Chair's Board Report - see minute
25.08.2022	42 22	DA to write to the Chairs of local NHS Trusts to confirm that Board members will be visiting emergency departments to engage staff as part of the programme of leadership visits.	DA	29.09.2022	Board	IP	
25.08.2022	43 22	The Board to receive an update on the retention (BAF) risk to seek assurance our mitigating actions are having a positive impact.	AM	29.09.2022	Board	IP	To be covered on the agenda
25.08.2022	44 22	Greater focus at the Board meeting in September on how much progress we are making in improving culture, using the data on bullying and harassment / ER cases to inform the level of assurance the Board can take.	PL	29.09.2022	Board	C	On agenda - 'Improving Culture' (also see escalation from AUC)

Key

	Not yet due
	Due
	Overdue
	Closed

NHS
South East Coast Ambulance Service
NHS Foundation Trust

	Item No	51-22

Name of meeting	Trust Board
Date	29.09.2022
Name of paper	Chair Board Report
Report Author	David Astley, Chairman

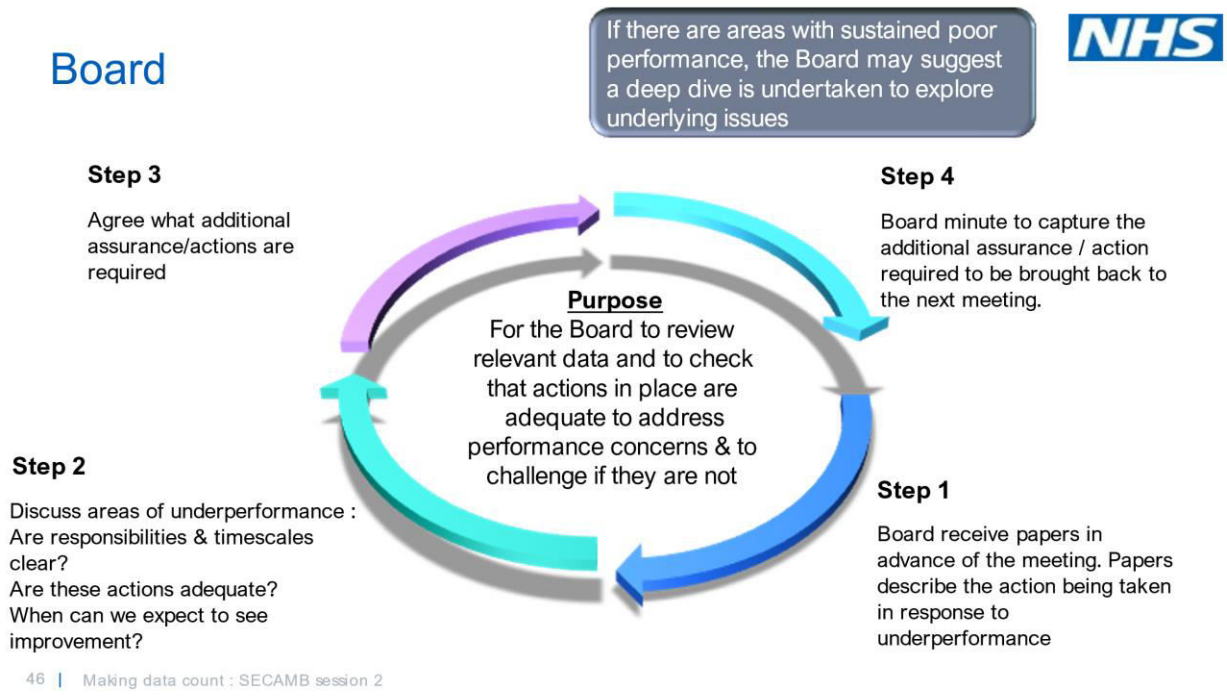
Board Meeting / Effectiveness

Today's Board Meeting

Since the last Board meeting in August we have continued to have robust conversations as a Board about the ways in which we can become more effective, both individually and collectively.

Siobhan and I asked our Improvement Director to undertake a formal peer review of our Board and committee meetings. Observations have now taken place for three of the committees and the reports related to the most recent meeting of the Workforce & Wellbeing Committee and the Quality & Patient Safety Committee have been received. I will provide a summary of the findings and actions we have taken in my report to the Board in October, once we have the reports from the other meetings, including this Board meeting.

The approach to this meeting has been amended, with the principal aim of ensuring a structure that helps lead the Board to have the right discussion. We will be using the assurance cycle we considered at the second 'making data count' session in August to help ensure focus and clear outcomes.



As set out on the agenda, we have three primary Board papers; the Board Assurance Framework; Integrated Quality Report and Improvement Journey. From our own reflections as a Board about how taking papers in order can sometimes lead to a more transactional discussion, the plan for this meeting will be to use these as reference documents. The agenda is then ordered against our strategic goals with areas of specific focus that are linked to the current key issues and risks, namely:

- Keeping Patients Safe
- Improving Culture
- Operational Performance & Efficiency
- Sustainability and Working with Partners

We then have a section on our Improvement Journey and specifically the immediate priority to ensure we can demonstrate significant improvement in relation to areas set out in the Warning Notice.

Using some of the early feedback from the committee peer reviews I mentioned, we have also changed the way the committees report to the Board. In addition to providing greater clarity on how the committees' focus aligns with the current BAF risks, these reports more directly set out the areas of escalation that require the Board's intervention.

At the end of the meeting I will ask for immediate reflections on this new approach and, as you can see from the agenda, there are two areas I am asking we address as a Board, which relate to the Warning Notice and what we must ensure, to become more effective.

Board Development

At our development session last month we had a further '**making data count**' session facilitated by NHSE. There was really positive feedback about how quickly we have developed our new IQR and how the Board had started to use this in a different way at the meeting in July.

We also spent time with the support of the Culture Transformation Lead at NHSE to receive an overview of the NHS **Culture and Leadership Programme** and the link to our Trust values and how these support better patient outcomes. The Board reflected on its responsibility in the context of this programme and formally signed up to it. At today's meeting I will be asking for an update on this from the Executive Director of HR & OD.

Linked to this programme, on Tuesday 27 September the Board will be attending a detailed briefing session to explore all of the metrics related to **people and culture** and our response to concerns, which has also now been strengthened in our IQR reporting. The Board continues to be concerned about the progress we are making in this area and this was highlighted too at the recent Audit & Risk Committee.

Following the **FTSU** development session in July, I expect all Board members to have completed the FTSU training by the end of September and booked on to one of the sexual safety workshops, which are scheduled as part of the Until it Stops campaign.

As part of our schedule of Board development to help improve our effectiveness, we have in October a

scheduled training session supported by NHS Providers, on **effective challenge and holding to account.**

Leadership Visits Feedback

An area of feedback from the last staff survey, which was highlighted by the CQC, related to a disconnect between the Board and the wider organisation. In addition to improving the quality of information we receive that more directly connects to what is happening in local operating units, control rooms and in support services, one of the ways we are seeking to address this disconnect is to get out and about much more, in order to listen to our people. Especially for our independent non-executive directors, this is critical to triangulating information with other sources. As a Board, executive and non-executive, we have undertaken a significant number of visits. The type of feedback is listed below and the themes emerging from this include:

-The impact of operational pressures and the decisions that leadership take to protect colleague welfare when we are in high levels of escalation. We have been told that some of the decisions being taken are adversely affecting staff morale, such as difficulties in approving Annual Leave or late shifts overrun, coupled with attending patients with long waits.

- Communication and engagement through and across some of our middle-management layers, as well as supporting our local managers to be visible and available to support staff. We have been told that some colleagues are disengaged and that we are not doing enough to explain the steps we are taking to improve things.

-Concerns about some of the changes we are making, in particular related to field operations rotas, and changes to some of our systems such as Datix and the new ESR Appraisal system, as well as the lack of opportunity for some of our staff to have protected time for CPD and development.

-And overall concern about the winter ahead, amidst the cost-of-living crisis which will affect both patients and staff.

I will ask Board members to keep these themes in their minds during today's meeting.

- Concern from crews about the impact on patients by not always being able to respond in a timely way
- Long waits for patients
- A gap in understanding about what senior leaders are doing to address the big structural issues / Lack of strategic change / A lack of forward planning
- Concern about winter (ability to meet patient need)
- The frequency of late sign-off and shift over-runs
- Rota changes and the adverse impact this might have on some staff
- Senior Management visibility including OUMs/OMs
- Local leadership – breakdown in cascade
- Annual leave not being approved
- Feedback that nothing has changed and sense that "they don't care about us"
- Some OTLs not feeling engaged
- A desire for senior management to deal more effectively with the minority of staff who

behave badly
- Accessibility of the new risk (Datix) and appraisal (ESR) systems
- Format of weekly bulletin not user friendly
- Impact of the cost of living on both staff and patients
- And feedback that more should be done to progress internal staff (career progression) and provide leave for CPD/development.

Council of Governors / AMM

We had a really productive Annual Members Meeting on 2 September. In addition to fulfilling our statutory duties in the presentation of the annual report and accounts, we took the opportunity to highlight our Improvement Journey and to launch the new Clinical Advisory Group. This has been established following recognition that we needed to enhance the clinical voice, to inform the decisions we make for our patients and our people.

Immediately prior to the AMM the Council of Governors held a general meeting. This focussed on holding the independent Non-Executive Directors to account for the performance of the Trust; a role they undertake extremely diligently. There were a number of issues the Governors expressed concern about related to how we are supporting the workforce and ensuring safe services, which reflect the discussions the Board have been having and will continue at this meeting. Governors are helped in their roles, in particular in assessing the effectiveness of the NEDs, by having the opportunity to observe Board committee meetings. This is used to inform the performance appraisals I undertake with my NED colleagues. I will be sharing the outputs of the committee effectiveness reviews with the Council of Governor and how the NED Chairs will be using this to ensure continuous improvement.

Southeast Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee Escalation Report

Overview of issues covered at the meeting 22.09.2022.

Item	Purpose	Link to BAF Risk
Board Committee Effectiveness / Improvement Journey Deep Dives	To receive an update on the ongoing peer review of the Board and its committees and support the plan for Improvement Journey committee deep dives.	Risk 257 – Improvement Journey
The committee provided its view on how the committee reports to Board could more specifically set out where gaps in assurance are identified and where Board intervention is needed. It supported the plan for each committee to undertake a series of deep dives to further assure progress against the Warning Notice, reinforcing the need to test the extent to which the improvements being made are sustainable. The committee acknowledged too that in light of some of the improvement relating specifically to the effectiveness of the Board, this is not just about the NEDs holding the executive to account for delivery. As a unitary Board we also need to continually reflect on the Board's performance and how it can improve so that it makes better decisions for the benefit of the public and our people.		
Risk Management	To seek assurance that our risk management process is effective.	Risk 257 – Improvement Journey
Risk management is a significant feature of the Warning Notice and so a key priority within the Improvement Journey. The committee did not receive the scheduled assurance paper (this will follow as part of a deep dive), and instead received a report describing the progress made against the Warning Notice and the key risks and how these are being managed. Concern was expressed about how clearly the report is able to demonstrate significant progress, especially with regards culture – see separate escalation below. The committee explored how an externally facilitated risk management seminar for the Board would help improve its understanding of risk and the impact of the improvement actions being taken. This will be scheduled shortly.		
Board Assurance Framework	To seek assurance that the evolving BAF is adequately aligned and reflective of the current principal risks.	Risk 257 – Improvement Journey
Noting the areas of further development, the committee believes the BAF is improving and is helping to ensure the Board is focussed on the right areas of risk. The risks were reviewed and in the context of the development planned, some challenge on ensuring more bottom-up risks and in how they are described so the language is more meaningful to patients and staff.		

Despite the positive step to appoint a very experienced QI lead, this person is not yet in post and therefore the committee is not assured; it has asked for assurance next time on the QI implementation plan as this is critical to how well we sustain the improvements within our Improvement Journey.

There was some debate about the operating model BAF risk, and how this might be described differently which the executive will consider and the committee agreed that in light of the earlier discussion, culture should be a separate BAF risk.

Overall, however, the committee has more assurance in the increasing effectiveness of the Board Assurance Framework.

Internal Audit Plan	To receive the outcomes of the internal audit reviews most recently completed	N/A
Since the last meeting, two reviews were completed in line with the annual plan, both demonstrating 'Reasonable Assurance'. One of these related to fleet management and this was the first time in several years that fleet received a positive outcome; it was able to demonstrate significant progress in relation to data quality.		
Counter Fraud	To seek assurance that the Trust has effective counter fraud arrangements.	N/A
The committee continues to be assured with the counter fraud arrangements in place. It explored the ongoing issue facing the whole sector, related to staff working in secondary employment while sick. The committee noted that there is little more to add to the measures already in place, which include taking swift investigations and action.		
Freedom to Speak Up	To seek assurance that the Trust has an effective speaking up culture and systems in place to ensure investigation and learning.	Risk (tbc) – Workforce / Culture
As the Board is aware from previous discussions, there is not a particular issue with the culture of speaking up, demonstrated by the high number of cases we receive. The issue continues to be with the systems we have in place to ensure effective investigations that drive learning. The paper received did not provide assurance in this area and did not demonstrate sufficient management grip. Some of this relates to capacity and the committee welcomed the investment in two deputy Guardians who start in October. This will certainly help to ensure improved processes, in addition to the move to Datix that is planned in the coming weeks. Despite the gap in assurance identified this is not a specific escalation to the Board on the basis that a separate report is being received by the Board this month.		
Resilience (EPRR)	To seek assurance that the issues	N/A

	identified against the EPRR core standards are being addressed.	
In 2021/22 the EPRR assurance process led to an overall rating of 'Partially Compliant' against the EPRR Core Standards and the Interoperable Capabilities. The paper sets out the progress made since then but did not provide sufficient clarity on the risks or how these have been quantified. The committee has therefore asked for a management response, which it will receive at its next meeting.		
Specific Escalation(s) for Board Action	**Board Committee Effectiveness / Improvement Journey Deep Dives**: The committee recommends that at the end of each meeting, the Board reflects honestly on how effective it has been.	
	Risk Management – Culture: There is limited assurance about the impact of our actions to improve the culture. The committee reflected that the Board is probably not sighted clearly enough on the data that is available to show how seriously issues such as bullying and harassment are being taken, e.g. speed on investigations / actions taken in response. There is a session scheduled for 27 September and there is specific focus on culture at the upcoming Board meeting. The committee agreed that this escalation goes beyond the remit of the workforce and wellbeing committee and requires Board intervention so that clear actions and expectations are set, given how central this is to everything we do.	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	53-22

Name of meeting	Trust Board
Date	29.09.2022
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 September 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:

- Increasing our oversight of risk management, including the Board Assurance Framework (BAF)
- Reviewing and refreshing the EMB reporting framework, including how risks and issues are escalated from teams and Directorates
- Revising the Internal Audit Plan

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 Since the last Board meeting, EMB have also reviewed a number of key investment decisions including:

- Expansion of the Clinical Education team
  Temporary excess travel costs as part of moves to the new Medway Make Ready Centre

7 **Engagement**

	On 31st August, I attended a national 'Winter Preparation' workshop for NHS Chief Executives, led by Amanda Pritchard, Chief Executive of the NHS. This was an extremely useful opportunity to bring together leaders from all parts of the NHS ahead of what we all recognise is likely to be a challenging winter period.
8	On 1st September, I was pleased to welcome Anne Eden, the NHS England Regional Director for the South East to our Crawley HQ for her first visit to our Emergency Operations Centre and to meet a number of colleagues. I know that Anne found it really useful to learn more about how the EOCs operate and the particular challenges facing them at present.
9	**Leadership engagement** As part of our commitment to improving how we listen to and engage with colleagues across the Trust, our programme of Leadership visits has continued during the month.
10	During September 2022, senior leaders have undertaken more than 20 visits to sites across the Trust, engaging with colleagues about the current issues they are experiencing and listening to their ideas on areas for improvement. This feedback is then reviewed by the Leadership Team at their fortnightly meeting, incorporated into our evolving Improvement Journey and specific actions taken if needed.
11	**Interim Director of Finance appointed** Following the announcement made earlier in the year, David Hammond, Executive Director of Finance will leave the Trust on 30th September 2022.
12	I would like to extend my thanks to David for the significant contribution he has made to the Trust since joining in 2008, including his leadership of a number of key projects including the development of a number of Make Ready Centres, new Emergency Operations Centre and 111 facilities, as well as a number of significant technical programmes.
13	Earlier this month, we were pleased to welcome Martin Sheldon to SECAmb who has joined as Interim Chief Finance Officer. Following a handover period with David Hammond, Martin will formally take up his new role on 1st October 2022.
14	Martin is an experienced Director, who has held a wide range of roles in the NHS and private sector. He will remain with us until a substantive Chief Finance Officer is appointed.
	B. Regional Issues
15	**Annual Members Meeting (AMM)** On 2nd September 2022 we held our Council of Governors and Annual Members Meeting at Lingfield Park Racecourse – the first opportunity to hold an in-person meeting for three years.
16	As well as conducting the formal business of the AMM, it was a great opportunity for us to showcase the work of a number of our frontline and support teams and of our volunteers. It was also great to see a number of our partners, including Air

17	Ambulance Kent Surrey Sussex, attend to support us. Thank you to all those who were involved as part of what was an enjoyable and positive day.
	C. National Issues
18	**Death of Her Majesty Queen Elizabeth II** We were deeply saddened by the passing of Her Majesty Queen Elizabeth II on 8th September and the Chairman and I passed on our formal condolences on behalf of everyone within SECAmb.
19	Ahead of Her Majesty's State Funeral, extensive planning was undertaken by the Emergency Preparedness Resilience and Response (EPRR) team, who worked closely with colleagues across the systems to understand and manage any potential operational impacts due to traffic and travel disruption and from the Bank Holiday on 19th September.
20	The team also worked closely with colleagues from London and South Central Ambulance Services to understand what support they may require, given the particular geographical impacts they faced. I was pleased that subsequently, we were able to provide a small number of operational colleagues to support London Ambulance Service on the day of the State Funeral.
21	A number of our staff and volunteers also took part in different events during this period in various personal capacities and I know were extremely proud to play a part in such historic events.
22	**'Our Plan for Patients'** On 22nd September 2022, the Rt Hon Therese Coffey MP, the Secretary of State for Health & Social Care announced 'Our Plan for Patients' – the government's plan to improve care for patients this winter.
23	The plan covers a number of areas within the NHS, however specific commitments relating to ambulance services include: • Increasing the number of call handlers in NHS 111 and in 999 by December 2022 to speed up answering of 111 calls and quicker dispatch of ambulances for those in greatest need following a call to 999. • Ensuring that NHS111 and ambulance services can signpost patients to the full range of services, for example having access to dedicated 24/7 helplines for patients experiencing a mental health crisis. • Reducing the time lost to ambulance handover delays and ensuring that ambulances can get back on the road swiftly, including by ensuring that all hospitals have clear escalation arrangements for when delays occur including deploying Hospital Ambulance Liaison Officers (HALOs) if needed. • Rolling out a new digital intelligent routing platform so ambulance trusts can support each other during the busiest periods by sharing 999 calls. • Exploring how we boost the volunteers supporting ambulance services, building

	on initiatives like the St John Ambulance auxiliary ambulance service.
24	Following the very recent publication of the plan, we will work through this in detail and agree, with our partners, how we can deliver against these commitments as a whole system.
25	**'999 Emergency Call Out' - documentary following the Joint Response Unit** Following the screening of the first episode on 17th August, we have been delighted to see extremely positive feedback (and excellent viewing figures) for Channel 5's documentary - '999 Emergency Call Out' - which follows the work of the Joint Response Unit (JRU), run jointly with Kent Police.
26	Six episodes of the 10-part series have been screened so far and continue to show to good effect the wide variety of calls that the JRU are dispatched to.
27	I remain extremely proud that through this series, we're able to showcase not only the work of the JRU but also of the wider SECAmb team.
28	**Ambulance Leadership Forum (ALF)** This year's Ambulance Leadership Forum took place on 6th and 7th September and I was pleased that a small team from SECAmb was able to attend and to hear keynote speakers including Suzanne Rastrick, Chief Allied Health Professions Officer for England, Matthew Taylor, Chief Executive of the NHS Confederation and Chris Hopson, Chief Strategy Officer for NHS England.
29	Immediately prior to ALF, the second Women in Leadership Seminar was also held, featuring guided discussions, debate and inspirational women leaders from within ambulance services and wider healthcare and I was especially pleased that a number of members from our Gender Equality Staff Network were able to attend this session.
30	I would also like to extend my congratulations to Yuri Kurek who received the Exceptional Student Paramedic award at ALF. Yuri was nominated by our Clinical Education Team for showing real dedication and commitment to her Paramedic Science degree, including travelling exceptionally long distances to travel to placements and staying away from home for extended periods in order to fulfil her course commitments - well done Yuri.
	D. Escalation to the Board
31	**Improvement Journey** Our Improvement Journey is covered elsewhere on the agenda, however I wanted to highlight here the continuing and significant emphasis that we are placing on delivering our Improvement Plan, which focusses on our key priorities and which takes account of the key CQC requirements, especially the Warning Notices and 'must do' actions.
32	**Operational Performance** All ambulance services remain under significant pressure at present as does the wider NHS system.

33	We are continuing to work hard to ensure that we provide as responsive a service as possible to our patients although recognise there are periods when the peaks in demand we experience outstrip the resources available to us.
34	These periods of escalation result in some patients, especially those in Categories 3 and 4, waiting longer at times than they should. We continue to raise with system colleagues the urgent need for alternative pathways to be available for some of these patients ahead of winter.
35	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.
36	Our REAP Level is regularly reviewed and on 2nd September, we decided to move from Level 4 to Level 3. This will continue to be reviewed by the Senior Management Team on a weekly basis and adjusted, if needed.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	54-22a

Name of meeting	Trust Board
Date	29.09.2022
Name of paper	Board Assurance Framework
Author	Peter Lee, Company Secretary

There have been some revisions to the BAF since the version that came to Board in August, as set out. In particular, sections A-C. The aim is to more clearly align the BAF with the strategic goals and priorities within the Improvement Journey.

The BAF will come to every other meeting of the Board and will be one of three primary documents, along with the Integrated Quality Report and Improvement Journey. These documents will also be used by Committee Chairs to help ensure every meeting of a Board committee takes a risk-based approach to where it should focus. This is reflected in the committee reports to the Board, where they now reference the related BAF risk.

The BAF was reviewed by the Audit & Risk Committee on 22 September; see its report to the Board (agenda item 52-22).

The BAF risks have also informed the focus of this Board meeting, as set out in the separate cover papers.

The Board is asked to use this report to inform its discussion and, in particular, cross referencing against the stated controls and mitigating actions and, using the assurance cycle referred to in the Chair's report, where gaps in control are identified, agree what further assurance/corrective action needs to be taken.

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

Board Assurance Framework
Section A: Strategic Direction

1. Strategic Goals / Corporate Priorities

1.1. This Board Assurance Framework is informed by Trust strategy '*Sustainable SECAmb'* and the related strategic goals. These are:

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

1.2. It also aligns with the current priorities within the Improvement Journey. These are:

- **People & Culture** *Improving our culture, engage our people, and support development of our teams*
- **Quality Improvement** *Embedding quality amongst everything we do*
- **Responsive Care** *Improving operational performance and patient care*
- **Sustainability & Partnerships** *Ensuring long-term sustainability*

1.3. These priorities will next be reviewed as part of the business planning cycle for 2023/24

Board Assurance Framework
Section B: BAF & Risk Overview

2. Introduction: The BAF

2.1. It is a requirement for all NHS provider Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks.

2.2. This includes the requirement to have a Board Assurance Framework that sets out the risks to the strategic plan by bringing together in a single place all of the relevant information on the risks to the Board being able to deliver the organisation's objectives.

2.3. This BAF is a continuation of the refresh presented at the last Trust Board, and includes the new Dashboard presented last month. This outlines the risks and how they could impact on the strategic goals. The detail of each risk is set out in Appendix A.

2.4. Section C has been added to provide context by identifying the vehicles and mechanisms for maintaining oversight of delivery.

3. Risk Management

3.1. There is currently insufficient assurance that the Trust's risk management governance is able to fully assure the Board. Rapid corrective work is being undertaken to address this situation, as set out in the Improvement Journey, and the Executive Management Board and Audit & Risk Committee are maintaining oversight of this.

3.2. At its meeting on 22 September, the committee asked that arrangements are made to organise an externally facilitated risk seminar for the Board. This will be scheduled in November.

3.3. From October, following some work to cleanse the risk register, a new temporary section (section E) will be added to the BAF that outlines the Trust's extreme risks within the corporate risk register. These are risks that are deemed to not explicitly affect the strategic priorities but as they score 15 or above, they are the highest (non-BAF) risks on the risk register.

4. Structure of the BAF Risk Report

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

4.2. To reflect the current issues within the organisation the goals have been re-ordered and the Board agenda has been organised against these goals. Due to the significant challenges with organisational culture and the feedback received from the staff survey the strategic goal regarding people has been ordered first.

4.3. The BAF is structured and mapped against the four strategic goals (outlined in table 1).

Table 1: Strategic Goals

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

Board Assurance Framework
SECTION C: Oversight & Delivery

5. Oversight & Delivery

5.1. There are a number of mechanisms for maintaining oversight and delivery of the four strategic goals and these are identified in Table 2. The most significant is the improvement journey which is aligned with the four strategic goals.

Table 2: Strategic Goals aligned with Improvement, BAU Delivery and Oversight

Strategic Goals	1. A Focus on People	2. Delivering Quality	3. Delivering Modern Healthcare for Patients	4. System Partnership
	Everyone is listened to, respected, and well supported	We Listen, Learn and improve	A continued focus on our core services of 999 & 111 Clinical Assessment Service	We contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent and Emergency Care
Improvement Journey Programme & Improvement Priorities	**People & Culture**	**Quality Improvement**	**Responsive Care**	**Sustainability & Partnerships**
	People	Patients	Service	Sustainable
	Improving our culture, engage our people, and support development of our teams	**Embedding quality amongst everything we do**	**Improving operational performance and patient care**	**Ensuring long-term sustainability**
Enabling Board Approved Strategies	▪ People Strategy ▪ Clinical Education ▪ ETD Strategy ▪ Inclusion Strategy ▪ Health & Wellbeing	▪ Clinical Strategy ▪ End of Life Care ▪ Dementia Strategy ▪ Medicines Optimisation ▪ Patient Experience	▪ Community Resilience ▪ Fleet Strategy ▪ Estates Strategy	▪ Green Strategy ▪ Digital Strategy
Board Assurance	Executive Managament Board & Workforce and Wellbeing Committee	Executive Managament Board & Quality and Patient Safety Committee	Executive Managament Board & Performance Committee	Executive Managament Board & Finance & Investment Committee & Audit Committee

Board Assurance Framework
SECTION D: Risks

6. BAF Risks

6.1. The Board Assurance Framework has eight existing strategic risks. Following review of the corporate risk register, EMB propose a new strategic risk relating to potential cyber-attack (risk ID 71).

6.2. Risk 13 has been broadened to capture the culture and leadership risk. As set out in its report to the Board, at the Audit & Risk Committee on 22 September it was agreed that further review was needed to ensure there is a separate risk on culture. This change will be made and reflected in the next version of the BAF.

6.3. Each strategic risk has been reviewed by the lead Executive Director and updated to ensure identified actions are appropriate and have appropriate timeframes. All changes since the last report to Board are indicated via red text or strikethrough font.

6.4. On 9 September 2022 the Risk and Assurance Group was reinstated. This group reviews all risks on the risk register and reports to the joint SMG/EMB. The risk portfolio is currently escalated and consequently an additional report on risk governance was reported to the Executive Management Board on 14 September 2022.

6.5. In addition, the Audit & Risk Committee has risk management as a standing item.

6.6. Each BAF Risk is aligned to a committee of the Board, with the relevant risks being considered at relevant meetings. This is being strengthened with the alignment of the risk register with the Improvement Journey and the schedule of committee deep dives.

6.7. In the actions sections of each risk we have referenced where they relate to a workstream within the Improvement Journey.

6.8. From October Section E will include the non-BAF ‘extreme’ scoring risks.

BAF Dashboard

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

Risk ref	Thematic Risk Title	Oversight Committee	Strategic Goal Impacted					Initial risk	Current Risk (Current Position)								Change	Target score	Target date
			1	2	3	4			Jul 21	Sep 21	Nov 21	Jan 21	Mar 22	May 22	Aug 22	Sep 22			
14	Operating Model	PC/QPS	✓	✓	✓	✓		20	20	20	20	16	16	16	16	20	⇧	08	Mar-24
255	Workforce – Recruitment	PC/WWC	✓	✓	✓	✓		20							16	16	⇔	04	Mar-23
13	Workforce – Culture	PC/WWC	✓	✓	✓	✓		16	16	16	16	12	12	12	16	16	⇔	08	Mar-24
17	Integration of 111 & EOC	PC/FIC			✓	✓		16				16	16	16	16	16	⇔	08	Oct-22
256	Quality Improvement	QPS		✓				16							12	12	⇔	04	Jun-23
257	Improvement Journey	All	✓	✓	✓	✓		12							08	12	⇧	04	Nov-22
15	Education Training & Dev	WWC	✓	✓				15	16	16	12	12	12	12	09	09	⇔	06	Mar-23
16	Financial Sustainability	FIC	✓	✓	✓	✓		16	16	16	16	16	12	12	16	16	⇔	08	Mar-23
71	Cyber Attack	FIC		✓		✓		16								12	NEW	09	TBC

BAF Risks

	BAF Risk ID 14 Operating Model	**Target Date:** March 2024

Underlying Cause / Source of Risk: Our operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need, and there is a risk that if we do not address this in a timely way then we will continue to fall short of achieving the standards set out in the Ambulance Response Programme and therefore delivering safe and effective patient care.	**Accountable Director**	Executive Director of Operations
	Committee	Quality & Patient Safety / Performance
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**20** (Consequence 4 x Likelihood 5)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

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

- Responsive Care priority within the Improvement Journey focusses on key actions to improve processes / use of resources, such as H&T, JCT (see Improvement Journey Update)
- Use of REAP and SMP to help match resource with demand
- Integrated Plan agreed with commissioners to increase clinical workforce to 2555 WTE
- Performance Cell capability is helping to forecast resource gaps / trajectory against ARP

Gaps in Control

- Slow progress moving to a more virtual model
- ~~EMB need much greater visibility on how this is progressing, e.g. PP rotas, PaCCs training and implementation~~
- Stated actions help to improve the current approach / contribute to future model but we haven't yet agreed the vision for a new operating model, internally or in collaboration with system partners.

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Operational Performance / ARP standards not being achieved (+) ARP trajectory for Q1 was met as report to August Performance Committee (-) low provision of hours ~~(-) REAP Level: 4~~ (-) High attrition is undermining the additional clinicians being recruited	Greater focus is needed at EMB and Board on the road map for how the operating model will be re-designed.

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**

Rota Implementation (RC-1a & b): Improve staffing allocations delivered through new rotas by day/hour according to demand/activity, delivering improved staff experience, more efficient utilisation of limited resources, timely responses to the highest-acuity calls, and improved patient outcomes and experience.	Director of Operations	16/12/2022	
Hear & Treat (RC-3): Increase the number of incidents where 999 calls are successfully completed without dispatching a physical resource, resulting in improved patient outcomes and experience, and improved staff experience, i.e., dispatching staff to the most appropriate calls.	Director of Operations	03/11/2023	
Dispatch Review (RC-4): Improve the efficiency and effectiveness of dispatch function, contributing to greater patient outcomes, experience and ARP performance across all categories.	Director of Operations	24/04/2023	
Job Cycle Time (RC-2): Improved overall ambulance availability through a reduction in job cycle time providing timely responses to the highest-acuity calls, improved patient outcomes and experience, and improved staff experience.	Director of Operations	30/12/2022	

	BAF Risk ID 255 Workforce - Recruitment	**Target Date:** **March 2023**

Underlying Cause / Source of Risk:	**Accountable Director**	Executive Director of HR
Risk that we do not achieve the recruitment plan to increase our clinical workforce to 2555 WTE, as set out in the 2022/23 Integrated Plan. This will result in consistently being unable to provide the target operational hours and therefore will impact adversely on patient care and staff wellbeing.	**Committee**	WWC / Performance
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

- Integrated Workforce Plan
- Additional Recruitment Events
- International Recruitment

Gaps in Control

The Trust is currently ~~70~~ 91 WTE under the workforce plan for 22-23 (July 2022), however with the planned additional recruitment the Trusts end of year position should be ~~10~~ 20 WTE below plan. There are further plans to recruit AAPs from Ireland which would negate this gap and help reduce any further gaps created by attrition. ~~However, with attrition double the expected level, if this trend continues the Trust will not realise any of the planned workforce growth this year~~ Attrition has improved in July but continues to be the single largest risk to the delivery of the 22-23 plan, with 31 WTE lost above plan.

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) Q1 Integrated Plan: ~~70~~ 91WTE below plan (-) On road hours significantly below target (-) Higher than normal turnover in EOC and 111 (+) ARP improvement trajectory on plan at Q1 / Relative position nationally	

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**
(P&C-7) To compensate against the additional attrition and known gaps in the recruitment pipeline there has been additional recruitment events held to recruit external AAPs.	Director of HR	31.03.2023	To date there have been ~~69~~ 85 successful candidates offered a position (Includes already started, 54 yet to start on a course and 13 have a TBC date)
(P&C-7) International paramedic recruitment - these candidates have a longer turnaround time from offer to start and any offers made going forwards will not likely start within this financial year.	Director of HR	31.03.2023	Offered to ~~25~~ 34 candidates so far (five started), with aim to offer 75 by 31.03.2023.

Proposal to utilise NQPs within the EOC if they have not yet obtained a C1 licence. This will enable the Trust to retain these staff and reduces the risk of candidates accepting offers at neighbouring services who accept NQPs without a C1 licence. This will also bolster the 999 clinical workforce teams' capacity over the winter period and increase hear and treat rates.	Director of Operations Medical Director		
(P&C-7) Recruitment Pathway examined to identify where efficiencies can be made	Director of HR	31.03.2023	Work has started to look into whether it is feasible to verbally offer a candidate at the end of the assessment day. It's recognised that there will be extra resource needed for this from recruitment to check that all the assessment paperwork is correct and the candidate has passed along with considerations prior to offer. This will significantly reduce the time taken to offer and have a positive impact on the overall time to hire. A pilot is to be discussed and agreed. Associate Director of Operations supporting this proposal. If this isn't a viable option the workloads of the recruitment team will be reviewed and resource moved to help accommodate assessment day administration, so that no delays are related to the subsequent increase of processing for one individual. This review and new process will be implemented by 01/10/22. Pre-employment check time taken to be added to the recruitment pipeline dashboard with a target date of 01/10/22. Power Bi to show this information. The review is in progress and is part of the ongoing work which utilises Lean 6 Sigma defining stable processes as part of the programme. This will utilise the fusion of the two disciplines – Lean which seeks to improve flow in the value stream and eliminate waste and Six Sigma which uses a powerful framework and statistical tools to uncover root causes to understand and reduce variation resulting in a defect free process. Each stage of the review will look at chunks of the process, and with careful work will define, measure, analyse, improve and then control the new processes. Without these key steps in place the recruitment team will continue to work with waste undetected. This process also needs data to enable the reflection and analysis to ensure that any adjustments made to processes are effective, and sustainable. ▪ Stage 1 to map current processes – target completion 01/10/22. ▪ Stage 2 to build effective measure of data – target 01/11/22. ▪ Stage 3 to analyse data and identify ineffective processes – target 01/12/22. ▪ Stage 4 Improve processes – target 01/01/22. ▪ Stage 5 Control processes and monitor for sustained improvements – target 31/03/23 The KPIs identified in the recruitment pipeline dashboard will show our progress and reduction in TTH. Target date to remain at 31/03/23 for completion.

	BAF Risk ID 13 Workforce – Culture, Leadership & Retention	Target Date: March ~~2023~~2024

Underlying Cause / Source of Risk:		
Risk that poor culture and leadership practice results in lower staff morale and higher turnover than planned. A specific associated risk is that we will continue to lose a significant number of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce.	**Accountable Director**	Executive ~~Medical~~ Director of HR
	Committee	WWC / Performance
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

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

Culture & Leadership:
- Commenced NHS Culture and Leadership Programme
- Implementing Just and Restorative Culture methodology and principles alongside programme of early resolution/mediation
- Until it Stops Campaign commenced
- Programmes of management development and leadership engagement to improve management practice (under collective brand of Made@SECAmb)
- New appraisal system places equal value on behaviours and performance

Loss of paramedics:
- Work in partnership with six higher education institutions (HEIs) for pre-registration paramedic education programmes
- Clinical Education Strategy & Delivery Plan
- Workforce Plan agreed as part of the Integrated Plan
- Raised at system assurance meeting and ICB Chief People Officer Meeting.

Gaps in Control
- There is no ICS/System workforce plan
- No Trust People Strategy and related plans

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Increase in B&H / Grievances (-) Feedback from Pulse Survey (-) Shortfall of paramedics / High attrition (-) Additional Roles Reimbursement Scheme could lead to a potential increased attrition of paramedics (-) Retention issues within paramedics/EOC/111 and some corporate teams e.g. HR (+) Planned increase in direct entry students converted to employees	Need greater visibility of the effective implementation of the retention plan

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
(P&C-7) Role specific Staff Survey/Exit Interview action plan for Paramedics and Urgent Care	Director of HR	31.12.2022	Retention Plan to be reviewed at EMB SMG on 21.09.2022

(P&C-7) Development opportunities for Paramedics to progress to Paramedic Practitioners and Critical Care Paramedics. As a minimum we recruit to our budgeted FTE for Paramedic Practitioners and Critical Care Paramedics	Director of HR	30.03.2024	Retention Plan to be reviewed at EMB SMG on 21.09.2022
(P&C-8) Development of a People Strategy and related plans	Director of HR	TBC	
(P&C-5) Delivery of the NHS Culture and Leadership Programme	Director of HR	TBC	
Implement the Just and Restorative Culture methodology and principles	Director of HR	TBC	

	BAF Risk ID 17 Integration of 111 & EOC	Target Date: October 2022

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

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

- Continue to engage with NHSE directly to seek responses and answers to the concerns and issues raised to date. The NHSE Integrated Urgent Care (IUC) central team has devolved responsibility for the implementation and communication of SVCC to the NHSE regional leads. As such, KMS 111 Head of Service has been in regular contact with the regional NHS E team (and national NHS E IUC Leads, when necessary, i.e., for telephony, commissioning, clinical and medical).
- We have full attendance at the three original NHSE national SVCC engagement sessions, in addition to all local NHSE SVCC meetings covering the three workstreams.
- Raised concerns via the AACE national forums.
- The Associate Director for IT has escalated his concerns and issues through to the national team. Internally, the Associate Directors for IT and for Integrated Care continue to work closely to ensure that SECAmb is fully compliant with the expectations of NHSE regarding the IT and subsequent operational implementation of SVCC.
- Implementation has been deferred to at least October 2022 – this is subject to funding that is yet to be agreed.

Gaps in Control

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Work with commissioners to close the funding gap	Director of Finance	Ongoing	
Re modelling the interface between 111 and EOC in terms of call handling and CAS	Director of Operations	TBC	TBC

	BAF Risk ID 256 Quality Improvement	Target Date: June 2023

Underlying Cause / Source of Risk:		
The lack of an organisational management systems approach to establishing Quality Improvement as a founding principle will lead to the inability to execute sustainable improvement throughout the organisation that is systematic, prioritised, coordinated, effective, and aligned through from policy to practice to resources available. This will have an adverse impact on patient care, staff well-being, resource sustainability and sustained improvement via the Improvement Journey.	**Accountable Director**	Executive Director of Quality and Nursing
	Committee	Quality & Patient Safety
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

- The overall requirement and QI (organic) approach agreed
- Deputy Director of QI appointed (due to start in Q3)
- Improvement journey and workstreams in place that are articulating top-level immediate risks that need addressing – monitored through the IJ structure
- Governance groups being refreshed and strengthened to ensure information flow is clear, consistent and comprehensive to address immediate interface between patient care, staff and resources.
- QMS/QI presented to some key stakeholders to inform immediate changes to provide good information two-way flows through Quality and Operational groups

Gaps in Control

No Quality Improvement Methodology In place

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
(QI-8) QI Strategy, Vision, Aims and Objectives to be developed	Director of Quality	April 2023	
(QI-8) Training plan to be established and underway	Director of Quality	April 2023	
(QI-8) Coordinated learning infrastructure/framework in place – see QI workstreams within the Improvement	Director of Quality	April 2023	
Board QI session	Director of Quality	Nov 2023	

	BAF Risk ID 257 Improvement Journey	Target Date: November 2022

Underlying Cause / Source of Risk:		
Risk that the Trust is not able to demonstrate significant improvement against the areas highlighted by CQC in the Warning Notice and Must Dos, which could lead to further reputational damage and/or regulatory action.	**Accountable Director**	Executive Director of Planning & Business Development
	Committee	Trust Board
	Initial Risk Score	**12** (Consequence 4 x Likelihood 3)
	Current Risk Score	**12** (Consequence 4 x Likelihood 3)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

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

- Improvement Plan is on place – through August this has bene re-prioritised to ensure focus on the Warning Notice and Must Dos.
- Monthly Board meetings established to assure delivery of the Plan.
- A programme of IJ deep dives scheduled for each committee – starting in September.
- External support accepted – HR Review; Finance Review; SI / Harm Review.
- Quality Summit and CQC Mock Inspection scheduled for September
- ~~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~~
- Application for NHSE/I funding and internal business case approved with recruitment ongoing.
- Improvement Journey Steering Group now chaired weekly by Director of Planning and Business Development.
- The programmes have been re-baselined and following a freeze on the 9th September there's a clear plan and focus on collating of evidence.
- Additional support is being drafted to help address the gap in communications / engagement with the programme.
- People and Culture Programme has been put under additional support under the internal "intensive support", this includes creating capacity within DDHR to lead on the programme and allocation of a dedicated PM
- A targeted register of evidence has been produced to support focus on outcomes by the expiry of the S29A (Warning Notices)

Gaps in Control

- Resourcing gaps and capacity constraints identified across the IJ programmes, in particular with delivery leads, not yet closed.
- Mock inspections originally planned for mid-August and mid-September have not gone ahead as per original plan due to on-going capacity issues within the Quality Compliance team and need to meet second CQC inspection data requests.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Latest Report to Board in August	The Board's Committees have not yet had the opportunity to conduct deep-dives against each of the critical workstreams due to timing. Deep dives to be scheduled before 1.11.2022

Mitigating actions planned / underway	Executive Lead	Due Date	Progress

Executive to agree how to close the IJ delivery lead gaps	Chief Executive	24.08.2022	Chief Executive has reached out to system partners to seek additional support for key roles. No additional resource has resulted from this avenue. Two Junior Project Managers have been appointed to support the RCG and P&C workstreams. QIG has a senior lead and a PM allocated, however this is still short by one PM as the current PM is re-allocated from other non IJ projects. P&C has nominated the Deputy Director of HR as senior project lead due to the likely risk that we will not be able to provide sufficient evidence that WN4 has progressed sufficiently. This has been coupled with significant additional focus from the IJ program team on supporting definition of deliverables and production of updated reporting dashboards.
(QI-2) Quality Summit	Director of Quality	08.09.2022	Held as planned. Outputs to come to EMB / Board. Outcomes will help shape on-going engagement with middle and senior managers, with the on-going focus being on the risks and opportunities identified within each of the 6 biggest areas of patient risk.
(IJ Portfolio) Mock Inspection	Director of Quality	Sept/Oct	A schedule of mock CQC inspections will carry on following a pre-defined scheduled, covering Polegate and Hastings on the 28th of September, Banstead, and Gatwick, on the 12 and 13th of October.
(QI-1) Improved reporting to Board to show impact of the actions on our people and patients	Director of Planning	Ongoing	Updated report scheduled for Board 25.08.2022. Updated IQR in line with Make Data Count Board Development. Updated reports to Board in September based on deliverables.
(S&P) Re-structured Board Agenda aligned to Trust Priorities and Improvement Journey	Company Secretary	29.09.2022	New approach to Board will support clearer alignment between the Improvement Journey Actions, the IQR and the Risk Register.
Preparation for expiry of the S29A Warning Notices	Director of Planning / Director of Quality	15.10.2022	Preparation for CQC re-inspection, inclusive of focus sessions on the evidence produced to address each WN shared with entire leadership team. Self-assessment to be conducted by all Board and Senior Managers through October.
(IJ Portfolio) Committee deep-dives	Committee Chairs / Company Secretary	01.11.2022 / Ongoing	A structured assurance deep-dive template is being approved at Audit Committee w/c 19.09.2022 to ensure a consistent approach for Board committees to scrutinise progress across each element of the Improvement Journey, and critically against the Warning Notices. Extraordinary deep-dive session to be scheduled before 1.11.2022.
Board Well Led Self-Assessment	Chairman / Company Secretary	October 2022	A well led self-assessment to be conducted late Sept / early October with a Board workshop in October (date tbc)

	BAF Risk ID 15 Education Training & Development	Target Date: March 2023

Underlying Cause / Source of Risk:		
Risk that we cannot consistently abstract staff for education training and development, due to a disparity in commissioning, resource, and operational pressures, which will lead to continued gaps in clinical and leadership development.	**Accountable Director**	Executive Director of ~~HR~~ Operations
	Committee	WWC / Performance
	Initial Risk Score	**15** (Consequence 3 x Likelihood 5)
	Current Risk Score	**09** (Consequence 3 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**06** (Consequence 3 x Likelihood 2)

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

- Key Skills delivery programme
- Management development programme started in July 2022
- Clinical Education Strategy
- Workforce / Integrated Planning & Training gap analysis
- Training Plan 2022/23
- Monthly core skills (stat/man) training compliance reporting on Power BI
- Agreed increased abstraction levels from 29% to 33% for 2022/23
- Adopted no cancellation approach to key skills

Gaps in Control

- Education, Training and Development (ETD) Strategy
- ~~Insufficient funding for the actual level of activity and abstractions~~

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
(P&C-6) Annual training plan 2022/23	Director of HR	31.03.2023	

	BAF Risk ID 16 Financial Sustainability	Target Date: March 2023

Underlying Cause / Source of Risk:		
The Trust is unable to plan to deliver safe quality and effective services in the medium or long-term due to uncertainty over future funding arrangements in both 999 and 111.	**Accountable Director**	Executive Director of Finance
	Committee	Finance & Investment
	Initial Risk Score	**20** (Consequence 5 x Likelihood 4)
	Current Risk Score	**20** (Consequence 5 x Likelihood 4)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**10** (Consequence 5 x Likelihood 2)

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

- For 22/23, the Trust has mitigated an original planning gap of c.£40m with non-recurrent funding from national allocations.
- Funding for the 2022/23 Integrated Plan for 2555 WTE, which improves ARP but does not achieve the standards.

Gaps in Control

- The stated controls are in year measures and unlikely to improve long term sustainability
- The ICS systems in Sussex and Kent have communicated to the Lead Ambulance Commissioner (Surrey ICS) that they will not commit to further funding for 23/24 without understanding the demand and capacity issues. Without rectification and agreement from the systems as to how to manage demand is required. The gap will likely increase if supply side measures (increasing WTE) is the primary solution.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) financial management: achieving plan (-) underlying funding gap / deficit (-) Cost Improvement Plan	We don't currently have a plan for addressing long term sustainability.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Financial diagnostic by NHS Improvement Director underway looking at internal and external issues.	Director of Finance	September	The report has been shared with the Board.
Discussion with commissioners about how to ensure longer term planning	Director of Finance	Ongoing	
Sustainability & Partnerships Programme within the Improvement Journey established	Director of Finance	Ongoing	Programme in the process of being established

	BAF Risk ID 71 Cyber Attack/Data Security	**Target Date:** TBC

Underlying Cause / Source of Risk: There is a risk that the Trust will not be able to prevent cyberattacks given the increasing number and complexity of recent attacks including attacks on key vendors (supply-chain attacks) used by the Trust.	**Accountable Director**	Executive Director of Finance
	Committee	Finance & Investment Committee
	Initial Risk Score	16 (Consequence 4 x Likelihood 4)
	Current Risk Score	12 (Consequence 4 x Likelihood 3)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	08 (Consequence 4 x Likelihood 2)

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

- Firewalls are in place to protect the Trust's network perimeter and control inbound / outbound traffic flow
- Permissions are based on least-privilege with staff only being given access to what they need as a minimum. Any request for increased permissions are logged and approved via Marval
- Anti-virus / Anti-malware is installed on server and laptop / desktop hardware and regularly automatically updated
- Servers and laptops / desktops are patched regularly
- The Trust and our CAD vendor are alerted to specific risks by NHS Digital to enable us to take swift resolution.
- In and out of hours, the Trust is able to now respond to cybersecurity alerts concerning specific devices and works to immediately disable impacted devices and accounts.

Gaps in Control

Some servers cannot be immediately patched due to operational impact. They are therefore scheduled for the earliest opportunity.
A standardised action card does not exist to explain how the initial response to a cybersecurity event involving a single user or device should be handled. This is being developed.
A standardised action card does not exist to explain the initial handling of a Trust wide cybersecurity event.
There is no security on-call team with the fall-back being to a mix of the skillsets that are on-call.

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
Controls enable prevention rather than cure. This is always better in cybersecurity as once an attack has occurred it is too late.	There needs to be an improvement around actions to take post attack to ensure we have appropriate control measures in place to minimise reputational damage, data loss and operational impact.

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**
Privilege access management (PAM) implementation, starting with suppliers, then internally	Director of Finance	TBC	Most suppliers are now working with the system and adjustments are being worked through with them to ensure it is fully meeting their needs before moving to internal staff.

An action card is being developed to cover single device or user cybersecurity incidents	Director of Finance	25.11.2022	
An action card is being developed to cover Trust wide cybersecurity events.	Director of Finance	25.11.2022	

Board Assurance Framework
SECTION E: Non-BAF Extreme Risks

[To be added in October]

Appendix 1 - Risk Scoring

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

Low **Moderate** **High** **Extreme**

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

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

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

NHS
South East Coast Ambulance Service
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Integrated Quality Report

Trust Board – September 2022

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

Contents

Improving Quality of Information to Board- September 2022

- Following and additional Board Development Sessions with NHSE, we have done further improvements to our IQR.
  - Control Limits have been recalculated for metrics where there are clear signs of process change.
  - Assurance grids have been introduced for every pillar of the Improvement Journey.
  - Addition of Bullying and Harassment Metrics added in under Employee Experience and Suspensions in People and Culture. This will strengthen the Board's visibility to some of the key metrics that help us assure how swiftly we are addressing ER cases.
  - A technical Narrative has been added to the side of each SPC chart, to help the data trends be better understood.
  - Operational Narrative training has been delivered to the Trust.
- Further improvement is still required.
  - Operational Narrative required more standardisation and additional training sessions will be delivered internally
  - There are learnings in the timeframes for reporting against Board dates, the current timelines are too compressed which is affecting time for data leads to provide quality narrative.
  - Metrics to be added in for Safeguarding level 3 in Quality Improvement.
  - Addition of an executive summary matrix for all areas.
  - Reduction of metrics and strengthening of targets to provide more meaningful icons.
  - Development of a SPC quality reporting framework that goes patient-to-board has been approved at EMB and engagement with operational managers at a divisional level will commence in October.
  - Further training opportunities will be sought through the support from NHSE, inclusive of incorporating better benchmarking data in the report to provide context to the Board against peer organisations.
  - Consideration to how we specifically direct the Board to metrics which are critical to Warning Notice.

Alignment Framework

Improvement Journey

Quality Improvement

We listen, we learn and improve

QUALITY IMPROVEMENT

- *Incident Management*
- *Medicines Management*
- *Patient Experience*
- *Safeguarding*
- *Safety in the workplace*
- *Impact on Patient Care*

Responsive Care

Delivering moderns healthcare

RESPONSIVE CARE

- *Ambulance Quality Indicators*
- *Call Handling*
- *Utilisation*
- *999 Frontline Efficiency*
- *Supporting the system*
- *111 Operation*

People & Culture

Everyone is listened to, respected and well supported

PEOPLE & CULTURE

- *Employee Experience*
- *Workforce*
- *Wellbeing*
- *Employee Relations*

Sustainability & Partnerships

Developing partnerships to collectively design and develop innovative and sustainable models of care

SUSTAINABILITY & PARTNERSHIPS

- *Delivery against Plan*

IQR Themes

Icon Descriptions

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

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

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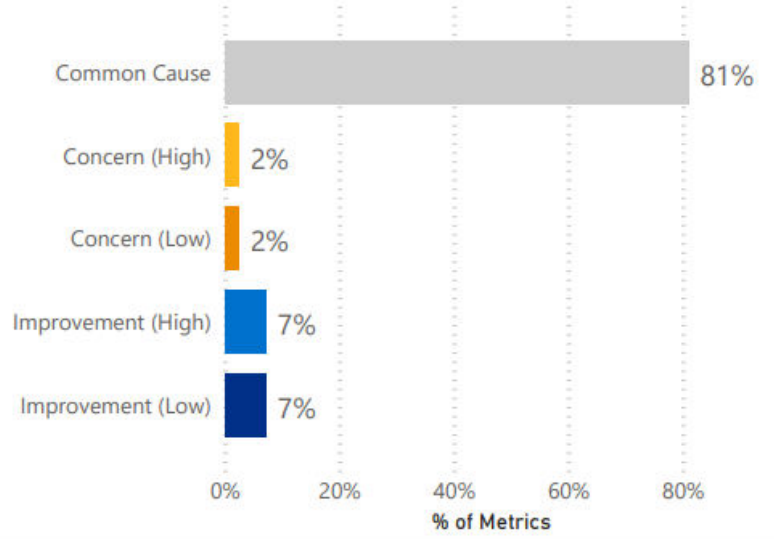
Quality Improvement

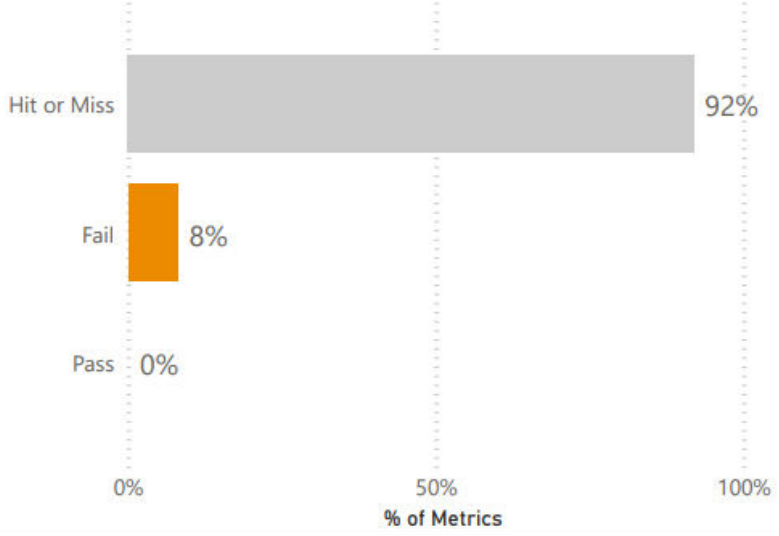
QUALITY IMPROVEMENT

Overview (1 of 2)

Variation Icon Summary



Assurance Icon Summary

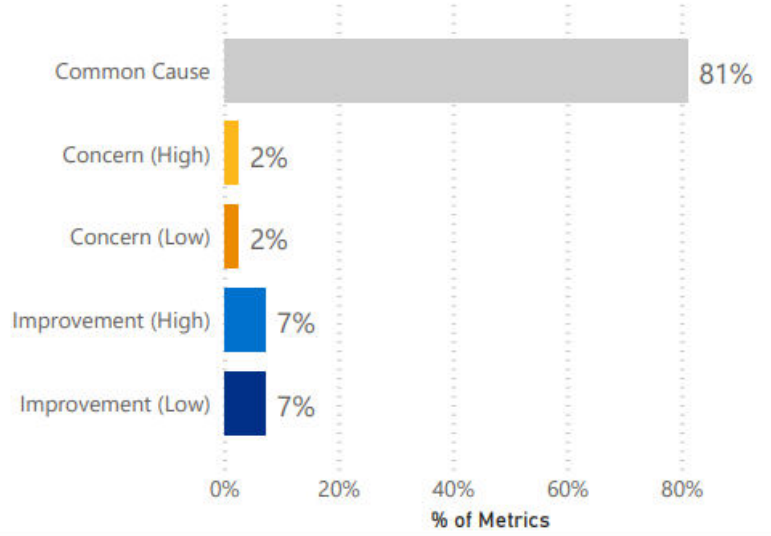


Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	May-2022	43.6%	45.1%	28.31%	47%	65.69%		
Cardiac ROSC ALL %	Quality Improvement	May-2022	22.3%	23.8%	15.42%	24.96%	34.51%		
**Sepsis Care Bundle %	Quality Improvement	Jun-2022	85.7%	85%	79.96%	84.86%	89.75%		
Cardiac Survival Utstein %	Quality Improvement	May-2022	23.7%	25.6%	8.21%	27.83%	47.44%		
Cardiac Survival ALL %	Quality Improvement	May-2022	8.7%	9.6%	3.99%	10.06%	16.12%		
Cardiac Arrest - Post ROSC %	Quality Improvement	May-2022	75.3%	76.8%	54.18%	74.13%	94.08%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Jun-2022	72.3%	64.7%	48.11%	61.91%	75.71%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Mar-2022	02:41:00	02:22:00	02:08:20	02:28:28	02:48:36		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Mar-2022	03:44:00	03:14:00	02:45:04	03:26:52	04:08:40		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Mar-2022	01:41:00	01:29:00	01:18:23	01:38:20	01:58:17		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Mar-2022	02:37:00	02:20:00	01:57:38	02:34:52	03:12:06		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Jun-2022	97.3%	96.3%	94.34%	96.69%	99.04%		
Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	May-2022	94.4%	93.8%	80.25%	90.29%	100.34%		
Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	May-2022	84.3%	77.9%	68.2%	78.51%	88.82%		
Number of Medicines Incidents	Quality Improvement	Aug-2022	190		74.9	145.6	216.3		
Single Witness Signature Use CDs Omnicell	Quality Improvement	Aug-2022		0	-5.47		37.09		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Aug-2022		0	-36.97		88.22		
Number of CD Breakages	Quality Improvement	Aug-2022	20		0.52	18.3	36.08		
Medicines Management % of Audits Completed	Quality Improvement	Aug-2022	82.6%	100%	79.18%	91.42%	103.65%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Aug-2022	103%		56.14%	93.8%	131.46%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Aug-2022	85%	100%	74.7%	85.2%	95.7%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Aug-2022	104%		81.99%	93.05%	104.11%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Aug-2022	93%		83.25%	97.95%	112.65%		
Number of Datix Incidents	Quality Improvement	Aug-2022	1464		852.17	1348.75	1845.33		
Number of Incidents Reported as SIs	Quality Improvement	Aug-2022	2		-5.34	5.3	15.94		
Duty of Candour Compliance %	Quality Improvement	Aug-2022	100%	100%	50.99%	91.45%	131.91%		

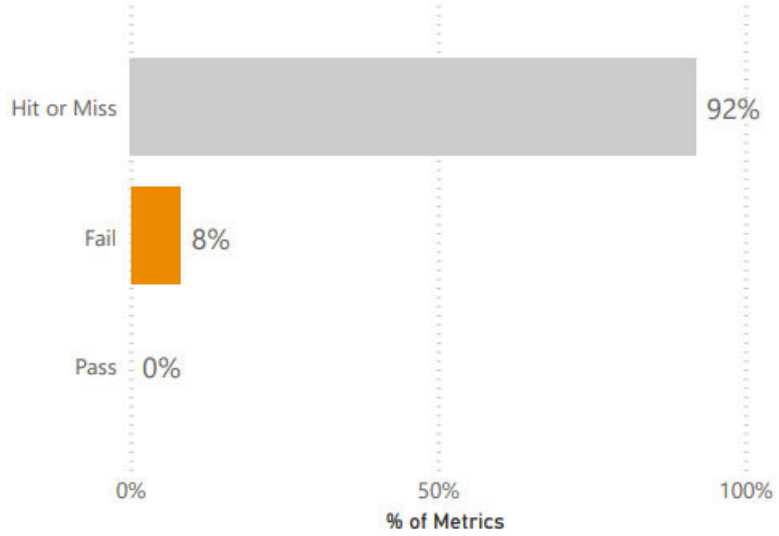
QUALITY IMPROVEMENT

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Aug-2022	84%	90%	74.37%	87.33%	100.3%		
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Aug-2022	82.2%	85%	81.75%	83.93%	86.11%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Aug-2022	50%	85%		50%			
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Aug-2022	111		43.18	86.3	129.42		
Number of RIDDOR Reports	Quality Improvement	Aug-2022	16		-0.14	11.2	22.54		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Aug-2022	41		60.27	88.73	117.19		
Deep Clean Compliance %	Quality Improvement	Jun-2022	68%	95%	41.46%	78.95%	116.44%		
Health & Safety Incidents	Quality Improvement	Aug-2022	30		12.93	31.55	50.17		
Manual Handling Incidents	Quality Improvement	Aug-2022	41		7.09	27.25	47.41		
Complaints relating to privacy and respect %	Quality Improvement	Aug-2022	0%		-0.16%	0.04%	0.23%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Aug-2022	32%		7.38%	33.29%	59.19%		
Complaints Reporting Timeliness %	Quality Improvement	Aug-2022	78%	95%	45.33%	80.47%	115.61%		
Number of Complaints	Quality Improvement	Aug-2022	85		34.59	81.35	128.11		
Complaints per 1000 999 Calls Answered	Quality Improvement	Aug-2022	0.11		-0.36	0.4	1.16		
Organisational Risks Outstanding Review %	Quality Improvement	Aug-2022	10%	30%	17.48%	52.51%	87.54%		
Number of Wellbeing Hub Referrals	Quality Improvement	Jun-2022	77	0	32.72	103.44	174.17		
Time Spent in SMP 3 or Higher %	Quality Improvement	Aug-2022	70.6%		12.51%	60.52%	108.53%		

QUALITY IMPROVEMENT

Summary

August 2022

	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement				Outstanding Actions Relating to SIs, Outside of Timescales Health & Safety Incidents
Common Cause		Cardiac Survival Utstein % Cardiac Survival ALL % Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Stroke - Call to Hospital Arrival Mean Single Witness Signature Use CDs Omnicell Duty of Candour Compliance % Hand Hygiene Compliance % Safeguarding Training Completed (Children) Level 2 % Deep Clean Compliance % Complaints Reporting Timeliness %		Number of Medicines Incidents Number of CD Breakages Number of Datix Incidents Number of Incidents Reported as SIs Violence and Aggression Incidents (Number of Victims - St... Manual Handling Incidents Proportion of Complaints Relating to Crew Attitude % Number of Complaints
Special Cause Concern		Medicines Management % of Audits Completed		

QUALITY IMPROVEMENT

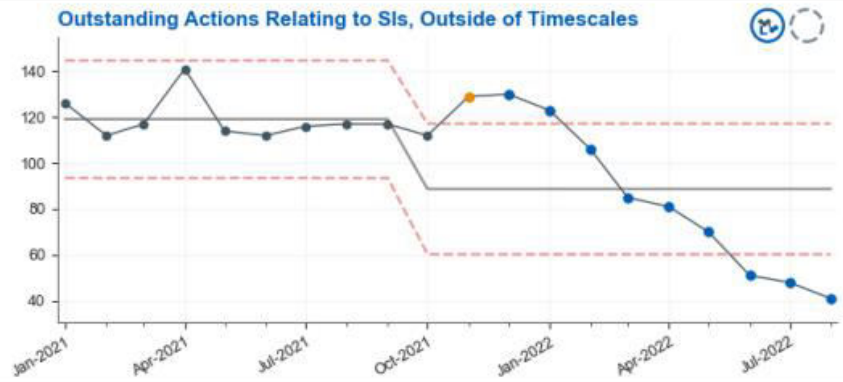
SIs & Incidents

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

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

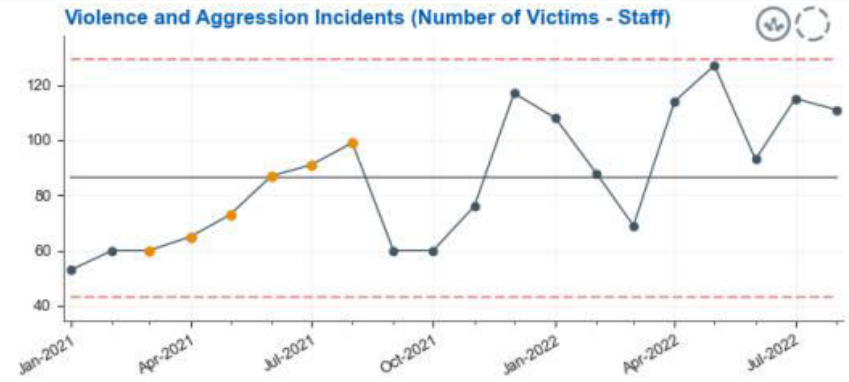
QS-1
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1464

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



QS-17
Dept: Quality & Safety
IP: Quality Improvement
Latest: 41

Special cause of an improving nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 111

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

What is the information telling us?

Number of reported SI's : The number of declared SIs has maintained at a consistent level, with Demand / Delayed attendance being the top theme month on month. The number of breached SI investigation was 17 cases demonstrating a downward trend from April 2022.

Outstanding Actions: The number of breached actions has reduced, during August as sustained downward trend has been seen with the number reducing from 51 to 41.

Incident reporting: The slight increase of incidents reported seems to predominantly relate to issues from patient's regarding community pharmacist redirecting patients to the 111 service.

What actions are we taking?

Number of reported SI's : Continue to hold weekly SI Group meeting, where there are with common themes investigations are conducted as part of a cluster review.

Outstanding Actions: Action owners / departmental heads are being regularly contacted to address these actions. The target is 0 by the end December, and the controls in place will achieve this target. There is an escalation process in place to avoid the number of open actions increasing in the future.

Incident reporting: The 111 / pharmacy concerns are being picked up via contract meetings to ensure that all pharmacists understand their contract obligations.

QUALITY IMPROVEMENT

Medicines Management

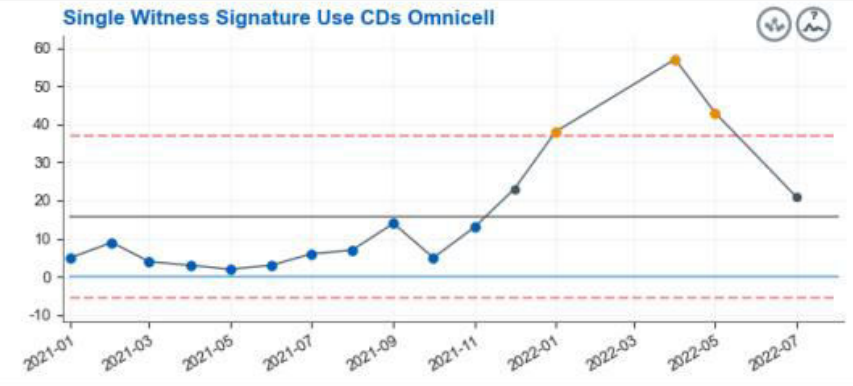
MM-1
Dept: Medicines Management
IP: Quality Improvement
Latest: 190

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

MM-7
Dept: Medicines Management
IP: Quality Improvement
Latest: 82.6%
Target: 100%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

MM-5
Dept: Medicines Management
IP: Quality Improvement
Latest: 20

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



MM-3
Dept: Medicines Management
IP: Quality Improvement
Latest:
Target: 0
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What is the information telling us?

Medicines Incidents The number of incidents reported has seen a slight increase in the last month, this is within our limits and is due to medicines pouch paperwork & tagging and ampoule breakages in the medicines pouch system

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

Medicines Management Audit is currently showing a slightly improved picture since June.

Single witness CD signatures The Trusts Chief Pharmacist had requested that all single sign outs are captured, this month is showing a reduction in incidents which is a positive move.

What actions are we taking?

Medicines Incidents - Pouch Review is one of the 12 projects identified by the Chief Pharmacist that are required around improving medicines optimisation. There are currently two risks on the corporate risk register that relate to medicines pouches. All mitigations possible are currently in place, however, this does not fully mitigate the risk. .

Medicines Management Audits – Due to Chertsey closing and Staines/Esher opening there has been decrease in compliance on the automated system. The Medicines Governance team will be concentrating on removing any stations that have been closed and that remain visible on the system.

Single witness CD signatures - A deep dive to identify any outlying stations and individuals where single witness CD signatures are occurring is being presented at MGG in October. Actions and learning will be distributed across the Trust using various communication methods

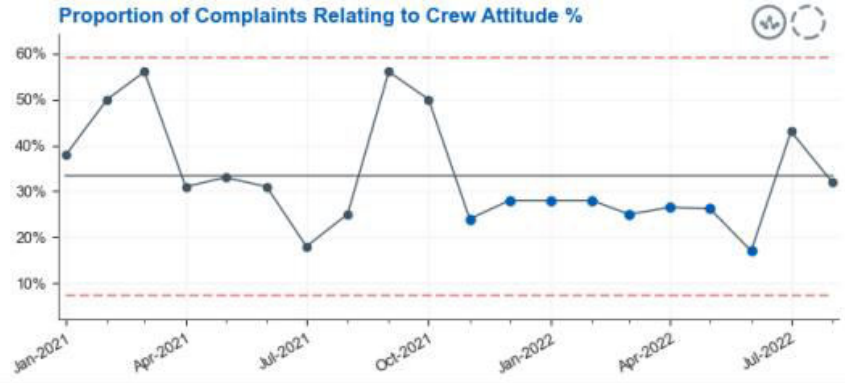
QUALITY IMPROVEMENT

Patient Experience

QS-5
Dept: Quality & Safety
IP: Quality Improvement
Latest: 85

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

QS-4
Dept: Quality & Safety
IP: Quality Improvement
Latest: 78%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-10
Dept: Quality & Safety
IP: Quality Improvement
Latest: 32%

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

QS-3
Dept: Quality & Safety
IP: Quality Improvement
Latest: 100%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What is the information telling us?

The number of complaints received has remained at a consistent level over the past few months. The clear theme related to delayed ambulance responses, with a reduction in those highlighting crew attitude as a concern.

The timescale to respond to complaints has dipped again slightly; this is primarily due to the vast number complaints relating to ambulance response delays (which equates to approximately 20% of all complaints) and the capacity of the investigator during the Summer annual leave period.

What actions are we taking?

The overdue complaints are being prioritised in date order and complainants receive a letter of apology including a date when they will receive the response. All complaints backlog will be resolved by November 2022.

QUALITY IMPROVEMENT

Safeguarding

QS-8
Dept: Quality & Safety
IP: Quality Improvement
Latest: 82.2%
Target: 85%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What is the information telling us?

In Sept 21 – over 100 new starters combined with similar number of leavers reduced compliance from >90% to 82%.

More recently apparently poor compliance with individuals own S&M training has led to a further fall. Level 2 training is not in the 2022/23 S&M offer as it was projected with a good level of compliance with existing staff, this standard could be maintained by ensuring any new starters completed the course. This data suggests that new starters are not being encouraged to do the course which is a potential issue with first line managers disseminating the requirement.

What actions are we taking?

In April 2022, based on data supplied by L&OD, the Safeguarding Team identified staff who had not completed the Level 1 and 2 Safeguarding (Children and Adult) training whilst it was part of the Discover package during 2020-2021 or as an element of the New Starter package.

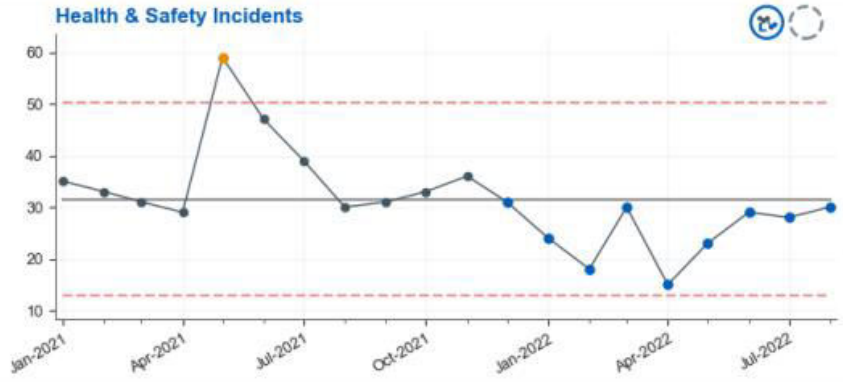
This data was used to contact all affected staff (720), at the end of April 2022, requesting that they ensured they completed the training, specifying whether they needed to complete the Adult, Child or both courses. Staff were requested to complete this by the end of May 2022. Emails were also sent to their managers.

Since sending these emails, about 50 responses from staff have been received, providing evidence of their compliance with these courses, due to inaccuracies in the data. The inaccuracies in the data supplied by L&OD has been raised via Datix as this inaccuracy is the difference between compliance / non-compliance.

There is an intention for the Safeguarding Team to send further communications to first line managers to remind them of the importance of this training for all new starters. The training will be re-introduced for all clinical staff from April 2023.

QUALITY IMPROVEMENT

Safety in the Workplace



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 30

Special cause of an improving nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.

QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 84%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 41

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 68%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What is the information telling us?

Health & Safety Incidents During Q1 Health and Safety incidents have decreased when comparing to the same period in Q1 last year.
The Health & Safety team will review the incident reporting culture during Q3 and Q4.

Manual Handling Incidents During Q1 2021 (88) Manual handling incidents were reported. In the same period Q1 2022 (64) Manual handling incidents were reported. During August 2022 staff reported 41 incidents which is a small increase when comparing to Aug 2021 were staff reported 33 incidents. Paramedics and ECSW reported the most amount of Manual handling incidents during August 2022. Overall, both staff groups reported 8 more incidents than August 2021.

What actions are we taking?

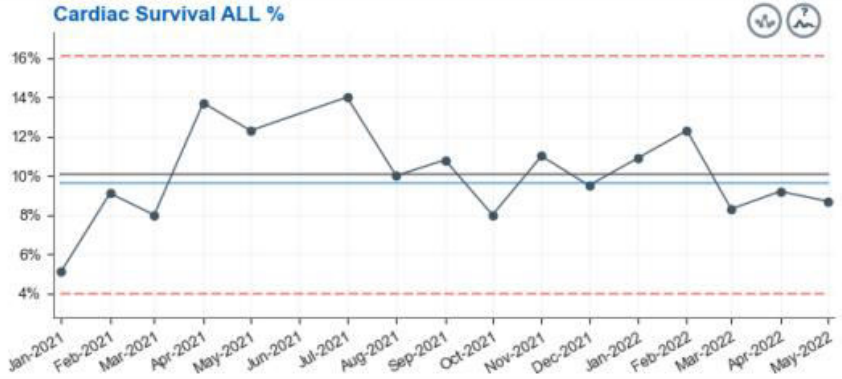
Health & Safety Incidents The Health & Safety Committee and regional subgroups will continue to monitor incident trends.

Manual Handling Incidents The Health & Safety Committee will continue to monitor incident trends.

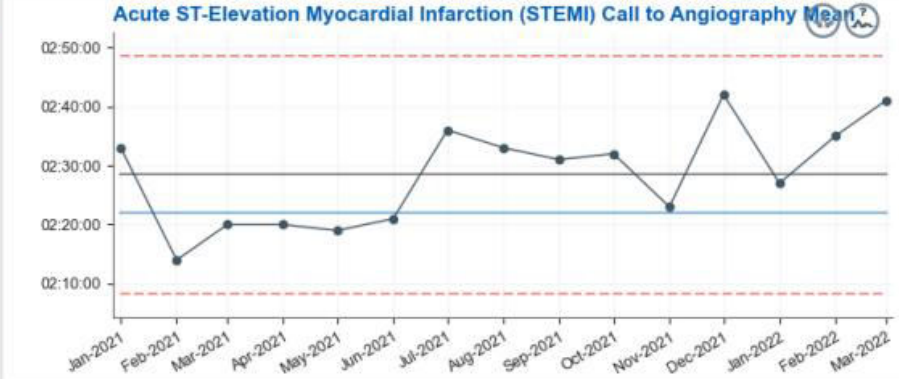
Hand Hygiene Data from the audits indicates a drop in compliance to Bare Below the Elbows and staff carrying hand gel.
A national position statement from AACE will be sent out to confirm the Bare Below the Elbows Policy for all Ambulance Trusts and the IPC Team will be promoting the use of individual hand gel to help support compliance with the hand hygiene procedure.

QUALITY IMPROVEMENT

Impact on Patient Care



M-4
Dept: Medical
IP: Quality Improvement
Latest: 8.7%
Target: 9.6%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:41:00
Target: 02:22:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

M-3
Dept: Medical
IP: Quality Improvement
Latest: 23.7%
Target: 25.6%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

M-8
Dept: Medical
IP: Quality Improvement
Latest: 01:41:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What is the information telling us?

STEMI – Call to angiography:
There is no significant change. Much of the time from call to angiography is influenced by ARP response times. Mean time on scene is currently 44 minutes, approximately the same as the 2019 audit which found 43 minutes (2019).

Stroke – call to hospital arrival mean:
There is no significant change. However, we know that in areas where pre-hospital stroke telemedicine or phone triage is used, time from hospital door to needle is significantly reduced.

What actions are we taking?

STEMI – Call to angiography:
Time on scene may be improved upon through continuing audit feedback and comms, an OU dashboard enabling individual crew discussion in addition to working closely with system partners on decision-making time reduction.
A change in the National AQI on the STEMI care bundle could focus on "on scene" times. This has been raised with NASMeD.
Stroke – call to hospital arrival mean:
There is a case for changing the 'call to door' standard to a 'call to needle' which will recognise the importance of the whole patient journey (and which will also align it to STEMI). This has been suggested to the national stroke group.

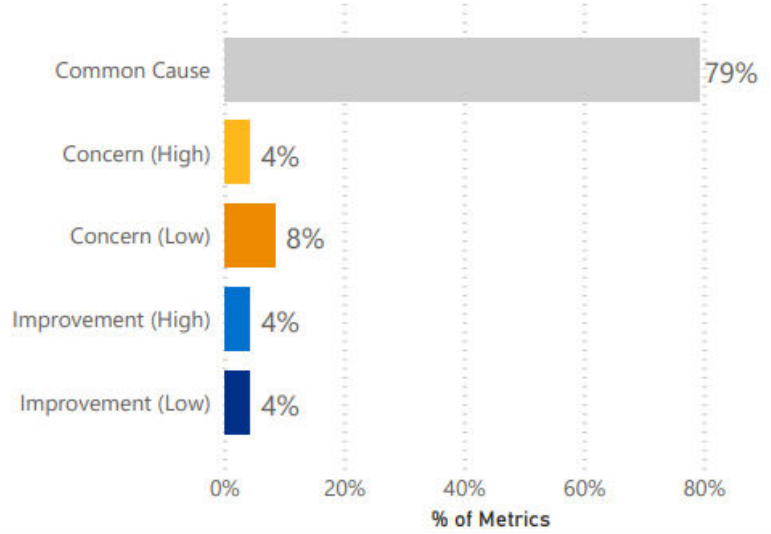
NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

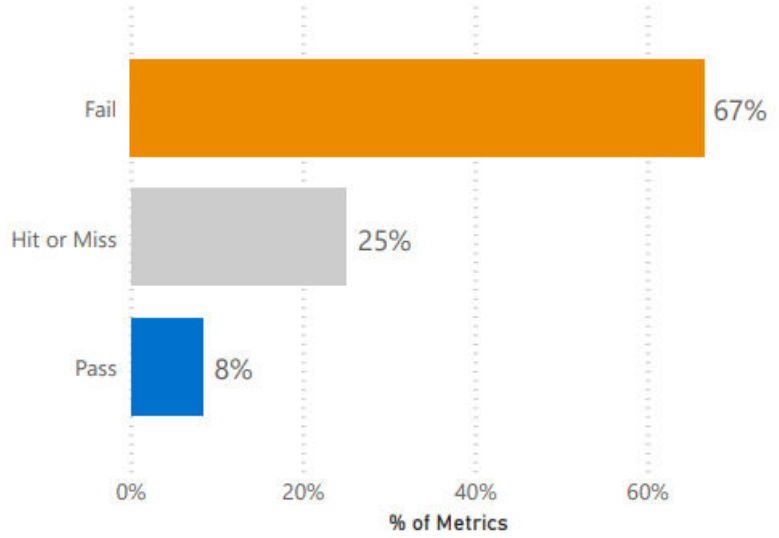
PEOPLE & CULTURE

Overview

Variation Icon Summary



Assurance Icon Summary



Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Aug-2022	3918.93	3946.96	3893.94	3935.99	3978.05		
Number of Staff Headcount (Exc bank and agency)	People & Culture	Aug-2022	4328		4288.26	4334.6	4380.94		
Vacancy Rate %	People & Culture	Aug-2022	5.8%	5%	3.53%	5.86%	8.19%		
Annual Rolling Turnover Rate	People & Culture	Aug-2022	18.1%	15%	16.27%	17.45%	18.63%		
Annual Rolling Sickness Absence	People & Culture	Aug-2022	9.9%	7%	8.78%	9.31%	9.84%		
Statutory & Mandatory Training % Year to Date	People & Culture	Aug-2022	50.8%	95%	13.32%	49.15%	84.97%		
Statutory & Mandatory Training Rolling Year %	People & Culture	Aug-2022	68%	95%	57.65%	68.43%	79.21%		
Appraisals Rolling Year %	People & Culture	Aug-2022	44.7%	80%	29.87%	37.9%	45.93%		
Appraisals YTD	People & Culture	Aug-2022	19.5%	85%	-2.51%	19.69%	41.88%		
Individual Grievances Open	People & Culture	Aug-2022	14		-0.49	8.75	17.99		
Collective Grievances Open	People & Culture	Aug-2022	3		-1.1	1	3.1		
Count of Grievances Closed	People & Culture	Jan-2022							
Bullying & Harrassment Internal	People & Culture	Aug-2022	3	0	-3.56	2.6	8.76		
Whistleblowing	People & Culture	Aug-2022	0		-0.69	0.15	0.99		
DBS Compliance %	People & Culture	Jun-2022	100%	100%	100%	100%	100%		
Disciplinary Cases	People & Culture	Aug-2022	6		-2.96	3.9	10.76		
999 Frontline Late Finishes/Over-Runs %	People & Culture	Aug-2022	52%	5%	44.62%	52.06%	59.49%		
Average Late Finish/Over-Run Time	People & Culture	Aug-2022	00:41:00		00:36:35	00:41:50	00:47:05		
% of Meal Breaks Taken	People & Culture	Aug-2022	98.1%		94.06%	97.71%	101.35%		
% of Meal Breaks Outside of Window	People & Culture	Aug-2022	57.7%		32.65%	55.68%	78.71%		
Current licence details held for Operational Staff %	People & Culture	Aug-2022	95.5%	100%	86.44%	92.64%	98.85%		
Freedom to Speak Up: Total Open Cases	People & Culture	Aug-2022	18		1.45	25.68	49.92		
Freedom to Speak up: Cases Opened in Month	People & Culture	Aug-2022	12		-2.26	6.32	14.89		
Freedom to Speak up: Cases Closed in Month	People & Culture	Aug-2022	2		-5.42	3.89	13.2		
Policies & Procedures Outstanding Review %	People & Culture	Feb-2022	44.8%	0%		29.41%			
Count of Until it Stops Cases	People & Culture	Aug-2022	6		-2.81	3.84	10.49		

PEOPLE & CULTURE

Summary

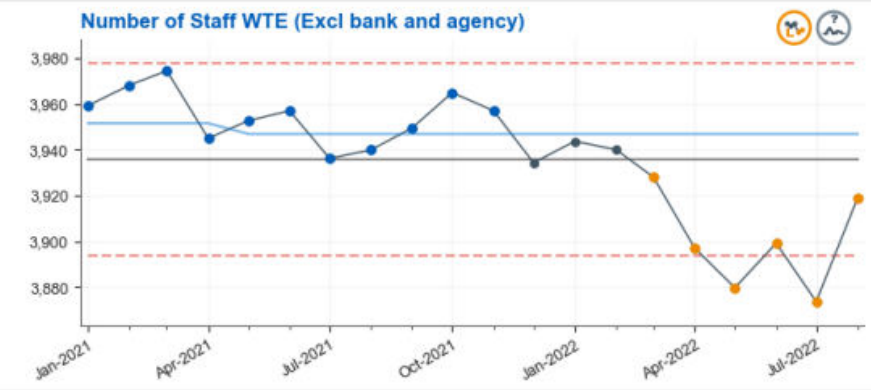
August 2022

Pass (P) | Hit and Miss (?) | Fail (F) | No Target

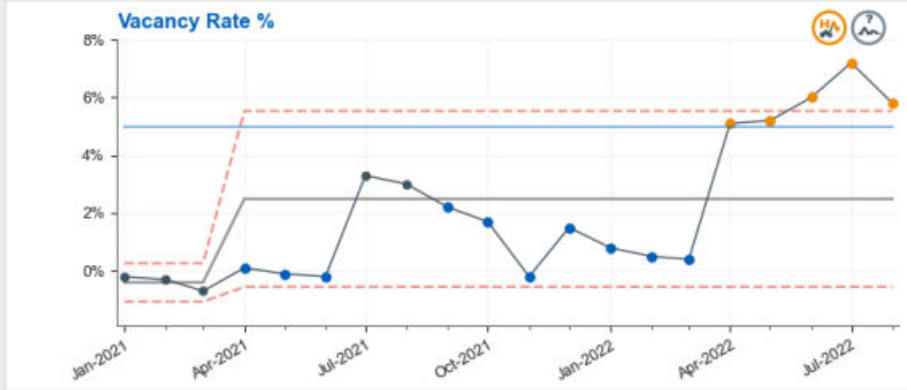
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement (H, L)				
Common Cause		Vacancy Rate %	Annual Rolling Turnover Rate Annual Rolling Sickness Absence 999 Frontline Late Finishes/Over-Runs % Number of Wellbeing Hub Referrals	% of Meal Breaks Taken Freedom to Speak Up: Total Open Cases Time Spent in SMP 3 or Higher %
Special Cause Concern (H, L)		Number of Staff WTE (Excl bank and agency)	Annual Rolling Sickness Absence	

PEOPLE & CULTURE

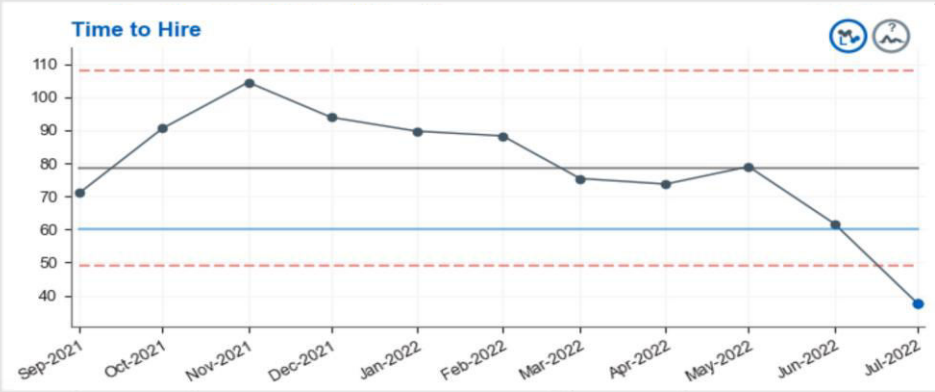
Workforce

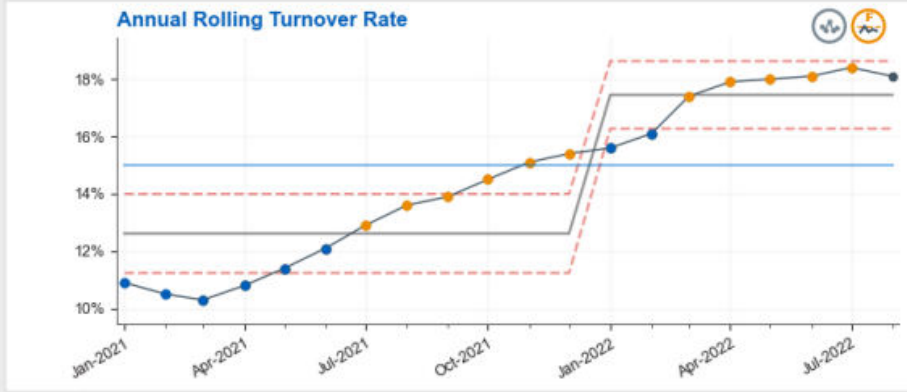


WF-1
Dept: Workforce HR
IP: People & Culture
Latest: 3918.93
Target: 3946.96
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-4
Dept: Workforce HR
IP: People & Culture
Latest: 5.8%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.





WF-7
Dept: Workforce HR
IP: People & Culture
Latest: 18.1%
Target: 15%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

What is the information telling us?

Since the decline in COVID-19 and the implementation of the Government's plan to return to normal we have seen a sharp increase in turnover. Our exit interview data is telling us that our people seek a better work life balance, better health and wellbeing, and more development opportunities.

We are seeing an increase in the projected level of vacancies by year end with the projected workforce pipeline gap. This is driven by increased turnover meaning more staff to recruit/replace and a larger ask in terms of total required headcount this year.

What actions are we taking?

A draft retention plan was considered by EMB in September and generated good interest. It was agreed that a small number of high impact actions should be focused upon and that these should be further developed in a workshop in October. Likely areas of attention will include more focus on the areas with highest turnover, developing a more flexible approach to careers and supporting staff more with development.

We have reviewed rota design and put forward proposals for change to improve the service to patients. Whilst our colleagues should see improvements in work life balance, it comes at a cost for some staff in terms of unsocial hours premia which will affect earnings potential. There are a number of collective grievances reflecting the concerns of some of our people over these proposed changes and these will be worked through to resolution with them in the next 2-3 months.

PEOPLE & CULTURE

Employee Experience (1 of 2)

QS-27
Dept: Quality & Safety
IP: People & Culture
Latest: 18

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

WF-10
Dept: Workforce HR
IP: People & Culture
Latest: 14

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

WF-41
Dept: Workforce HR
IP: People & Culture
Latest: 6

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

WF-42
Dept: Workforce HR
IP: People & Culture
Latest:

Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

What is the information telling us?
Despite significant work to address the perceived culture of bullying and harassment, it is still too early to measure its impact. Cases are down in all three metrics against the previous month, but we can see a history of variable levels of employee relations and FTSU cases, there is little certainty about future activity levels due to their nature. We will need a longer period to fully assess the impact and satisfy ourselves that we are making progress.

What actions are we taking?
We have invested in 2 additional FTSU support WTEs, with both starting in Q3 of 2022. A review of the FTSU governance and reporting by adding FTSU information to the Datix cloud system will give us better detail on the cases and themes by the end of November 2022.

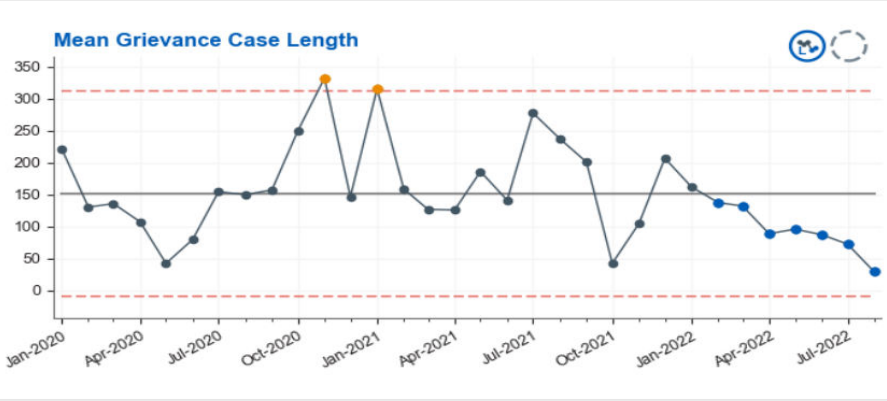
What actions are we taking (cont.)
Whilst employee relations cases have continued at a high level, the analytics assessing performance on individual cases are proving helpful in identifying where the most urgent/longer-standing cases are. The HR teams continue to be highly pressurised though and we are currently seeking additional capacity from the CSU.

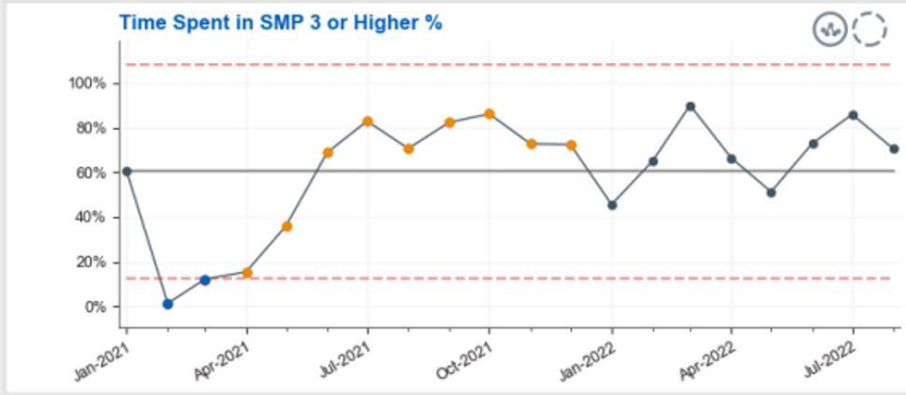
Fundamentals, and other leadership development training, is under way and our plan is to monitor the effectiveness and impact of this – particularly the areas where it is most needed, in the leadership of field ops and EOC/111.

Additional sexual safety training sessions have been procured to enable all managers to attend

PEOPLE & CULTURE

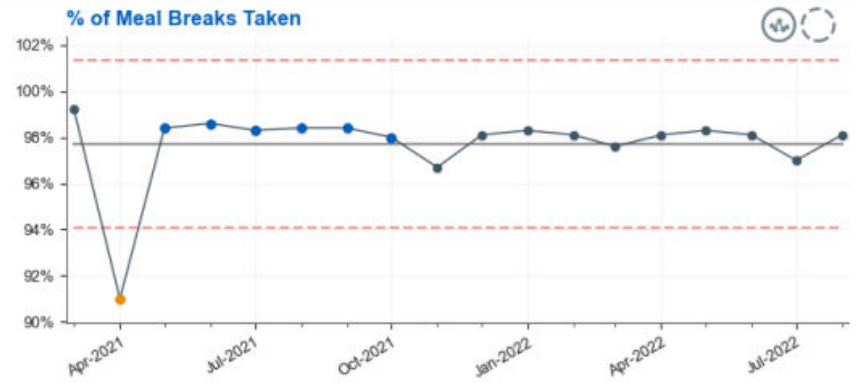
Employee Experience (2 of 2)





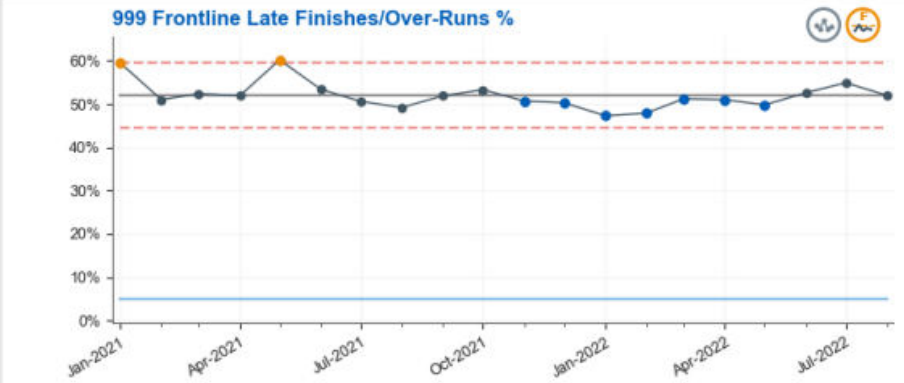
999-14
Dept: Operations 999
IP: Quality Improvement
Latest: 70.6%

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-27
Dept: Operations 999
IP: People & Culture
Latest: 98.1%

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-15
Dept: Operations 999
IP: People & Culture
Latest: 52%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

What is the information telling us?

This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.

Overall handling time for grievances is broadly in line with the policy requirements of the Trust.

Due to the continuing challenges regarding demand and resource provision (as indicated via the time at SMP 4 or higher chart) there has been an impact on the meal break provision and late finishes/over-run.

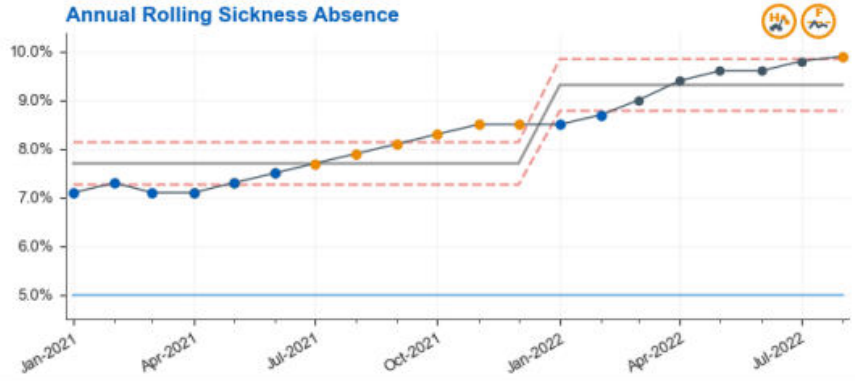
What actions are we taking?

Continued focused work on the grievance process, from greater support for informal resolution though the investigation and hearing phases. As an example, an area of highest grievances in the Trust was in 111, sustained focus by the HRBP with the senior management of EOC/111 has reduced the number of grievances.

The capability to improve the meal break and late sign-off metrics is directly related to increasing the resource availability in relation to demand received. Actions to contributing to this are located in the Responsive Care slides below, focusing abstraction management, review of demand, recruitment and retention.

PEOPLE & CULTURE

Employee Sickness



WF-8
Dept: Workforce HR
IP: People & Culture
Latest: 9.9%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

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

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

What is the information telling us?

Annual Rolling Sickness – Despite a comprehensive support plan from HR to address Operational Sickness earlier in the year, we see sickness at almost 100% above target. This is not unique to SECAmb. NHS Digital shows data from April 2022 shows Support to Ambulance Staff at 10.4% and Ambulance Staff themselves at 8.8%.

Benchmarked data shows Support to Ambulance Staff and Ambulance Staff placed 1st and 2nd for NHS absence.

May's results will be published 29th September, and a report covering April 2022 to June 2022 is expected 27th October 2022.

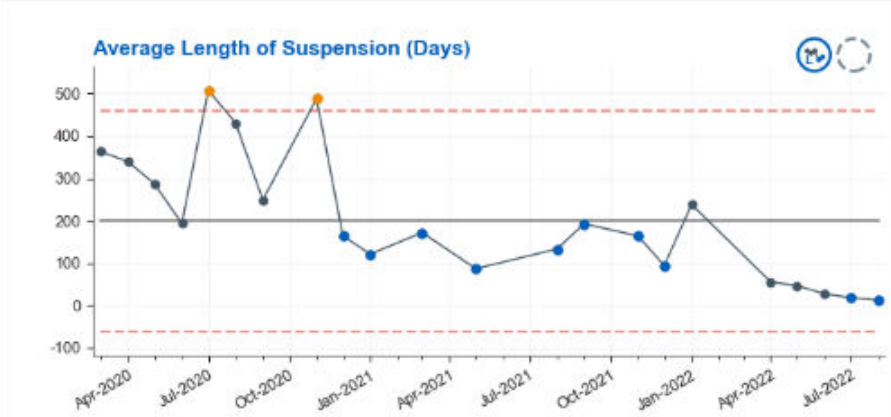
What actions are we taking?

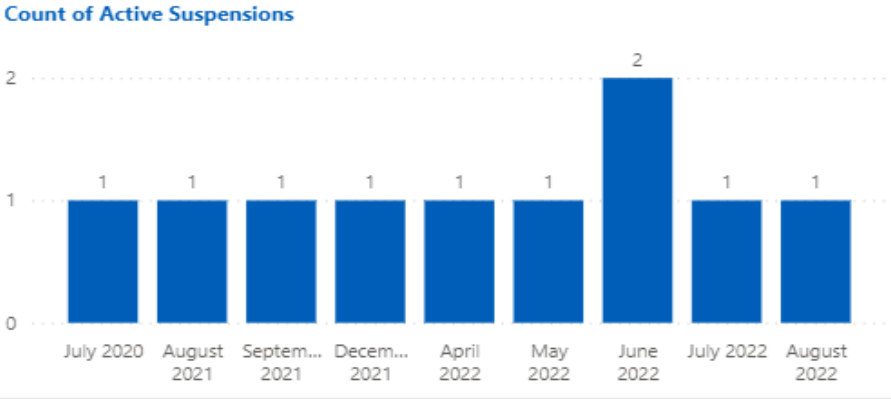
Annual Rolling Sickness – COVID pay protection comes to an end across the NHS 1st September 2022, and for SECAmb 2nd October 2022. Those colleagues currently off with COVID will revert to normal sick pay provision and management through the Managing Health and Attendance Policy.

Those colleagues on Alternative Duties Pathway 3 will revert to Pathway 2 which has much more stringent processes and timelines. As COVID has accounted for approximately 4% of absence, we expect to see a significant improvement in sickness absence by February 2023.

PEOPLE & CULTURE

Employee Suspensions





What is the information telling us?

We deal with all the most serious cases of alleged misconduct through initial consideration by two executive directors – through a process of suspension risk assessment. This is a clear and logical process* which ensures that we treat all requests to consider suspensions in the same way.

The information also tells us that we have good data systems of monitoring and reviewing suspensions which have been augmented by data availability and analytical capacity through PowerBI (fed by Selenity – our employee relations case management system).

**The criteria used to consider whether to suspend or not are – is there a staff (including self) safety risk; is there a risk to patients and would it be possible to investigate the case if the member of staff were at work.*

What actions are we taking?

Weekly reviews of all suspended staff by HRD and Ops Director (supported by Employee Relations Manager and HRBPs who report and provide assurance that cases are being managed as proactively as possible) continue.

Sustained focus has now led to closure/resolution of some longer standing cases as well as a marked reduction in the average length of suspension which is forecast to continue over the next quarter.

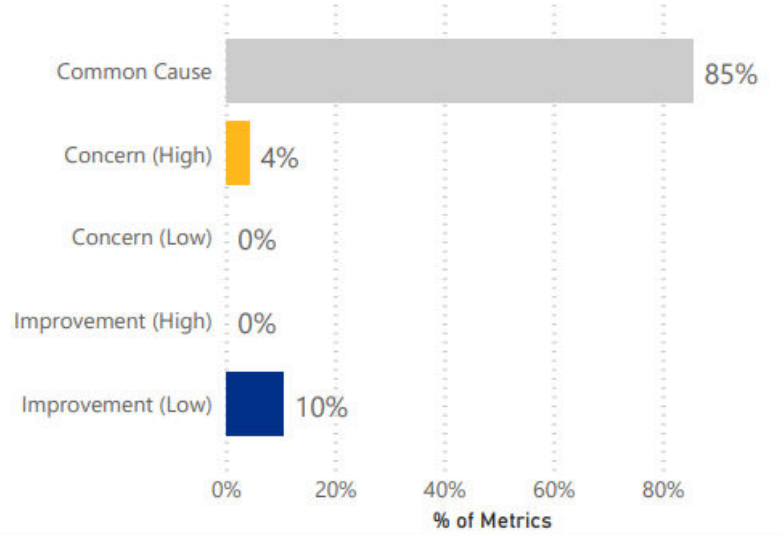
NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

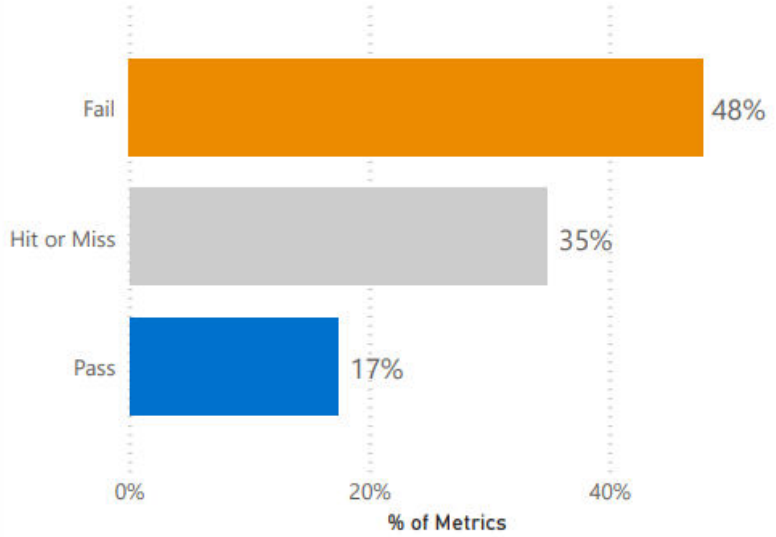
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary

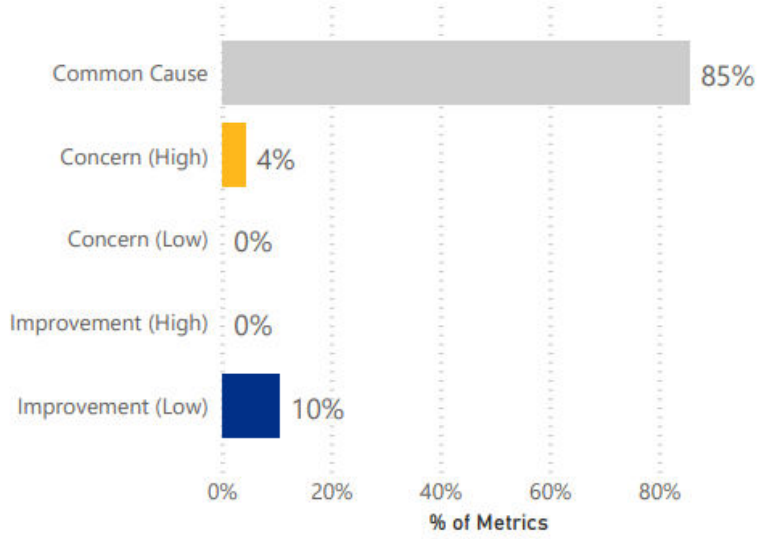


Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Aug-2022	85.5%	100%	83.54%	89.59%	95.65%		
Provided Bank Hours %	Responsive Care	Aug-2022	0.6%		-0.17%	0.77%	1.71%		
Provided Overtime Hours %	Responsive Care	Aug-2022	10.7%		6.98%	11.16%	15.33%		
Provided PAP Hours %	Responsive Care	Aug-2022	6%		4.23%	5.62%	7%		
999 Operational Abstraction Rate %	Responsive Care	Aug-2022	37.6%	28%	24.27%	32.6%	40.93%		
JCT Allocation to Clear at Scene Mean	Responsive Care	Aug-2022	01:16:37		01:16:09	01:17:39	01:19:08		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Aug-2022	01:56:28		01:52:35	01:55:24	01:58:14		
Hear & Treat %	Responsive Care	Aug-2022	9.4%	10%	7.54%	9.67%	11.8%		
See & Treat %	Responsive Care	Aug-2022	32.3%	35%	30.15%	31.7%	33.25%		
See & Convey %	Responsive Care	Aug-2022	58.1%	55%	55.6%	58.75%	61.9%		
Responses Per Incident	Responsive Care	Aug-2022	1.1	1.09	1.08	1.09	1.1		
Section 135 Mean Response Time	Responsive Care	Aug-2022	00:00:00			01:01:30			
Section 136 Mean Response Time	Responsive Care	Aug-2022	00:34:18		00:11:46	00:27:09	00:42:32		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Aug-2022	1.7%		0.9%	1.39%	1.88%		
Number of Hours Lost at Hospital Handover	Responsive Care	Aug-2022	4503.91		2306.56	3837.77	5368.98		
CFR Attendances	Responsive Care	Aug-2022	1601		786.37	1265.45	1744.53		
FFR Attendances	Responsive Care	Aug-2022	145		104.77	289.85	474.93		
ECAL Mean Response Time	Responsive Care	Aug-2022	00:23:04		00:21:35	00:23:29	00:25:24		
999 Remaining Annual Leave FY	Responsive Care	Aug-2022	32%			42.76%			
Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	Responsive Care	Jan-2022	30.2%			30.89%			
Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	Responsive Care	Jan-2022	17.9%			48.04%			
Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	Responsive Care	Jan-2022	51.8%			21.06%			
Vehicles Off Road (VOR) %	Responsive Care	Aug-2022	12.5%		7.13%	10.75%	14.38%		
% of DCA vehicles off road (VOR)	Responsive Care	Aug-2022	15%			12.3%			
% of SRV vehicles off road (VOR)	Responsive Care	Aug-2022	10%			7.3%			
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Aug-2022	181		107.55	225.06	342.56		

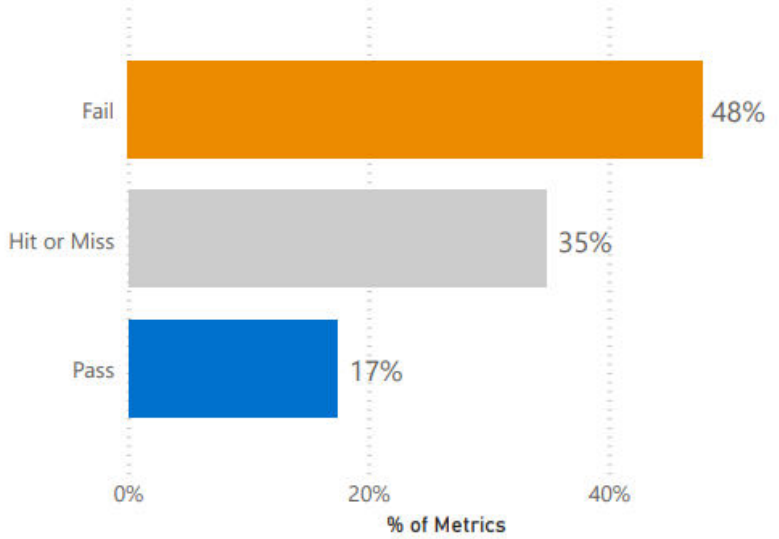
RESPONSIVE CARE

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary

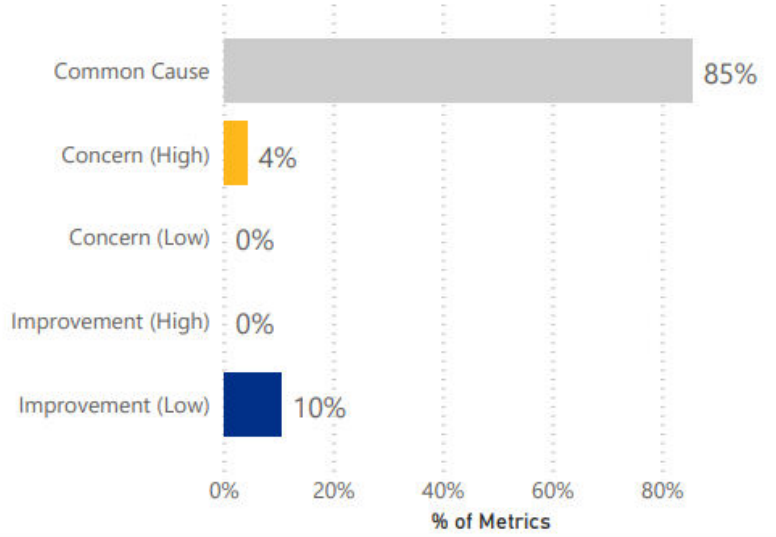


Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of RTCs per 10k miles travelled	Responsive Care	Aug-2022	1.2			0.76			
% of planned vehicle services completed	Responsive Care	Aug-2022	62%			72.9%			
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	May-2022	95%	95%		94.71%			
Average Wrap Up Time	Responsive Care	Aug-2022	00:17:43	00:15:00	00:17:07	00:17:36	00:18:06		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Aug-2022	49.2%		46.99%	50.84%	54.69%		
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Aug-2022	61.7%		55.42%	61.89%	68.35%		
Duplicate Calls %	Responsive Care	Aug-2022	25.8%		21.02%	25.76%	30.51%		
111 Calls Offered	Responsive Care	Aug-2022	97252		85055.87	116865.55	148675.23		
111 Calls Answered in 60 Seconds %	Responsive Care	Aug-2022	35.4%	95%	11.65%	37.12%	62.58%		
111 Calls Abandoned - (Offered) %	Responsive Care	Aug-2022	15.7%	5%	4.03%	16.69%	29.35%		
111 to 999 Referrals (Answered Calls) %	Responsive Care	Aug-2022	6.9%	13%	7.61%	8.48%	9.34%		
999 Referrals	Responsive Care	Aug-2022	5185		6263.62	7983.1	9702.58		
A&E Dispositions %	Responsive Care	Aug-2022	9.1%	9%	7.39%	8.7%	10.01%		
A&E Dispositions	Responsive Care	Aug-2022	6854		7234.13	9159.55	11084.97		
Clinical Contact %	Responsive Care	Aug-2022	49.4%	50%	45.87%	48.64%	51.41%		
Ambulance Validation %	Responsive Care	Aug-2022	97.2%	85%	91.69%	95.47%	99.26%		
999 Calls Answered	Responsive Care	Aug-2022	76148		57502.76	78640.14	99777.53		
Incidents	Responsive Care	Aug-2022	58961		53909.3	62275.7	70642.1		
999 Call Answer Mean	Responsive Care	Aug-2022	00:00:32	00:00:05	00:00:11	00:00:25	00:01:02		
999 Call Answer 90th Centile	Responsive Care	Aug-2022	00:01:57	00:00:10	00:00:36	00:01:24	00:03:25		
Cat 1 Mean	Responsive Care	Aug-2022	00:09:08	00:07:00	00:08:00	00:08:57	00:09:54		
Cat 1 90th Centile	Responsive Care	Aug-2022	00:16:27	00:15:00	00:15:04	00:16:14	00:17:24		
Cat 1T Mean	Responsive Care	Aug-2022	00:11:02	00:19:00	00:09:43	00:10:55	00:12:07		
Cat 1T 90th Centile	Responsive Care	Aug-2022	00:20:11	00:30:00	00:18:19	00:20:01	00:21:43		
Cat 2 Mean	Responsive Care	Aug-2022	00:35:28	00:18:00	00:21:47	00:33:33	00:45:19		
Cat 2 90th Centile	Responsive Care	Aug-2022	01:13:29	00:40:00	00:41:49	01:08:29	01:35:09		
Cat 3 90th Centile	Responsive Care	Aug-2022	06:49:05	02:00:00	02:33:18	06:35:14	10:37:10		

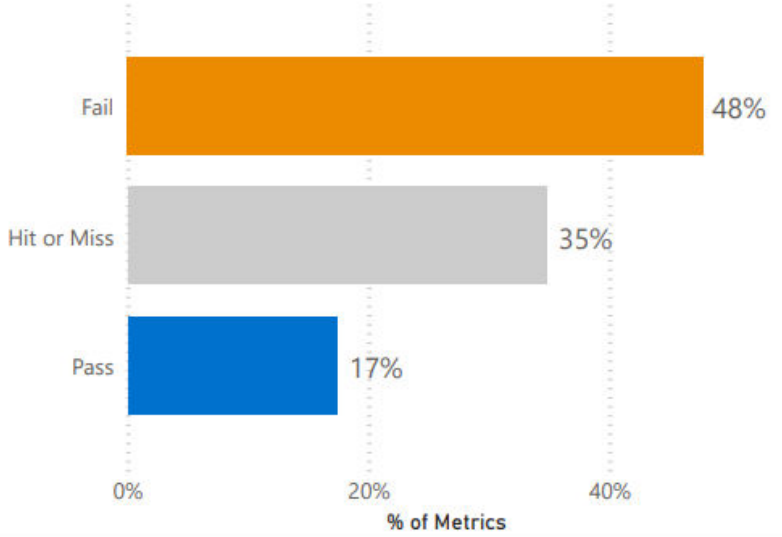
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Cat 4 90th Centile	Responsive Care	Aug-2022	11:14:23	03:00:00	03:35:48	08:13:09	12:50:29		
HCP 3 Mean	Responsive Care	Aug-2022	03:05:50		01:14:13	03:02:29	04:50:45		
HCP 3 90th Centile	Responsive Care	Aug-2022	07:26:47		02:06:42	06:52:17	11:37:53		
HCP 4 Mean	Responsive Care	Aug-2022	04:25:43		01:49:55	03:52:17	05:54:40		
HCP 4 90th Centile	Responsive Care	Aug-2022	10:23:10		03:31:46	08:34:40	13:37:35		

RESPONSIVE CARE

Summary

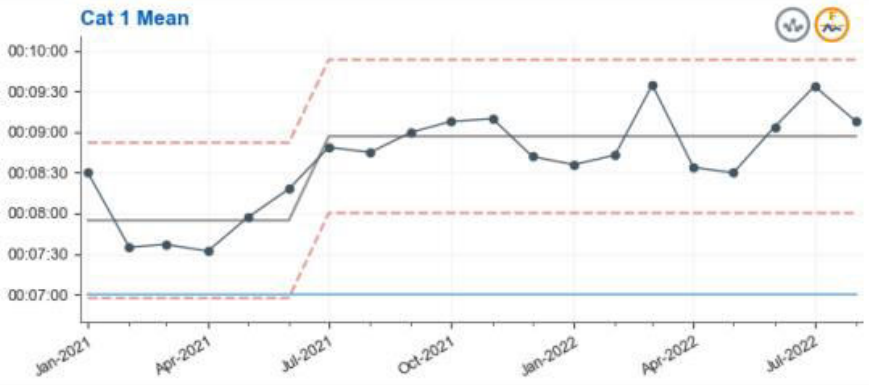
August 2022

Pass (P) | Hit and Miss (?) | Fail (F) | No Target

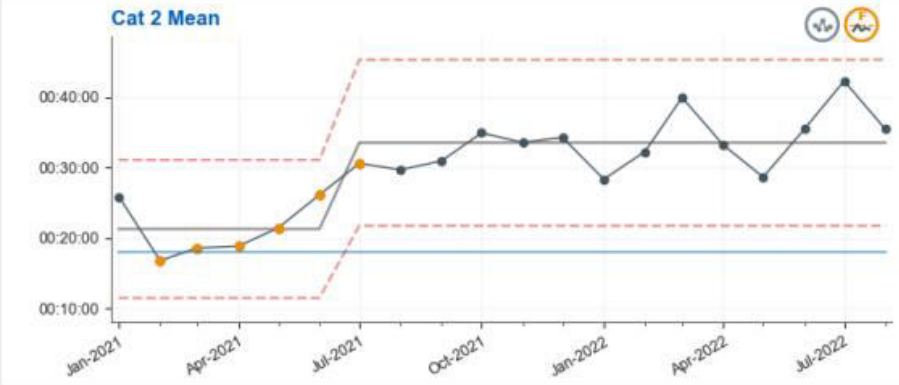
Special Cause Improvement (H, L)	111 to 999 Referrals (Answered Calls) %			
Common Cause		Hear & Treat % Responses Per Incident 111 Calls Abandoned - (Offered) % A&E Dispositions %	999 Frontline Hours Provided % See & Treat % Average Wrap Up Time 111 Calls Answered in 60 Seconds % Cat 1 Mean Cat 2 Mean Cat 3 90th Centile Cat 4 90th Centile	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Number of Hours Lost at Hospital Handover ECAL Mean Response Time Incidents Cat 2 Proportion (Cat 1-4) Duplicate Calls % 111 Calls Offered 999 Calls Answered Incidents
Special Cause Concern (H, L)				Number of Hours Lost at Hospital Handover

RESPONSIVE CARE

Response Times

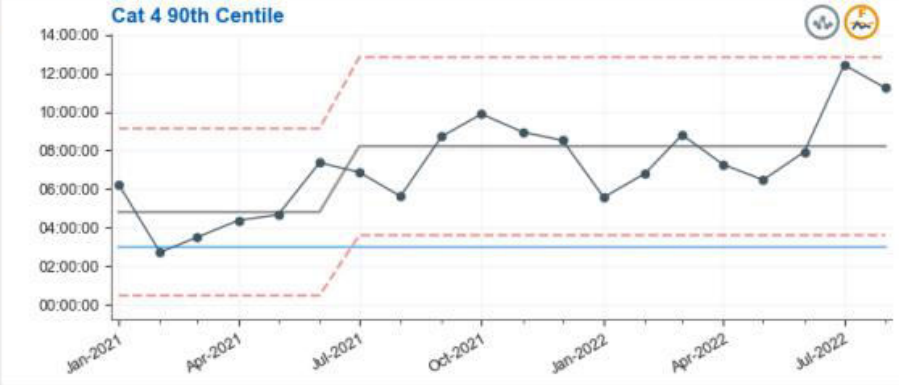


999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:09:08
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:35:28
Target: 00:18:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

999-5
Dept: Operations 999
IP: Responsive Care
Latest: 06:49:05
Target: 02:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-6
Dept: Operations 999
IP: Responsive Care
Latest: 11:14:23
Target: 03:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

What is the information telling us?

- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years. This performance has been strongly impacted by the fluctuating demand and resource availability – in the most recent couple of months, the resource hours produced has been very significantly impacted by an elevated level of sickness and high levels of annual leave.
- The charts have also all show that the in the variations seen, the processes contributing to these performance metrics are not capable, and therefore SECAmb will continue to fail to achieve improvements against these ARP performance metrics.

What actions are we taking?

- Maintenance of high proportions of revalidation of C3 & C4 calls from 111 and within 999 EOC to ensure that all calls requiring attendance have been appropriately assessed.
- Continued focus on optimising resources through maintain overtime and abstraction management
- Continued engagement on a local and strategic level regarding hospital handover process to minimise lost hours where possible.

Note: All of these actions are ongoing and sit under the Operations Directorate.

RESPONSIVE CARE

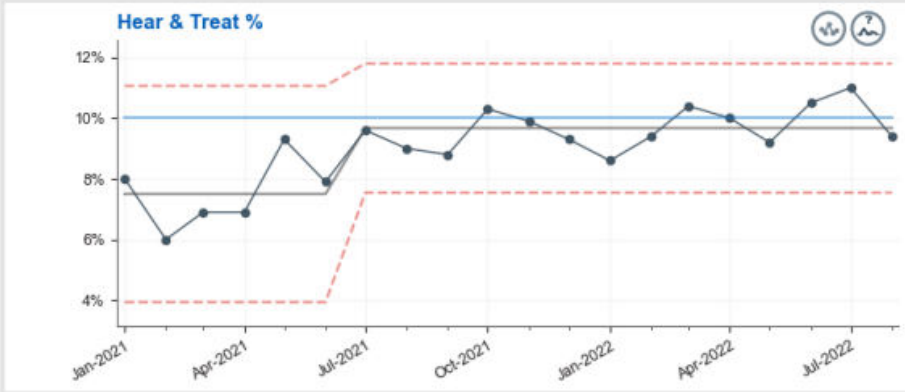
EOC Emergency Medical Advisors

999-10
Dept: Operations 999
IP: Responsive Care
Latest: 76148

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

999-33
Dept: Operations 999
IP: Responsive Care
Latest: 25.8%

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-9
Dept: Operations 999
IP: Responsive Care
Latest: 9.4%
Target: 10%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What is the information telling us?

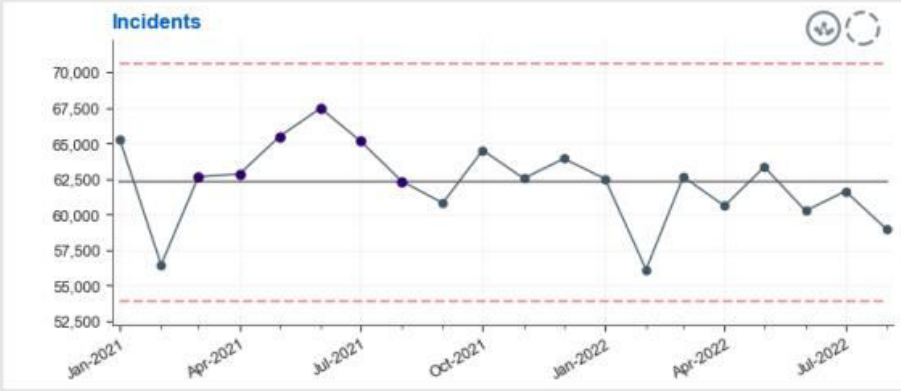
- This narrative relates to the overall efficiency and effectiveness of the call-taking functions within EOC.
- Over the duration of this period, there was an increase in total calls answered while an increase in ***duplicate calls*** % increased. The usual reason for the increase in duplicate calls relates to patients calling back if there has been a perceived or real delay in response, sometimes including a change/worsening of patient condition. Whilst this may be because of reduced actual numbers of staff, over this period, significant numbers of new staff were recruited and trained resulting in a decrease in overall call-answering efficiency as they became proficient.
- ***Hear and Treat*** performance is demonstrating fluctuating performance over the previous year, consistently around 10%, rather than an improving trend.

What actions are we taking?

- Continued recruitment of EMAs in line with trajectory, recognising increasing recruitment challenges in the Crawley area, and the impact on the move to the new site in Gillingham due in mid-2023.
- Focus on improving aux time – close monitoring via EMA Team Leaders. This area of work has been dded to the workplan for this group.
- Hear & Treat is a specific workstream within the Improvement Journey Programme – supported by a detailed action plan including learning from other Trusts

RESPONSIVE CARE

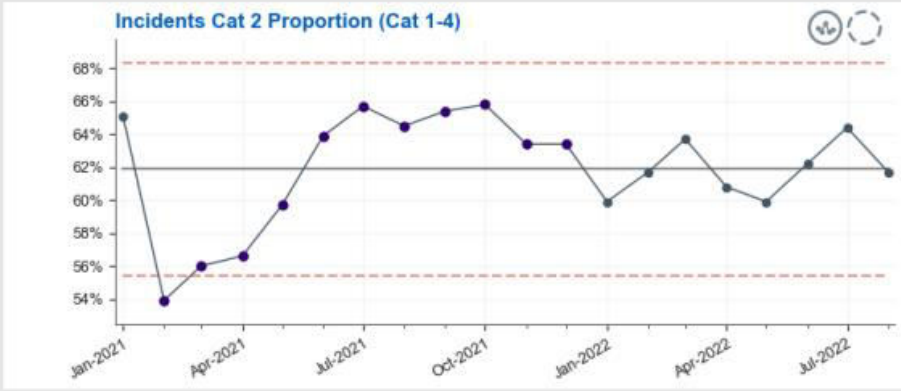
Utilisation



999-10
Dept: Operations 999
IP: Responsive Care
Latest: 58961

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 85.5%
Target: 100%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-32
Dept: Operations 999
IP: Responsive Care
Latest: 61.7%

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.9%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

What is the information telling us?

- There are multiple contributors to 999 demand, and where possible actions are taken to reduce inappropriate call volumes arriving in the 999 service line:
- From the 111 service there is a very high revalidation rate for all calls being passed to 999 (consistently above 95%) which is resulting in the reduced referral rate from 111.
- From the above, since May 2021, there has been very significant fluctuations in **frontline hours** provided – this has directly impacted on the Trust's ability to respond physically to incidents, hence the trend seen of a slow reduction in total number of incidents managed.
- Frontline hours impacted by high abstraction levels, mainly driven through sickness. In particular, for Q1 the **attrition** has been double that planned, further creating a gap between planned resources and available resources.
- The recruitment plans remain c.30 WTE short of target, efforts continue through the international recruitment.

What actions are we taking?

- Continued revalidation of appropriate 111 calls, in line with contractual agreements.
- Continued focus on optimising resources through abstraction management and optimisation of overtime to provide additional hours.

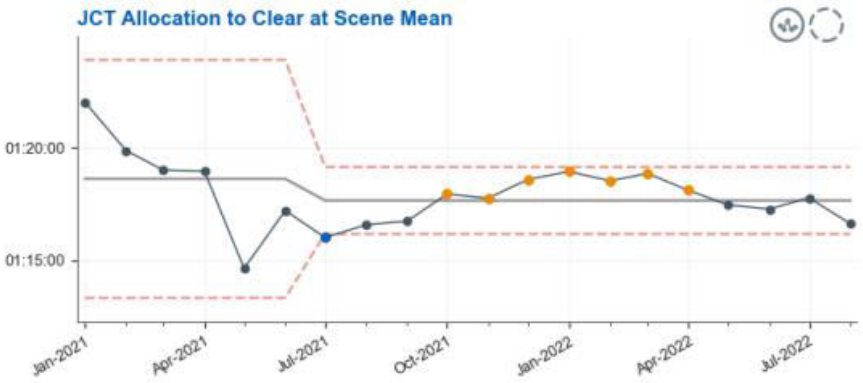
RESPONSIVE CARE

999 Frontline

999-17
Dept: Operations 999
IP: Responsive Care
Latest: 1.1
Target: 1.09
Common cause variation, no significant change. This process will not consistently hit or miss the target.

999-13
Dept: Operations 999
IP: Responsive Care
Latest: 00:23:04

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:16:37

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:56:28

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

What is the information telling us?

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

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

Job cycle time (JCT) provides a single metric between two points in the incident journey and is directly impacted by a number of activities including running time to the incident (local or distant depending on demand and resource availability) and duration of time spent on scene. The latter is usually dependent on the patient's presenting complaint where often the sickest patients are moved from scene more quickly whereas the lower acuity incidents may required longer to make referrals for ongoing care within the community.

What actions are we taking?

- The Trust commissioned a review of the Dispatch function, and the recommendations are currently being worked up as part of the Responsive Care Group plan.
- Continued focus on delivery of Paramedic Practitioner hubs to ensure optimal response to ECALs from crew staff, also support to work with OOH GP/primary care call-backs
- Increased focus on JCT, linked to outcomes and on-scene decision-making including delivery of appropriate care bundles, ePCR use etc. This is a key workstream with the RCG plan and the Clinical Advisory Group will be integral in identifying and driving improvements in this area.

RESPONSIVE CARE

111/999 System Impacts

111-5

Dept: Operations 111
IP: Responsive Care
Latest: 9.1%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

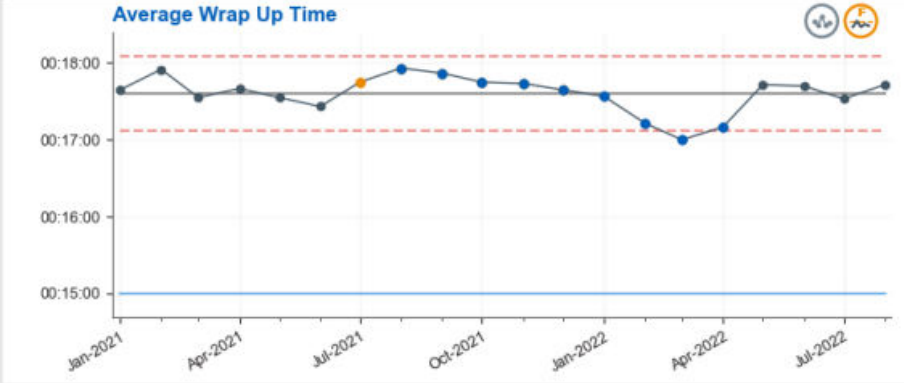
999-9

Dept: Operations 999
IP: Responsive Care
Latest: 32.3%
Target: 35%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

999-24

Dept: Operations 999
IP: Responsive Care
Latest: 4503.91

Special cause of a concerning nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.



999-31

Dept: Operations 999
IP: Responsive Care
Latest: 00:17:43
Target: 00:15:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

What is the information telling us?

- SECAmb services (999 and 111) are key components of the emergency and urgent care health system in the SE region – this narrative provides an overview of the metrics which describe this component
- The ***111 to ED dispositions*** have been maintained at a good level since the introduction of ED disposition revalidation, supported by direct booking.
- In comparison, the level of **see & treat** provided has decreased since the start of the Covid Pandemic, below the 35% ultimate target, however further work is ongoing regarding promoting and recording of the use of care pathways as an alternative to Emergency Departments.
- ***Wrap-up time*** had shown some improvements bit this has not been sustained resulting in a performance that is still in excess of the target.

What actions are we taking?

- Maintain 111 to ED revalidation, to support improved outcomes for system partners, particularly when they are under pressure through appropriate DOS management – this is monitored within the Trust and through contract meetings with commissioners.
- Local teams continue to engage with local systems to understand and be able to access community pathways of care. Additional work has been commenced ahead of winter regarding enhanced care to elderly fallers.
- Continued partnership working with hospitals relating to hand over time, both on a local and strategic level, monitored at the weekly (Friday) system (Commissioners + SECAmb + NHSE) calls.

RESPONSIVE CARE

111

111-1

Dept: Operations 111
IP: Responsive Care
Latest: 97252

Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

111-3

Dept: Operations 111
IP: Responsive Care
Latest: 15.7%
Target: 5%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

111-2

Dept: Operations 111
IP: Responsive Care
Latest: 35.4%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

111-4

Dept: Operations 111
IP: Responsive Care
Latest: 6.9%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

What is the information telling us?

- The call activity and demand in 111 above that which SECAmb is contractually commissioned and remunerated for
- The service's responsiveness remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned call.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment challenges and reduced efficiency, a poorer performance has been seen.

What actions are we taking?

Trust has been successful in negotiating a new financial settlement for the 111 service during 222 which has enabled the Trust to recommence recruitment and training of staff into early 2023.

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

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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

ID	Metric	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£23521.20	£29157.60	£23450.50	£24049.10	£25088.10	£24865.50	£24640.50	£28750.10	£22741.10	£23107.80	£29732.80	£24477.20	£25014.60	£24422.00	£592.60		
F-9	Income (£000s) YTD	£116853.80	£146011.40	£169461.90	£193511.00	£218599.10	£243464.60	£268105.10	£296855.20	£22741.10	£45848.90	£75581.70	£100058.90	£125073.50	£122112.00	£2961.50	£302761.40	£180649.40
F-2	Operating Expenditure (£000s) Month	£25040.50	£27981.60	£24300.60	£24785.10	£26396.10	£25269.10	£24949.00	£25280.70	£25308.00	£25680.00	£24694.40	£24916.90	£25431.00	£24793.00	£638.00		
F-10	Operating Expenditure (£000s) YTD	£122828.40	£150810.00	£175110.60	£199895.70	£226291.80	£251560.90	£276509.90	£301790.60	£25308.00	£50988.00	£75682.40	£100599.30	£126030.30	£123502.00	£2528.30	£302344.80	£178842.80
F-3	Capital Expenditure (£000s) Month	£412.32	£855.48	£395.11	£2905.10	£2476.90	£2428.81	£0.00	£11423.73	£1055.46	£1769.56	£1629.39	£2403.24	£1558.40	£2339.00	£-780.60		
F-14	Capital Expenditure (£000s) YTD	£5254.58	£5910.07	£6305.18	£9210.27	£11687.18	£14115.98	£14115.98	£25539.71	£1055.46	£2825.02	£4454.41	£10088.65	£11647.05	£18469.00	£-6821.95	£37224.13	£18755.13
F-4	Cost Improvement Plan (CIP) (£000s) Month	£250.00	£238.00	£161.00	£250.84	£181.32	£963.31	£392.69	£1676.00	£83.87	£124.50	£160.00	£163.63	£0.00	£357.00	£-357.00		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£830.00	£1068.00	£1229.00	£1479.84	£1661.16	£2624.31	£3017.00	£4693.00	£83.87	£208.37	£368.37	£632.00	£632.00	£1237.00	£-605.00	£5598.00	£4361.00
F-6	Surplus/Deficit (£000s) Month	£-1519.30	£1176.00	£-850.10	£-736.00	£-1308.00	£-403.60	£-308.50	£3469.40	£-2566.90	£-2572.20	£5038.40	£-439.70	£-416.40	£-371.00	£-45.40		
F-7	Cash Position (£000s) Month	£38289.00	£40507.00	£46592.00	£45791.00	£43638.00	£47832.00	£53937.00	£62555.00	£52948.00	£45599.00	£44224.00	£40728.00	£41594.00	£39922.00	£1672.00	£39922.00	£0.00
F-8	Agency Spend (£000s) Month	£234.08	£168.06	£154.98	£192.19	£255.95	£284.74	£170.08	£445.26	£352.65	£338.74	£597.00	£558.40	£378.25	£448.00	£-69.75		
F-16	Agency Spend (£000s) YTD	£1107.84	£1275.89	£1430.87	£1623.06	£1879.01	£2265.41	£2435.49	£2880.75	£352.65	£691.39	£1288.39	£1846.78	£2225.04	£2240.00	£-14.96	£5498.00	£3258.00

What is the information telling us?

The Trust's financial performance for the 5 months to 31 August 2022 was as planned, with a deficit of £1.4m. The forecast for the year is in line with the planned breakeven position on the assumption that: -

the Trust and Commissioners deliver against the FY2022/23 contract for both 999 and 111

the Trust will deliver against the underpinning assumptions in the integrated plan including the agreed efficiency improvements

At month 5, specific areas of concern that will impact the Trust financial forecast position are:

Ability of the Trust to meet its recruitment and retention targets

The impact of the rota review on the 2022/23 plan

The financial impacts of the Improvement journey. This relates to both the cost of the journey itself, and the capacity and focus of the organisation to deal with BAU, meaning a potential increased risk going into winter

The volume and value of cost pressures being submitted by the organisation signalling a potential lack of understanding of priorities within the wider Trust. These are all unfunded.

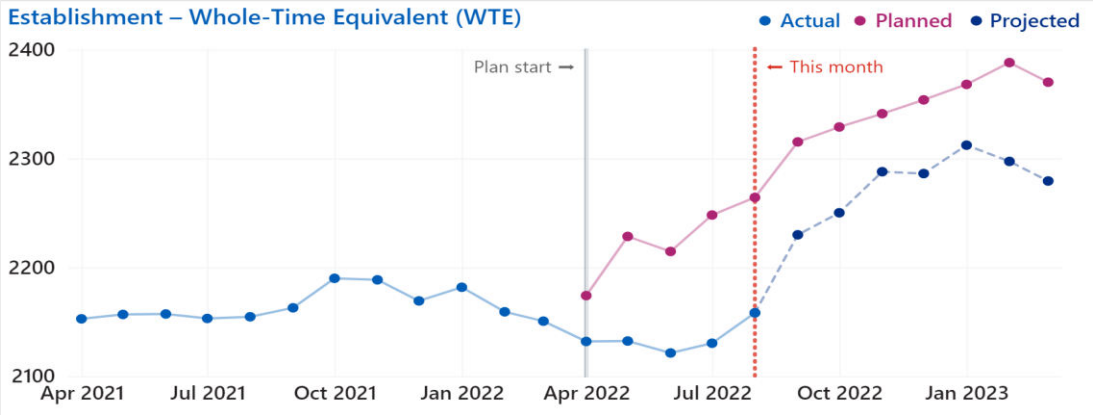
Ability within 111 to change the service offering quickly enough to meet the new service specification agreed by the Operations Director. Failure in this area will mean continuation of the current overspend, which will not be able to be rectified in the remaining months of the year. (This is also of concern due to the requirements related to the Integrated Routing Platform and the Single Virtual Contact Centre)

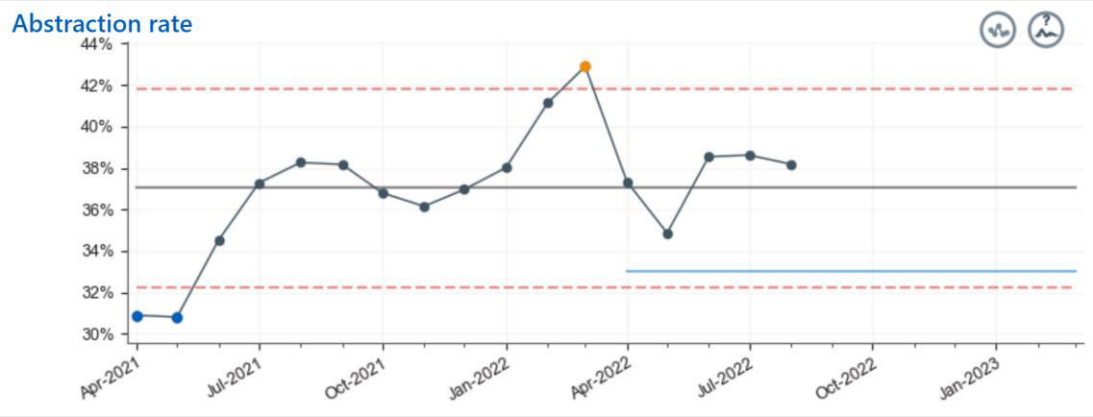
What actions are we taking?

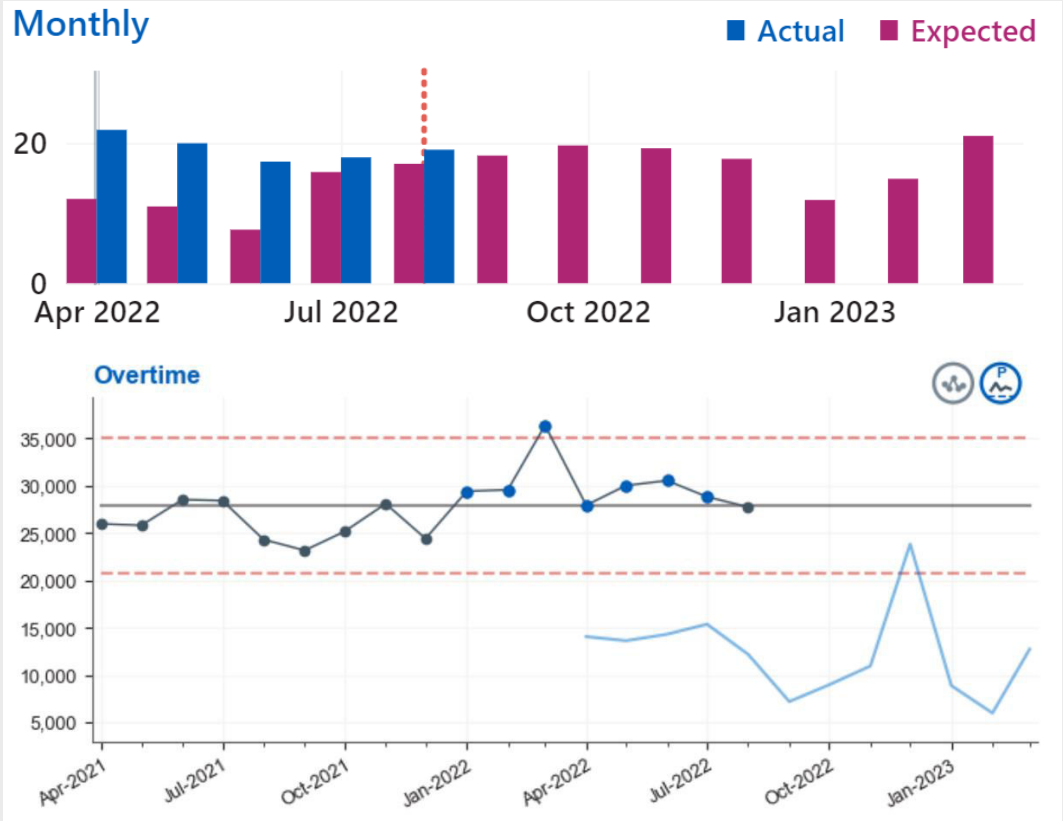
- The Trust continues to engage with commissioners to secure: -
  - All funding related to 2022/23
  - The recurrent future funding required for both 999 and 111 in response to the increased demand placed on it – or that the Lead ICS system will manage demand on 999 and 111 more effectively
  - A reforecasting exercise is being undertaken to understand the impact of non-delivery against the integrated plan during the first 5 months of FY 2022/23. This will inform the financial outturn for 2022/23 and rectification actions required
- That line of sight of the financial position and forecast is given more prominence on the Executive and Board agendas in response to the governance reviews and CQC feedback
- The new CFO will specifically ensure that: -
  - There is a better understanding of where the Trust sits against delivery of the efficiency target (of £5.6m, being 1.9 per cent of planned operating expenditure) and will ensure the Board takes corrective actions where appropriate
  - A rigorous approach is being taken to control any expansion of the cost base beyond the planned level. This will include changing the organisational approach to investments and organisational benefits realisation.

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan







What is the information telling us?

- The responsive care workstream has several component parts and the metrics here are linked to specific actions – as we progress the work these will go through a triangulation process to link different components into a coherent narrative.
- One of the most significant challenges relates to workforce provision. The 2 components here refer to the total workforce size and the abstraction rate , i.e how many employees do we have and how many of them are delivering care/undertaking operational works.
- We remain under target for our overall workforce plan for frontline 999 resourcing for the year to date, with a projected shortfall forecast by end of year of -91 WTE against target, because despite a strong recruitment programme, we are seeing increased levels of attrition.
- In addition, the abstraction rate continues to fluctuate, and remain generally above the target level of 33%

What actions are we taking?

- Mitigating resource gaps through the increased use of overtime with some additional incentivisation of specific periods (days/shifts) when there are the greatest challenges, also focusing on skill mix by increasing the update of Non-Emergency Transport (NET) crews cover to support HCP and inter-facility transfer calls.
- Additional recruitment for international staff continues - most recently with expansion into Ireland, and soon to include Australia, in particular we have had over 200 AAP applications for the October intake, and up to an additional 30 international recruits through the Ireland programme.
- Work on abstractions continues as per the previous slides in terms of process, accountability, oversight and reporting at all levels.
- Due to the changed landscape against plan, we are re-forecasting the year-end position in terms of performance and patient safety, to be presented at Performance Committee in October.

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Appendix

Appendix 1: Glossary

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

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

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	TBC

Name of meeting	Board
Date	23.09.2022
Name of paper	Improvement Journey - Executive Summary to the Board
Trust Priority Area	**Improvement Journey**
Author / Lead Director	David Ruiz-Celada, Executive Director for Planning and Business Development
Primary Board Papers	BAF Risks 20
Executive Summary	This report summarises the progress made through the Improvement Journey (IJ) portfolio during the month of September 2022. The main BAF risk (ID: 257) remains scored as a 12 due to ongoing challenges in producing the target evidence we've identified for the 4 Warning Notices. There is a significant focus on tracking and achieving the evidence by the end of October as per the Section 29A Warning notices (S29A) expiry. The portfolio has been subject to a re-baseline by the 9th of September. Based on this and the signed off Registry of evidence, our current progress is of 31%, leading to an overall programme rating of "red" for the period, as at this stage we have not signed off sufficient evidence to be assured that we have made significant improvement towards addressing the Warning Notices. Section 4 identifies gaps in assurance and provides 16 corrective actions to be taken through October to ensure we are in a strong position to provide the Care Quality Commission (CQC) with concrete evidence of significant progress towards improvement before the expiry of the S29A. The remaining risks associated with the programme are within the respective programme risk registers and highlighted within the individual workstream reports. The biggest risk to the portfolio is project resources and the Trust's ability to recruit skilled project managers, followed by the ongoing challenges of effectively engaging and communicating the overall programme. Delivery against Warning Notice 4 within the People and Culture programme remains challenging, and the Board cannot be assured that significant progress has been made to address the culture of bullying and swiftly address staff concerns. Extraordinary deep dives are recommended monthly for all Board committees to ensure the Board has sufficient time to understand the progress being made towards improvement as it remains accountable for the portfolio delivery.
Recommendations, decisions or actions sought	In the context of this Strategic Goal the Board is asked to test the controls and mitigating actions set out in the Board Assurance Framework; Integrated Quality Report and Improvement Journey and, where it identifies gaps, agree on what corrective action needs to be taken by the Executive Management Board.

Kommentar [MW1]: I think leave as is for the time being, as there is a lot of partial completion items in the registry

1. Portfolio overview

Portfolio name: Improvement Journey	**Overall workstream status:**	
	Forecast status with actions completed by next reporting period	
Accountable executive: Executive Director for Planning and Business Development	**Oversight:** Board	
Start date: 30th June 2022 (Approval at Board)	**Projected completion date:** N/A	
Update date: 20th September 2022	**Next update due:** 20th October 2022	

1.1. Background and portfolio aim and objectives

1.1.1. The Improvement Journey is our delivery of framework across the organisation, developed in response to the Care Quality Commission (CQC) and NHS Staff Survey feedback in early 2022.

1.1.2. Each programme is led by an executive, with support from a second member of the Executive Management team. The oversight of the Improvement Journey portfolio sits with the Director of Planning and Business Development:

	Executive Lead	Secondary Lead	Workstream Aim
QUALITY IMPROVEMENT	Director for Quality and Nursing	Medical Director	*We listen, we learn and improve*
PEOPLE & CULTURE	Director of HR and OD	Director of Operations	*Everyone is listened to, respected, and well supported*
RESPONSIVE CARE	Director of Operations	Director of Planning and Business Development	*Delivering modern healthcare for our patients*
SUSTAINABILITY & PARTNERSHIPS	Director of Finance	Director of Planning and Business Development	*Developing partnerships to collectively design and develop innovative and sustainable models of care*

1.1.3. The objectives for each programme have initially been defined by the immediate need to address Section 29A warning notices issued to the Trust by the CQC, and the associated "Must do" (MD) and "Should do" (SD) actions received in the report in June 2022 (Appendix 1).

1.1.4. In addition to this, on 14 June 2022, the Trust formally entered the national NHS England Recovery Support programme (RSP), provided to all trusts and integrated care boards (ICBs) in segment 4 of the NHS Oversight Framework (2022). As a result of this, the Trust has been allocated an Improvement Director and is required to meet a set of "RSP Exit Criteria" (Appendix 2).

1.1.5. Lastly, the Board commissioned RSM UK (provider of audit, tax and consulting services) to conduct a review of the governance arrangements put in place by the Trust to assure progress against the Improvement Journey. As a result of this review, 11 "RSM considerations" were made (Appendix 3).

1.1.6. The Improvement Journey's outcomes for this initial period of improvement are articulated in Appendix 5. As we develop our Quality Improvement (QI) approach – it is the aim of the Trust that any QI initiative, whether it be directly or indirectly impacting patients, will be facilitated through this framework. More importantly, whilst there has been every effort to involve staff at all levels in the development of the plans through the setting of the Trust priorities in June, this plan has been mainly driven by the executive and middle-to-senior management due to the immediate nature of the requirements for

improvement and the focus on Well-Led. After November (expiry of the S29A), there will be a focus on implementing and developing a "Patient-to-Board" approach to QI, ensuring anybody across SECAmb can be a part of our Improvement Journey.

1.2. Summary since the last report (Board Report – August 2022)

1.2.1. It was reported in August that the Improvement Journey was struggling to appoint and resource skilled project managers for the four core programmes. During the reporting period, two project managers commenced with the Trust to support the People and Culture and Responsive Care (specifically RCG 5) programmes. Following a period of high annual leave during August, each programme has now been allocated a senior delivery lead and a project manager. There remains an overall shortage of three project managers across the full portfolio, and we have sought support from system partners and have already had expressions of interest from a range of individuals whom we hope to be able to onboard through October.

1.2.2. The Sustainability and Partnerships programme has been allocated to the Interim Director of Finance as the Executive Lead, supported by the Director of Planning & Business Development. An outline of this programme, together with a proposed resourcing profile, is to be developed and reported on within the next reporting period.

1.2.3. The Portfolio Steering Group has identified delivery challenges within the People and Culture programme. As a result, this programme has been placed in "intensive support", which has included a suite of actions such as re-prioritising the workload of the Deputy Director of HR & OD to enable reassignment to deliver this programme, re-allocation of a new project manager to support the programme's re-baselining, and the IJ Portfolio team and Improvement Director conducting a detailed review of the evidence required for warning notice 4 (Culture Transformation) within the *CQC Evidence Registry*. In addition, the Board is scheduled to have a detailed review of the Employee Relations caseload, grievances and suspensions on the 27th of September, and the Executive Management Board will be monitoring the relevant metrics for warning notice 4 on a weekly basis going forward.

1.2.4. An engagement and communications plan has been developed with a rolling programme of key weekly messages and videos to be communicated to all members of staff. Despite this, overall engagement and communication of the portfolio remains a trust-wide risk, currently scored as 15. The Trust is seeking additional support from an external party that specialises in internal communications and engagement to assist in enhancing this activity.

1.2.5. To improve overall Board awareness of the progress and areas of concern, a programme of deep dives for Board sub-committees has been scheduled, following a structured deep dive approach using the NHSE "Make Data Count" methodology.

1.2.6. A full revision of the BAF and corporate risk registers has taken place to ensure the Improvement Journey actions and risks are aligned so that the delivery of these will directly improve the associated risks.

1.2.7. We have set up an Improvement.Journey@secamb.nhs.uk address for colleagues across the Trust to provide ideas for improvement or to contribute to the journey, and over 120 listening days/shifts/visits have taken place since mid-June, with more than 30 visits taking place the last 30 days.

1.2.8. As a result of this engagement, the Executive Manage Board has considered changes to the approach relating to the rota review, and social media community page, improved the Improvement Journey communications approach, and is developing a "Patient-to-Board" improvement framework as the first step towards a QI mature organisation as measured by the CQC. The themes emerging from the leadership visits are also now embedded in the Board agendas and the Chair's report.

2. Overall progress against outcomes

2.1. Progress against CQC deliverables (based on signed-off evidence and as of 18.09.2022**)** - see appendix 2 for descriptions and appendix 4 for the detailed progress table.

2.1.1. Overall progress against meeting the WN target evidence is **31%.**

2.1.2. Overall progress against meeting the MD target evidence is **23%.**

2.1.3. The greatest portfolio risk concerns progress against WN4, currently scored as a 20. The plan underpinning the programme is not mature enough to provide assurance that the minimum set of deliverables will be available by the end of October to satisfy WN4. An additional senior project manager has been re-tasked to support with capacity in delivering two business cases on the implementation of the Culture and Leadership Programme, supported by NHSE, and increased capacity to address the Employee Relations (ER) caseload, ensuring we are quicker at addressing issues raised by our people; both with a target date of the end of October.

2.1.4. The Sustainability and Partnerships programme has now been initiated, initially deferred until the end of September by the Executive Management Board following the just being developed as the prioritisation exercise initially focussed on the other areas. This supports parts of the WN1 in relation to Board Effectiveness, however progress is being made but until dedicated resources can be allocated there is difficulty in extracting evidence submissions. This situation will improve now the interim DOF has been appointed, work is underway to formalise scope, outcomes and plans for the Sustainability and Partnerships workstream, of which Board Effectiveness is part of.

2.1.5. Regarding WN2 and WN3, there are credible plans outlined within the Quality Improvement programme to achieve significant progress by the 1st of November. The QI programme has been short by one dedicated project manager; however, cover has been sought by the existing Medical directorate Project Manager. A full-time project manager is due to commence at the start of October and has been allocated to this programme.

2.1.6. Regarding the "Must-Do" actions, the majority of these are incorporated within one of the four warning notices, with the exception of MD1, 3, 5, and 8. These sit within the Responsive Care programme, which is resourced by a senior programme director from the Operations directorate.

2.1.7. Should-do actions will be considered following the expected expiry of the S29A warning notices in November 2022.

Warning notice - S29A			Must-do actions			Should-do actions	
Warning notice - S29A	**Completion %**	**Forecast by 1st Nov**	**Must-do actions**	**Completion %**	**Forecast by 1st Nov**	**Should-do actions**	*Not monitored until November*
WN1	40%	*75%*	**MD1**	25%	*30%*	**SD1**	
WN2	30%	*60%*	**MD2**	14%	*40%*	**SD2**	
WN3	40%	*70%*	**MD3**	40%	*50%*	**SD3**	
WN4	14%	*40%*	**MD4**	40%	*70%*	**SD4**	
			MD5	13%	*30%*	**SD5**	
			MD6	40%	*70%*	**SD6**	
			MD7	13%	*30%*	**SD7**	
			MD8	0%	*30%*	**SD8**	
						SD9	
						SD10	
						SD11	
						111SD1	
						111SD2	

2.2. Progress against RSP Exit criteria - see appendix 2 for descriptions

2.2.1. Reporting on progress against the RSP Exit criteria will be available from the November Board.

2.2.2. The Board saw the RSP Exit criteria as agreed with NHSEI at the Board in July. The exit timeframe is 9-12 months and is therefore not a priority for reporting at this stage whilst the Trust concentrates on demonstrating significant progress against the warning notices.

2.3. Progress against Internal Audit RSM considerations - see appendix 3 for descriptions

2.3.1. Overall progress against achieving the RSM considerations is **76%**.

2.3.2. The in-progress actions are on track for completion in Q3 22/23.

3. Improvement Journey Risks, Issues, and Interdependencies

					Pre mitigated (Gross Score)						Post mitigated (Target Score)		
Risk ID	Risk Impact Category	Risk Title (short title)	Risk Cause and Effect (What might happen? What is the expected impact?)	Risk Owner	Impact (1-5)	Likelihood (1-5)	Overall Severity (1-25)	Risk response	Mitigations Action (risk manager and due date for each action)	Next Review Due Date	Impact (1-5)	Likelihood (1-5)	Overall Severity (1-25)
R7	Quality People Reputation	Communications & Engagement	There is not a formalised mechanism to penetrate messages through the organisation which could impact the IJ effectiveness in reaching all staff members. This is directly linked to the BAF risk in that the Trust will not be able to demonstrate significant improvement against the areas highlighted by the CQC in the warning notices and must-dos, which could lead to further reputational damage and/or regulatory action.	Janine Compton	5	4	20	Treat	12-week communications and engagement plan developed, however, this remains one-way focused and it is acknowledged that there is presently limited opportunity and openings for staff (particularly frontline staff) to directly contribute to, engage with and learn about the Improvement Journey. To ensure a consistent narrative and alignment across the core programmes, there is a requirement for Improvement Journey champions to address this interdependency (i.e., wellbeing, quality improvement and culture transformation).	28/09/2022	5	3	15
R8	Schedule Quality	People & Culture programme: intensive support	The People & Culture programme has not been updated to an appropriate mature standard where progress can be monitored and is not currently able to demonstrate significant improvement against the relevant areas highlighted by the CQC, i.e., WN4.	Ali Mohammed	5	4	20	Treat	The People & Culture Programme has been placed into intensive support to ensure additional support is made available to the programme team to deliver improvement against WN4 and the associated must-do actions. This includes creating capacity for the DDHR&OD to lead the programme, introducing an additional senior project manager to support business case completion, and allocating a dedicated full-time project manager to the programme. Additionally, the Portfolio Steering Group is reviewing the programme's progress weekly against the intensive support checklist, with a weekly update provided to the CEO and EMB. Additional Senior PM allocated to support Business Case Development for CLP.	28/09/2022	4	3	12
R2	Schedule Quality	Demand	Due to operational demand or unforeseen service pressures, some portfolio delivery timeframes could be impacted.	All SROs	4	4	16	Tolerate	Weekly programme group and Portfolio Steering Group meetings are in place to keep to deadlines, ensuring ongoing assessment of unforeseen risks or issues and identification of appropriate controls and mitigations, with direct escalation to EMB as required. A fortnightly review of operational pressures is incorporated within the Joint Leadership Team meetings, considering any impact on the Trust's Improvement Journey.	28/09/2022	4	2	8
R3	Schedule Quality	Timeframes	Due to tight timeframes for delivery and lack of project resource continuity, some milestones could be delayed.	All SROs	4	4	16	Tolerate	Weekly programme group and Portfolio Steering Group meetings are in place to monitor deadlines and progress. A monthly Trust Board report provides level 1 and 2 summaries of activities planned, delayed and outstanding. PCG, RCG and QIG now have dedicated delivery lead and project support, with SPG currently undertaking resource profiling.	28/09/2022	4	2	8

4. Assurance and Actions for the reporting period ahead

4.1. Warning Notice 1

Progress	Gaps	Actions
(+) There have been changes to the way senior management and the Board operate, and evidence submitted demonstrates increased alignment between Risks, Trust priorities and action plans as a result of the establishment of the Improvement Journey. (+) Increased public board meetings, changes within the Executive Team and Board, and establishing a joint SMG/EMB fortnightly meeting, is supporting the on-going alignment of the wider leadership team. (+) Senior managers (at Board and immediately under the Board), have engaged positively in the commitment to ensure daily engagement with clinical frontline, EOC/111 or support services. Over 120 visits have been completed in 3 months, and feedback received is discussed every fortnight at SMG/EMB.	(-) The evidence folders are only partially completed, and the actions to help improve Board effectiveness remain ongoing. (-) The Sustainability and Partnerships programme has yet to develop a full plan to reflect the changes undertaken to increase Board effectiveness. (-) There is a need to increase the overall visibility of the Board on the progress of improvements made.	**Action 1:** The executive leads (interim DOF and Director of Planning) and company secretary to mature the workstream for Board effectiveness so that it's reflective of activities underway and planned by the Board in October. **Action 2:** The Improvement Journey portfolio team, supported by the DDQN, will develop a framework for all senior managers and the Board to ensure alignment of the improvements achieved through October 2022.

4.2. Warning Notice 2

Progress	Gaps	Actions
(+) Robust plans are in place, with ongoing work required to fully embed a "patient to Board" consistent reporting framework becoming a clear workstream for engagement with middle management groups to get involved in the Improvement Journey. (+) Development of the IQR and re-structure of the overall Board approach to allow for better triangulation between quality, risk, performance and action plans. This has followed the "Making Data Count" method, focussing on the introduction of SPC charts as a result of Board development and working with external partners. (+) Changes to ToR for Board committees, approved by the Board in July 2022, a dedicated deep-dive template and a reviewed cycle of business.	(-) Inconsistency in the delivery lead for the Quality Improvement programme (3 individuals in 3 months). The programme now has a senior Delivery Lead supported by an interim project manager, however, other projects may be impacted within the Medical Directorate whilst the interim cover is provided until a full-time dedicated project manager commences in October. (-) Despite significant progress made in areas for this WN, there is a lack of evidence signed off into the evidence folders due to timing in the reporting. (-) There is not sufficient time within the Board meetings to appropriately scrutinise the detail of the actions underpinning improvement across the entire portfolio, and the committees of the Board do not meet often enough to keep up with the pace required to ensure the Board have appropriate oversight of the Improvement Journey.	**Action 3:** A business case for tranche 2 funding will be submitted to BCG in September 2022, allowing for advertising beyond the short fix-term which has caused challenges through recruitment. **Action 4:** Increase the frequency of Board committees to support the structured deep dives.

4.3. Warning Notice 3

Progress	Gaps	Actions
(+) Re-instatement of the Risk Assurance Group (RAG) in line with	(-) As with WN 2, inconsistency in the delivery lead for the programme	**Action 5:** Executive leads for Quality Improvement and Responsive Care to

the Trust's policy. (+) BAF risks have been re-aligned to the Improvement Journey to strengthen the sustainability of the programme and relevance to risks (not only CQC deliverables). (+) Significant reduction in outstanding actions relating to SIs and reduction of outstanding Datix incidents, in line with trajectories.SI Actions reduced to 27 and Breached SI's reduced to 14. Original outstanding incident backlog down to 22 (+) Significant engagement with middle-senior management was achieved through the facilitated patient journey and risk mapping workshop in August, followed by the Quality Summit where over 60 colleagues from SECAmb and the systems attended. (+) Appointed Deputy Director for Quality Improvement to start in November.	under QIG. (-) No formal actions or next steps have been yet agreed upon following the Quality Summit, engagement with the facilitators is ongoing to help define next-steps (-) Despite significant progress made in areas for this WN, there is a lack of evidence signed off into the evidence folders. (-) No progress is evidenced against the embedding of a QI methodology across the organisation. (-) There remains significant work required to cleanse the risk register. (-) Board have not completed the Board Risk Training in line with the policy (every 2 years).	work with their programme delivery leads to develop a "next steps" plan following the Quality Summit, focussing on patient risk management and ongoing engagement with the organisation, to be reviewed as part of the "Keeping patient safe" deep dive at the next QPS committee. **Action 6:** Executive leads for Quality Improvement to develop a framework for "patient-to-Board" driven QI across the organisation. **Action 7:** Board to be scheduled to complete Risk Management training as per policy as part of the Board Development plan.

4.4. Warning Notice 4

Progress	Gaps	Actions
(+) Reporting has improved with increased clarity on the key metrics. EMB is to monitor weekly progress. (+) Board development on FTSU and a follow-up FTSUG report to Board in September. (+) Board approved the launch of the Culture and Leadership Programme in August 2022. (+) Board deep dive briefing into WN4 performance metrics scheduled for 27.09.2022. (+) 83 attendees so far on the Sexual Safety training completed by September (14.64% of total) with a further 162 booked. (+) JPF approved Dignity at Work policy (+) As evidence in the IQR, overall average length of active suspensions has reduced on a continuous low trend.	(-) No dedicated project manager until recently has caused a significant lack of visible progress against WN4. (-) The People & Culture programme has not been updated to an appropriate mature standard where progress can be monitored, following the change freeze on the 9th of September. (-) Pulse Survey for Q3 implies a lack of improvement in the overall colleague morale. The low response rate of 117 is expected due to the decision to not promote the survey until the following reporting period. (-) Key workforce metrics continue higher than targets. (-) Not all Board members completed the full FTSU training following the FTSUG Board Development in June.	**Action 8:** The People & Culture programme will remain under "intensive support" by the IJ portfolio team. Additional capacity has been sourced with a senior project manager supporting the completion of business cases by the end of October to begin the implementation of the Culture and Leadership programme designed by NHSE. **Action 9:** Executive Lead has re-prioritised all work within the senior HR team to focus on delivering the outcomes required by the end of October. **Action 10:** NHSE FTSU report received with recommendations on how to improve the function. The embedding of the recommendations within the Improvement Journey plan is to be completed by the October Board. **Action 11:** 100% completion of FTSU Training by all Board members by the October Board. **Action 12**: EMB will review the core Warning Notice metrics on a fortnightly basis as part of the standard agenda.

4.5. Must-dos and Should-dos

Progress	Gaps	Actions
(+) The evidence registry is starting to provide visibility of target evidence for must-dos not covered within the WNs.	(-) Generating should-do evidence has not been a priority with most WN evidence still outstanding.	**Action 13:** Development of should-do tracker and updated programme of work by Board meeting in November by the IJ portfolio team working with individual workstreams.

4.6. RSP Exit Criteria and System Assurance / Collaboration

Progress	Gaps	Actions
(+) Mapping to the WN and MD actions demonstrates strong alignment between deliverables. (+) Over 8 system /external engagements actively supporting programmes.	(-) 9–12-month horizon means that specific tracking of progress has not commenced.	**Action 14:** Development of RSP Exit Criteria tracked by Board in November by the IJ project team working with individual workstreams.

4.7. RSM Recommendations

Progress	Gaps	Actions
(+) High-level completion of recommendations with credible actions in place to complete 100% in Q3.	(-) No mapping of "Better by Design" workstreams has been completed yet onto the Improvement Journey. (-) No evidence of progress made to redefine the long-term strategic aspirations of SECAmb and how these will inform the Improvement Journey.	**Action 15**: Sustainability and Partnerships programme to lead definition of the roadmap to the 31st of March, ensuring the ongoing sustainability of the Improvement Journey based on long-term Trust plans and a refreshed Strategy.

4.8. Programme, Risks and Engagement

Progress	Gaps	Actions
(+) All programmes have some form of dedicated resources now, however, there remain 3 WTE gaps. (+) Improvement Journey banners are being produced for each operational reporting base. (+) Weekly Portfolio Steering Group ToRs refreshed and now chaired by the Director of Planning, providing executive oversight and weekly escalations to EMB. (+) NED champion identified and attending the Portfolio Steering Group on a fortnightly basis to support an increased understanding of the programme across the full Board (NED and Exec).	(-) Whilst there's a communications and engagement plan underway, this is still one-way communication heavy and there is little opportunity for frontline staff to directly contribute to the Improvement Journey. (-) The overarching Improvement Journey BAF risk (20) remains scored as 12 with a target risk score of 4. (-) The Board's overall understanding of the full extent of the programme remains a challenge. (-) Funding does not currently cover beyond the 31st of March, causing continuity and recruitment challenges for project resources. (-) Due to the different levels of maturity in the workstreams, there is little interdependency mapping possible at this stage. The need for localised resources to drive improvement across different areas (culture, improvement, quality, financial efficiencies) has been identified	**Action 6:** As above **Action 16**: Scheduled Board engagement plan as part of CQC preparedness framework to be embedded in October, with a focus on simplifying actions taken since the inspection in March 2022. Deep dives are scheduled in stepped frequency as per **Action 4.** **Action 17**: Tranche 2 funding for extended resources to support challenged programmes and extend funding for existing roles beyond the 31st of March due to BCG in September 2022. **Action 18**: Actions from this Board report to be transferred to the BAF risk (20).

5. Appendixes


Appendix 1 - CQC Deliverables.docx


Appendix 2 - RSP Exit Criteria.docx


Appendix 3 - RSM Recommendations.do


Appendix 4 - Evidence Progress Tra


Appendix 5 - CQC Warning Notice Regis


Appendix 6 - Internal Intensive Support Log

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	55/22

Name of meeting	Trust Board
Date	29.09.2022
Name of paper	Executive Summary to the Board
Strategic Goal	Delivering Quality
Lead Director(s)	Dr Fionna Moore, Executive Medical Director Robert Nicholls, Executive Director of Quality & Nursing
Primary Board Papers	BAF Risks 14 and 252 Integrated Quality Report Improvement Journey
Executive Summary	**Risk:** Within Medical there are five extreme risks (27, 31, 34, 136 and 28) all of these sit within the medicines portfolio, all mitigations that are possible are in place already. Two business cases are in development (Medicines Transformation and relocation of Medicines Distribution Centre - MDC) and due to be presented to the October BCG that will work to mitigate or remove the risk. Risk 28 is proposed for closure as this is now an issue, the Trust has evidence of drug seeking behaviour within the 111 EPS. This is being reviewed by SMG and actions will be required to enable this risk to be closed. Within Quality & Nursing there are two BAF Risks: Risk 14 - BAF Risk - Patient Quality and Safety - Risk that our operating model is not suitably designed to ensure efficient and effective management of demand and patient need. The impact of this risk is represented in the trends from serious incidents highlighted in the IQR. Risk 252 - Board assurance of effective risk management across the Trust - As a result of non effective risk management governance, scrutiny and policy compliance across the Trust there is an increased risk of adverse events being realised that may negatively impact on our strategic objectives and priorities and presently we are unable to afford reasonable assurance to our board that risk across the Trust is being managed effectively. **IQR:** Elements from the medical directorate within the IQR relate to medicines management (incident recording, audit and controlled drug oversight) and a limited set of clinical outcomes (Cardiac arrest survival, STEMI and stroke care). In view of concerns raised by interventional cardiologists around long on scene times, an escalation is being raised at NASMeD to review the current care bundle. Data clinics are ongoing within Medical to develop the IQR content. A deep dive to identify any outlying stations and individuals where single witness CD signatures are occurring is being presented at MGG in October. The IQR for Quality & Nursing highlights the following areas: Serious Incidents & Incidents, work continues to progress on the outstanding SI actions with 41 still remaining open, this work is progressing well, with good cross directorate engagement to deliver the agreed timeline Incidents reported by the 111 Pharmacy team are increasing, this is being

	reviewed as part of our contract. The Patient Experience continues to work on the overdue complaints, the team are actively engaging with the complainants where possible, and the team are positive that the November deadline will be achieved. Safeguarding L2 compliance continues to be an issue, this is partly due to data integrity, some staff have completed their L2 training, but it is not showing on ESR. Concerns have been raised on new starters, as this is an area where the L2 compliance is highlighting that there is potentially a gap in the induction process. L2 training is not included in this years statutory and mandatory training, but is part of the mandatory training for new starters. A recommendation is for the Trust induction process to be reviewed. Safety in the workplace is continued to be monitored through the Heath & Safety Committee and regional sub groups. Hand hygiene compliance continues to be an issue but is being actively monitored by both the IPC teams and IPC Champions. A position statement from AACE has been received on bare below the elbow is due to be published by the 30th September in the Trust. Deep clean compliance continues to be a concern and is being actively monitored through contract meetings. **Improvement Journey:** **QIG 5**: Medicines Management. The common theme throughout the risks, IQR and improvement journey is the dependence on the capacity of the medicines governance team and relocation of the MDC. Below is the progress made so far: The business case for the Medicines Transformation Programme Manager is in final stages of approval. Job description for Medicines Safety Officer has been developed Capacity review completed on current medicines governance team to inform Medicines transformation business case. **QIG 9**: End of Life Care EOLC oversight group has been established and a baseline analysis of EOLC activity has been completed **QIG2:** Serious Incidents backlog is progressing well and is on target to be delivered by the end of December. Breached open actions has been reduced to 14. **QIG** 3: Risk management continues to progress with a new policy being approved and implemented. Reviews of all risks are underway. The Leadership team are reviewing all extreme risks currently on the register on 05 October. The Trust has appointed an experienced Deputy Director of Quality Improvement (Jo Turner) who starts with the Trust on 31 October. A Board development day is planned for November to outlay the plans for QI across

	the Trust.
Recommendations, decisions or actions sought	In the context of this Strategic Goal the Board is asked to test the controls and mitigating actions set out in the Board Assurance Framework; Integrated Quality Report and Improvement Journey and, where it identifies gaps, agree what corrective action needs to be taken by the Executive.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	55-22

Name of meeting	Trust Board
Date	29 September 2022
Name of paper	Safeguarding Annual Report - Executive Summary to the Board
Lead Director	Rob Nicholls, Executive Director of Quality and Nursing

The Annual Report was presented to the Quality and Patients Safety Committee on 21 July 2022. The report seeks to provide assurance to patients, service users and key stakeholders that South East Coast Ambulance Service NHS Foundation Trust is discharging its Safeguarding responsibilities:

- Working Together to Safeguard Children 2018 guidance and Section 11 of the 2004 Children Act. All staff have a statutory responsibility to safeguard and protect the children and families who access our care.
- Section 42 of the Care Act 2014 put adult safeguarding on a statutory footing for the first time in addition to embracing the principle that "the person knows best".
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007.

The report also evidences areas of good safeguarding practice and highlights how key areas of safeguarding learning have been shared across the organisation.

There are two key areas of risks to note from the annual report:

- **Capacity within the Safeguarding Team:** SECAmb has a good safeguarding reporting culture. From April 2021 to March 2022 there were 23,777 safeguarding referrals made to local authorities via Trust's safeguarding team. This figure represents a 17% increase from the previous year challenging the current capacity within the safeguarding team to manage such high number of referrals. The team has 7.0 wte staff that comprise of a nurse consultant, specialist advisors and coordinators. In addition, the safeguarding team provides an on-call service, training and the nurse consultant for safeguarding and the safeguarding lead attend external partnership meetings. Capacity within the safeguarding team was identified in the July 2022 CQC report.
- **Safeguarding Training:** Over 2021/22 over 83% of staff have successfully completed the level 1&2 safeguarding courses. The Trust did not meet the 85% training target as outlined in the Contracting standards agreed with the Trust's lead commissioners. Level 3 safeguarding training is included in Trust's mandatory training for all registered practitioners. During the pandemic level 3 training was offered as a web based training was it was delivered in Q1 and Q2 of 2021 achieving a 65% compliance. Training was subsequently suspended in Q3 and Q4 due to operational pressures.

The following are mitigations and further actions needed:

- The safeguarding team has a consistent number of staff redeployed under the Trust's alternative duty scheme. On average the team has additional 2.0 wte supporting the team each month. Whilst this is not substantive roles it provided support within the team to manage existing demands.
- An addition 0.5 WTE staff has been seconded to the team until April 2023.
- A business case is in development for 2.0 WTE band 5 safeguarding coordinators. The business case will be reviewed through the business case approval process by the end of

September 2022. • The Executive Director of Quality and Nursing will meet in October 2022 with the Heads of Adult Social Care across Kent Surrey and Sussex to further analyse the demand, its impact on the Trust and agree any further support including the streamlining of referrals. • Level 3 training programme re-implemented in September 2022. This is an on-line programme that will help to increase attendance by clinical staff. Since the launch,178 staff have been enrolled onto the programme – there are 350 places between September 2022 to December 2022. The Operating Unit Managers and the Executive Director for Operations receives monthly data on training compliance.	
Recommendations, decisions or actions sought	For Assurance

Safeguarding Annual Report 2021/22

Authors: **Philip Tremewan, Nurse Consultant for Safeguarding**
Gareth Knowles, Safeguarding Lead
Jenny Churchyard, Safeguarding Practitioner
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Contents

1. Introduction

Throughout 2021/22 South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has striven to meet its statutory responsibilities in the care and protection of patients of all ages. This report demonstrates to the Trust Board and external agencies how SECAmb discharges these statutory duties and the report offers assurance that the Trust

has effective systems and processes in place to safeguard patients who access our services. We continue to deliver a high-quality credible service to patients and families, whilst reflecting continually on areas for learning and improvement.

2021/22 has been dominated by the on-going challenges of the coronavirus pandemic that have impacted on the majority of departments across the Trust including the Safeguarding Team. However, the team are confident that diligent business continuity planning has ensured that vulnerable children, looked after children, young people and adults at risk have been protected and supported during these challenging times.

The existing statute which continues to underpin the work of colleagues who support healthcare practitioners delivering services to children is in line with Working Together to Safeguard Children 2018 guidance and Section 11 of the 2004 Children Act. All staff have a statutory responsibility to safeguard and protect the children and families who access our care.

The legislation which frames the work of colleagues in adults' services is influenced by the introduction of the The Care Act 2014. The introduction of The Care Act 2014 put adult safeguarding on a statutory footing for the first time in addition to embracing the principle that "the person knows best". In addition our work to safeguard adults is informed by The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007.

SECAmb recognises that safeguarding is everyone's business and strives to support the Department of Health's six principles of Safeguarding:

- **Empowerment** – People feel safe and in control, give consent to decisions and actions about them. They should be helped to manage risk of harm either to themselves.
- **Protection** – Support and help for those adults who are vulnerable and most at risk of harm
- **Prevention** – Working on the basis that it is better to take action before harm happens
- **Proportionality** – Responding in line with the risks and the minimum necessary to protect from harm or manage risks
- **Partnership** – Working together to prevent or respond to incidents of abuse
- **Accountability** – Focusing on transparency with regard to decision making.

The Annual Report provides the readers with the following detail:

- An overview of the national and local context of safeguarding
- An overview of the areas of practice included in safeguarding within the Trust
- An update on safeguarding activity within 2021/22
- Assurance that the Trust is meeting its statutory obligations and the required national standards with regard to safeguarding
- An overview of any significant issues or risks regarding safeguarding and the actions being taken to mitigate these.

2. Governance and Commitment to Safeguarding

As an NHS Service provider SECAmb is required to demonstrate that there is safeguarding leadership and commitment at all levels within the organisation and that we are fully engaged in support of local accountability and assurance structures, via the Safeguarding Boards across Kent, Medway, Surrey, and Sussex. Most importantly, SECAmb reinforces the principle that safeguarding is everybody's responsibility and develops a culture of continuous learning and improvement to promote the safety and welfare of adults at risk, children and young people and looked after children.

SECAmb ensures that its senior management is committed to safeguarding at Executive and Non-Executive level at Trust Board. Safeguarding is always included in the annual cycle of business and comes within the scope of influence and scrutiny of the Quality & Patient Safety Committee. The Trust have robust governance structures and systems in place in line with Working Together to Safeguard Children 2018 and the Care Act 2014.

Evidence of SECAmb's commitment to safeguarding includes clear statements on the Trust's website demonstrating how our services safeguards the welfare of children, young people and adults.

The Trust's Safeguarding function sits within the portfolio of the Nursing and Quality Directorate and is led by the Executive Director for Nursing & Quality. The work of the department is scrutinised at the Safeguarding Sub-Group (SSG) meeting jointly chaired by the Nurse Consultant for Safeguarding and Safeguarding Lead. Terms of Reference for the group highlights the required core membership and includes senior roles and individuals from a wide range of operational, educational, HR, staff partnership and commissioning colleagues.

During the year the Safeguarding Lead continued to provide strong leadership on operational safeguarding across the Trust and support the Nurse Consultant for Safeguarding and Director of Quality & Nursing in delivering high standards of care and experience to patients. At the time of writing the total skill mix of the Safeguarding Team at SECAmb is:

Job Role	Band	WTE
Nurse Consultant for Safeguarding	8b	During the year 21/22 the Nurse Consultant acted up into a Deputy Director for Nursing and Quality for 5 months.
Safeguarding Lead	8a	1
Specialist Safeguarding Practitioners	7	2
Safeguarding Coordinators	5	3.5

The skill mix allows for focus on the Trust's internal and external safeguarding responsibilities. However, a continued year-on-year increase in safeguarding referral numbers continues to challenge capacity within the team to meet the expected demand. The focus includes representation at Safeguarding Adults Boards, Safeguarding Children's Partnerships and child death review panels across Kent, Surrey and Sussex. Additionally, during 2021/22 there had been continued investment in the Trust's approach to safeguarding training, including the introduction of Level 3 face to face training via Teams for registered clinicians across SECAmb's 999 and 111 services.

Standing agenda items at each SSG meeting provide assurances to the Trust Board and Executive Team. These include a review of the Trust's Safeguarding policies and procedures, departmental workplan, safeguarding risks and monitoring progress against safeguarding action plans following Serious Case Reviews, Domestic Homicide Reviews, Safeguarding Adults Reviews or Section 11 returns.

Regular assurance evidencing how the trust is discharging its safeguarding responsibilities is provided to the Designated Professionals at Surrey Heartlands Integrated Care System (ICS), SECAmb's lead commissioners for its 999 service.

- Submission to the Surrey Heartlands ICS Designated Safeguarding team of an annual report and 6 monthly update that provides a narrative and data against each of the standards
- Submission of exceptions reporting for any areas of non - compliance with the standards as identified
- Submission to the Surrey Heartlands ICS Designated Safeguarding team of Section 11 audits undertaken and resultant action plans for the Surrey Safeguarding Children's Partnership
- Providing evidence at contract and assurance meetings
- Named / Lead professionals meetings/supervision with Surrey Heartlands ICS, Designated Safeguarding team and use of the Annual Assurance Framework Report
- Providing information to the Surrey Heartlands ICS Designated Safeguarding team in the twice yearly Dashboard on safeguarding activity.
- Providing evidence at Surrey Safeguarding Adults Board, Surrey Safeguarding Children Partnership meetings and sub groups
- Participating in Surrey Heartlands ICS Designated Safeguarding team and SSCB and SSAB audits and inspections
- Demonstrating the Trust's commitment to preventing modern slavery and human trafficking by evidencing a Modern Slavery Act statement on its public facing website

Although the Surrey Safeguarding Adults Board and Surrey Safeguarding Children Partnership remain lead Boards for SECAmb, throughout 2021/22 continued commitment have been noted in SECAmb's representation at Safeguarding Board meetings across Kent, Medway, Surrey and Sussex.

Safeguarding Risks

1) **Capacity within the Safeguarding Team**

   With a 17% year on increase in safeguarding activities, there is a risk that the Safeguarding Team risk burnout unless a system is introduced to manage them in a smarter way.

   Mitigating actions are in place where members of the Safeguarding Team continue to work to process and transcribe referrals to Datix and in the meantime the Safeguarding Lead will work with leaders in EOC Systems and IT to implement a Safeguarding module within the Trust's Cleric system. Implementation of this module will result in a more efficient use of time taken to process safeguarding referrals. This is a joint piece of work with other ambulance trusts.

   We have utilised the trusts alternative duties pathway and we had had several staff come and shadow our team to learn how to process referrals under the supervision of the Specialist Safeguarding Practitioners. In Q4 they were processing over 35% of our referrals. Alternative duties placements not only support our team but also gives other members of SECAmb a chance to work within the Nursing and Quality directorate and understand more about the safeguarding function. However, there are inherit risks with non specialist staff undertaking what is a skilled area of work and several incidents have been investigated where the root cause can be attributed to inexpert decision making by alternative duties staff.

   A new way of working has been introduced in Q3 which saw the safeguarding coordinators working in a more efficient way to help manage the increasing demands on the service. There is now a Duty Coordinator tasked each day to take ownership of the telephone and email inbox, prioritising referrals and acting as a single point of contact for urgent enquires.

   Additionally, there was increased pressure on team capacity November 21 to the end of reporting period as the Band 8b Nurse Consultant role was not backfilled whilst the post holder was on secondment. However, additional short-term funding was used to increase capacity within the Safeguarding Coordinator function.

3. Policies, Procedures and Guidelines

As a commissioned NHS provider SECAmb must ensure that staff are aware of the Trust's Safeguarding policies and any associated guidance and procedures.

The Safeguarding function assumes lead responsibility for several organisational policies, all of which have been ratified and are in date. The policies are:

- Managing Safeguarding Allegations Policy and Procedure
- Mental Capacity Act Policy, currently out to consultation in anticipation of update and review

- Freedom to Speak Up: Raising Concerns Policy
- Safeguarding Supervision Policy

Policies due to be ratified 22/23
- Safeguarding Policy for Children, Young People and Adults
- Safeguarding Referrals Procedure

4. Appropriate Training, Skills and Competencies

The *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* Intercollegiate Document defines the safeguarding training expectations for all individuals working in healthcare. The document sets out five levels of training based on roles throughout the organisation.

During 2021/22 SECAmb has delivered L1&2 Safeguarding training to new starters only. All registered clinicians will over the next three years will be expected to complete level 3 Safeguarding training. Since the start of the 2021/22 over 83% of staff have successfully completed the level 1&2 safeguarding courses. Contracting standards agreed with the Trust's lead commissioners require 85% training compliance over the course of the year.

Outlined in the Intercollegiate Document are the expected competencies for level 3 training. Registered practitioners are required to undertake L3 face-face training. This is mandatory training that would normally be delivered through classroom-based sessions, so following a pause due to the Covid-19 pandemic, the Safeguarding Team have been offering web based learning via Microsoft Teams. These training sessions were delivered in Q1 and Q2 and achieved a total highlighting that a total 65% of eligible staff had successfully undertaken the training during this time. No training was delivered in Q3 or Q4 on the advice of the Executive Management team due to a spike in service demand.

As a result of the increased demand and highest level of surge management throughout the winter, the Trust made the decision to postpone its Key Skills training in an attempt to ensure enough clinicians were able to provide operational support across the service. Subsequently training figures stagnated during this time. The Safeguarding Team are working alongside senior operational leaders to reinstate the required training.

During the autumn of 2021 the Nurse Consultant for Safeguarding delivered Board level training in line with the expectations and competencies outlined in the Intercollegiate Document. The training was delivered as part of a Board Development Day that included CEO, Executive Team, and Non-Executive Directors.

Impact of Training

During 2021/2022, Safeguarding Level 3 training was constantly refreshed with updated changes of legislation and recommendations from reviews that SECAmb had contributed to.

The trends of note that were seen in Safeguarding Adult Reviews and S42 enquiries concerns around self-neglect and those who may refuse a safeguarding referral irrespective of how their self-neglect may be affecting their mental or physical health or having an impact on others around them. Extra guidance was added in around self-neglect and

professional curiosity to ensure that staff with patient interface had an enhanced knowledge of the subjects.

A new slide regarding professional curiosity has been included in the Level 3 training. This is to ensure that we are looking at the whole situation when attending a patient including any history we are given as well as the environment the patient is in. A doubled crewed ambulance attended a patient who was displaying signs of self-neglect the crew having recently completed safeguarding training completed a clutter score assessment and made referrals to both the local authority and the Fire & Rescue service via the safeguarding team. Feedback was received from the district council safeguarding officer that an multi agency plan of care had been put in place between housing and social care.

A concern was highlighted to the Safeguarding on-call service regarding a child who was in the company of 4/5 older men and bystanders had raised concerns, but she did not seem to know them well and appeared fearful. The clinician who raised this had undertaken her safeguarding training where information was included of the indicators of sexual exploitation as a result of this the police and local authority put plans in place to support the family and the child in line with the expectations of The Children Act 1989.

5. Effective Supervision and Reflective Practice

Safeguarding Supervision for the Trust's Safeguarding Lead and Nurse Consultant is undertaken by the relevant Designated Nurse for Safeguarding within clinical commissioning.

- Nurse Consultant has provided supervision to the Paramedic Practitioners on an ad hoc basis where they were requested to by the Deputy Medical Director.

- Specialist Safeguarding Practitioners have provided supervision to Frequent Caller Team and Safeguarding Coordinators in a group format.

- Specialist Safeguarding Practitioners in Q4 took part in a Safeguarding Supervision training course for two days.

6. Effective Multi-Agency Working

2021/22 Safeguarding Referral Information

The department has continued to see increases in referral activity. During the 2021/22 a total of 23,715 safeguarding referrals were made to local authorities across Kent, Surrey, Sussex and Hampshire. This equates to an increase of 18% increase compared to the previous year. All referrals continue to be reviewed by members of the Safeguarding team before forwarding to the relevant local authority.

We continue to see a high level of social concerns which were not self-neglect but where crews felt they had no other path to refer the patient into so a safeguarding referral is reported, to ensure some support is offered to their patient in often complex situations. This lead in 2021/22 to the safeguarding team beginning to use social issues as a primary concern option. The addition of this sub category allows for easier identification of cases that are primarily due to social issues. This enables the team to provide meaningful feedback to the wider system.

Increasing care needs continues to be in the two concern types that the safeguarding team receive. These referrals although the initial concern is not overtly safeguarding, a review of a patients care needs by social care can often identify other concerns such as inadequate care provision or identifying other unmet needs. Continued inadequate care provision can often lead to poor health outcomes leading to the possibility of more emergency and, urgent care being required. Cases in which SECAmb have had multi agency involvement with, have resulted in patients being moved to residential care homes (With their consent), where perhaps their needs can be better met.

More often than not self-neglect is categorised as increased care needs by the fact that someone is self-neglecting they have an unmet care need. Partners within social care have asked us to share our concerns we see re self-neglect as many cases that have reached Safeguarding Adult Review stage have often begun with self-neglecting behaviours.

Hoarding behaviours as a form of self-neglect, often can be an indicative factor of mental ill health worsening. The SECAmb safeguarding team have become an important ally in the work alongside our partner agencies, working with people who self-neglect, we have often been, especially in the earlier parts of 21/22, one of the only services seeing the inside of a person's home, as although a person may present to their GP/friends/family as a person coping with life their home can often show a different story of a person who is the beginning of their journey to perhaps needing social care support.

Research indicates that a person consenting to early help with an unmet care need will often not require further intensive support later. If there is no consent then the safeguarding team will work in collaboration with social care to establish if this person is already known or if the self-neglect has escalated to other areas of their lives, for example, hoarding behaviours are so severe that reaches Fire & Rescue Service thresholds for mandatory involvement.

Safeguarding referrals for children constitute 20% of the total number of referrals despite the under 18 population accounting for around 10%of SECAmb's workload. This is indicative of staff feeling confident to raise concerns when they identify family or child in need of support.
The Specialist Safeguarding Practitioner, Safeguarding Lead and Safeguarding Nurse Consultant have continued to work collaboratively with NHS England safeguarding teams, Local Authorities, CCG, Local Authorities as well as other health partners such as hospitals, Midwifes, Health Visitors and GPs to ensure the pathways we use to send SECAmb referrals onto are correct and are meeting the needs of the making safeguarding personnel agenda.

Safeguarding on Call
The Safeguarding on call service started in September of 2020. Safeguarding on call is staffed by 2 Specialist Safeguarding Practitioners and one Safeguarding Lead, 356 days a year 24 hours a day on a rota basis. SECAmb are the only ambulance service across the country who offer a safeguarding on call service. It has proven to be effective, particularly outside office hours, where specialist safeguarding support was previously not available.

The aims of the service are

- To provide specialist safeguarding advice above and beyond what may be expected of our staff.

- Support with protracted incidents where there is a safeguarding element to support staff in a timelier total scene time and reduce job cycle times
- To enable staff to concentrate on the clinical element of an incident
- To provide links between other emergency services and/or social care
- Escalate concerns to other key services and system partners across the region
- To provide timely information to Child Death teams following a child death this ensures a timely response to the family as appropriate, support for staff immediately after a child death.
- Attend scenes only where necessary to provide specialist advice at incidents such as Free Births where clinicians are not expected to have the required skill set to deal with what can be a difficult scenario. A safeguarding specialist can provide support to the clinicians on scene allowing them to carry on caring for their patients.

Safeguarding on call ask for feedback to ensure we are meeting the needs of the staff who use the service and during the year 21/22 we took 204 calls.

Below are some examples of feedback and details of the incident below to give an idea of incidents we have supported with.

Incident 1

Complex call, for parent critically unwell following an overdose with four young children on scene. Father prevented from attending the property due to injunction, however clinician on scene unable to achieve police attendance, thereby delaying conveyance in a timely manner. On Call escalated to duty inspector and achieved Police patrol on scene promptly.

Feedback from clinician on scene

> '*I was feeling very out of my depth and the Police were not able to attend, on scene and having exhausted all avenues, I called Safeguarding on Call. I am so glad that I did, I spoke to a Safeguarding Practitioner, and she was amazing! Within 10 minutes I had the police at the door of the address to safeguard these 4 vulnerable (and potentially abused) children.'*

Incident 2

This incident was an ongoing issue where SECAmb Safeguarding Practitioners were working alongside Social Workers, Mental Health Professionals, and the patients GP.

The Patient repeatedly refused to work with partner agencies, and they felt their only option was to call the ambulance as the patient had been on the floor for an extended period and was becoming potentially very unwell.

In this complex situation, Safeguarding On-Call were able to offer advice and guidance to the clinicians involved, support their clinical decision making and reassure them what they were doing was appropriate. Using the expertise of the Safeguarding on call service the crew were able to determine the patient's mental capacity and make a best interest plan for this patient. Subsequently there was a safe hospital transfer and outcome for this patient.

Feedback from Clinicians Involved

> *Absolutely invaluable! Collaboration between the Safeguarding On Call and the Ashford Urgent Care Hub resolved a safeguarding and Mental Capacity issue which had been*

ongoing for almost a month. Where previous GP, Rapid Response had failed to safeguard the patient. A Teams meeting between SGOC and Ashford UCH, formulating a best interest plan and coordinated response to the patient where we were able to admit the patient to hospital after an extended period of laying on the floor and refusing admission.

Incident 3
This incident involved an intoxicated Mother and her two-year-old. The crew had already been on scene for a while and, the mother was unfortunately not very forthcoming with information that would help them safeguard this patient and her child.

To support the crew and enable them to keep a short on scene time as necessary, Safeguarding on Call supported them by checking with Police, Social care, and NHS Spine that the details patient was giving was correct and establishing if the child on scene had another place of safety to go to. Sadly, the incident did take a turn with Mother becoming aggressive, so the advice to the crew changed, Police were contacted for support of taking Mum and Son to hospital as a place of safety

Feedback from Clinician at Scene

I spoke to the safeguarding on call team, during a difficult job overnight.

They were fantastically helpful throughout, providing both inputs, acting as a sounding board, and reassurance that our plans were appropriate.

Being able to delegate tasks such as contacting social services directly, consulting of NHS spine etc was very helpful in freeing me up at scene to focus on other tasks

Developments in Partnership Working

During 2021/22 SECAmb have been involved with working closely with a number of key partners but in particular the team supporting care homes in Surrey Heartlands ICS. As a result of this work the Trust supported the ICS and wider system partners to recognise a home in Surrey where a number of concerns demonstrated significant concerns for the residents' welfare and safety. This was shared with the CQC and SECAmb were commended in the exemplary work that was carried out to mitigate the risks for vulnerable members of the community.

The Safeguarding Team have worked alongside the Kent Health Visiting teams to develop a mechanism to highlight lower level concerns (eg minor injuries sustained at home) we have received for the youngest patients that we care for and their families. Engagement took place with service delivery leads across Kent to share the work of the ambulance service and the value of the information we hold and has been well received.

Safeguarding referrals that have a Mental Health element make up 31% of the referrals that the team process, with this in mind a new mental health pathway between Kent and Medway Partnership Trust and SECAmb was developed for referrals to be sent for Kent patients directly to them that met the agreed criteria. There are plans to expand this type of arrangement to other areas and localities across SECAmb's footprint during 2022/23.

Safeguarding training delivered and communications circulated throughout the year focused on the area of self-neglect and detrimental hoarding behaviour, including the relative fire risks associated with this behaviour. The training encourages staff to consider a referral to local Fire and Rescue services. Attempts to gain consent are always made, however if the hoarding reaches a pre-determined threshold where it is having an impact on others living

in the household or others who live in close proximity, a referral without consent made be reached.
SECAmb have continued their partnership working with local authorities, specifically working with Brighton & Hove City Council and Surrey County Council to develop threshold documents that support the local authorities by streamlining pathways, easing pressure on their services. This process ensure that those vulnerable members of society can receive appropriate care and intervention in a timely and structured way.

Child Death Reviews
Members of the Safeguarding Team continue to be involved in the multi-agency Child Death Review process, which now supplies information to the National Child Mortality Database.
During 2021-2022, SECAmb has reported on a total of 185 cases: 54 in Surrey, 76 across Sussex including Brighton & Hove and 55 in Kent & Medway.

With the introduction of the revised Child Death Review arrangements from September 2019, SECAmb's involvement has largely moved from attendance at the Child Death Overview Panels to a more proactive role within the analysis stage of the process, Specialist Safeguarding Practitioners attending Joint Agency Review (JAR) meetings and Child Death Review Meetings (CDRM), representing, or supporting the operational staff. Child Death Overview Panels (CDOP) are attended at the Chair's request to provide SECAmb specific input for certain cases.

During 2021/22 all CDOP meetings have taken place via Microsoft Teams, which has provided a different dimension to the meetings and enabled the Specialist Safeguarding Practitioners to play a more active role. During this year we also saw operational staff being able to observe these meetings remotely where it was felt appropriate. Feedback to the attending crews where they have been requested to be kept up to date is provided via email or where, if the Specialist Safeguarding Practitioners feel it is needed, or it has been requested as Covid restrictions were relaxed it was provided face to face.

The purpose of the CDOP process is to identify "modifiable factors" and learning that may help to prevent similar child deaths in the future. Some practical learning has been brought back to SECAmb and passed to operational staff through Informatics posters and informing training and CPD events. Following information shared at Sussex CDOP about the ICON programme (Information for parents about infant crying to avoid abusive head trauma) these principles were shared with NHS digital and incorporated into NHS Pathways.

A positive that has come out through the CDRM process is that through the Safeguarding on call provision we are now able to in real time able to inform the Child Death teams in each area that a child has died and is on their way to hospital. This enables Nurse Specialists for Child Death working within clinical commissioning to respond quicker e.g meet the family and crew at the hospital ensuring there is continued support for the family where needed.

As the ambulance service is often the first agency on scene of an incident and can report its findings in cases of child deaths, it is common that SECAmb's contribution is often unique and invaluable; informing the CDR process and that information being fed into the wider actions and recommendations for Health, Education and Social Care that result from the panel as well as to the National Child Mortality Database. During 2021/22 we began to start

collecting more social and environmental information from attending crews by asking them to fill in a child death report form. This is often something that the staff themselves find helpful as a way of writing out what the scene looked like, who else was present and any other observations of note.

Specialist Safeguarding Practitioners now have a regular section on the Learning from Deaths agenda, chaired by the Deputy Medical Director, where they share learning for child deaths that SECAmb have been involved with.

Multi-Agency Safeguarding Assurance
Throughout 2021/22 SECAmb provided regular assurance about its safeguarding function to the Safeguarding Adults Boards, Safeguarding Children's Partnerships and Clinical Commissioners across Kent, Medway, Surrey and Sussex. Exception reporting and six-monthly dashboard returns were submitted in line with other NHS providers to Surrey Heartlands ICS. The information was subsequently shared with all Safeguarding Boards across the region. Regular reporting included assurance on:

- SECAmb's policy developments in relation to Safeguarding Supervision
- Prevent activity
- Safeguarding training
- Referral activity
- Serious Incidents that had a safeguarding theme

Areas of challenge in SECAmb's safeguarding assurances and governance are discussed and agreed at the Safeguarding Sub-Group and through Safeguarding Supervision with Designated Professionals at the CCG.

SECAmb's Contribution to wider Multi-Agency Enquiries
The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened.

The findings from the enquiry are used to decide whether abuse has taken place, whether the adult at risk needs a protection plan and whether any wider learning can reduce future risk.

The Trust in 2021/22 were requested to contribute to 70 enquires, an increase from 34 throughout 2020/21. The reason for this increase maybe multifactorial however it is likely to be as a result of increased response times meaning patients waiting longer for ambulances and social care providers working in a tight financial envelope meaning less community resources.

During 2021/22 SECAmb changed the way we record the S42s we receive by differentiating between those where the trust was considered at fault and those where the

trust was asked to provide evidence. 13 S42s were about potential harm that a patient may have received in our care or where there has been a time delay. The other 66 were S42s that the Trust was asked to provide a summary of involvement as concerns had been raised on the care delivered by other providers.

Areas of learning for SECAmb are recorded and monitored at the bimonthly Safeguarding Sub-Group. The example below highlights the outcome of a Section 42 enquiry and the subsequent learning for the Trust in relation to the patient's experience whilst waiting for an ambulance.

Care Act - Section 42 Enquiry - case summary

Patient called 111 as her dog had bitten her ear
111 called back on several occasions but closed the call when no contact was made
The patient called back the following day as she had missed the calls and an ambulance was arranged

On hospital examination it was found the damage to the ear was significant and likely to have profound consequences for the patient as she was already hearing impaired and this impacted her ability to wear hearing aids
It was found that the original call have been handled effectively meaning a better experience for the patient and a greater chance of saving the ear.

Areas of learning Section 42 Enquiry
The Trust highlighted the fact that major trauma to the ear was not sufficiently recognised within the NHS Pathways triage system and raised to NHS digital for potential revision in future updates.

Requirements under Section 47 of the Children Act
Under the requirements of the Children Act (1989) a section 47 investigation will involve social care receiving a referral from SECAmb or another agency that results in a local authority suspecting that the child is suffering or likely to suffer significant harm. A Strategy Discussion Meeting will be held to decide whether to initiate enquiries under Section 47 of the Children Act 1989.

Strategy Discussions/Meetings will contact SECAmb to establish if the Trust have had any information in relation to the children or family as it is acknowledged that SECAmb will often have information that others will not be due to the way our service is accessed. The Safeguarding Team supported 21 Section 47 enquiries during the reporting year.

Children's Act - Section 47 Enquiry - case summary
SECAmb were asked to participate in a strategy discussion for a child who we attended when intoxicated. When intoxicated the child disclosed that she had been sexually abused by her father. A Specialist Safeguarding Practitioner attended a strategy meeting and discussed our involvement in the case. SECAmb were thanked for their contribution and vigilance as this was the first time, she has disclosed said abuse.

A Section 17 enquiry is a query in relation to a Child in Need assessment under the Children's Act 1989. A child is defined as being in need either through disability or poor health and they are unlikely to achieve or maintain a reasonable life or a reasonable

standard of health or development, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority. There were no Section 17 investigations that SECAmb were asked to support during 2021/2022.

7. Reporting Serious Incidents (SIs)

Contained within the safeguarding commissioning standards are the expectations that SECAmb will ensure that any serious incidents are reported and are investigated in line with the Serious Incident Framework. Additionally, the Trust needs to ensure that any serious incident related to safeguarding children and adults is reported to the lead commissioners. As has been highlighted elsewhere within this report regular exception reporting to the lead commissioner provides assurances on the overlap between SIs and safeguarding. A senior member of SECAmb's Safeguarding team sits as a core member of the trust's Serious Incident Group (SIG). Representation from Safeguarding is also documented in the Terms of Reference for SIG.

According to the Serious Incident Framework developed by NHS England in 2015, the purpose of SI investigations in the NHS is to identify learning to prevent recurrence. The Framework. SIs in the NHS also include 'actual or alleged abuse…acts of omission and organisational abuse where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring'. This includes abuse that resulted in or was identified through a Safeguarding Practice Review, Safeguarding Adult Review, Safeguarding Adults Enquiry where delivery of NHS funded care caused or contributed towards the incident.

During 2021/22 the Trust declared 67 Sis, 7 of these had a safeguarding element because of adults or children at risk receiving sub-optimal clinical care where Local Authority safeguarding thresholds were met. An SI was declared because of incidents relating to staff conduct that met the safeguarding thresholds documented within the SECAmb's Managing Safeguarding Allegations policy. Further information on these cases will be addressed in Section 10 of this report.

Examples of safeguarding concerns coordinated by the safeguarding route included:

- Operation Carp – Theft by distraction burglaries of patient's medication by two staff members who are no longer employed.
- Time delays have been escalated via the SI process, during the SI process it has been looked at whether the time delay caused harm to the patient. If the case meets the criteria for a S42 then SECAmb will raise this.

Learning from SI investigations with safeguarding concerns are reviewed at the Trust's Safeguarding Sub-Group where any subsequent assurance or risks are escalated via the Clinical Governance route jointly chaired by the Executive Medical Director and Executive Director for Nursing & Quality.

8. Engaging in SCRs/SARs/DHRs/Partnership Reviews

In line with the Local Safeguarding Children Partnerships arrangements the key guidance for Safeguarding Practice Reviews (SPRs) (formally Serious Case Reviews) is *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* (D; for Safeguarding Adult Boards (SABs) the Care Act 2015

introduced the requirement to undertake Safeguarding Adult Reviews (SARs). Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

Safeguarding activity across our key partners and local authorities continues to demonstrate year on year increase in activity. During 2021/22 SECAmb were asked to contribute to 82 Serious Case Reviews, Safeguarding Children's Reviews and Domestic Homicide Reviews. This is an increase in the number for the previous year.

Throughout April 2021 – March 2022 SECAmb were asked to contribute Summaries of Involvement to commissioning Safeguarding Boards and Community Safety Partnerships to 54 an increase of 30 on the previous year SPRs/Rapid Reviews, 41 SARs an increase of 5 on the previous year and 14 DHRs across Kent & Medway, Surrey, Sussex and Hampshire. The number broken down into each local authority is:

- 1 Brighton and Hove SCR
- 2 East Sussex SAR
- 1 East Sussex DHR
- 9 SPR/Rapid Reviews Children East Sussex
- 7 DHR Surrey
- 17 SCR/Rapid Reviews Surrey
- 3- SAR Surrey
- 10 Rapid Review/Safeguarding Practice Reviews West Sussex
- 1 DHR West Sussex
- 5 DHR Kent
- 17 SCR/Rapid Reviews Kent
- 36 SAR Kent

Areas of wider learning following these reviews have been shared across the organisation using various methods, including training examples, to cascade.

9. Safer Recruitment and Retention of Staff

The Trust's Recruitment and Selection Policy and Procedure confirms that all job descriptions include a statement on the roles and responsibilities to safeguard and promote the welfare of children, young people and adults at risk of abuse and neglect. The safeguarding statement in all job descriptions take into account the work of all staff and volunteers throughout the organisation. All contracted services or individuals that work in regulated activity for the Trust follow safer recruitment processes.

In line with commissioning standards for safeguarding, SECAmb has a process in place to respond to positive Disclosure and Barring Service (DBS) concerns. All cases whereby a disclosure is made or a DBS check identifies previous convictions/cautions etc. will be reviewed by the DBS panel. The panel will consist of a member of the HR recruitment team, a senior operational manager and a senior safeguarding representative. The HR representative will ensure that the decisions made, and the rationale for them, are captured, shared in a timely manner and held securely. All decisions will be made by the operational and safeguarding representatives.

Assurance provided by the Trust's Recruitment Service Centre stated that at the time of writing SECAmb had eleven employees (0.25% of the total) who were outstanding with DBS renewal. For the new starters in 111 / EOC – they do not have any access to patients for the first 4 weeks of employment whilst they are in training. If the DBS is not back within this timeframe hiring managers are informed and they are not able to work unsupervised for the period until it comes back

10. Managing Safeguarding Allegations Involving Members of Staff

SECAmb is required to adhere to statutory guidance in Working Together to Safeguard Children 2018, the Care Act 2014 and the Safeguarding Boards' multi-agency procedures. The Trust therefore has a duty to report any incident where a member of staff has behaved in a way that has or may have harmed a child/adult at risk, acted inappropriately towards a child/adult at risk or committed a criminal offence against or related to child/adult at risk.

The Trust's Managing Safeguarding Allegations policy and procedure sets out how SECAmb manages any allegations against employees relating to the abuse of children and adults at risk.

This policy seeks to prevent and address abuse by those who work with both children and adults at risk, particularly children and adults who may be at increased risk and may be unable to protect themselves from harm because of their care and support needs.

The policy sets out the Trust's commitment to safeguarding children and adults from abuse and neglect and gives direction to enable the Trust to deliver an appropriate response. The procedures also clarify the actions than the Trust are expected to take in the event to the relevant external agencies including the Local Authority Designated Officer (LADO) and the Care Quality Commission (CQC) if appropriate.

During 2021/22 allegations of a safeguarding nature were made against a total of 27 members of staff. 21 allegations met the threshold of the Managing Safeguarding Allegations policy. Safeguarding were consulted on the remaining cases but did not require escalation via the safeguarding route. This demonstrates over a 20% reduction compared to the previous year.

Concerns escalated via the safeguarding route included:

- allegations of sexual harassment and predatory behaviour both inside and outside of the workplace.
- allegations of serious sexual misconduct
- perpetrating domestic abuse and allegations of controlling and coercive behaviour.

All cases had been managed in line with the Managing Safeguarding Allegations policy with evidence that risk assessments were undertaken as per the Trust's Disciplinary Policy where concerns arose about the employee's behaviour occurring outside of their employment with the Trust.

Where allegations have been made either by the patient, member of the public or member of staff, in addition to discussion with police, local authority and CCG, cases have been escalated to the Serious Incident Group for consideration in line with the Managing Safeguarding Allegations policy.

Following an escalation in increased numbers of serious safeguarding allegations made against SECAmb staff for the year from October 2020 – October 2021, the Safeguarding Lead and Nurse Consultant were requested to present a paper to a dedicated sub-group of the trust's Quality and Patient Safety (QPS) Committee during the autumn of 2021. The sub-group was set up to further explore the issues and to seek assurance that there was senior leadership oversight that provided grip and traction on these concerns. It was chaired by the Chair of QPS and consisted of the NED with responsibility for safeguarding and Executive Directors of Operations, Nursing & Quality and HR. Additionally further support was provided by the Trust's Freedom to Speak Up Guardian who had also received whistleblowing disclosures identifying concerning behaviours.

The paper highlighted a number of key themes that were consistent across the allegations.

The themes highlighted: -

- The majority of alleged perpetrators in the above cases are male.
- 8 alleged perpetrators were female, one was engaging with another male perpetrator, 2 female perpetrators were engaging with each other
- Where concerns had been disclosed regarding the female perpetrators, only one was related to inappropriate sexual behaviour
- Where known, all the alleged victims are female.
- 12 cases relate to behaviours IN the workplace. 5 cases relate to conduct outside of the workplace and are a mixture of colleagues and unknown individuals. 52% of the cases relating to sexual harm involve contact with other SECAmb employees.
- 2 cases involving sexual harm involved conduct with or relating to children. This is a reduction in the number compared to last year's figures. The prevalence of paedophilia in the adult male population is notoriously difficult to measure, but it is often placed between 1-5% (this does not suggest 1-5% of people will act on or commit an offence). This suggests that whilst 2 cases in 15 months seems high, it is far less representative than in any similar sized cohort of individuals.
- 5 cases of domestic violence were recorded. In contrast to the observation above, it's known that domestic abuse and violence (DVA) is very prevalent in any given cohort, and estimates suggest between 1 in 3 and 1 in 7 women will experience DVA in a lifetime. This suggests that DVA is under reported.
- 15% (6) of cases involved patients, of these cases were 4 dismissed following review by the police. This could suggest that staff are better at maintaining professional boundaries with patients than their own colleagues. It could also suggest that fellow professionals are more likely to raise a concern when something happens to them that they do not find acceptable. Finally, it is possible that there is an unconscious bias to give more credence to an allegation from a professional, not a patient. In some of the cases involving patients, there was a history of poor mental health. This could again invoke bias, although there is no evidence that is the case.

Assurance can be provided that Safeguarding involvement in allegations of a safeguarding nature ensures wider patient safety in supporting vulnerable individuals who suffered abuse as a result of a SECAmb employee. Secondly, assurance can be provided that a senior member of the Safeguarding leadership team is consulted on cases appropriately. Thirdly, assurance can be provided that concerns are escalated to the police, LADO, CQC and

commissioners in a timely way. Finally, partnership working between Safeguarding, HR and Operational Teams ensures that referrals were made to the HCPC or relevant regulatory authority where appropriate.

11. Mental Capacity Act Policy

The Mental Capacity Act 2005 (MCA) provides a legal basis for determining an individual's capacity to make decisions at the time they need to be made.

The Trust's MCA policy is for all staff working within SECAmb who are involved in the care, treatment and support of people over the age of sixteen (living in England or Wales) who are unable to make some - or all - decisions for themselves.

The policy is designed primarily for all staff who have direct patient contact; however, all staff have a duty to act in accordance with the MCA.

Following the findings of the 2018/19 Clinical Audit Department MCA audit that demonstrated gaps in the Trust's MCA compliance, the Trust increased Mental Capacity Act classroom based Key Skills training over the past two to three years. However, as has been highlighted previously in the report, 2020/21 and 2021/22 has seen how the global challenges of the coronavirus pandemic has had on the Trust's ability to deliver safeguarding training across the Trust.

The trust during 2021/22 has seen an increase in enquiries through the on-call service in regard to MCA queries.

The trust's MCA policy and procedure has been reviewed and updated in line with national guidelines and terms. This has been done with support from external subject matter experts at Surrey Heartlands and Surrey CC alongside colleagues within the trust.

Liberty Protection Standards information was delayed due to the Covid pandemic therefore information regarding this will be shared with staff where necessary as more information comes in.

12. Conclusion

Despite the significant challenges presented by the Covid-19 pandemic, 2021/22 we saw increasing demand on the safeguarding function across the Trust. Safeguarding is 'everybody's responsibility'; the year has demonstrated new and innovative practices that embedded safeguarding approaches within other vital functions of the Trust's business and directorates. Closer partnership working with the Trust's key stakeholders has demonstrated improved outcomes for vulnerable people across Kent, Medway, Surrey and Sussex.

The work of the Safeguarding Sub-Group continues to flourish and is responsible for scrutinising and gaining assurance of every aspect of the Trust's safeguarding function. A consistent focus on raising awareness of domestic abuse, low level parental mental health and increasing care needs for vulnerable people as a result of lockdown has seen a considerable increase in referrals to the Safeguarding Team who in turn have contributed to increases in the trust's contribution to internal and externally commissioned multi-agency reviews across Kent, Surrey & Sussex.

Learning from incidents, complaints and safeguarding reviews have allowed the team to contribute to organisational learning and the priorities for 2021/22 will ensure that, despite the best efforts of a global pandemic, protection and learning will be central to the safeguarding function.

SECAmb Board

QPS Committee Escalation Report

Overview of issues covered at the meeting on 15.09.2022

Item	Purpose	Link to BAF Risk
Quality Summit	To update the committee on the recent summit and any early outputs / next steps	Risk 14 – Operating Model Risk 256 – Quality Improvement
This is our first Quality Summit and the plan is to have two each year, in September and March. The idea is to use these to ensure a collective understanding with system partners of the key delivery issues affecting patient safety and quality. The focus of this summit was about keeping patients safe when the service is experiencing high demand. Specific areas were identified where risks occur such as in call taking; triage; clinical oversight; dispatch; on scene assessment and care; and decision making. Each of these were explored in detail to establish mitigations. The committee asked for a written summary next time and sight of the Terms of Reference. Members will be invited to future summits.		
Safeguarding	This was a management response to gaps in assurance identified at the previous meeting, related to the Annual Report, seeking further assurance on capacity of the team, how we identify and take action arising from trends, and training compliance.	N/A
A helpful management response was received but the committee is still not fully assured that there is the capacity to deliver the level 3 training, 85% by 31 March 2023. The committee is not escalating this to the Board, but asking it to note this gap in assurance and that further assurance has been requested for the next meeting, specifically in relation to training and timescale for the business case for the additional roles.		
Medicines Management	To seek assurance on progress with this priority within the Improvement Journey.	Risk 257 – Improvement Journey
The quality of paper received was not of the standard expected and so despite the information provided verbally by the Chief Pharmacist, which was helpful, the committee was unable to take adequate assurance. There is much in the workplan, including the development and approval of business cases. There are a number of risks identified on the risk register and this is reassuring in terms of visibility of the issues. However, many of the actions listed do not have timescales. One business case was approved by the Executive Management Board in September for a programme manager to lead the 12 distinct programmes. It is however unclear yet when this person will be in place. Overall, while the committee acknowledged there are plans in place, the executive has not demonstrated sufficient tangible progress. The committee is not escalating this to the Board for specific action, but rather to note the gap in assurance identified and that the committee has asked for further assurance at the next meeting.		
Incident & Harm Governance	To seek assurance on progress with this priority within the	Risk 257 – Improvement Journey

	Improvement Journey.	

The Trust continues to make good progress in achieving the targets set to reduce the backlog of breached SI actions and investigations. The demand on services means that the SI team still see much poor patient experience, however new learning is being identified regularly and steps are being taken to develop a more formalised approach in the identification and dissemination of this learning.

Now that the new NHS Patient Safety Incident Response Framework (PSIRF) has been published management will be working closely with commissioners and partners over the forthcoming months to develop the mechanisms for implementing this new framework. A briefing paper will come to the Board in November setting this out.

In summary, the committee takes reasonable assurance from the progress made to reduce the backlog of Sis., but there is more still to do to ensure learning and how this is communicated.

Infection Prevention & Control	To seek assurance that the controls in place are effective in ensuring the right culture and management for IPC.	N/A

The Head of IPC joined the meeting to set out the controls in place to ensure a good IPC culture. The audits are showing partial compliance in different areas and this is about the completion of audits. Training is ongoing and this is aimed at ensuring better data, which is the case with hand hygiene. There was a gap in assurance identified related to the process of quality assuring the audits and the committee asked for the SPC charts to reflect the format within the new IQR. Otherwise, the committee was reasonably assured overall with the controls for IPC.

Clinical Audit	To seek assurance on the delivery of the clinical audit plan and how this is supporting delivery of safe and effective care to patients.	Risk 256 – Quality Improvement

The audits have been completed as per the agreed plan. However, some of the tier 1 audits (national requirement) are showing that we are below the national average. This led to a constructive discussion about some of the quality indicators and where we fail on some of the care bundles, this is due to a specific item, such as recording the pain score / blood sugar level, as the Board has been previously made aware. The clinical view is that some of these indicators are in fact less significant in terms of patient outcomes and there is a national drive to adjust these requirements. The committee asked the medical director to ensure this is raised to national medical directors who are decision makers on the ambulance quality indicators and ask for a timeframe for review on what we are being assessed against, given the increasing clinical view that some measures aren't right.

Some of the actions arising from clinical audit are overdue and while the position is improving the committee has asked for further assurance on the plan to reduce this further still.

Research & Development Annual Report	To seek assurance that the R&D continues to be effective and contributes to the experience of our people and patients.	N/A

We are fortunate to have a really experienced and passionate Head of R&D who attended the meeting to present this annual report. Key headlines include us still seeing growth in activity and in our strategic aim to grow capacity for research within our workforce.

The annual report was helpful and some suggestions were made to strengthen it in future, such as more detail / assurance on how we are fulfilling our obligations, including those that arise when we are a sponsor

of a study. The internal governance appears strong with a system sub-group which meets monthly. There is also a portal where people can seek advice on research and the intranet has various resources. Good assurance was received too about how we follow the national framework requirements on governance and the close links with the IG team on data sharing.	
Specific Escalation(s) for Board Action	There are no specific escalations for Board action arising from this meeting

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	56-22

Name of meeting	Board
Date	29.09.2022
Name of paper	People and Culture - Executive Summary to the Board
Strategic Goal	Focus on People
Lead Director	Ali Mohammed, Executive Director of HR and OD
Primary Board Papers	BAF Risks 255 (Recruitment), 13 (Culture, Leadership and Retention) Integrated Quality Report (slides 17-24) Improvement Journey (People and Culture)
Executive Summary	In terms of key people risks, we continue to operate at a sustained level of high operational pressure leading to increased staff turnover and sickness – both of which are compounded by poor staff experience, culture and management. Internal communications and staff engagement are also consistently flagged as needing improvement and change. The latest national quarterly pulse survey (July 2022) also reflects the operational pressure and poor staff experience – consistent with the 2021 staff survey. The IQR reflects this through the key metrics set out in the Overview (slide 18) and the number of processes currently assessed as likely to fail against year-end targets *(note – where processes do not lend themselves easily to target numbers e.g. open FTSU cases, benchmarking with similar Trusts should, in future, help provide useful data for improvement purposes).* Whilst time to hire is significantly improving through process improvements, this will not offset sufficiently the turnover rates. EMB has discussed the future approach to staff retention on 21 September 2022 and agreed that a small number of high impact actions should be focused upon for the remainder of 2022/23 and that these should be further developed in a workshop in October. Likely areas of focus will include those areas with highest turnover, developing a more flexible approach to careers and supporting staff more with development. Staff concerns continue about late sign offs and meal breaks - our capability to improve in this area is directly related to increasing the resource availability in relation to demand received as well as redesign of working patterns and focusing more on abstraction management. Whilst employee relations and FTSU cases remain at a high level, sustained focus on the most serious cases (these normally involve staff suspensions) has resulted in improvements as evidenced by the falling number of staff now suspended due to alleged serious misconduct. As a proportion of cases, we are still seeing a high number of cases related to sexual misconduct but this was also expected due to encouragement to staff to report alleged misdemeanours as part of the Until It Stops sexual safety campaign. Training workshops for all managers in sexual safety at work continue.

	As part of the Improvement Journey, improved focus through better analytics has allowed improvements in employee relations case handling times. We have also now started the NHS Culture and Leadership Programme with a Board commitment session in August 2022 and have committed to develop a modernised approach to employee engagement with increased capacity being sourced to work on this from NHSE. Importantly, other key activity within the People and Culture work programme has been commitment to implementation of a Just and Restorative Culture. A specific workshop was held with EMB/SMG on 21 September with a commitment to further workshops in October 2022. Key HR and union representatives have undertaken development in early resolution methodologies (Routes to Resolution training provided by TCM, a specialist employment training provider) with the aim to resolve as many ER cases informally as possible. This is a critical intervention in reducing our overall caseload as well emphasising and supporting the critical role of line managers in respect of managing their teams.
Recommendations, decisions or actions sought	We continue to face a number of operational and workforce challenges. These are reflected with the BAF and Trust Risk Register. It may be that a further specific BAF risk is necessary in respect of culture and **it is recommended that the Board should agree this.** The work set out in the Improvement Journey People and Culture workstream focuses initially on those areas within the CQC warning notices but importantly also starts to address the deeper issues in respect of culture, leadership and staff experience. **It is recommended that the Board endorse the actions taken to date and individually and collectively own and support the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience.** The **Board should also discuss** whether additional measures and support are required to progress this critical workstream – this should then be tasked to the Executive to ensure delivery infrastructure is in place.

Southeast Coast Ambulance Service NHS Foundation Trust

WWC Escalation Report to the Board

Overview of issues covered at the meeting 26.08.2022.

Item	Purpose	Link to BAF Risk
Improvement Journey – People & Culture	To seek assurance on progress with this priority within the Improvement Journey.	Risk 13 – Workforce / Retention Risk 257 – Improvement Journey Risk (tbc) – Workforce / Culture
Noting that this meeting was the day after the Trust Board meeting, which received the Improvement Journey, the live plan was tabled. The committee acknowledged that there is insufficient progress and supported the decision by the executive to put this programme in to 'intensive support'.		
Management of Violence & Aggression	This was a management response to gaps in assurance identified at a previous meeting, related to the effectiveness of measures we have in place to support staff and keep them safe.	Risk 13 – Workforce / Retention
The quality of this paper was poor and so it was difficult to seek any assurance. See escalation below.		
EOC/111 Culture Action Plan	To seek assurance on progress with the established action plan and to assess its impact on the cultural issues identified.	Risk 13 – Workforce / Retention Risk (tbc) – Workforce / Culture
While the committee acknowledged the progress, indicated by the Good CQC rating earlier this year, there is still concern about progress and pace. The paper did not help as it had too many gaps. See escalation below.		
Leadership & Management	To seek assurance on progress with the fundamentals management / leadership programme, e.g. that the scheduled sessions are taking place and that they are effective.	Risk 15 – Education Training & Development Risk (tbc) – Workforce / Culture
The committee really welcomed this given the gap in training in the past few years. Training places have been increased to cope with the demand, which is positive. It only started in July and so while the committee explored its impact and whether it will cater adequately for the different demographics it is too early to make a proper assessment of this. The executive did assure the committee that it will be kept under		

constant review so adaptions / improvements can be made between cohorts, using the feedback received.		
Development of a Retention Plan	To seek assurance on progress with the development of this plan.	Risk 13 – Workforce Retention
A draft plan was received and the committee provided some feedback on the areas requiring development. Including the need to triangulate this with the workforce plan.		
Clinical Education	To seek assurance that we are delivering against this strategy and specifically that it is helping to support the 2022/23 Integrated Plan.	Risk 255 – Workforce Recruitment
The committee was reasonably assured with the progress against approved Clinical Education and Training Strategy 2022-25. It was also made aware of an issue with marking by Crawley College and how this was being escalated to ensure the right corrective action.		
Medway Move	To seek assurance that we are effectively managing the people issues connected to the move to / opening of Medway.	Risk 13 – Workforce Retention
This helped to ensure better awareness of the issues affected some of the people involved in this move, which is part of the Trust's strategic estates plan. There are over 100 staff that potential won't be moving and the consultations are ongoing, and a clear plan is expected by the end of October. The project team has ensured the risk(s) are recorded on the risk register. The committee will at its next meeting review this risk and the mitigations.		
Staff Survey / Pulse Survey	To seek assurance on the actions in response to the staff survey and their impact. And to ensure greater visibility on the programme of pulse surveys and what intelligence this is providing.	Risk 255 – Workforce Recruitment Risk 13 – Workforce / Retention Risk (tbc) – Workforce / Culture
The committee is not assured by the actions taken or overall engagement with the workforce on the specific feedback from the staff survey, especially locally.		
Health & Wellbeing	To seek assurance that we are doing all we reasonably can to ensure the health and wellbeing of our workforce.	Risk 13 – Workforce / Retention
This item was deferred due to staff sickness. However, the committee took the opportunity to reflect		

feedback from recent leadership visits where staff have expressed concern about wellbeing impacts on them from the rota review. The committee asked for more information about this, which will be included in the deferred health and wellbeing paper.	
Specific Escalation(s) for Board Action	**Management of Violence & Aggression**: The committee has sought assurance a number of times in this area over the past 12 months and is concerned by the lack of any 'strategy' or action plan to give assurance that we are adequately managing incidents of violence and aggression.
	EOC/111 Culture: Acknowledging the progress that has been made, as reflected by the CQC Good rating of 111, the committee identified concern about the slow pace in some areas (not helped by the paper not being of good quality) and the apparent lack of senior ownership to drive the changes identified by the review in 2021. There is also potential adverse impact on the workforce plan and no scenario planning evident.
	Staff Survey: There is a lack of progress by local teams throughout the Trust to engage with their people on the staff survey feedback. And in the context of the most recent Pulse Survey results, there is concern that, notwithstanding the work via the Improvement Journey, there has been insufficient engagement to demonstrate to our people that changes have been / are being made.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	57-22

Name of meeting	Trust Board
Date	29 Sept 2022
Name of paper	Executive Summary to the Board
Trust Priority Area	**Delivering Modern Healthcare**
Author / Lead Director	Emma Williams, Executive Director of Operations
Primary Board Papers	BAF Risks: 13, 14, 16, 17, 255 Extreme/Corporate Risks: 22, 23 Integrated Quality Report 25 to 36 incl. Improvement Journey slides 24 to 34
Executive Summary	The delivery of the operational model within SECAmb is highly complex with a multitude of dependencies and interfaces across the south-east region with health and other local partners. These factors create and sustain risks and issues which directly contribute to the sustainable performance of the 999 and 111 services. The most significant risks at present relate to three components: 1. The design of the operational model of delivery 2. Sustainable staffing through successful strategies of recruitment and retention 3. The required engagement with and implementation of changes to the national guidance regarding delivery of care <u>The design of the operational model of delivery</u> The BAF risk (ID 14) describes the underlying issue that the operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need, and as a result the national performance standards are not being met. Whilst the current model has undergone some development over time, it is still based on core principles which no longer fully recognise the delivery environment in which we find ourselves. For example, the plan to have a majority registrant workforce delivering physical care through face-to-face vehicle-based delivery is neither sufficiently flexible nor dynamic to be able to respond to the sustained changes in demand that are being seen at present. This is true for whole trust demand as it is for specific patient groups such as the increasing workload associated with urgent and social care type presentations being seen today. The overarching metrics for the success of the delivery model are the Trust's compliance with the national Ambulance Response Programme targets for call answering and response times to C1 through to C4 incidents. These response times are shown in the IQR 'Response Times' slide where the charts show that performance against these targets have not been achieved since early 2021 – a pattern of performance seen across the

	ambulance sector. Through the Improvement Journey Programme, several actions identified will directly contribute to the development of the new delivery model. For example: • The creation of the Clinical Advisory Group (CAG) will bring together clinicians from across the Trust, who will undertake work designed to challenge and improve the quality and mechanisms of care delivered to patients. • In addition, the recent review of the dispatch function with the Emergency Operations Centre (EOC) by external experts has provided additional recommendations for changes and improvements designed to ensure the function is more efficient and thus delivery improved patient care and staff working conditions. • Finally, there is additional focus on the 'Hear & Treat' component of the model, recognising that hybrid working for staff is increasingly attractive, and for many patients who have become accustomed to receiving support for all of life's functions on a remote basis, having clinical assessment, support and guidance is entirely appropriate for a range of needs. <u>Sustainable staffing through successful strategies of recruitment and retention</u> Whilst the success of the model of care delivery is based on its integral design, fundamentally it will only deliver the level of responsive, quality care that the Trust requires if it is staffed sufficiently. The recruitment and retention of staff across all operational areas and services lines are two of the most significant risks and issues we have at present. BAF risk ID 225 describes the issues relating to recruitment, focusing on the requirement to meet the contract level of staff (whole time equivalencies – WTEs), whereas BAF risk ID 13 is linked directly to the retention of our workforce. The metrics in the IQR for these components sit not just in responsive care, in terms of outputs/impacts, but also in People & Culture and Sustainability & Partnerships. There is recognition that there are increasing market challenges to recruiting Paramedics, both already qualified and those newly qualified from university, with an increasing number being attracted to join health and care settings outside ambulance services. The reasons for this position is varied, however some feedback indicates that the greater diversity of career options including portfolio careers is making non-ambulance options more attractive from a longer-term view, as well as considerations of better terms & conditions in some sectors. Within the workforce components of the Improvement Journey, there are many actions focused on the recruitment pipeline, from improving the overall planning and functionality of the recruitment processes to a significant project looking at the recruitment of international Paramedics and non-registrants, supported with funding from Health Education England. To date, the Trust has seen its first 9 international Paramedics arrive in the UK, and an additional 30 recruits from Ireland (at Technician and/or Trainee

	Associate Ambulance Practitioner (TAAP) be offered positions. With regards to the issue of retention, there is an understanding that some staff are leaving to go to other health care providers such as those described above, others are leaving health altogether, and core reasons relate to the terms and conditions currently being experienced. Work that is undergoing to address rotas with field operations, have been designed in conjunction with staff to not only meet the demand need in terms of patterns of patient presentation, but also to provide opportunities for work-life balance improvements to be planned into the new rotas. One of the other key activities sustained across the financial year to date has been the ongoing delivery of clinical key skills training for operational staff. This training is very important to all clinicians as it provides dedicated time to undertake refresher training, learn lessons from incidents and undertake some collaborative team working/learning with colleagues. Historically, as the Trust moved up escalation levels, this training was paused, sometimes for prolonged periods, however the Board made a risk-based decision to maintain the delivery of this training for the benefit of both patients and staff. <u>The required engagement with and implementation of changes to the national guidance regarding delivery of care</u> This section is quite broad and covers more tactical issues such as hospital handover times and significant structural changes such as the implementation of the Single Virtual Contact Centre across the south-east region 111 providers. End point dispositions for patients can be varied, from the classic transportation to local Emergency Departments (EDs) through to the referrals to new community and urgent care pathways including those associated with Same Day Emergency Care (SDEC) and virtual wards. The effective use of such pathways contributes to the right care outcomes for patients as well as reduced flow through the EDs, which in turn improves the position relating to overall flow through the hospital. It is also evidenced that 'see and treat' or 'see and refer' options have a shorter job cycle time and therefore also benefit the wider Trust, enabling greater efficiency in terms of reaching more calls with a timelier fashion. The actions related to this work sits within the Responsive Care Group workstream and is represented within the IQR in the 999 Response and 111/999 Systems Impact slides. Also of significant importance in this section is the risk described in BAF risk 17 relating to the integration of 111 & EOC. The risk description fully describes the associated concerns: *'There is a risk that the plan for the 111 and EOC operational models will be affected as a result of Single Virtual Contact Centre plans which are in progress following a mandate from NHS England. This may lead to negative impacts on performance, patient safety, provider agency and strategic direction.'* When the 111 service was implemented following the successful bid in 2019, and integral function supported by the commissioners was for the 111 and 999 EOC functions to be integrated in terms of workforce, function, and processes. It was felt, and has since been realised, that by using this strategy greater efficiencies and effectiveness could be achieved. However, with the advent of the Single Virtual Contact Centre (SVCC) that is being

	implemented at the instruction of NHS England, the integration of 111 with 999 EOC must be dissolved, so that the 111 service can better integrate now with the Surrey, Hampshire, and other southeast regional areas. Whilst the SVCC implementation is not within the Improvement Journey as a specific action, there are several others specifically relating to the efficiencies and effectiveness of both the 111 and 999 EOC services, all of which are important to improve the quality and responsiveness of the service and mitigate the risks caused by the required separation.
Recommendations, decisions, or actions sought	1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area. 2. That the Board note the quality metrics and performance against this Trust Priority Area. 3. That the Board note the actions being undertaken to address the risks and improve performance within this Trust Priority Area.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	57-22

Name of meeting	Trust Board
Date	29 Sept 2022
Name of paper	Winter Planning Update
Responsible Executive	Emma Williams, Executive Director of Operations

Winter planning is part of the NHS annual cycle of business to prepare providers and systems for the expected changes in demand over the period.

In addition, the winter planning activities include instructions from both regional and national bodies regarding priority areas of work across the range of providers and commissioners.

This paper is a summary of the planning to date, including the development of the draft winter plan that is scheduled for initial completion and approval at EMB at the end of September.

Recommendations, decisions or actions sought	For assurance

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

Introduction

This paper summarises the approach to winter being taken by the Trust as part of the annual planning cycle.

This year additional considerations have been included such as:

- Recognition that the UK is still at Covid Pandemic level 2 which means that COVID-19 is present in UK, but the number of cases and transmission is low,
- There are continuing significant patient flow issues across the south-east region that are directly contributing to handover challenges which in turn contributes to a reduction in availability of SECAmb resources to attend calls,
- Workforce challenges due to much higher levels of abstraction continue to result in delayed responses to calls – both call answering and attendance to incidents requiring an on-scene assessment/conveyance.

Internal planning and preparation

- A review of last year's plans by all operational service lines and directorates, and lessons identified have been incorporated in the development of the year's plans. The plans also include Performance Cell predictions of demand and resourcing across the 111 and 999 services.
- The individual plans are being collated and quality assured prior to internal approval and then sharing with commissioners – the deadline for the is the end of September 2022.
- The Trust Outbreak plan has been updated in line with national guidance
- The work to deliver improved rotas within Field Operations continues with the intention to ensure resource provision planning is more aligned to actual need, and therefore ensure a more sustained, better performing service resulting in optimal patient care.
- There is continuing recruitment at pace for Emergency Medical Advisors & Health Advisors across the 999 Emergency Operations Centres and the 111 Service Line – this is being done in line with plans & trajectories agreed with commissioners, and in-line with the national intentions linked to the Integrated Routing Platform in 999 and the 111 Single Virtual Contact Centre strategies.
- Further considerations needs to be given to the potential impact and response approach during periods of adverse weather planning.
- Risks:
    - Aging infrastructure in specific sites and the implications of service delivery from them for both staff and support functions, e.g. Coxheath.
    - Potential industrial action and the implications on maintaining a safe service.
    - Potential impact of worsening socio-economic situation on staff, particularly those in the lower paygrades.

External engagement and partnership working

- Continued participation in Local Health Resilience Partnerships (LHRPs), working with health provider partners across all counties to develop shared plans for the continuation of care delivery in all circumstances.

- Continued participation in county-based Local Resilience Forums (LRFs) winter preparedness programmes – each forum holds an annual summit delivering integrated planning across health and non-health organisations
- Participation in local, regional, and national exercises:
  - Local, e.g. contingencies associated with acute trust concerns above/beyond current delivery challenges
  - Regional, e.g. contingency planning for utilities outages
  - National, e.g. attendance at the Winter Preparation Event – Winter Preparedness: Reducing Risk and Sharing Good Practice (London, 28/09/22)
- Risks:
  - Potential industrial action across health and other agencies/services
  - Fragility of the provider networks, particularly in social care and the impact on patient flow in health
  - Potential worsening socio-economic pressures resulting in an increase in levels of vulnerability in the community
  - Increased scrutiny and reporting requirements at a regional level
  - Lack of consistent, sustainable system approaches through to resolution for individual provider issues

Horizon scanning

It is essential that we remain vigilant to new and emerging risks and issues which include, but are not limited to:

- Covid new variants
- Influenza outbreaks
- Norovirus and Respiratory Syncytial Virus (RSV)
- Fragility in the supply chain – medical and other essential supplies (suppliers and products)
- Political instability including on an international scale

Additional considerations

On 12 August 2022 a letter was sent to Integrated Care Board Chief Executives and Chairs, and NHS Foundation Trust and NHS Trust Chief Executives and Chairs, from Amanda Pritchard, Julian Kelly and Sir David Sloman entitled Next steps in increasing capacity & operational resilience in urgent & emergency care (Appendix 1).

This letter outlined several core objectives and key actions for operational resilience and provided a new approach to working together for performance and accountability. These objectives have been developed in partnership with the wider NHS, and within the letter, with support from NHS England, through the sustained implementation of all the objectives, systems should be able to better manage pressure across the pathway, supporting improved flow for patients in emergency departments.

The key objectives applicable SECAmb are listed below with updates of the current SECAmb approach/position:

Demand & capacity

- Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500.
    - The Trust continues to recruit to the plan agreed with commissioners which is in-line with the national planning expectations to support the implementation of the Single Virtual Contact Centre.

Ambulance Service Performance

- Implement a digital intelligent routing platform and live analysis of 999 calls.
    - The Trust continues to engage with the development and implementation of this programme – currently expected to go live mid-October.
- Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand.
    - SECAmb are in a stronger position for this due to the continued implementation of the 'Immediate Handover procedure' when queuing ambulances meet the threshold.
- Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-ED capacity.
    - Through local team engagement as well as via Strategic discussions, the issue of handover remains a priority and one that is scrutinised by all partners.
- Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls.
    - The approved fleet strategy sets the direction for the use of single response vehicles, recognising the Trust prioritisation of double-crewed ambulances. The CQUIN for 2022-23 relating to falls is rolling out a programme to trial pairs of Community First Responders (CFRs) to attend elderly fallers who are still on the ground.
- Model optimal fleet requirements and implement in line with identified need.
    - See above
- Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts.
    - Working with St John Ambulance who won the bid to deliver this service continues to ensure all appropriate governance is in place – recognition that the offer is for a maximum of 1 ambulance per NHS Trust per day (24hrs).
- Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce.
    - SECAmb already have this in place, however the team are reviewing the current provision to ensure it meets the demand.
- Increase the use of specialist vehicles to support mental health patients.
    - There are ongoing discussions with Trust commissioners to consider this and in the week ending 16 Sept 2022, the Lead Commissioner submitted a bid on behalf of all SECAmb commissioners relating to potential numbers of specialist vehicles they would like – delivery isn't expected until 2024.

Appendix 2 shows the ambulance extract from the ICS assurance framework related to these national requirements. Included are comments as to SECAmbs current position.

Next steps

Action	*Description*	*Owner*	*Deadline*
Plan completion	Completion of the development of the 2022-23 SECAmb Winter Plan, recognising that it will remain a live document, under constant review.	Dave Williams. Head of Resilience & Specialist Operations	23/09/22
Plan approval	Once complete, the plan will progress to the Executive Management Board for approval on 28/09/22, after which it will be shared with ICB system resilience and planning leads.	Dave Williams. Head of Resilience & Specialist Operations	28/09/22
Plan monitoring & oversight	Follow-up and monitoring will be via the Resilience Team with oversight through the Resilience Forum with updates and escalations to the Senior Management Group.	Dave Williams. Head of Resilience & Specialist Operations	October 2022 onwards
Review of risks	All risks associated with the plan (including those listed within the paper) are under review and will be updated/entered onto the risk register by mid-October at the latest noting that further work is required to quantify likelihood and impact on several of them.	Dave Williams. Head of Resilience & Specialist Operations	14/09/22
Plan delivery	Local teams will continue to deliver their functions, enacting the plan as, when, and where required.	Local team leadership teams	Ongoing
Incident Coordination Centre (ICC)	In line with other Trusts, consideration of the implementation of a winter Incident Coordination Centre is being worked up to assist in communications with partners at a local, regional, and national level.	Dave Williams. Head of Resilience & Specialist Operations	14/09/22

Appendix 1: Extracts from Letter: Next steps in increasing capacity & operational resilience in urgent & emergency care [NHS England, 12 August 2022]

Source: NHS England » Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

Letter to:
- Integrated Care Board Chief Executives and Chairs
- NHS Foundation Trust & NHS Trust:
  - Chief Executives
  - Chairs
- Regional Directors

From:
Amanda Pritchard, NHS Chief Executive, Julian Kelly, Chief Finance Office – NHS England & Sir David Sloman, Chief Operating Officer – NHS England

Core objectives and key actions for operational resilience

Our collective core objectives and actions are to:

- **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
- **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
- **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
- **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

This plan is underpinned by a new approach to how organisations in the NHS work together – the Health and Care Act 2022 has enshrined Integrated Care Systems in law. Although this winter presents significant challenges, it is an opportunity to show how these new ways of working can make a real difference to patients and join up the entire urgent and emergency care pathway in ways we've been unable to do before.

Appendix 2: Extracts from Assurance Framework: Next steps in increasing capacity & operational resilience in urgent & emergency care [NHS England, August 2022]

Source: assurance-framework.xlsx (live.com)

The Assurance Framework in its entirety is designed to be a helpful tool to support ICBs in their responsibilities to both support and hold the system to account on committed deliverables. We have a unique opportunity to co-design how we evolve this assurance mechanism in a way that it brings the NHS together with a strong sense of responsibility and accountability. ICBs are asked to consider during their September Boards what their trajectories should be against the key metrics identified in the plan. These will be used to monitor progress and delivery in collaboration with the NHSE regional teams, performance against key metrics; sample **Scorecard** and indicative **Dashboard** included.

Urgent & Emergency Care (UEC) Framework: Ambulance (AMB), Ambition - Patients receive timely emergency and urgent ambulance care and conveyance, with minimal delays

Within this framework are 12 components including: Integrated Urgent Care (111), Ambulance, High Intensity Users, Alternative Acute & Community Pathways, Emergency Department (ED), Treatment in the Emergency Department, Staffing (in EDs/Acutes), Urgent Treatment Centres, Flow, Mental Health, Operational Management Escalation and Integrated Care Boards (ICBs).

Below is the table of ambulance components

Key lines of enquiry (KLOEs)	Current SECAmb response/position
AMB - 5. 999 call handling capacity with trajectory in place to achieve consistently a mean call response of less than 10 seconds.	Recruitment trajectories continue to be shared in a biweekly basis building on agreed workforce plans.
AMB - 6. Accessible system-wide capacity with activity to each per month, to reduce unnecessary ambulance conveyance to ED, including an updated Directory of Services for ambulance service referral to e.g. UCR; frailty services; mental health; SDEC and UTCs	Directory of Services in place, overseen by commissioners across each ICB. Local Operating Units support non-ED & referral pathway usage.
AMB - 7. Escalation processes to reduce excessive handover delays (>60) including the use of Hospital Ambulance Liaison Officers (HALOs) and how are you assured that minimum care standards are provided to any patient delayed in an ambulance?'	Handover delays monitored in live time by tactical hubs. HALOs implemented as required to support handovers including implementation of the 'Immediate Handover procedure'.
AMB - 8. Is current demand/opportunity for clinical capacity being met in EOCs to optimise Hear and Treat rates.	Further work to be done in this area – specific improvement plan in early stages, linked to the Responsive Care Workstream.
AMB - 9. Outline activity per month to enhance current paramedic access to clinical advice to improve See and Treat and time on scene e.g. through Clinical Assessment Service; 'call before convey' and ED virtual consultation models.	SECAmb provides clinical decision support through the provision of Paramedic Practitioner hubs and the Clinical Assessment Service in 111 for Kent & Sussex. Other support is available via Surrey 111 and SPoAs for community/mental health services in specific areas.

AMB - 10. Improve the integration of NEPTS as part of discharge planning to reduce the time spent ‘waiting for transport’.	NEPTS (Non-Emergency Patient Transport Service) is not applicable to SECAmb.
AMB - 11. Increase awareness of the Healthcare Travel Cost Scheme to support patient discharge.	SECAmb are not involved in patient discharge.
AMB - 12. How does the NEPTS service in the local systems meet the requirements of the NEPTS Review?	NEPTS (Non-Emergency Patient Transport Service) is not applicable to SECAmb.

SECAMB Board

Performance Committee Report

Overview of issues covered at the meeting 11.08.2022.

Item	Purpose	Link to BAF Risk
Single Virtual Contact Centre	To seek assurance that we are managing this risk effectively.	Risk 17 – Integration of 111 & EOC

There was discussion about the extent to which this risk sits with the ICS given that as a provider we will provide what we are commissioned. We are not in a position to go live due to issues still related to funding which is a requirement to be able to joint this initiative. There are also some issues to work through related to data.

The committee noted that there are risks and also opportunities. The BAF risk is framed in the context of the potential adverse impact of our strategic direction for integrating 111 and EOC. However, there is also a risk related to the impact on resources to validate calls for 999.

A more detailed review is scheduled for the next meeting in October, to ensure greater clarity on the issues related to quality, workforce, performance, and strategy.

IQR – Responsive Care **Q1 Integrated Plan** **12 week look forward**	Using this information to seek assurance that we are doing all we reasonably can to meet patient demand.	Risk 14 – Operating Model Risk 255 - Workforce Recruitment Risk 13 – Workforce / Retention

The committee reinforced the need to measure the extent to which we are meeting the standards set out in the Ambulance Response Programme, against the trajectory we have agreed with system partners, which is what we are commissioned to achieve.

The committee challenged the executive to pull out more clearly how we can contribute to the system in manging demand in different ways to help then reduce pressure elsewhere, such as emergency departments. There is a sense that we miss the opportunity to set the strategic context, acknowledging that there is work to align the system. For example, on the one hand CQC is understandably seeking assurance that we do more to meet the demand in category 3 (ARP) and on the other commissioners are scaling back resources in 111. The executive described a need for a system risk discussion and will raise via the System Assurance Meetings.

There was a detailed review of the progress with the Integrated Plan 2022/23. Despite the challenges to always respond in a timely way to patients (which is seen across all ambulance services), the Trust did in Q1 meet the agreed ARP trajectories. However, this is caveated by a recognition that there were a number of circumstances that led to this; not all the related plans were achieved. The national ARP benchmarking report also confirmed that SECAmb is in the top half of the tables for Category 1, 2 and 3.

The IQR will show these trajectories from September.

The integrated plan was helpful but the committee did ask that future reports more overtly link to patients

and quality, so that we tell the *story* of performance in relation to our people and patients. Also, where there are trends indicating concern more detailed information to inform the assurance that related actions are adequate.

There was also specific action for the next meeting, which relates to the Responsive Care priority in the Improvement Journey, where the committee has asked for a deep dive in to:

- Hear & Treat – while this is showing improvement further assurance is needed to inform the confidence in meeting the 13% target for year end, acknowledging this is a key driver for better responsive patient care.
- Job Cycle Time – to better understand the actions and how these will improve patient care

Lastly, there was a thorough review of the provision of hours to meet patient need. Sickness in particular is a significant barrier to ensuring more resources are available to respond to patients. In addition, we are not yet at establishment and attrition is much higher than planned. This risks completely undermining our recruitment plan. The committee is extremely concerned by this – see the escalation below.

Responsive Care IJ Priority	To seek assurance on progress	Risk 14 – Operating Model Risk 257 – Improvement Journey
Overall reasonably assured with progress. However, some concerns were identified related to rota implementation; the framework was clear but there is little data on progress, despite this starting in January. A management response was requested for the next meeting on the rota review. The committee also asked more generally for better information to include the evidence and impact, which the director of planning confirmed was in the plans anyway for the IJ reporting to Board from August.		

Specific Escalation(s) for Board Action	**Integrated Plan**: There is a significant risk (BAF risk 13) 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. *NB - This was escalated via the Chair's report in August with an action agreed to update in September (see minute)*

SECAMB Board

Finance and Investment Committee (FIC) Escalation Report

Overview of issues covered at the meeting on 08.09.2022.

Item	Purpose	Link to BAF Risk
Financial Performance & Planning	To seek assurance that we are managing our resources in line with plan.	Risk 16 – Financial Sustainability

Key points at Month 4:

- In line with the planned deficit of £1.0m for that period / forecast for the year remains consistent with the breakeven plan, although a number of material risks including the uncertainty on funding for both 111 and 999.
- Mismatch between funding and expenditure in 111 – working with commissioners to close this gap.
- Non-pay budgets are underspent by £1.6m
- Frontline hours are averaging 5.9 per cent below the planned level based on 2555 WTE / compensated by high level of overtime (11% of the frontline hours provided)
- The targeted level of efficiencies is weighted towards the back end of the year; £0.6m at month 4, a shortfall of £0.2m
- The underlying position, based on our current year plan and an assessment of non-recurrent funding sources, is a deficit in the range between £7.6m to £15.3m

The committee reinforced the need to engage commissioners in planning for a longer period than just one year. It also expressed concern about the impact on our people by the high percentage of overtime and the reduction in clinicians in 111 (in line with commissioning intentions) and the quality impact of this. See the related escalations below.

In addition, the committee identified an apparent anomaly whereby in 111 CAS demand is down compared with last year and with this year's plan, yet performance is poor and costs are high (over budget). It challenged the executive about the extent to which there is a clearly understood narrative that explains this and has asked for a report explaining this to come to the next meeting.

In terms of planning, the committee noted the risk escalated to the Board by the Performance Committee in August about the high attrition undermining the recruitment plan. It also noted that abstraction is 38% against the plan of 33%, accounted in the main by high sickness levels. See escalation below.

Commissioned Contracts	To seek assurance that we are effectively managing our contract and identify any potential issues, risks or opportunities.	Risk 16 – Financial Sustainability

This is a regular update to the committee on the Trust's NHS commissioned contracts and services and includes horizon scanning of potential business. The committee continues to be reasonably assured and there are no specific issues to bring to the Board's attention, save the ongoing discussions related to the extra £2m 999 funding from each ICB that was agreed.

Capital Plan	To seek assurance in the delivery of the capital plan.	Risk 16 – Financial Sustainability
The capital spend to date is £10.0m against a plan of £16.1m. The £6.1m underspend is mainly due to timing in relation to the Medway scheme, and this is expected to catch up by the year end. The plan is supported by the ICS, funded from cash, and aligns with the Trust's strategic priorities.		
Strategic Estates	To seek assurance in relation to our strategic estates programme	N/A
Statutory compliance across the estate remains at a satisfactory 98% high level, and we continue to maintain the build fabric and environmental quality of our properties at Category B: satisfactory; *sound, operationally safe and exhibits only minor deterioration* as stipulated in our Estates Strategy. We are currently marketing our surplus properties which have an estimated total market value of £14m. Several stations will be replaced by suitable ACRP's strategically located to support operational performance; linked to the Responsive Care priority. Pipeline projects have been identified following an end-user estates workshop. The next stage is to prioritise our investment based on H&S, patient need, operating model and affordability. Assurance was sought that this will be developed in collaboration between the Performance Cell, Operations and Finance.		
Patient Level Information Costing System	Update for awareness	N/A
This was a very helpful report of the activity and cost quantum per currency of SECAmb's 2021/22 Patient Level Costing (PLICS) submission, which was submitted in August 2022. This shows an 8.0% decrease in cost per incident compared to 2020/21. This is a combination of a 10.9% increase in activity, due to the impact of the lockdown in the early part of 2020/21, and 2% increase in cost quantum. Once we are satisfied that the PLICS information is robust and comparable between ambulance trusts, we intend to use it to enhance our reporting, inform contract discussions, add financial values to productivity metrics and undertake benchmarking exercises. The committee welcomed this helpful data which has the potential to enhance sector reporting.		
Green Delivery Plan	To seek assurance this is progressing as planned, following the strategy that the Board reviewed in January 2022	N/A
A verbal update was provided confirming that the plan is progressing supported by the Consultant we commissioned to help us identify the road map linked to the strategy. In Q3 there will be engagement sessions to seek ideas and a comms will follow in December. The committee received assurance that we are on track for the end of year for the Board to sign off the plan.		
Medico-Legal Costs	To increase visibility of the costs associated with personal injury claims against the trust.	N/A
The company secretary provided a helpful report setting out costs related to personal injury claims (patients and staff). As the Board will know, we are part of the NHS risk pooling scheme run by NHS Resolution the contribution for which is based on the type and size of the Trust. The number of claims is small relative to other parts of the NHS and we are even slightly below the average compared with our peers. The		

committee received the current financial data based on actual payments and what is held in reserve based on the assessment of the claim. It is reasonably assured by this and the way we manage claims, supported by our legal services team.

IT	To seek assurance with the effectiveness of the IT function	N/A

The committee received a good summary of the core Digital / IT activity for the period between August 2021 and July 2022 and is assured by the significant areas of deliver, including:

- 6% reduction in IT budget (2022/23 vs. 2021/22)
- C.£500k cost improvements (CIPS) delivered in 2021/22
- Delivery of Banstead MRC in December 2021, on-time, on-budget
- Removal of all legacy Windows Server operating systems
- Delivery of mandatory cyber awareness training module for all staff across the Trust
- Ambulance Data Set (ADS). Mandatory migration to national ADS
- Audio Visual hardware implementation at key sites across the Trust
- Booking & Referrals Standard (BaRS). First of type testing for the new BaRS technology (that will ultimately replace Care Connect) for making bookings into system partners
- Migration of defibrillator data to the British Heart Foundation's Circuit system, aligned with other Ambulance Trusts
- Implementation of nationally mandated Single Virtual Contact Centre (SVCC) for 111 and Intelligent Routing Platform (IRP) for 999
- Secure email accreditation
- Successful bid for £4.458m of NHSx Unified Technology Fund (UTF)
- Successful bid for £250k of NHSx Unified Technology Fund (UTF) specifically for cyber / IT security
- Implementation of Verkada CCTV into all key IT areas, including environmental monitoring for key rooms / facilities
- Expansion of backup solution to meet additional data volumes and enhanced security requirements
- Expansion of existing hyper-converged infrastructure to accommodate additional data volumes and virtualisation requirements

The committee picked up the action from the Board in March when it received a draft Digital Strategy. The plan was to bring this back in Q1 2022/23 for approval, to include a timeline for development of the other two aspects of the overarching strategy, e.g. Data and how we use clinical information/data. The committee accepted that other things have taken priority and will ask to see this in Q4.

Fleet Management	To seek assurance that sufficient progress is being made against the management actions arising from the fleet internal audit in 2021/22	N/A

Good assurance was received on the work being undertaken within Fleet to progressively address the management actions raised, and to strengthen the control framework thus providing the Trust Board assurance these areas are being managed effectively. The committee also noted that the draft report from the subsequent Fleet internal audit report has concluded 'Reasonable Assurance' supporting the committee's own level of assurance.

Specific Escalation(s) for	**Overtime and impact on staff**: In the context of the challenges to provide adequate road hours, how are we assessing the impact of staff being asked to do lots of overtime, both

Board Action	in terms of not exceeding the limit of hours each week, and the knock-on effect in terms of burnout / sickness. There was some suggestion that the data might show the high rates of overtime is undertaken by a relatively small cohort of people. The Board is asked to follow this up.
	111 Clinicians: In line with commissioning intentions, there plans to be fewer clinicians in 111 CAS and the Board is asked to seek assurance that there has been a proper assessment of the quality impact of this.
	Sickness Management: The Board is asked to seek assurance that enough is being done to manage sickness given the consistently high levels and the impact on patient safety and staff wellbeing?