South East Coast Ambulance Service NHS Foundation Trust

Extraordinary Trust Board Meeting
held in public

27 October 2022
09.00-10.30

Banstead MRC

Agenda

Item No.	Time	Item	Paper	Lead
Board Governance				
62/22	09.00	Welcome and Apologies for absence		Chair
63/22	09.01	Declarations of interest		Chair
64/22	09.02	Minutes of the previous meeting: 29 September 2022		Chair
65/22	09.03	Matters arising (Action log)		PL
Our Improvement Journey				
66/22	09.15	Improvement Journey Report: Warning Notice Progress ▪ Quality Improvement ▪ Responsive Care ▪ People & Culture ▪ Sustainability & Partnerships		DR
Closing				
67/22	10.25	Review of Meeting Effectiveness		Chair
68/22	10.27	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, 29 September 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
Robert Nicholls	(RN)	Executive Director of Quality & Nursing
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Christopher Gonde	(CG)	Associate NED
Janine Compton	(JC)	Head of Communications
Martin Sheldon	(MS)	Consultant
Peter Lee	(PL)	Company Secretary
Steve Lennox	(SL)	Improvement Director
Kim Blakeburn	(KB)	FTSU Guardian for item 56-22 only

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.

This is DH's last Board meeting and DA took the opportunity to thank him for his service to the Trust over the years.

47/22 Apologies for absence

None

48/22 Declarations of conflicts of interest

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

49/22 Minutes of the meeting held in public 25.08.2022

The minutes were approved as a true and accurate record.

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50/22 Action Log [10.03-10.04]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

51/22 Chair's Report [10.04–10.11]
DA used his report to set the context for the meeting, explaining the different approach being taken aimed at helping to drive the right discussions, and framing the agenda against the Trust's strategic goals. The primary papers (BAF, IQR and Improvement Journey) will be used as reference documents and DA encouraged directors to refer to specific pages during the discussions. As illustrated in the report, DA confirmed that the plan is to use the assurance cycle as a guide, to help draw effective conclusions where a significant gap in assurance is identified.

In terms of becoming more effective, DA referred to the areas of development the Board is prioritising and confirmed the peer review of the Board and its committees he requested, which is ongoing. NHSE is observing today's meeting as part of this review.

One of the areas of Board development relates to FTSU and following the session in July with the National Guardian, the Board committed to complete the national training, and DA asked that this is done by the end of October, noting the IT glitch that has only recently been resolved. DA also reinforced the need for all Board members to have booked on to the one of the sexual safety workshops.

DA explained that, as set out in the papers today, one of the main concerns as a Board is the progress we are making with improving our culture. DA will be asking AM later to update on the NHS culture and leadership programme which the Board signed up to in August. DA reinforced that it is the Board who sets the tone and so we must be united in how we act and live our values.

DA also highlighted the really positive step to establish a Clinical Advisory Group, as showcased at the recent Annual Members Meeting. FM confirmed that the Group has met twice; with the most recent meeting involving front line staff who had been vocal on airway management. The early focus of the Group is on how we disseminate information to staff in a way it can be best utilised. DA reflected that these are our senior clinicians helping to shape future policy / strategy. TQ added that he and LS have been invited to observe a future meeting.

Lastly, DA reminded the Board to keep in mind the staff feedback from recent leadership visits as directors explore the issues through today's agenda.

52/22 Audit & Risk Committee Report [10.11–10.18]
MW summarised the output of the last meeting, confirming that there is nothing to escalate related Internal Audit and also with Fraud Prevention, which is in a good place currently. The main focus of the committee reflects today's Board agenda – risk management; culture; and freedom to speak up (FTSU), all of which feature in the Warning Notice. MW then summarised the position with each of these:

- Risk management - the committee has some assurance with the work to improve the risk register and it reinforced the importance of ensuring greater clarity of risk and how they are being mitigated. The committee recommended a risk seminar for the Board to reflect on risk and it's understanding of how it is operating. This is being planned by the director of quality and nursing.

- Culture – the committee is not assured in this area and believes progress is too slow. It believes that more remedial action is needed to recover position, and MW confirmed that the Board is taking this seriously demonstrated by the focus of today's agenda.

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- FTSU – the committee concluded that while people are raising issues, it is not assured that we currently have robust systems to ensure learning and action to deal with systemic issues; more management grip is needed to demonstrate to people a fair and just culture. Additional resource is now in place (two FTSU deputy guardians), which is a positive step, but more work is needed to develop systems.

DA thanked MW for this summary. There were no questions, on the basis that the agenda will lead to right discussion in these areas. The specific escalation to the Board related to culture will be picked up under item 56/22 – Improving Culture.

DR reflected that while the BAF is improving, what is missing is the control metrics to help the Board be clearer on how the controls link to the IQR, like we have done in the Improvement Journey.

Action
To further improve the BAF, where controls/actions are deemed to mitigate a risk, or where the risk increases, include a link / cross-reference to the relevant IQR metric(s).

DA then asked for Board's view on the BAF, given the way it has been developed over recent weeks. The Board fed back that it is much better; more informative, which helps to drive agendas.

53/22 CEO Report [10.18–10.45]
SM took the Board through some of the key points from her report, starting with the work of EMB where she reflected a theme on the effort to improve risk and risk management reporting. We spent time at EMB looking at progress with policy changes, training, and migration to Datix Cloud. There is much work ongoing and the next phase is to ensure real coherence of reporting risks through the organisation. Despite the positive progress, SM reinforced that it is very much work in progress.

SM referred to the meeting of EMB yesterday and its focus on the infrastructure of management groups, reviewing the TOR, reporting lines and effectiveness. A schedule of Chair's reports to EMB is being developed and over time the Chief Executive report to Board will reflect the issues from these groups, so that it is more consistent with the discussions via the management governance framework.

In terms of investment decisions, SM outlined that while it is a priority to expand clinical education to help ensure workforce supply meets future demand, there is a real question of affordability. DH and MS have been working closely with the Head of Clinical Education to revise the business case to make it more affordable.

In addition to the areas in the report under 'engagement' SM explained that she was invited to a ministerial round table help yesterday where there was clear commitment and understanding about how we work as a system to improve our response to patients. This includes areas such as pathways, pressures points in social care and work on handover delays. In response to the Chair's earlier reference to the importance of leadership visits and listening to our people, SM outlined some changes in how we communicate, including the weekly bulletin which is now more interactive. We closed the community Facebook page due to concerns about how this was being used; feedback has been largely positive about this step and we are working on alternatives to help better support our values.

SM thanked staff for their efforts over the last period including in support of the planning for the Queen's funeral.

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The last section of the report is escalation to Board and SM confirmed that the Improvement Journey will be covered later on the agenda. She noted the escalation from Audit & Risk Committee related to culture and confirmed that this aligns with the view of the executive. There are plans in place to address this, which AM will respond to shortly.

Lastly, related to operational performance, SM explained that EMB is not quite there yet with the level of reporting it needs to better manage the business. Reporting we have is good at serving external requirements but at executive management-level we need to distil the really important metrics (linked to IQR) so we can be clearer with Board what actions / improvements we are making. The plan is that EMB reporting will better align with the IQR and Board reporting.

DA thanked SM for her summary and for making a stand in addressing the cultural issues, by taking down the community Facebook page. DA reinforced that the tone set by the Board is critical as is the tone set by the chief Executive. The standards of behaviour we expect everyone to uphold is really clear by the Trust values and once and for all we must ensure anyone not in line with our values can find somewhere else to work.

MW has received feedback that the Chief Executive weekly message is going down well. He was pleased to hear about the discussion at ministerial level and the focus on a whole system approach and asked if a system plan will be published that shows how the system will work to address some of the imbalances we are experiencing. SM responded that ICBs have been asked to create a winter plan. Importantly, on accountability, they have been asked by NHSE to add parts of this to their BAF, so it will be reviewed at their Board meetings held in public. SM felt ICBs are being held to account more publicly than before. In addition, new commissioning guidelines for ambulance services will also help.

In order to ensure the Board has greater visibility of the steps being taken at system level to manage the issues impacting our provision of services that are beyond our control to address, the following action was agreed.

Action In order to provide a better understanding of the work at system level to manage some of the issues impacting on our ability to provide timely response to patients, the Chief Executive Report to Board to include a section on this; specifically how the ICBs are taking action through their Winter Plans and the extent to which this is having a positive impact.

SS referred to the clinical education business case and, acknowledging the issue of affordability, asked about the timescale given the pressures on the workforce plan. She also asked about workforce planning nationally and regionally and whether there is commitment for a regional workforce plan, especially given the numbers of paramedics moving to other parts of the health service. SM responded that the issues we have with the business case currently is that it isn't clear enough about the capacity increase and how it relates to the workforce plan. MS added that it is now developed enough to enable us to submit to the Surrey Heartlands (SH) Innovation Fund, which we did yesterday. In the meantime, more work is needed to stage the investment in a sensible way, linked to priorities and where we need additional capacity. We hope to conclude this in the next week and will hear from the SH Innovation Fund shortly.

DA summarised that we need to maintain pace with this and given the importance of this to delivery of our workforce plan asked for update at the next meeting to check progress.

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Action
The Board to receive an update in November confirming progress with the Clinical Education business case and assurance that capacity will be in place to help support delivery of the workforce plan.

SM then responded to the question from SS on workforce planning, confirming that there is currently a lack of coherence both regionally and nationally. Minsters yesterday acknowledged that we need a fully funded national workforce plan and there is some work to develop this in the Autumn. However, SM suggested that the question is whether this will inform a regional plan; she felt this will probably be the case and certainly our influence is increased at ICB level. SM raised last week with ICS colleagues that if there is a call on paramedics, we won't achieve timely responses in 999. SM updated that our lead commissioner is moving from SH to Sussex and we are now engaging with people officers who are a more cohesive leadership team, and so this provides an opportunity to work via the Sussex ICB to take this area of workforce planning forward.

DA welcomed this and opportunity SM refers to.

LS reflected positively about recent comms, which includes more of "you said we did". LS asked for assurance that there will be even more of this. SM confirmed that the staff survey launches next week and the Chief Executive message will pick up these types of messages. In addition, and in response to feedback from our people, SM confirmed the plan for different approaches to comms and engagement to ensure real things that make a difference to staff.

54/22 Primary Board Papers
As reflected by DA in his report to Board the primary board papers will be used as reference documents to inform the areas of focus within the agenda.

55/22 Keeping Patients Safe [10.45-11.35]
FM introduced the Board Story about a patient and the distress they experienced following a very long wait for an ambulance. The film was then played.

DA reflected that this was a really moving story, which helps frame the next discussion about quality and keeping patients safe. He asked the Board to therefore keep this film in their minds when exploring the issues.

RN talked first about the quality improvement (QI) workstream aimed at helping to support keeping patients safe; it is linked to the Warning Notice. There were no issues to specifically escalate from this workstream, but RN did confirm the appointment of the QI lead (deputy director-level), as set out in the related BAF risk. This person is due to start in October and their main task will be to start the implementation of our QI strategy; so by 1 April 2023 we will have a strategy and delivery programme in place.

RN then summarised the link with the IQR, referring to pages 10-15. On page 10 (SI incidents and violence and aggression) RN confirmed that there is an improving picture with the reduction of the SI backlog; this is ahead of the trajectory we set. To ensure this is sustained, we have set a lower tolerance for escalation which requires the intervention of RN or FM.

On violence and aggression, RN updated the Board on the steps being taken. Noting the escalation from the workforce and wellbeing committee (WWC), DA asked that we defer questions on this, until we get to this section later on the agenda.

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FM confirmed that all mitigations for medicines management risks are in place. An issue relating to drug seeking behaviour in 111 CAS; has been escalated nationally.

FM then referred to STEMI and the significant improvement in care bundles; it is first time we have exceeded 75% and while FM acknowledged this is positive, she explained it relates to what we have always done (in giving analgesics) which is now recognised.

The Board noted the work FM outlined with the cardiac network and the escalation nationally to change the care bundle, removing parts that hinder rapid removal from scene which will reduce on scene time.

MW referenced the Board Story and the experience of waiting too long for an ambulance. He acknowledged that we won't always be in a position to respond promptly and/or in line with the standards set by the ambulance response programme (ARP) but asked for assurance that we should ensure people waiting always receive a welfare call; MW asked how we are delivering against this as the IQR does not include data on welfare calls. FM responded that the patient in the film phoned a number of times so in such circumstances wouldn't get a welfare call. However, we do try and ensure a clinician calls back when there are significant delays and we aim to give a realistic timeframe. MW asked if we monitor compliance with policy for welfare calls and asked again what the performance level currently is, reinforcing that such assurance is key given the likely delays through the winter period. EW explained that we do monitor welfare checks but was unable to provide specific information and so the Board could not be assured. DA therefore asked for the following action to close the gap in assurance identified.

Action
The Board seeks assurance about the extent to which we are compliant with the standards relating to completion of welfare calls for patients experiencing significant delays. If there are gaps in compliance the Board requires information about how this will be addressed, in particular given the likely increase in delays over the winter period.

HG asked how we have learnt from the patient's experience in the Board Story related to him being asked to make his own way to hospital when this was not clinically appropriate. FM responded by accepting there is learning and then explaining that there are times when it is safer to make own your way. SM added that she signs off the more complex complaints and confirmed that as part of this she knows that calls are audited and that staff involved in decision making have reflective conversations about what they could have done better. This all goes into complaint response letters, so we ensure a full response related to learning and the actions we take to help prevent recurrence.

HG came back on the point by asking whether another staff member would know today that if someone had a dislocated hip, they must not be asked to make their own way to hospital. FM confirmed that if they were clinically competent then she would expect this.

HG then referred to the IQR, which for the QI section identifies two areas that have a failing process, neither of which RN has commented on. These are NHS Pathways audits and wellbeing hub referrals. On NHS Pathways audit compliance FM explained that these are audits of calls identified as non-compliant. There is more work needed to ensure compliance in call taking and to help with this we are undertaking live audits so call handlers get real time feedback.

TQ noted that there are a number of areas in the IQR that do not have targets. DR responded that the progress we made this month relates to the Grids and the provision of more detailed assurance. He accepted there are still too many metrics and the next part of the development is to review this to ensure we have the right metrics. Then we will recalculate the tolerance levels of the upper and lower limits, before

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ensuring targets are in place where the metrics require them. Some metrics will not have targets, such as RIDDOR and this is why the emphasis is on the analysis of trends.

DA asked that where there is no target by design then this should be made clear.

Action
In the IQR, where a metric has no target by design then this should be confirmed in the report so it is clear.

LS observed the recent meeting of the Patient Experience Group where it was noted that 20% of complaints relate to delays. She welcomed the fact that we investigate each one, as some ambulance services do not, but rather simply offer an apology. By ensuring each one is investigated we maximise the learning. RN confirmed that we have circa 2,000 plaudits each year, to give some balance.

DR asked if the Board Story would be categorised as 'no harm'. FM confirmed that it would as putting a hip back is relatively straight forward but accepted the point behind this question related to the very poor patient experience. DR added that patient harm increases significantly when delays occur, but this would not be counted so we need to think in the round about the fuller impacts. FM agreed and outlined the work ongoing to sub divide category 2 calls to ensure better clinical prioritisation.

SM reminded the Board that the experience shared by the patients in the Board Story included the lack of communication and information and so as MW started this discussion, we should be asking how we seek assurance that there is accountability in the control room. This links to action already agreed about welfare calls.

RN then introduced the Annual Safeguarding Report, outlining the two key areas of focus. Firstly, capacity in the safeguarding team. There is a good safeguarding referral culture with on average 24,000 a year which is increasing; hence creating a capacity risk. The actions taken include the use of alternative duties staff (two staff on average at any one point), and also seconded support. In the meantime, a business case is being developed to provide two substantive roles, although RN confirmed that this is not just about adding resource but understanding demand as within the 24,000 referrals there are some that are not truly safeguarding but more do to with care needs. We are therefore in discussion with local authorities about this. The second areas of focus is on ensuring training compliance; RN referred to the IQR which demonstrates good compliance with level 2 (85%). However, level 3 training was started last year in Q1 but then suspended due to operational pressures; it has now restarted.

SS noted the significant increase in safeguarding referrals and assumed there is likely to be more in 'neglect' due to the cost of living issues. She asked therefore if the resource in the business case RN refers to is sufficient, given this increase is likely to continue. RN responded that while we cannot ignore the financial constraints, this is not just about resource, as he mentioned, it is also about how we deal with demand and the Local Authority have a role in this. DA supported this reinforcing that we can't be the answer for everything, as with this we need to be clear with our partners what we expect from them.

CS asked about the aim for level 3 training and RN confirmed we are currently at 68% with the aim to get to 85% by April 2023.

Quality and Patient Safety Committee (QPS) Report
TQ summarised his report and reflected that the focus of the Quality Summit aligns with today's Board Story. On medicines management, noting what FM said earlier about mitigations, TQ confirmed that the committee is not fully assured and will be following this up and will escalate accordingly.

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While there is no specific escalation to the Board, SM referred to the gaps in assurance and management action noted by the committee. She explained that one of the issues being picked up in the committee effectiveness reviews is the role of the executive and the need to always ensure the provision of quality information, first time. For example, with safeguarding training SM suggested that we should be able to be clearer on actions and provide confidence in delivery. DA agreed and this is part of our development and improvement.

DA summarised the key actions agreed arising from areas where the Board has sought greater assurance. He noted that the main headline issue under this agenda item has been *delay* and the impacts on both patient safety and patient experience.

56/22 Improving Culture [11.35-12.39]

FTSU Guardian Report

KB joined to present her report, explaining that the purpose is to give an overview of the development of the service. She highlighted the following key points:

- 20 concerns have been raised during the first quarter of the year, which is consistent with same period in previous years.
- Hotspots include 111, Polegate & Hastings, and Tangmere and Worthing
- Top themes include culture, management process and procedure, and bullying and harassment
- We have recruited two deputy FTSU Guardians, starting in October/November. One of their first tasks is to update the policy in line with the recently published national policy.
- FTSU has received peer support from NHSE; their report was received recently and will inform the related part of the Improvement Journey
- Training modules via the National Guardians Office is now part of our statutory / mandatory training programme.

CS asked if people are raising concerns first with local managers. KB explained that as Guardian she only gets involved once these avenues have been exhausted and going forward the plan is to work more proactively to support managers to resolves issues.

PB asked if staff know the difference between FTSU and a grievance. KB explained that FTSU is the informal route to raise concerns and AM added that our vision is to deal with things closer to the point of origin; he did not think the origin of concern matters e.g. via a grievance or FTSU. DA agreed that the important thing is that we ensure we hear about concerns so we can deal with them.

RN reflected that the appointment of the two deputies is significant as this will ensure capacity to improve data quality and provide more proactive approaches and triangulation of information.

DR linked this to the Improvement Journey and specifically Warning Notice 4; our ability to listen and address issues promptly.

DA thanked KB for ger report and summarised that we are assured that we have well trusted FTSU Guardian. There is further work needed to address themes, under culture in particular, which is the next agenda item. And it is positive that we have invested in more support in this area.

AM then outlined from his report to the Board some of the work to improve culture, linking to the relevant parts of the BAF, IQR and Improvement Journey. He reminded the Board of our strategic goal and the importance of recruiting people with our core values, which now forms part of our recruitment processes.

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Also, in developing people as part of appraisals and ensuring training and development, so everyone is clear that we must have a low tolerance for poor behaviours.

In terms of his executive summary, AM referenced the sustained level of high pressure and the impact of this on (high) turnover and sickness. At the Audit & Risk Committee (AUC) last week we looked at time-to-hire and as set out in the IQR there is good progress with this, but this won't off set the significant turnover rate. Therefore, at EMB last week we reviewed a revised retention plan for the year and the steer from this meeting was to ensure greater focus on a smaller number of high impact actions. AM reminded the Board of our high recruitment drive and the aim to significantly increase our total establishment.

AM then referred to the Until it Stops campaign, which is ongoing. He updated the Board that we now have a sufficient number of workshops to cover all line manager for which this is mandatory; most have attended and/or are booked on and AM reflected the positive feedback to-date. DA reminded all Board members to ensure they have booked on to a workshop.

With regards the Improvement Journey, AM confirmed the recent briefing session for Board members on employee relations work, with the aim of increasing the visibility of the current issues. Actions were agreed then to increase capacity to manage employee relations cases and also to deliver the culture and leadership programme; a 3-month Road Map has been established, which will be considered by WWC.

DA took questions noting the AUC escalation.

DR referred to the feedback from staff summarised in the Chair's Report and asked, given the cost of living issues, whether we are doing enough to support staff. AM responded that we are working with Unions to develop a range of measures of support, e.g. paying expenses sooner. He also reflected the national work on cost of living and we are pushing nationally for more detail.

SM felt that we need to see more information in the IQR related to grievance cases. On the matrix in the IQR the one that comes up is rolling sickness absence; we are failing this target and the statistical process charts show an increased data point each month. In light of this, SM asked what the Board requires from the executive and/or its committees to provide assurance that action is being taken to address this trend. In response to this the following action was agreed.

Action
The Board asked that EMB reviews the reasons driving high sickness rates to ensure there is a clear understanding of the factors and the actions being taken in response. EMB will then agree how to escalate to WWC or directly to the Board.

SS asked about leadership and management courses, referring to data seen at WWC confirming circa 400 staff are eligible for the courses which have set up over the next 2-3 years, but are not yet fully booked. Also, related to appraisals, SS asked for assurance that all staff are at least scheduled to have an appraisal. Lastly, SS noted some feedback from recent leadership visits about a lack of department meetings and an over reliance on formal communication from the internal comms team, therefore an apparent gap in local engagement. SS expressed concern that this contributes to the poor culture we have. SM responded by reflecting that she is used to the HR team providing compliance reports that set out patterns and issues with compliance, for managers to then pick up and address. SM asked AM and EW to work together to get this assurance on appraisals and training to WWC.

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Action
AM and EW to jointly report to WWC providing assurance on the steps to ensure completion of appraisals and the leadership/management training courses.

In response to the point about department meetings and local engagement, EW explained the Teams A-F management structure, e.g. Teams A meetings of senior managers; Teams B meetings of OUMs and 111 EOC and support Business Managers; and Teams C being OTLs and MRC managers. She added that most OUs run regular meetings but acknowledged it is variable with difficulty getting everyone together, which is why there is more recent consideration being given to a staff forum-type approach. SM reinforced the need to find different ways to communicate and engage, given these challenges. SM is in the process of seeking external expertise to support the development of different approaches and will update the Board on this in due course.

DR noted from the leadership visits feedback that staff are describing issues with visibility and engagement of local managers. DA agreed and linked this to the point SM made about needing to find different ways to engage.

There was then a discussion about the extent to which we are focussing on symptoms or root causes, with agreement that we need to do both. The Board acknowledged the Leadership and Culture Programme is due to commence next month and the aim of this will be to get to the root cause, while addressing some of the symptoms along the way.

DR linked this discussion to patient safety, with high sickness, high attrition, and poor culture. He confirmed that we are not on track with our overall workforce plan and so are reforecasting, which DR felt would likely show an adverse impact on patient care. He confirmed that it could be that we are as much as 10 minutes off where we thought we would be related to Cat 2.

DA summarised that the experience of staff is crucial to delivery of patient care. What the Board has concluded is that we need a firmer plan to address the immediate cultural issues, to help us demonstrate that we are making the progress we need to make quicky, then a longer-term plan to really address the root causes; so we are asking for a short and a long-term plan. In the meantime, the Board is not assured, but has agreed some specific actions. In relation to capturing the risk, the Board has asked that the BAF be updated to ensure a separate risk on Culture.

WWC report
SS summarised the report and focussed on the three escalations. Triangulating the last two with the earlier discussions, including data from FTSU, SS confirmed that we have identified some hotspots such as Polegate and Hastings and EOC/111. The committee focussed on EOC/111 due to high employee relations issues.

DA asked if we have a process to address this. EW explained that she and AM are the executive sponsors for the 111/EOC culture programme. This is focussing on how the actions taken are having a positive impact, i.e. what has changed. AM added that we had meeting recently where we asked the team to more clearly demonstrate how things are different; there is some progress but not sufficient. DA took assurance that this has executive leadership. EW felt that we are in a better place with data to really establish the issues, and underlying stories.

DA confirmed that the Board has considered these escalations and heard that the executive believe steps are being taken.

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With regards the escalation about the management of violence and aggression, RN outlined some of the actions being taken. For example, we have a new Violence and Aggression Group started this week looking at the violence reduction standards and he will update WWC how we are implementing these. One of the key things is in raising awareness to ensure better reporting; we know Medway has more incidents and so are exploring why and how to better support staff there. Also, RN confirmed the gap in de-escalation training; we have online training but need to get more face-to-face simulation training in place. SS noted the plan to provide assurance to WWC on how we are applying the national standards.

[Break 12.40-12.57]

57/22 Operational Performance & Efficiency [12.57-13.31]
EW provided an overview linking this to BAF risk 14 (Operating Model). She confirmed there are three specific items to bring to attention of Board. Firstly, the Clinical Advisory Group (CAG) has been established to help ensure a clearer clinical voice driving decisions. Secondly, sustainable staffing which links to two BAF risks discussed earlier related to recruitment and retention. In the southeast we have the highest turnover rate compared with nationally so there are challenges across the SE region. In terms of implementation of changes as per national guidance, EW confirmed we are working with system partners on the Single Virtual Contact Centre (SVCC) which helps synergies in 111 but will adversely impact integration with EOC.

DA then opened up to questions.

DR noted that one of the failing processes in the IQR is late finishes / overruns, which links to culture. He knows that we are undertaking a dispatch review and asked if there is confidence that this will help address this issue. EW responded that some of this is not in our control e.g. handover delays at emergency departments. However, the rota review will help and there is always the balance between staff welfare and patient safety. In light of these challenges only likely to increase over winter, DR suggested that the Board should keep this under close review given it is so central to morale issues.

In the context of the wider system discussions, CG asked how confident we are in our ability to deliver safe services during the winter period. EW outlined some of the system discussions about the different things we can do related to pathways; she feels the systems are more aware and the regional team is more focussed.

HG noted that relatively speaking our performance is good in Cat 2 which is where the higher proportion of activity is but is poor for Cat 3 and 4. He asked what our strategy is for these groups of patients. EW responded by explaining that we have a plan to engage the system / nursing homes on pathways and using CFRs more. Community trusts for example have urgent response teams and we are working with them to see if they can support too.

There was then a further discussion about attrition and the impact this has on our ability to provide hours to meet patient demand. DA reinforced the importance of a robust retention plan, as discussed earlier.

TQ asked in relation to SVCC whether we are exploring opportunities as well as mitigating risks. For example are others learning from us given we have some of the highest revalidation rates. EW explained that SVCC is just about answering calls, the rest relates to the contract and each service providers have different contractual requirements. On revalidation, 96% of calls from 111 to 999 are revalidated. EW confirmed the expectation is to go live by November but suspects it might not be quite so soon.

Building on the point HG made about Cat 3 & 4, MW asked if we have a methodology so that when we find something works, we can scale it up. EW confirmed that we don’t have this in place, but RN reflected that this is where QI will help. MW was not so sure as he felt it is wider than QI, and more about service development.

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DA asked if there is a timescale on the development of our new operational model. DR responded that in year we have the Improvement Journey (workforce plan; hear and treat; JCT). The BAF risk related to the operational model is a separate risk about redesign which we can't do ourselves and so need to work with system on this; DR felt this will likely be a multi-year journey, but we currently do not have a timeline.

DA summarised that the Board cannot be assured on the immediate to short term operational performance, given the significant pressure on services and the fact that other parts of the system are not functioning as well as they could be. He then turned to the paper in the pack on the Winter Plan.

<u>Winter Plan</u>
EW explained that this is part of the annual cycle and the initial draft plan is due to be submitted tomorrow. The paper sets out our approach to review and learning from last year, in addition to the risks, such as the risk of industrial action. A horizon scan section is included noting COVID is increasing. Yesterday we reported the first flu outbreak. There are also supply chain issues, and so a number of risks to whole system working.

The expectations set from NHSE are summarised in the paper including St John Ambulance providing support to the ambulance sector; although this is likely to have a limited impact in real terms. Lastly, EW confirmed that the paper also includes next steps and that as always, the plan will be 'live'.

DA clarified with the Board that it is content with the approach to the Winter Plan.

<u>Performance Committee</u>
There was nothing to escalate as the issues raised by the committee about the workforce plan and retention has been covered already

58/22 Achieving Sustainability / Working with Partners [13.31-13.55]
DH took the Board through the risks set out in the IQR, confirming that we are in line with the existing plan based on stated current positions. We will be reforecasting and the Board will be notified of any changes. DH then covered the following issues, some of which have been already been explored during this meeting.

- Recruitment and retention – DH explained that this is not just as simple as saying we aim for x WTE. The reality is that we are putting out as many hours as we can through incentives and overtime, which plays into the staff wellbeing discussion earlier. Financially, we are underspending in some areas and overspent in others
- Improvement Journey – this is a financial risk we need to keep under review
- SVCC – we don't really understand the impact yet, not just at provider level but also ICB. For example, how commissioner intend to ensure providers get paid for taking others' calls.

The next step is to complete the reforecast, testing the assumptions in the integrated plan, and discover whether commissioners will follow through on the commitments they made at the start of the year.

MS added that the reforecast will be done in the next two weeks and that the recommendations from the external finance review the Board has seen will be taken forward.

DA noted that there are some things not in our control but some things are such as the efficiency programme; he asked DH where we are with this, as it will be key to when we hold commissioners to account. DH responded this is inherent in the integrated plan and so needs to play out in the reforecast. He reinforced money is tight and there is no more and so we need to use it more efficiently to deliver our priorities.

DRAFT

MW gets the need to sort this year, but looking ahead, there is pressure on NHS funding, a new lead commissioner, and some degree of uncertainty on our operating model. He suggested that we can't be on the back foot for next year and so must have clarity on our planning assumptions. We are rightly focussed on the Warning Notice but MW asked when will we return to the operating model so it can be costed. DR noted there are two different questions; the first is about the need to start planning now for next year with clear scenarios by Christmas. He agreed we need clarity on next year and this will give the head space to understand next two years. DR is unsure about the question on the operating model, reflecting the difficulty in understanding our patients today, let alone in 5-10 years' time. Therefore, in parallel with next year, we need to have discussions internally and externally about the longer term. MW asked what the inherent risk is then to finances. For example, to the challenge from the system about us being over resourced. SM responded that we are providing data but need to be clear that we are in October still with no signed contract. The SECAmb budget sits within Surrey Heartlands ICS but SM has asked for Sussex to be part of the discussions to mitigate what MW is saying, as what happens this year has a significant bearing on next year. SM confirmed it will be a risk, and this is the mitigation.

The Board supported this approach.

<u>FIC report</u>
HG summarised the outputs of the most recent meeting. The external review MS referred to earlier noted that financial information needs greater visibility at the full Board so everyone has a more equal understanding. FIC supports this. MS is working on the level of detail the Board will need that strikes the right balance. The Board noted this.

In terms of the financials, as DH confirmed, we are year to-date in line with plan but HG explained that this gives the Board a false level of comfort given the issues and risks for the rest of the year. There is much of the plan, such as CIP, that is back ended. HG feels this is a big warning sign, hence the committee's request for a reforecast; the committee is concerned that a breakeven position is not achievable. Also, the underlying position includes non-recurring income savings and provision releases and so there is added concern about the position for next year, unless we resolve these. The worst case is between a £7-18m underlying deficit.

DA summarised that future Board agendas will need to ensure greater visibility of the financial risks. The Board noted we are where we expected to be, noting the significant risks.

In terms of the other specific escalations from FIC the following was confirmed:

Overtime and impact on staff – A conversation has been started at QPS about this and how sustainable it will be to rely so heavily on overtime. The Board agreed that QPS will follow this up and update the Board accordingly.

111 Clinicians – The Board agreed that this is a system assurance discussion as this is what we are commissioned to deliver. The executive will be clear with commissioners about what we think the impact is.

Sickness Management – see the earlier action agreed related to this.

DRAFT

59/22 **Warning Notice Progress** [13.55-14.03]
DR highlighted the following:

- 31% of the evidence we said we would have, has been received. We forecast 65% by December. The main risk related to Warning Notice 4 (Culture). We escalated over the summer the issue of resourcing and we now have more stable management in place and rebased each plan.
- Risks are highlighted. In terms of comms and engagement a copy has been provided to the Board of a draft booklet describing what we have learnt and where we are in the Improvement Journey; this is to be used to engage with our staff. DR reinforced the need to make this meaningful to all staff as much of the Warning Notice relates to Board and senior management. Over the next period we need to make the improvements more accessible to staff and engage them in the work, aligned with the QI methodology being developed.
- There is not much science behind the RAG rating but we have a number of key actions to close the gaps and will report to Board against progress.
- People and Culture is in 'intensive support' as confirmed previously.
- Lastly, we have a schedule of structured committee deep div, as agreed by AUC last week. The report template has been agreed.

DA thanked DR for this summary and opened to questions.

Noting that WN 1-3 is RAG-rated Amber, PB asked how confident we are in being able to demonstrate significant improvement by November. DR referred to the booklet and the actions set out, confirming that he is confident we will deliver, but noting the challenge in being able to demonstrate impact, e.g. the way the Board is working such as the structure of this meeting has changed, but will take time to embed. So DR is confident we will take the actions we said we needed to take but demonstrating impact will be more difficult.

DA summarised that the Board is not currently assured, but there is much work ongoing to ensure progress; we are aware of the risks and mitigations in place. The urgency is understood by the Board, and the need to give assurance to our system partners that we have the credibility to make the long term improvements.

60/22 **Review of Board Effectiveness** [14.03-14.08]
The Board felt that the new structure worked, which should lead to clearer actions and ensure a more overt link to quality. It was however a long meeting and so members agreed to reflect on how we can become more efficient with perhaps more signposting under each heading to what the real issues are. This doesn't stop NED scrutiny but if we agreed say top 3 issues against each item this would help. There was a sense that there was better quality of conversation, with more triangulation and challenge. The Board agreed that fewer IQR metrics will help drive more focussed discussions.

61/22 **AOB**
None

There being no further business, the Chair closed the meeting at 14.09

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

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

Date ___________________________

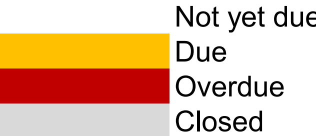
DRAFT

DRAFT

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
25.08.2022	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	Letter drafted to go out to chairs of the acute hospitals - said board making quality visits to check welfare and wear name badges etc. And only enter building with permission of local manager.
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
29.09.2022	52 22	To further improve the BAF, where controls/actions are deemed to mitigate a risk, or where the risk increases, include a link / cross-reference to the relevant IQR metric(s).	PL	01.12.2022	Board	IP	
29.09.2022	53 22a	In order to provide a better understanding of the work at system level to manage some of the issues impacting on our ability to provide timely response to patients, the Chief Executive Report to Board to include a section on this; specifically how the ICBs are taking action through their Winter Plans and the extent to which this is having a positive impact.	SM	01.12.2022	Board	IP	
29.09.2022	53 22b	The Board to receive an update in November confirming progress with the Clinical Education business case and assurance that capacity will be in place to help support delivery of the workforce plan.	FM	01.12.2022	Board	IP	
29.09.2022	55 22a	The Board seeks assurance about the extent to which we are compliant with the standards relating to completion of welfare calls for patients experiencing significant delays. If there are gaps in compliance the Board requires information about how this will be addressed, in particular given the likely increase in delays over the winter period.	EW	01.12.2022	Board	IP	
29.09.2022	55 22b	In the IQR, where a metric has no target by design then this should be confirmed in the report so it is clear.	DR	01.12.2022	Board	IP	
29.09.2022	56 22a	The Board asked that EMB reviews the reasons driving high sickness rates to ensure there is a clear understanding of the factors and the actions being taken in response. EMB will then agree how to escalate to WWC or directly to the Board.	SM	09.11.2022	EMB	IP	
29.09.2022	56 22b	AM and EW to jointly report to WWC providing assurance on the steps to ensure completion of appraisals and the leadership/management training courses.	AM EW	10.11.2022	WWC	IP	

Key



Not yet due
Due
Overdue
Closed

	Agenda No	66-22

Name of meeting	Trust Board
Date	27.10.2022
Name of paper	Improvement Journey - Executive Summary to the Board
Trust Priority Area	**Improvement Journey**
Lead Director	David Ruiz-Celada, Executive Director for Planning and Business Development
Author(s)	David Ruiz-Celada, Executive Director for Planning and Business Development Matt Webb, Associate Director of Strategic Partnerships & System Engagement
Link to BAF Risk	BAF Risk 257
Executive Summary	This report summarises the progress made through the Improvement Journey (IJ) portfolio during the month of October 2022. The main BAF risk (ID: 257) remains scored as a 12 due to ongoing challenges in demonstrating significant progress against the Section 29A warning notices. There is a substantial focus on tracking and achieving supporting evidence by 18th November as per the Section 29A warning notices expiry. Current progress against meeting target evidence is 60% for the warning notices and 54% for must-do requirements, up from 31% and 23% respectively, as reported at the September Board. Having observed a significant improvement in evidence being submitted by each Improvement Journey programme, the overall portfolio rating has been altered from *red* to *amber*. A series of peer-review sessions, supported by internal subject matter experts and external parties, will be completed through November to assure against the evidence submitted. However, it should be noted that achieving the submission of evidence targets does not necessarily mean impact has been demonstrated throughout the Trust. In addition to evidence-focused peer-review sessions, the Board development day planned for 24th November will focus on the findings of the peer reviews for warning notices one to four. This is expected to also help us highlight areas for continued improvement required and to shape the Improvement Journey plans beyond the expiry of Section 29A. It is anticipated that the Care Quality Commission (CQC) will observe the Trust Board in December, followed by a re-inspection of the Section 29A (S29A) warning notices. Section 4 of this report identifies gaps in assurance and provides corrective actions to be taken through November ensuring the Trust is in a strong position to provide the CQC with tangible evidence of significant progress before the expiry of the S29A warning notices. The remaining risks associated with the portfolio are detailed within the respective programme risk registers and highlighted within the individual workstream reports. Programme resource continuity and continued challenges in effectively engaging and communicating the Improvement Journey remain the greatest risks to the portfolio. Whilst significant progress has been demonstrated regarding evidence collation for warning notice four, the People & Culture programme remains challenged from a delivery perspective and the Board cannot be fully assured that sufficient progress has been made to address the culture of bullying and swiftly address staff concerns. Extraordinary Board sub-committee deep dives are planned to continue throughout November and December ensuring the Board has sufficient time to understand the progress being made towards improvement as it remains accountable for the portfolio delivery. The first of these focused reviews took place on 14th October through the Workforce Wellbeing Committee (WWC), concentrating on the People & Culture programme.
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.

1. Portfolio overview

Portfolio name: Improvement Journey	**Overall portfolio status:**	
	Forecast status with actions completed by the next reporting period:	
Accountable executive: Executive Director for Planning & Business Development	**Oversight:** Trust Board	
Start date: 30th June 2022 (Approval at Board)	**Projected completion date:** N/A	
Update date: 27th October 2022	**Next update due:** 1st December 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 – September 2022)

1.2.1. Board Effectiveness / WN1 - The Interim Chief Finance Officer has assumed executive oversight for the Sustainability & Partnerships programme from 14th September. The programme workstreams have been reviewed and comprise 1) financial sustainability, 2) Executive and Board effectiveness, 3) strategy and planning for 2023/24, 4) procurement improvement and 5) Green Plan development. Detailed plans are being developed for each of the five programme workstreams, with a high-level six-month plan to 31st March 2023. These will include addressing the areas identified through the external NHSE finance review.

1.2.2. An external effectiveness review by the Improvement Director and NHSE colleagues of committees concluded in October. This will be followed by an internal Well-Led review by the Improvement Director.

1.2.3. Quality of Information / WN2 - Following the positive feedback received on the Trust Board in September, the Board will adopt a new agenda format structured around the Trust's four priorities as outlined in section 1.1.2. The Board focused on bringing together the improved BAF and new Integrated Quality Report, receiving updates against delivery of improvement for each area, rather than going through reports individually. This strengthened the triangulation of information and the quality of the discussion as a result.

1.2.4. The development of the IQR continues following a bi-monthly improvement cycle and will be focussing on the continued improvement of narrative training and right-sizing the number of metrics reported on at the December Board.

1.2.5. Finally, the Executive has accelerated the work to develop an executive-level dashboard that enables it to understand and triangulate areas of concern across different dispatch desks on Quality, Patient Safety, Performance, and Workforce indicators. This is being developed in close consultation with local managers to ensure it serves both as assurance as well as an effective mechanism for the escalation and mitigation of risks, issues, and concerns.

1.2.6. Risk, Clinical Governance and Quality Improvement / WN3 - NHS England has offered support to the incoming Deputy Director of Quality Improvement when they join on the 1st of November.

1.2.7. Reduction of open Serious Incidents (SI0 actions has now reduced from 107 in March to 31 in October, with all open Datix incidents in March now closed. The Trust remains on track for achieving a 0% backlog of SIs by November 2022. The Improvement Director will also be conducting an effectiveness review of the SI process.

1.2.8. The Risk Assurance Group (RAG) is now meeting weekly, however, there is a recognition that further work is still required in this space. The first risk report to EMB has been delivered in October, aiding the improvement of providing effective oversight of risks alongside the improved EMB integrated dashboard supporting WN2. The risk register review for moderate and high risks is 68% completed in mid-October (63% at the end of September).

1.2.9. People & Culture / WN4 - The People & Culture programme remains under intensive support. BAF risks 255 (Recruitment) and 13 (Culture, Leadership & Retention) have been updated to reflect the status of the programme. An additional senior project

manager has been assigned to the programme to support the progression of two business cases concerning the *Culture Transformation & Leadership programme* and Employee Relations (ER) caseload. Business cases are expected to be presented to the Business Case Group (BCG) at the end of October. This element of the programme remains one of the greatest risks, with an unmitigated scoring of 20 and a mitigated score of 12.

1.2.10. The Board undertook a detailed review of the Employee Relations caseloads, grievances, and suspensions on 27th September, followed by a review of the relevant metrics for WN4 by the Executive Management Board. It has been identified that the existing metrics for measuring the volume and trajectory of bullying and harassment cases require further refinement and are not currently successful in providing assurance or an understanding of case numbers, case volume, case complexity, and case duration. These will be resolved through two planned workshops with support from the NHSE Make Data Count team, including a focused session with non-executive directors on the additional levels of assurance required. The Chartered Institute of Personnel & Development (CIPD) is also being consulted to support the development of the right metrics for the Executive and Board to track.

1.2.11. A 30, 60 and 90-day Employee Relations plan has been created to focus the immediate priorities for the workstream. Significant progress has been made against the evidence registry, some examples of this include increased visibility of open ER cases and breaches of policy, evidence of following Trust processes for suspensions, responding quickly to concerns when they are raised, increased completion of sexual safety training by managers and the appointment of additional FTSU resources.

1.2.12. <u>Communications and Engagement</u> - The Improvement Journey Portfolio team monitors the communications and engagement plan as developed with the Leadership Team. The month of September comprised several key messages, including an overview of the Improvement Journey, how the Trust is tackling inappropriate behaviours, a review of the Quality Summit, FTSU, leadership visibility, learning from incidents, changes to staff engagement and the launch of the 2022 NHS Staff Survey (currently with a response rate at 31% as of 17th October 2022).

1.2.13. Despite good progress being made throughout September, overall engagement and communication of the portfolio remains a trust-wide risk, currently scored as 15. The work to mitigate this risk commenced in October with external specialised consultancy support to help shape the Trust's internal communications & engagement strategy and associated mechanisms, as well as supporting the Trust to improve how it engages with its people on the Improvement Journey in the short-term and moving forward. This risk will be reviewed further next month, monitoring the progress being made through this activity.

1.2.14. <u>Board deep-dives</u> - To improve Board awareness of the progress and areas of concern, a programme of deep dives led by each programme's respective Board sub-committee has commenced, with the first of these taking place on 14th October through the Workforce & Wellbeing Committee (WWC). The WWC undertook a focused review of the approach being taken to bullying & harassment and sexualised behaviours, the proposed Culture Transformation & Leadership programme, and staff wellbeing (see appendix 8). Further Improvement Journey deep-dives are planned for the months of November and December.

2. Overall progress against outcomes

2.1. Progress against Warning Notices and Must-Dos

2.1.1. Overall progress against meeting the WN target evidence is 60%, an increase from 31% reported to the Board in September.

2.1.2. Overall progress against meeting the MD target evidence is 54%, an increase from 23% reported to the Board in September.

2.1.3. Progress against CQC deliverables is based on evidence submitted by each

Improvement Journey programme as of 18th October - see appendix 1 for descriptions and appendix 4 for the detailed progress table.

2.1.4. A series of peer-review sessions, supported by internal subject matter experts and external parties, will be completed through November to assure against the evidence submitted. However, it should be noted that achieving the submission of evidence targets does not necessarily mean impact has been demonstrated throughout the Trust.

2.1.4.1. 17th October – 4th November: Three-week evidence review commenced on Monday 17th October 2022 by the core Improvement Journey Portfolio team.

2.1.4.2. 2nd week of November: All programme delivery leads will conduct a review day against the CQC findings and the well-led KLOEs.

2.1.4.3. 3rd week of November: External peer-review of evidence provided by a combination of internal SMEs and external system partners, e.g., Integrated Care Board (ICB) quality leads.

2.1.4.4. 24th November: Board development day focussed on the findings of the peer reviews for warning notices one to four. This is expected to also help the Board and Executive highlight areas for continued improvement required and to shape the Improvement Journey plans beyond the expiry of Section 29A.

2.1.4.5. 1st week of December: The CQC is expected to observe the Trust Board, followed up by a re-inspection of the warning notices.

Comparison of the previous month

	Sep-22	Oct-22
Overall Progress against WN	31%	60%
Overall Progress against MD	23%	54%
Overall Progress against SD	n/a	n/a

Warning notice - S29A				**Must-do actions**			
Warning notice - S29A	***Forecast by Nov 2022***	**Completion % Sep 2022**	**Completion % Oct 2022**	**Must-do actions**	***Forecast by Nov 2022***	**Completion % Sep 2022**	**Completion % Oct 2022**
WN1	*75%*	40%	48%	**MD1**	*30%*	25%	71%
WN2	*60%*	30%	66%	**MD2**	*40%*	14%	78%
WN3	*70%*	40%	48%	**MD3**	*50%*	40%	59%
WN4	*40%*	14%	78%	**MD4**	*70%*	40%	48%
				MD5	*30%*	13%	20%
				MD6	*70%*	40%	57%
				MD7	*30%*	13%	63%
				MD8	*30%*	0%	40%
Above forecast target							
<10% of forecast target							
>10% of forecast target							

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

2.2.1. The Trust formally entered the national Recovery Support Programme (RSP) on the 14th of June, with the Board reviewing the RSP Exit criteria as agreed with NHSE at the Board in July. An RSP entry meeting was held with the national and regional NHSE teams and ICBs on Friday 14th of October. The following meeting with the national team is expected in 6 months' time.

2.2.2. RSP progress is not currently being actively monitored, however, an internal assessment based on the progress against the warning notices and high-level milestone plan can be found in Appendix 2. This is consistent with the reported position by the Trust's Improvement Director to NHSE. Progress is mainly rated "green" as improvement has been achieved against most exit criteria, however, *amber* and *red* components remain regarding clarity on how the Trust is achieving triangulation of data to mitigate risks across the organisation and around People & Culture related areas.

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

descriptions

2.3.1. Overall progress against achieving the RSM considerations is 77%.

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

3. Improvement Journey Risks, Issues, and Interdependencies

Risk ID	Risk Impact Category	Risk Title (short title)	Risk Cause and Effect (What might happen? What is the expected impact?)	Risk Owner	Pre mitigated (Gross Score) Impact (1-5)	Pre mitigated (Gross Score) Likelihood (1-5)	Pre mitigated (Gross Score) Overall Severity (1-25)	Risk response	Mitigations Action (risk manager and due date for each action)	Next Review Due Date	Post mitigated (Target Score) Impact (1-5)	Post mitigated (Target Score) Likelihood (1-5)	Post mitigated (Target Score) Overall Severity (1-25)
R7	Quality People Reputation	Communications & Engagement	There is no formalised mechanism to penetrate messages through the organisation which could impact the IJ's 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).	19/10/2022	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, with CEO attendance from October for increased oversight.	19/10/2022	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 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 the EMB as required. A fortnightly review of operational pressures is incorporated within the Leadership Team meetings, considering any impact on the Trust's Improvement Journey.	19/10/2022	4	2	8
R3	Schedule Quality	Timeframes	Due to tight timeframes for delivery and a lack of project resource continuity, some milestones could be delayed.	All SROs	4	4	16	Tolerate	Weekly programme 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 leads and project support, with SPG currently undertaking resource profiling.	19/10/2022	4	2	8

4. Assurance and Actions for the reporting period ahead

4.1. Warning Notice 1

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) Positive feedback received from public September Board following re-structured agenda and approach, aligning the BAF, IQR, and Improvement Journey action plans to the Trust's four priorities. (+) Clinical Advisory Group established and has started to progress scoping and design of the Clinical Strategy. (+) Executive lead and project manager appointed to Sustainability & Partnerships programme. (+) External effectiveness review of Board and sub-committees conducted and completed during September. (+) Board effectiveness workstream of the Sustainability & Partnerships programme has been expanded to include Board and sub-committee, Executive Management Board and supporting governance group effectiveness.	(-) Committee and external effectiveness review recommendations have not yet been transposed into a cohesive action plan. Not yet able to assess what these mean for internal corporate governance, or how they relate to Board development and effectiveness plans. (-) There is no current plan for a programme of periodic internal "well-led" reviews. (-) Plans are outstanding to ensure continuity of the Improvement Journey beyond the sprint phase, including a plan for an effective and sustainable approach to communication, engagement, and visible leadership beyond Q3.	**Action 19**: Improvement Director, Company Secretary and S&P programme lead to transpose effectiveness review recommendations, Board development and effectiveness actions into one cohesive plan that can be related back to a Training Needs Analysis for the Board. **Action 20**: Executive to develop a planning process for 2023/24 that incorporates the plans for delivery of improvement as well as budget, workforce, performance, etc. Executive to utilise this process as a mechanism for engaging middle to senior managers on the development of the sustainable improvement plans to the end of 2023/24.

4.2. Warning Notice 2

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) Further development of Patient to Board reporting arrangements with new sub-workstream added to the Quality Improvement programme to clearly define actions and framework. Initial EMB dashboard discussed on 26th September. (+) Evidence of committees/groups beginning to embed new changes through revised meeting formats, focused reporting and increased challenge. (+) Joint internal governance review planned for end of October with commissioners. (+) ToRs for all Quality Governance Group subgroups revised and pending approval by November. (+) Survey to scope QI capability across the Trust under development and scheduled for dissemination at end of October. (+) Quality Improvement programme metrics continue to be developed by the BI team, with five core metrics reviewed during each programme meeting.	(-) Patient to Board reporting framework under development. Significant automated data gaps identified, meaning manual reporting may be required initially. (-) Engagement of middle and first-line managers in developing Patient to Board quality governance and reporting remains a gap. (-) Inability to provide assurance on regional/local performance and quality actions (as identified within Performance Committee). (-) Some CQC evidence remains outstanding due to capacity constraints internally. (-) Dissemination of key messages from QGG is delayed due to cancellation of September's QGG meeting.	**Action 21:** Executive dashboard to be developed iteratively, demonstrating that progress and triangulation have started beyond the IQR at Board.

4.3. Warning Notice 3

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) *Thematic Analysis of Patient Harm from Datix delivered* across various clinical teams. Analysis is being furthered, providing a significant step forward in the development of insight into harm. (+) Model for harm reviews developed and governance being approved. Five types of harm model implemented for the first time in an ambulance service. (+) Subject matter experts are now invited to the Serious Incidents Group (SIG) as required. (+) Operational managers are now seeing fewer SIs and Datixs with less actions due to streamlining of central processes. (+) Reduction of incident-related actions in line with trajectories. (+) Joint EMB and SMG risk training delivered on 5th October. Risk Seminar planned for Board in November. (+) New Learning Forum established with case studies being developed for publication trust wide.	(-) Next steps and formal actions following the Quality Summit are still outstanding. (-) Assurance that the quality governance is now effective. (-) Field operations Quality & Patient safety meetings are often cancelled and/or deferred due to a lack of quoracy or operational pressures. (-) The refreshed Risk Management Policy requires further attention to ensure satisfactory risk management and reviews, as well as clear processes for effective escalation and de-escalation of risks. (-) The risk register review is yet to be completed.	**Action 24**: Executive Director of Quality & Nursing, supported by the DDQN, to transpose Quality Summit learning and actions into one cohesive plan that can inform the Improvement Journey. **Action 25:** Risk and Incident Lead, supported by the Executive Director of Quality & Nursing, to revise the Risk Management Policy following feedback from EMB and SMG on 5th October.

4.4. Warning Notice 4

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) Additional Senior PM allocation to programme has benefitted pace of delivery and progress on key actions (i.e., business cases for Culture & Leadership programme and HR Capacity increases) (+) Additional FTSU resource introduced and communicated to Trust. (+) CQC evidence registry revised and realigned to cross-reference Improvement Journey master plan. Evidence submission above target. (+) Two workshops have been planned, including one with non-executive directors, to discuss workforce metrics that will provide sufficient assurance and monitoring. (+) Completion of external FTSU review is now informing the Improvement Journey action plans for FTSU improvement over the next 12 months.	(-) Whilst good progress has been made in providing evidence to address the CQC WN4, the maturity of the People & Culture programme remains challenged, with CEO-led intensive support arrangements continuing. (-) Finalised Culture & Leadership programme plan is currently delayed pending business case sign-off. (-) Whilst workforce reporting frequency has improved, the proposed metrics have not been successful in providing assurance or understanding of case numbers, volume, complexity, or duration. (-) Further work is required to ensure meaningful insights are created from the Employee Relations dashboards, inclusive of integration in patient-to-Board reporting framework led in WN2.	**Action 22:** Executive Lead to support progress of the Business Case for Culture and Leadership Programme to ensure delivery can commence. **Action 23:** Reporting for ER, FTSUG and workforce metrics, inclusive of insights, to be completed and embedded into EMB, WWC and IQR reporting, following the development workshops in October.

4.5. Must-dos and Should-dos

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) Evidence registry continues 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(p):** Development of should-do tracker and updated programme of work by the IJ Portfolio team and delivery leads. Update to be provided at the Board meeting in November.

4.6. RSP Exit Criteria and System Assurance / Collaboration

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) National entry meeting with NHSE completed on 14th October. (+) Mapping to the WN and MD actions demonstrates strong alignment between deliverables. (+) Financial sustainability (SPG) workstream has been reviewed to include financial delivery in-year, financial sustainability for future years and delivery of benchmarking information. (+) NHSE review of Trust finances has been completed and was presented to FIC on 26th September. (+) Self-assessment of financial sustainability is being completed and will then be subject to internal audit.	(-) 9–12-month horizon means that specific tracking of progress has not commenced.	**Action 14(p):** Development of RSP Exit Criteria tracked by Board in November by the IJ project team working with individual workstreams.

4.7. RSM Recommendations

Progress (additive to September report)	Gaps	Actions (continued from September report, p indicates previous action)
(+) 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(p)**: Sustainability & 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 (additive to September report)	Gaps	Actions
(+) All programmes now have some form of dedicated resources, however, there remain 3 WTE gaps. (+) Improvement Journey banners are being produced for each operational reporting base. (+) 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 Executive). (+) Work has started to review the Trust's internal communications and	(-) Whilst there is a communications & 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 portfolio remains a challenge. (-) Funding does not currently cover beyond the 31st of March, causing	**Action 17(p)**: 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 November 2022. **Action 18(p)**: Actions from this Board report to be transferred to the BAF risk register (257). **Action 20:** as above.

engagement approach (+) Improvement Journey booklet developed by Portfolio Steering Group for dissemination to Band 8s and above, outlining the overarching portfolio purpose. (+) Improved "*you said, we did*" communications, with emphasis on 2-minute videos built around staff feedback received through leadership visits.	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.	

5. Appendixes

Appendix 1 - CQC Deliverables.docx

Appendix 2 - RSP SECAMB entry meeti

Appendix 3 - RSM Recommendations.do

Appendix 4 - Evidence progress (O

Appendix 5 - CQC evidence reigstry (Oct

Appendix 6 - 42-22 IJ Board sub-commit

Appendix 7 - 43-22 IJ Board sub-commit

Appendix 8 - WN 3 and 4 deep-dives - 27

Warning Notice 3 (Risk, Clinical Governance and Quality Improvement) **and Warning Notice 4** (People & Culture) deep-dives

27th October 2022

Trust Board

Warning Notice 3

Warning Notice 3 - Risk, Clinical Governance and Quality Improvement

"Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements

As of 15 March, there was a backlog of open Datix incidents (1,500), with no risk stratification within these

There was a concern that harm was not being addressed appropriately when undertaking harm, death, SI, and Datix reviews"

SECAmb Planned Outcome by November

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

Target Evidence

Completion Status	48%

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

Summary of improvements to date

- **Strengthened the SI process e.g. MDT Serious Incident Group (SIG)** : meets weekly to review all moderate and above incidents and oversee the management of SI investigation and final reports, recommendations and actions. The group is chaired by the Deputy Director of Quality and Nursing and members include Clinical representation from the medical directorate (2); Operating Units Managers; legal; safeguarding, EOC, SI team and Field Operations.
- **We have addressed the backlog of SIs, open SI actions and open Datix. Our staff have exceeded the trajectories set**. All SI from 2019 to 2021 have been cleared and to date there are 8 outstanding SIs; Open actions have reduced from 104 (April 22) to 26 (Current) and all the open Datix 1000+ (April 22) have been closed.
- **Preventing further backlogs:** breach tolerance escalation point to Director Q&N and MD to intervene. 0% SI open actions and 5% open Datix; maximum of 5 SI breaches. The number of After Learning Action Reviews have increased.
- **Learning from SIs, incidents and complaints needs further work** but we have started to incorporate SI cases into education and training; implemented 2 mins case review videos; more After Actions Reviews; Use patients' stories at our Quality Governance Group; Joint 111 & 999 and Field Ops Quality & Patient Safety Group incorporating review of SI reports and shared learning.
- **We have carefully considered our approach to Harm Reviews.** Our Consultant Paramedics have researched the methodology of how harm reviews are conducted and testing the methodology over the next few weeks looking at Medication Incidents (Adrenaline 1:1000). In the meantime, we have conducted 260 harm reviews this year. Thematic Harm Review undertaken looking at the last 3 years datix incidents this will support QI projects; informs harm reviews and trend analysis.
- **We are improving how risks is understood and managed across the trust.** A new risks management policy is in place and an e-learning programme developed (97% risks owners trained); A Risks Assurance Group established to review all high and extreme risks; The Risks Register is currently being reviewed to ensure accuracy of information; risks rating and reporting.
- **Quality Summit Implemented in September** 22 – keeping patients safe especially when under high demands. We identified 6 areas of risks and used patients' harm from incidents cases to understand the impact it has on the patient and family.

Plans for improvement going forward

- **Closely monitor SIs; Open actions and Datix over the winter months** as the Trust responds to the winter pressures. This will be achieved via the weekly Quality Improvement Group and Serious Incidents Group. More resources into the SI team to support this work.
- **Review of decision-making pre- Serious Incident Group meeting** - The Head of Patient safety will undertake an audit of the decision-making process that occurs prior to the Serious Incident Group (i.e., what is included and excluded from SIG).
- **Strengthening the model of SI allocation** and implement buddy type system into the investigation process to provide support and expertise for the investigating manager. It will standardise our approach, reduce variations and increase the quality of the output.
- **Further support work with Quality Patient Safety Groups** (QUAPS) to embed all aspects of quality governance, risk management and learning.
- **Review of the Quality of Investigation Reports** - we have asked the Quality Team at NHSE to conduct independent peer reviews conducted every 2 months.
- **Review the responses to staff who raise an incident** - we will need to develop a feedback mechanism that informs staff of the outcome and learning after raising an incident.
- **Developing a bottom-up Quality Dashboard** we are working with all operational staff, BI and Quality Team to have a quality dashboard that connects quality governance across the Trust.
- **Quality Summit output** to be integrated into the Improvement workstreams and a mechanism feedback to staff achieved.
- **Quality Improvement framework** to be developed with staff and a QI programme implemented from April 2023.
- **Continue to strengthen Risk Management** ensuring that it is fully understood and embedded across the Trust; support directorate risk leads via RAG and training to maintain consistency of risks scoring; review and robust evidence-based mitigation.
- **Patient Safety Incidents Response Framework (PSIF)** to be fully understood across the Trust and plans in place to fully implement this ahead of September 2023

Key metrics

- 0% SI open actions and 5% open Datix; maximum of 5 SI breaches. The number of After Learning Action Reviews have increased.
- All risks on the risk register are reviewed in line with the Trust's risk management policy.
- There is clear evidence of how learning is achieved across the organisation.
- Bottom-up Quality Dashboard developed, accessible and aligned to Integrated Quality Report.
- Model of Harm reviews implemented by November 2022.
- PSIRF seminars initiated from November 2022 and implementation plan reviewed by the Quality and Safety Committee by February 2023.
- Actions from the Quality Summit aligned and reported through the appropiate improvement workstreams.

	March 22	19 Sept 22	10 Oct 22
Breached SI's (legacy ones)	27	14	11 (3 all in final stages)
Breached SI actions	107	27	31
Open incidents	1500	1175	984
Breached incidents	1020	285	152

	Aug 22	Sept 22	Oct 22
Risk Register Reviews (moderate and high risk)	50%	63%	68%

Warning Notice 4

Warning Notice 4 - Culture of Bullying

"There was a culture of bullying across the organisation

There was a failure to act swiftly to address staff concerns

There was a dismissive culture where staff raising serious concerns did not have their concerns acted upon

There was a 'lack' of ability to hear, address, or resolve incidents in a timely fashion and in line with Trust policies"

SECAmb Planned Outcome by November

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

Target Evidence

Completion Status	78 %

ID	Improvement required	Actions taken / Plan of action (What is it, and how does it impact/benefit the requirement?)	Evidence
WN4-1	Key metrics: Workforce, culture and wellbeing	**Descriptor:** Key metrics that will be used to measure this requirement.	1) Total open and closed formal grievances
			2) SPC chart reporting on the mean time from issue being raised to outcome for grievances completed by month
			3) Month-by-month run chart of time taken to respond to bullying & harassment allegations and grievances using in-month data to create box plot for each data point
			4) Proportion and total amount of staff suffering from detriment when raising concerns (allegations of victimisation)
			5) ER trendline of cases over time for sexualised behaviours and bullying and harassment
			6) Ratio of upheld grievances of sexualised behaviours and bullying & harassment referred for disciplinary investigation by a MDT v those recommended for resolution by other means (as per new Civility at Work Policy)
WN4-2	Acting swiftly to address staff concerns	**Descriptor:** Provide the evidence for safeguarding / risk assessments and weekly review of suspensions with fortnightly letters.	1) Evidence of process being followed for suspensions and associate risk assessments
			2) Trajectory demonstrating improvement in timeliness of investigations and concluding cases towards policy set standard timelines.
			3) Scope and design FTSU 90-day tracker
WN4-3	Listening to staff	**Descriptor:** Demonstrate how SECAmb has a greater ability to listen to staff concerns than it did in February 2022	1) Bi-weekly audit of PageTiger views of 2021 staff survey results and notes on action plans/improvements
WN4-4	Training and development of managers specific to addressing dismissive culture across the organisation	**Descriptor:** Evidence that two specific parts of the SECAmb Leadership Development programme have a clear delivery plan and trajectories for developing leaders and managers trust-wide	1) Trajectories for completion of sexual safety workshops and mediation courses - to include availability, uptake and six-month forward look
			2) Plan to measure and evaluate immediate and longer-term impact of sexual safety and mediation training
WN4-5	Zero-tolerance stance	**Descriptor:** Demonstrate how the Workforce & Wellbeing Committee and Board utilise information regarding bullying, harassment and sexual safety to ensure effective decisions which support Trust staff.	1) CEO weekly message reiterating Trust values and zero-tolerance stance
			2) Communications plan to address a zero-tolerance stance on sexualised behaviours and B&H, including progress to date
			3) Evidence that the Board minutes and agendas are reflective of the challenges the Trust is trying to resolve in relation to WN4
			4) Minutes of SMG, EMB, WWC, and The Board reveiwing and discussing trends shown in the ER Dashboard
WN4-6	Framework and policies for raising concerns	**Descriptor:** Evidence of a clear process for raising concerns at SECAmb which managers and staff understand	1) Launch of new Dignity at Work (Civility and Respect) at Work Policy and delivery against comms plan
			2) Attendance rates at Module 1 of Fundamentals vs trajectory
			3) Feedback scores from attendees on Module 1 of Fundamentals v trajectory
			4) Construct and publicise available pathways for staff to raise concerns (FTSU, mediation, grievance, 1to1's)
			5)Additional resourcing in FTSU (East and West)
			6) Completion of FTSU learning at inductions
			7) Delivery of a comms plan to publicise the FTSU e-learning module deployment
			8)Reporting of completion of the FTSU e-learning module
WN4-7	Culture and Leadership Programme	**Descriptor:** Evidence of implementation of Culture and Leadership Programme and measures of impact	1) Commencement of the Culture and Leadership Programme
			2) Development of a immediate People Strategy with clear outcomes and trajectory against each element.

Summary of improvements to date

- **Commenced 'Until it Stops' Campaign in June** – the Trust has designed a program based on the Equality & Human Rights Commission (EHRC) on preventing sexual harassment at work.
- **Commenced Fundamentals line management in July** – this is the first part of an in-house management development programme and will be rolled out over 27 cohorts of 20 delegates over 24 months. An explicit part of this program is compassionate leadership, emotional intelligence, and bullying and harassment.
- **Developed metrics on employee relations** – existing PowerBi dashboards have been refined to understand better grievances, disciplinary, and bullying and harassment incidence and duration against the policy. These will be further refined to meet the needs of Board assurance and management grip and control on case relative complexity.
- **Recruited additional FTSU resources in September** – two new deputy FTSU guardians (East and West) have been recruited and are in place.
- **Commenced training for managers to address bullying and harassment in July** - 80 have attended with 222 booked to attend.
- **Strengthened the Trust's Dignity at Work Policy and re-issued in September** – this refreshed in line with legal changes and the EHRC campaign on sexual harassment at work, and places the policy framework on a stronger footing.
- **Implemented a communications plan on zero tolerance** that demonstrates the commitment from the Board, EMB, and SMG on a zero tolerance culture.
- **Designed training and recruiting Dignity at Work Advocates** – these volunteers will be the first point of contact for people wishing to have a conversation about bullying and harassment and help signpost support or referral. As of Oct 18, 14 people had signed up.
- **Refreshed and implemented FTSU training for all staff** – from front-line staff to the Board, training on Listen Up and raising concerns has been refreshed and rolled out.

Plans for improvement going forward

- **Implement the NHSE Culture and Leadership Program (CLP)** – subject to a business case, commence the CLP including acquiring program resources
- **Develop and implement an immediate People Plan** – focusing on actions complimentary to the CQC WN4, but also addressing the Must Do's and Should Do's a short-term (i.e. 12 to 18 month) plan will be developed and implemented.
- **Develop and implement a long-term People Strategy** – complimentary and where appropriate, informed by the CLP, a long-term People Strategy will be developed and implemented.
- **Develop and implement a long-term employee engagement improvement strategy** – Based on the NHSE Employee Engagement Strategy, develop and implement a specific plan that meets SECAmb peculiar needs.
- **Develop and implement an Employee Listening Plan** – this links in to the employee engagement strategy above.
- **Complete the implementation of the Appraisal Project** – this is the roll out of the new look appraisal form and process based in ESR.
- **Agree and implement CPD investment plan with HEE** – to identify and target HEE investment for CPD.
- **Develop and implement SECAmb's Education and Training Strategy** - to ensure that the Trust equitably supports and develops staff according to need, and targets resources on need.
- **Develop and implement a refreshed Health and Wellbeing strategy and service** – to support individuals psychological, emotional, and physical needs so that they can be their best selves in work.

Key metrics

- It has been identified that the proposed program metrics for measuring volume and trajectory of bullying and harassment cases have diverged from the definitions used by HR. Secondly, metrics that have been proposed to date have not been successful in providing assurance or understanding of case numbers (i.e. incidence), case volume (i.e. number of issues within each grievance), case complexity (i.e. the relative complexity of each issue raised), and case duration (i.e. adherence to duration of policy stages and in total).

- This will be resolved by conducting two workshops:
  - Non-Exec. Directors to discuss workforce metrics that would provide them with assurance
  - A follow up meeting with workforce and BI specialists.

- In preparation for both meetings, HR is meeting with the Senior Research Advisor – Data, Technology, and AI from the Chartered Institute of Personnel and Development.

	Total Cases	Trend Duration	Longest Unresolved Case
Grievances (Oct 22)	93		478
Grievances (Feb 22)	36		635
Disciplinaries (Oct 22)	33		376
Disciplinaries (Feb 22)	14		596

	Total Suspended	Suspension % of all cases	Mean duration
Disciplinaries (Oct 22)	10	30.30%	61.5 days
Disciplinaries (Feb 22)	5	35.71%	358.8 days

Financial Sustainability

Sustainable

Financial Sustainability – Delivery against our plan

September 2022

IPRID	Metric	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
F-1	Income (£000s) Month	£29,158	£23,451	£24,049	£25,088	£24,866	£24,641	£28,750	£22,741	£23,108	£29,733	£24,477	£25,015	£26,914	£24,409	£2,505	N/A	N/A
F-9	Income (£000s) YTD	£146,011	£169,462	£193,511	£218,599	£243,465	£268,105	£296,855	£22,741	£45,849	£75,582	£100,059	£125,074	£151,988	£146,521	£5,467	£307,843	£10,053
F-2	Operating Expenditure (£000s) Month	£27,982	£24,301	£24,785	£26,396	£25,269	£24,949	£25,281	£25,308	£25,680	£24,694	£24,917	£25,431	£26,753	£24,448	(£2,305)	N/A	N/A
F-10	Operating Expenditure (£000s) YTD	£150,810	£175,111	£199,896	£226,292	£251,561	£276,510	£301,791	£25,308	£50,988	£75,682	£100,599	£126,030	£152,784	£147,950	(£4,834)	£307,253	(£9,461)
F-3	Capital Expenditure (£000s) Month	£655	£395	£2,905	£2,477	£2,429	£0	£11,424	£1,055	£1,770	£4,860	£2,403	£1,558	£3,060	£2,916	£144	N/A	N/A
F-14	Capital Expenditure (£000s) YTD	£5,910	£6,305	£9,210	£11,687	£14,116	£14,116	£25,540	£1,055	£2,825	£7,685	£10,089	£11,647	£14,707	£21,385	(£6,678)	£33,412	£2,704
F-4	Cost Improvement Plan (CIP) (£000s) Month	£238	£161	£251	£181	£963	£393	£1,676	£84	£125	£260	£164	£0	£0	£404	(£404)	N/A	N/A
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£1,068	£1,229	£1,480	£1,661	£2,624	£3,017	£4,693	£84	£208	£468	£632	£632	£632	£1,641	(£1,009)	£5,598	£0
F-6	Surplus/Deficit (£000s) Month	£1,176	(£850)	(£736)	(£1,308)	(£404)	(£309)	£3,469	(£2,567)	(£2,572)	£5,038	(£440)	(£416)	£161	(£39)	£200	£590	£592
F-7	Cash Position (£000s) Month	£40,507	£46,592	£45,791	£43,638	£47,832	£53,937	£62,555	£52,948	£45,599	£44,224	£40,728	£41,594	£38,072	£37,838	£234	£43,060	£2,174

What is the information telling us?

The Trust's financial performance for the 6 months to 30 September 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: -

1. the Trust and Commissioners deliver against the FY2022/23 contract for both 999 and 111
2. the Trust will deliver against the underpinning assumptions in the integrated plan including the agreed efficiency improvements.

At month 6, specific areas of concern that will impact the Trust financial forecast position are:

1. Concluding its contract negotiations for both 999 and 111.
2. Ability of the Trust to meet its recruitment and retention targets
3. The impact of high sickness levels and the rota review on the 2022/23 plan
4. 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.
5. 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.
6. Ability within 111 to change the service offering quickly enough to meet the new service specification agreed by the Operations Director and delivering the required staffing to join the Single Virtual Contact Centre

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What actions are we taking?

The Trust continues to engage with commissioners to secure: -

1. all funding related to 2022/23
2. 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 6 months of FY 2022/23. This will inform the financial outturn for 2022/23 and rectification actions required

That line of sight of the underlying financial position and forecast is given more prominence on the Executive and Board agendas in response to the governance reviews and CQC feedback

We will specifically ensure that: -

1. 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
2. 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.