South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

15 December 2022
10.00-14.00

Banstead MRC

Agenda

Item No.	Time	Item	Paper	Lead
Board Governance				
62/22	10.00	Welcome and Apologies for absence		Chair
63/22	10.01	Declarations of interest		Chair
64/22	10.02	Minutes of the previous meeting: 27 October 2022		Chair
65/22	10.03	Matters arising (Action log)		PL
66/22	10.05	Chair's Report		DA
		Board Effectiveness Review		
		Board Development		
67/22	10.25	Audit & Risk Committee Report		MW
		EPRR Annual Assurance Assessment		EW
68/22	10.35	Chief Executive's Report		SM
69/22	Primary Board Papers	a) **Board Assurance Framework** b) **Integrated Quality Report** c) **Improvement Journey**		
Delivering Quality				
70/22	10.55	**Keeping patients safe**	Board Story	FM
			BAF Risks 13, 14, 15, 255, & 256 Improvement Journey IQR	RN
			Learning from Deaths Report	FM
			Quality & Patient Safety Committee Report	TQ
	11.35	Break		
Focus on People				
71/22	11.40	**Improving Culture**	BAF Risks tbc, 13 & 15 Improvement Journey IQR	AM
			East Kent Maternity Review	FM
			Workforce & Wellbeing Committee Report	SS
Delivering Modern Healthcare				
72/22	12.20	**Operational Performance & Efficiency**	BAF Risks 13, 14, 17 & 255 Improvement Journey IQR	EW
			Performance Committee Report	HG

Delivering Sustainability & Partnerships				
73/22	12.55	**Achieving Sustainability / Working with Partners**	BAF Risks 14, 16 & 17 Improvement Journey IQR	MS
			Finance & Investment Committee Report	HG
Our Improvement Journey				
74/22	13.20	**Regulatory Compliance / Strategic Priorities 2023-24**	BAF Risk 257	DR
			Improvement Journey	
Board Effectiveness				
75/22	13.40	▪ Improving quality of information to the Board ▪ Improving professional curiosity and triangulation		Chair
Closing				
76/22	13.45	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

Agenda No	63-22

Name of meeting	Trust Board
Date	15th December 2022
Name of paper	Declarations of Interests
Trust Priority Area	N/A
Author	Company Secretary

The Trust maintains a Register of Interests, which includes each member of the Board of Directors. On appointment, new members are required to declare any interests and any changes during the year must be declared to the Trust Secretary immediately and then formally at the next meeting of the Board.

The Register is reviewed annually and, in addition, at the start of each meeting members are required to declare any interests not already recorded that may be relevant to the items being considered.

The Register of Interests for Board members most recently updated is found below – Appendix 1.

Recommendations, decisions or actions sought	To Note.

Appendix 1 – Register of Interests

David Astley	Chairman	A Director of Yoakley Care Share Ltd and Yoakley Care Trustee Ltd, a charitable company that manages almshouses and a care home. Daughter Emma is a Director at PWC Consulting who sometimes works with the public sector.
Siobhan Melia	Chief Executive Officer	None
Emma Williams	Executive Director of Operations	Husband, David Williams, works at SECAmb as Head of Resilience and Specialist Operations – not directly line managed and recruited was through the formal Trust process.
Martin Sheldon	Interim Chief Finance Officer	None
Ali Mohammed	Executive Director of HR and L&OD	Trustee at LHA London – a housing charity in central London from October 2019 to September 2023. This is a non-financial professional interest, unpaid but reimbursement of receipted travel expenditure.
Fionna Moore	Executive Medical Director	Medical Director, Location Medical Services Medical Director Medicare EMS

Robert Nicholls	Executive Director of Quality and Nursing	None
Michael Whitehouse	Independent Non-Executive Director/Senior Independent Director/Deputy Chair	Board member and chair of Audit Committee of Medicines and Health Care Products Regulatory Agency Member of Audit Committee of Republic of Ireland Audit Committee.
Howard Goodbourn	Independent Non-Executive Director	None
Paul Brocklehurst	Independent Non-Executive Director	Trustee for Myeloma UK
Chris Gonde	NeXT Director	None
David Ruiz-Celada	Executive Director of Development and Planning	Minor shareholding (<1%) of RUTI Immune, a trained immunity vaccine for COVID-19 which is under development and currently at stage 2 trial. Father (Luis Ruiz-Avila) is involved in the biomedical sector, focussed in entrepreneurial, executive and investor activities, in early-stage drug discovery and development, helping companies transition from clinical proof into global pharmaceutical development and eventual commercialisation. Companies with influential role: • Kintsugi Therapeutics (Minor shareholder & board member) • Biointaxis (Minor shareholder, non-executive director business advisory role) • Leukos Biotech (Minor shareholder, CEO) • Ruti Immuni (Minor shareholder, CEO) • Affirma Bio (Minor shareholder & board member) • ONSTX Olavide Neuron (Minor shareholder & board member)

		• Janus Project (owner) • Other Companies with minor shareholding (<25k€ investment or <5% capital): Oxolife, Methinks, Devicare, Zecardio, Nuubo, BHV Partners) • Investor in healthcare specialized VC funds Asabys Partners, Inveready, Alta Life Sciences
Subo Shanmuganathan	Independent Non-Executive Director	Board Trustee for Amnesty International Non-Executive Director Bromley Community Interest Company, Non-Executive Director for the Crown Prosecution Service.
Tom Quinn	Independent Non-Executive Director	Emeritus Professor, Kingston University. Undertaking research funded by National Institute for Health Research, British Heart Foundation, and Gas Safety Trust. External examiner for Paramedic Studies degree at University of Limerick, Ireland. Member of Domain Expert Group, Myocardial Ischaemia National Audit Project. Volunteer roles with European Society of Cardiology, member of Task Force on Allied Professions). Volunteer role: Trustee/Director of British Association for Immediate Care. Volunteer role: Trustee of Aston Defibrillator Funds, Farnham. Volunteer role: Clinical Director, HeartStart Farnham Lions. Volunteer role: Trustee, Hale Community Centre. Volunteer role: British Cardiovascular Society/Intensive Care Society, UK Cardiogenic Shock Steering Group. Volunteer role: British Cardiovascular Intervention Society Out of Hospital Cardiac Arrest Focus Group.
Liz Sharp	Independent Non-Executive Director	Board Trustee, Queen Elizabeth's Foundation for Disabled People (Care and Rehabilitation Services, Mobility and Residential Services Charity). Board Director, The Grange 2016 (Supported living in Kent) Member of the Royal College of Nursing Professional registration with the Nursing and Midwifery Council

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 27 October 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
Martin Sheldon	(MS)	Chief Finance Officer
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

In attendance:

Christopher Gonde	(CG)	Associate NED
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Steve Lennox	(SL)	Improvement Director

Chairman's introductions

DA welcomed members, those in attendance and those observing to this extraordinary meeting to check progress with the Improvement Journey – the meeting is also available via MS Teams to join live.

62/22 Apologies for absence

Tom Quinn (TQ) Independent Non-Executive Director

63/22 Declarations of conflicts of interest

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

64/22 Minutes of the meeting held in public 29.09.2022

The minutes were approved as a true and accurate record.

65/22 Action Log [09.02-09.03]

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

DRAFT

66/22 Improvement Journey - Warning Notice Progress [09.05-10.32]

SM reminded the Board about the focus on the Warning Notice, arising from the Well Led Inspection earlier in the year. The findings of the subsequent inspection of our emergency and urgent care service was published yesterday and this is being incorporated in to the Improvement Journey; many of the issues already align to the priorities within the plan. As the biggest gaps relate to Warning Notice 3 and 4, SM suggested the Board uses this meeting to focus on these areas, in particular.

RN then outlined the progress within Waring Notice 3, related to governance and risk management. He clarified one inaccuracy in slide 6 related to the backlog; this is where the CQC identified circa 1500 open incidents and RN confirmed we have now cleared this backlog. With regards open breached Sis, RN confirmed that we had 27 in April and to-date the number is 10, one of which is from 2021; this has been reviewed and subject to some further work will be signed off / closed. We also have 23 open actions and this is a downward trend from 107 back in April. RN next outlined the steps to improve the governance for incident management to ensure this improvement is sustained. On harm reviews, RN confirmed we are introducing a new methodology and will provide further details about this in due course.

DA noted the gaps that still exist and before opening up to questions he encouraged board members to seek assurance on related timelines.

In relation to Warning Notice 3, PB asked how far on track we are. RN confirmed the shortfall is around the terms of reference for some groups, which will then increase the % of evidence available. RN also outlined the work to ensure we don't build up a backlog of incidents / Sis over the winter period. PB asked RN how we intend to absorb the work during this period. RN responded that we are looking to seek additional support.

MW challenged the executive to ensure in its forward plans that the right model is in place for the management of incidents and Sis so that we ensure sustainable improvement. In response to tis the Board agreed that through the IQR it will continue to check overdue SI actions and via the quality and patient safety committee (QPSC) will monitor the open incidents that have breached the timeframes.

MW then asked if the executive is confident that we understand risk management, not just the process. RN responded by outlining the steps to ensure this. MW acknowledged that we need to collective understanding at Board and this will be picked up at risk deep dive in November. FM added that in terms of clinical risk, we look at the whole pathway and pick up different risks along this pathway. This led to a discussion about who owns aspects of the clinical risks when waiting to handover patients at emergency departments.

SM reflected that there are three main parts of Warning Notice 3 and RN has given a given good articulation on how clinical and corporate governance is working together and the approach to the management of risk. With regards the incident backlog, while it is improving, we do still have a backlog, but we don't have yet a clear risk stratification for all the open cases. SM challenged the Board on where it seeks assurance on this, including how we will know our harm review process will be effective. LS felt it needs review first at QPSC then to Board; we need data over time to see trends and to confirm how we ensure learning. MW expressed some assurance by this discussion but challenged further a need to ensure we get to the root cause to prevent recurrence. In other words, deal with the systemic issues leading to patient harm.

Action

Until it is confident with the ongoing management of incidents, QPSC to have a standing agenda item that monitors the numbers of open incidents that have breached the timeframes. Where there are significant breaches, it will assess how the risks are established. It will then report to the Board its level of assurance.

DRAFT

Action
QPSC to review the new approach to harm reviews to ensure this helps to lead to identification of systemic issues / risks and subsequent learning.

HG explored the number of open incidents and how the Board receives data that tells the story and confirms the level of risk it represents, e.g. what should the number be and what is the oldest etc. SM explained that we don't currently report the data in this way but it does highlight the use of SPC charts for trends over time. The Board acknowledged this gap in assurance which will be followed up by the actions agreed (above). SM reinforced that one of the reasons we are focussing on Warning Notice 3 is because despite the progress we know there is work still to do.

There were then some questions from the independent non-executive directors about risk process, including how management is ensuring regular risk reviews. RN responded by explaining that managers are engaging risk owners and the Risk Assurance Group now meets weekly until we are in a more stable position. RN expects that by the time the Board next meets there will be greater compliance of risk reviews (up to about 85%) and better quality of risk description.

DA summarised that in relation to Warning Notice 3 the Board acknowledges the good progress that is being made, in particular with the incident backlog and related governance systems and process. The executive has been open about the scale of the challenge and a significant backlog remains. There is a need to look at the oldest incidents and QPSC will be seeking related assurance and report back to the Board accordingly.

DR noted that the Quality Summit was two months ago and we should be in a better position to articulate the outcomes. RN accepted this challenge and confirmed we now have the data from this which we are now turning in to actions. The Board noted that this and that QPSC has the Quality Summit on the agenda at its next meeting in November. It asked RN to ensure that in future Summits we keep our partners informed on the outputs and next steps in a timelier way.

Action
In its scheduled review of the Quality Summit in November, QPSC to seek assurance that we are following through on the actions.

The Board then turned to Warning Notice 4. AM outlined progress with the cultural issues we have. He explained that during COVID all employee relations cases were paused as per national guidance and so this had an impact. However, notwithstanding this we do have a high number of cases; circa 200 a year which is much higher when compared with our peers. AM then provided some information about the improvement in the timeliness of dealing with cases, confirming that we can now track each stage of pathway of employee relation cases; we will therefore start to report issues arising from this analysis through management structure to ensure improvements continue to be made. AM also confirmed the gap in FTSU data and work being done to address this.

DA asked that we aim to better understand the root cause for why we have such high numbers of cases. This led to a discussion about the link between taking concerns seriously and staff confidence in speaking up, and also about our recruitment process and needing to be clearer about expectations linked to our values. The Board reinforced that we need all our people to have a positive experience from their first contact with the Trust, and when they join to feel supported and developed.

DRAFT

LS asked about FTSU and the extent to which we have improved how we record cases. AM confirmed that there is still work to do to review the FTSU pathway, like we have done for employee relations cases. At present it is not integrated. LS followed this up to ask if we have data on the closure of FTSU concerns. RN responded that we are working on this with the Datix system. LS continued to challenge on the point asking how management gets visibility of the numbers of cases. RN confirmed that the FTSU Guardian currently records this in a spreadsheet.

The Board reinforced the need for better visibility of this and asked the audit and risk committee (AUC) to follow up on the timeline and seek assurance with the controls in place to record and report cases raised under FTSU. RN added that we will see more trend analysis in next bi-annual FTSU Guardian report to the Board.

Action
AUC to receive assurance that the process for using Datix to record FTSU cases is implemented.

The Board noted the theme related to how we track progress of cases, whether incidents, employee relations or FTSU, whereby we tend to see metrics giving averages but not longest waits, i.e. the extremes. It therefore asked that in the development of the IQR the executive establishes how the data can help the Board to test the related process(es).

SM suggested that while WWC needs to see information on the number of cases open over time and the longest time to resolve, plus some thematic themes, this is different to what the Board needs which is, over time, whether the cases are increasing or decreasing, and whether timeliness is improving. The Board agreed.

RN asked how we will test the extent to which our interventions on bullying and harassment training is having the intended impact. AM responded that the only way to do this is to track what staff are feeding back and how we manage cases and asking people raising concerns about how we have dealt with them. AM added that 25% of cases relate to bullying and harassment (incl. sexual safety), so we have lots of data to test impact. He then suggested that there is individual and collective responsibility on all board members and leaders to push these messages on culture, which we should hold each other to account for.

PB noted that the employee relation cases have doubled since February and asked why given this workstream is to reduce cases; there is no comment on this in the paper. AM responded by explaining one factor is the impact of raising the profile of sexual safety. SM agreed with this and explained that in light of the very high number of cases, we aren't as decisive and timely given the capacity to deal with such high numbers. We therefore need absolute clarity on taking a zero tolerance to behaviours not in line with our values and once proven sanctions must be applied much sooner. SM added that she completed the training this week and heard lived experiences which cannot be right in 2022. We therefore need to be stronger in our actions to ensure all staff are protected and we need to deliver actions more overtly to match our words.

AM felt that we can demonstrate improvement but like SM says, managing such high numbers is difficult. We need to reduce numbers by about 80% to bring us in line with our peers.

DA summarised that there are standards we must not tolerate in future. The Board needs assurance on the tracking and monitoring of cases to help demonstrate we are taking decisive action, in order to give confidence to our people.

DRAFT

SS asked about the RAG rating being reduced to Amber and challenged whether this is really accurate given the work still to do. DR confirmed that the RAG rating is made at programme level based on actions / evidence, narrowly in response to the Warning Notice. He then described a need to change the Improvement Journey approach from the sprint to a marathon, so that it is driven strategically rather than by regulatory actions.

MW was struck by what SM said about the importance of equality of treatment and asked her whether she is happy with the pace on this Warning Notice. SM responded that she is not happy with the pace but understands why it is the pace it is; we have limited resource in a team subjected to an incredibly high case load of cases. SM reflected that she has never seen such volume or complexity. SM is in discussion with AM about how to ensure different interventions arising from the external HR review that will come to Board in November. SM confirmed that we have a path to improvement but it will take time. The broader element on the Culture and Leadership Programme is work in progress, which the Board is leading in the context of setting the culture.

DA confirmed that the Board stands united on this and understands the position. He then summarised that we note progress has been made, albeit with some significant issues still to resolve, including the high numbers of cases, which the executive is taking action to address.

Lastly, under this agenda item, DR provided a final summary of the Improvement Journey and the progress made across each of the four areas. He reinforced that we continue to focus on the Warning Notice up to December when we will start the transition to a more sustainable approach, ensuring more engagement with front line staff so that the Improvement Journey evolves bottom up. Acknowledging that for good reason it has to-date been driven at senior level, given the link to leadership in the findings of the Well Led inspection.

The Board agreed that related to Warning Notice 1 and the issue of 'disconnect' this continues to be helped by the outputs of the leadership visits. There has also been positive feedback externally from the quality of the Board meeting in September, which we need to build on. The Board effectiveness review which links also to Warning Notice 2 (quality of information) is nearing its conclusion and the next step is to drive the quality of information through the organisation to ensure better management and triangulation.

DR explained that we will utilise the business planning process to ensure the Improvement Journey is evolved more bottom up so that by the time we get to April 2023, all our people understand the improvement focus and what this means for their own personal objectives.

The Board noted the plan for an internal peer review of the Improvement Journey, followed by a review from system partners ahead of the session as a Board at the end of November. This will all then feed in to the Board meeting on 1 December which will be when we will need to demonstrate significant improvement against the Warning Notice, prior to the session with CQC.

DA then asked MS to summarise the finance slides, which he did, reinforcing that while we have a £1.4m deficit in line with plan, this is masking significant issues and risks. For example, we have been over reliant on non-recurrent savings which is not sustainable. There is also still an issue with the lead commissioner related to funding and discussions are ongoing to try and resolve this. Despite this, MS reflected the opportunities that exist that will help us achieve the breakeven target.

DA thanked MS for this update and noted the Board will have more time to review the financial position at the next meeting.

DRAFT

67/22 Review of Board Effectiveness [10.32-10.33]
DA asked about the level of assurance. MW reflected there has been good work and thanked the executive for their honesty. The Board concluded that we are on a journey and assurance is increasing, with the caveat that we need to continue pushing to maintain pace.

68/22 AOB
None

There being no further business, the Chair closed the meeting at 10.34

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

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
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	C	BAF report now includes reference to the relevant SPC chart in the IQR - see version on the agenda 15.12.2022
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	15.12.2022	Board	IP	To be picked up in the CEO report to Board and under the agenda item - keeping patients safe.
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	15.12.2022	Board	IP	Verbal update to be provided at the meeting on 15 December.
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	15.12.2022	Board	IP	On the agenda - keeping patients safe
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	15.12.2022	Board	C	Confirmed in the IQR - new icon that highlights were there is no target by design.
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	This was revieved by EMB on 09.11.2022 and is covered on the agenda - see cover paper for Improving Culture and link to the IQR
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	C	Covered at the most recent meeting - see Board Escalation Report on the agenda
27.10.2022	66 22a	Until it is confident with the ongoing management of incidents, QPSC to have a standing agenda item that monitors the numbers of open incidents that have breached the timeframes. Where there are significant breaches, it will assess how the risks are established. It will then report to the Board its level of assurance	RN	tbc	QPSC	IP	Added to the agenda of QPSC from January 2023
27.10.2022	66 22b	QPSC to review the new approach to harm reviews to ensure this helps to lead to identification of systemic issues / risks and subsequent learning.	RN	17.11.2022	QPSC	C	This was considered at the meeting on 17 November - see the QPSC Board Escalation Report
27.10.2022	66 22c	In its scheduled review of the Quality Summit in November, QPSC to seek assurance that we are following through on the actions.	RN	17.11.2022	QPSC	C	This was considered at the meeting on 17 November - see the QPSC Board Escalation Report
27.10.2022	66 22d	AUC to receive assurance that the process for using Datix to record FTSU cases is implemented	RN	Jän.24	AUC	IP	The report to AUC was deferred from the meeting on 7 December for the reasons set out in the committee's Board Escalation Report. It will schedule an extraordinary meeting in January 2024. In the meantime, the IQR now includes additional metrics, including the numbers of FTSU cases.

Key

- Not yet due
- Due
- Overdue
- Closed

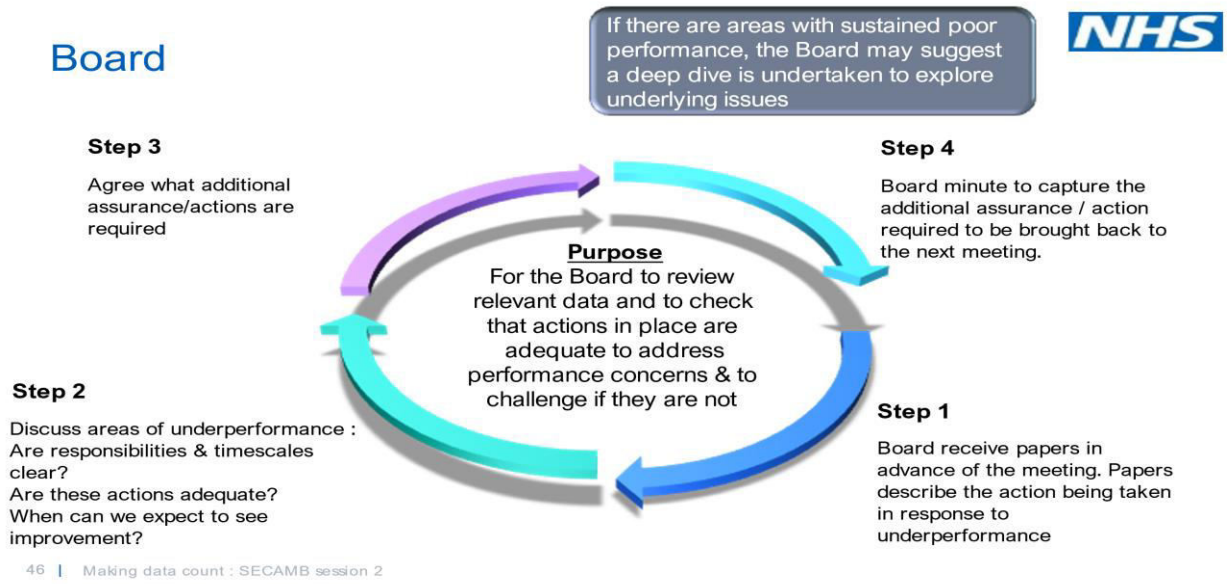
South East Coast Ambulance Service
NHS Foundation Trust

		Item No	66-22
Name of meeting	Trust Board		
Date	15.12.2022		
Name of paper	Chair Board Report		
Report Author	David Astley, Chairman		

Board Meeting / Effectiveness

Building on the change of approach to Board meetings we made in September, this meeting follows the same format, where the agenda is ordered against our strategic goals with areas of specific focus that are linked to the current key issues and risks arising from the primary board papers – the Board Assurance Framework; Integrated Quality Report; and Improvement Journey.

Reflecting on the meeting in September, there were some good examples where this worked well, as demonstrated by the issues captured in the action log. On today's agenda we will follow these issues through to complete the assurance cycle. For example, where the Board asked the Executive to review the reasons driving high sickness rates to ensure there is a clear understanding of the factors and the actions being taken in response. In the context of the IQR we will be seeking further assurance in this area. Another example was the challenge about how we are keeping patients safe, specifically in relation to welfare calls; we will explore this in detail under the section on Keeping Patients Safe. And lastly, I note the further improvement in the BAF, as directed by the Board last time, which now draws a clearer link to the relevant metrics and SPC charts.



These are all positive steps in the right direction and, as Chair, I am clear the Board must continue

to ensure improvements are made. The development session we had in October on effective challenge / holding to account, facilitated by NHS Providers, was really beneficial to our improvement journey. Some of the outputs we agreed then included:

- Ensuring greater clarity on actions arising from the Board
- Refining push and pull assurance through committee planning meetings, and being more precise about specific assurance the Board requires
- Checking in with each other to test how the challenge is landing
- Arranging effective report writing training for those regularly tasked with writing assurance reports for the Board

This aligns with the findings of the Board Effectiveness Review our Improvement Director has undertaken (Appendix 1). This really helpful review will be used by each Committee Chair and Executive Lead, to ensure the recommendations are implemented. From January, their reports to the Board will include a section setting out progress. Some of the recommendations have already been considered and I was pleased to hear positive feedback about the most recent meeting of the workforce and wellbeing committee, where the papers were much improved leading to better quality discussions.

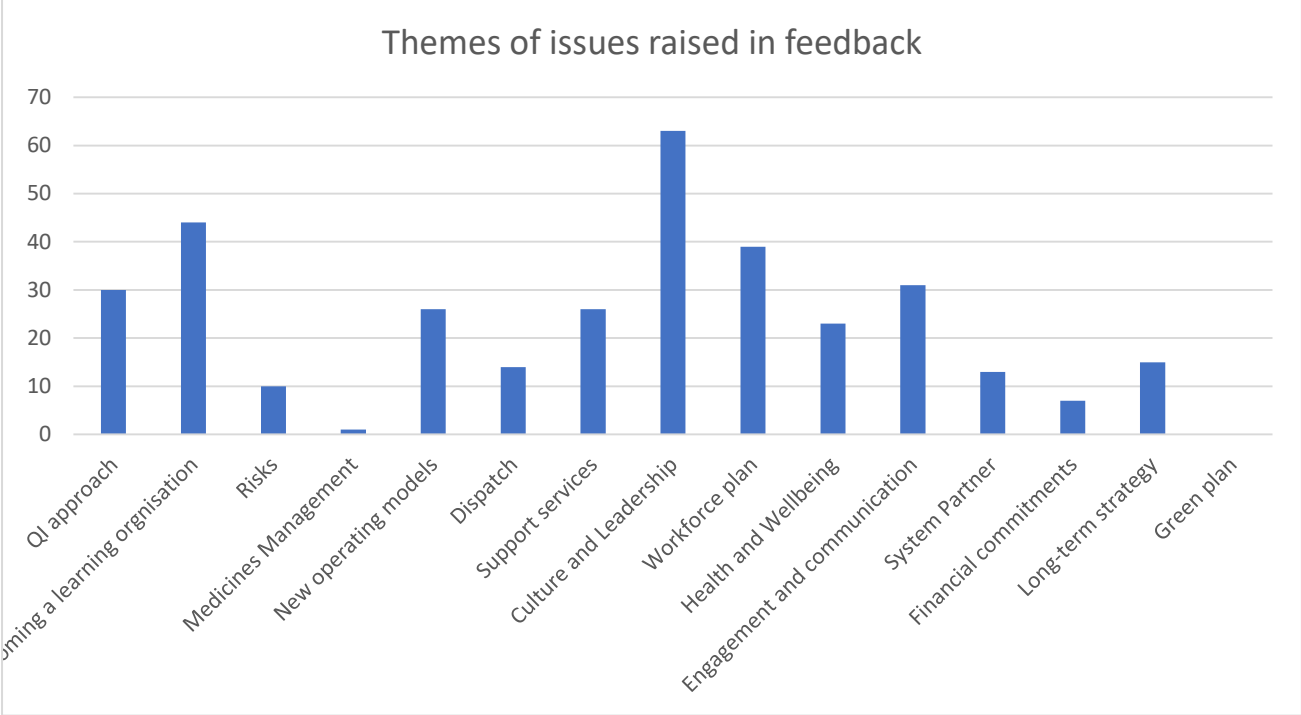
There are also recommendations for the Board itself, and as I have outlined, we have already taken steps in how we structure meetings. In my reports to the Board I will describe the extent to which the Board is becoming increasingly effective. At the end of the meeting I will ask for immediate reflections on the meeting and in particular the two areas confirmed on the agenda, which relate to the Warning Notice.

One of the primary duties of the Board is to set the organisational culture, and we know this is a critical issue for us and central to our Improvement Journey. I have set aside time in our Board development programme to focus over the next few months on how we discharge this duty. The separate paper (Appendix 2) sets this out and I will be asking for the Board to formally support this approach.

Leadership Visits Feedback

An area of feedback from the last staff survey, which was highlighted by the CQC, related to a disconnect between the Board and the wider organisation. In addition to improving the quality of information we receive that more directly connects to what is happening in local operating units, control rooms and in support services, one of the ways we are seeking to address this disconnect is to undertake leadership visits in order to listen to our people. Since the meeting in September some of the issues arising from these visits include:

- The visibility of senior leadership and the quality of two-way communications.
- Over-allocation of resources for non-emergency responses, for example should we be attending urgent community calls or change the triage process?
- Continual Professional Development, and concern that staff have limited options available to them.
- Recognising success and whether we can do more to improve moral.



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

Council of Governors

The Council of Governors (COG) met on Monday 5 December, in Brighton. We used the opportunity to receive an update on the recent Critical Incident (IT outage) and on our planning for the upcoming industrial action. The Chief Executive will cover both these issues in her report to the Board.

There were a number of other issues the Governors expressed concern about related to culture and how we are supporting our workforce and ensuring safe services, including the specific points listed below all of which will be a focus on today's agenda:

- How the Board and COG continue to seek assurance that we address the cultural issues
- Importance of appraisals and that everything is done to achieve the 85% target.
- Focus on the recruitment pipeline and ensuring clinical education has the resources it needs to support this
- Move to Medway and how the delays will impact service provision and staff

The Director of Planning & Business Development attended the meeting to update the COG on the progress with our Improvement Journey and in particular against the Warning Notice following a number of peer reviews during November. Feedback was also provided on the output of the joint Board and COG last month, which was used to engage on the priorities for 2023/24 which will inform our business planning. This will also be covered on today's agenda.

The recent Governor elections concluded last month (six public and one staff). Inductions for our new Governors are being arranged for January, in time for their terms of office starting in March

2023. All our Governors give their time voluntarily and are central to our governance framework; it is the COG who hold the Board to account on behalf of the public.
Board Appointments
We are currently in the process of recruiting to four Board posts; one NED; the Chief Executive; Chief Medical Officer; and Chief Finance Officer. I will update verbally on progress as the recruitment to two of these posts (NED and CFO) are due to conclude in the coming days.

South East Coast Ambulance Service NHS Foundation Trust

Effectiveness & Well-Led Review 2022

Part 1 - Effectiveness

1. Introduction & Methodology

In 2022 the Care Quality Commission (CQC) undertook a comprehensive review of the Trust. The outcome for the Trust was an overall score of *requires improvement* and a score of *inadequate* within the well-led domain.

The Trust's response was to work with the local system and NHS England to develop an Improvement Plan. This plan identified several actions that would lead to rapid improvements within the well-led domain. In particular, the need to have a greater understanding of the Board and the effectiveness of the Board's committees.

To support the effectiveness report, the Trust also agreed with the NHS England regional team and the Integrated Care System to co-commission a Well-Led stock-take. This would help provide a check and balance that improvements within well-led are being effective and are acting as a platform for wider improvement.

It was agreed to align these two interventions into a single piece of work and allow the effectiveness review to inform the well-led review.

This report is the outcome of the effectiveness portion of the review and has been undertaken through a series of observational exercises. These have been led by Steve Lennox, the Trust's Improvement Director from NHS England. The director was supported by the following colleagues from the national Recovery Support Programme.

- Sinthujaah De Silva, NHS England Deputy Director of Intensive Support
- Louise Pramas, NHS England Culture Transformation Lead
- Samantha Riley, NHS England Director of Making Data Count
- Matthew Fox, NHS England Director (Finance) of Intensive Support
- Anna Lynch, NHS England Senior Manager
- Cathy Geddes, NHS England Improvement Director
- Simon Elliott, NHS England Deputy Improvement Director

Several detailed reports were rapidly produced after each Board/committee observation and shared with the relevant committee chair and secretary. This report summarises the common themes and important issues and makes recommendations for all Board/committees at a corporate level. To assist with implementation a suggested prioritisation is provided in Appendix A. All recommendations from the individual detailed reports are provided within appendix B.

The well-led portion of the work has a longer timeline and will be part 2 of this review. Therefore, to provide earlier assurance to the system the effectiveness review is being made available in advance, as part 1.

2. Terms of Reference

The Terms of Reference of the effectiveness component were agreed by the CEO, Chair, Regional Director, and the Improvement Director. It was agreed the review process would include:

- Observation of at least one Trust Board by at least two members of the National NHSE RSP team.
- Observation of at least one of each trust Board Committee (listed below) by at least two members of the National NHSE RSP team.
    - Quality & Patient Safety
    - Audit & Risk Committee
    - Workforce & Wellbeing Committee
    - Performance Committee
    - Finance & Investment Committee)
- Interview/meeting with each committee chair
- If appropriate, interviews with other members of the Board or committees
- A review of any papers and recordings associated with the Board or committees
- A review of the proposed Board Development programme

Unfortunately, due to the availability of experienced observers it was not always possible to provide two observers. There were two committees, Performance Committee and Audit Committee that had one observer. However, on all occasions the findings were quality assured by members of the Recovery Support Programme prior to sharing with the Trust.

It was also agreed that the output of the combined report would include:

- High level independent review of the Board and on the workings of each committee to include an independent view of the operating effectiveness of the Board and its immediate subcommittees
- How effectively the Board and committee structure maintains oversight and assurance of risk management
- Recommendations and learning for the Board and each committee
- If appropriate, recommendations on the quality of papers and information going to Board
- How effectively the organisation manages risk, the process for refreshing the BAF and Board oversight of this

- Identify any opportunities for learning. In particular, a view as to why the Board was not better sighted and acting on the risks that CQC's Well led inspection identified (as identified below in "Additional Information"). This will be addressed in Part 2: Well-Led

3. Findings

There was a very varied picture across the committees with some committees being more effective than others. Lessons from the observational review were being rapidly shared and the Trust was also implementing actions from the improvement plan. Consequently, changes were being implemented during the review which meant committees observed later in the process fared slightly better.

The following section gives an overview of the recommendations across six themes. The individual committee recommendations are listed in full within appendix B.

- Theme 1: Committee/Board governance
- Theme 2: Quality of information
- Theme 3: Committee/Board scrutiny and assurance
- Theme 4: Committee/Board organisation
- Theme 5: Link to wider corporate business
- Theme 6: Other/General (not themed)

The analysis for this overarching report has given rise to a very small number of new recommendations at corporate level.

The Trust will significantly strengthen the assurance and governance of the committee process by making improvements in the following areas.

3.1 Theme 1: Board/Committee Governance

The governance controls were in place (Terms of Reference, plan, agenda, recording). The improvement plan had required all existing committees to have reviewed their Terms of Reference and this was completed in July 2022. Consequently, there was evidence that all committees had a framework and were working within their Terms of Reference. However, the Trust uses the Standing Orders to provide a framework for the Board. These lack the same clarity and as they sit elsewhere, they appear less accessible to the Board membership.

The quality of the minutes was good. At times, they were lengthy and on occasion appeared to be verbatim. Minutes that are too detailed are often unhelpful as information can be hard to find and confidence in accuracy is more challenging for the committee chair. There was also some inconsistency in the way assurance was recorded. There would be a benefit in moving towards a house style where all minutes are recorded in a similar way.

All committees had a cycle of business in place. The cycle is agreed at the start of the year, but on-going visibility is not clear. There is no reference to it during the committee meetings. This means the membership are unaware if papers have been deferred, for what reason, and what solution was proposed. Failure to deliver an update on time is an important part of the assurance process.

Recommendations arising from committee and Board governance

- **Develop Terms of Reference for the Trust Board**
- **Consider a house style for the recording of all minutes and aim for consistency in language regarding assurance**
- **The cycle of business to be reviewed at every Board/committee meeting and the reason for any deferrals to be clearly recorded**

3.2 Theme 2: Quality of Information

The quality of information appears to be the biggest challenge. The Board and committees will be unable to reach their full potential if they are restricted by the quality of information and the flow of information. This is currently subject to a warning notice from the CQC.

This is recognised by the Trust and considerable improvement has been made to the quality and presentation of data. This has been achieved in a very short time frame. This was specifically acknowledged by the national lead *for Making Data Count* who has been working with the Trust. There is now good quality data available and there is evidence that this is being used to drive discussion and challenge at Board level. The Trust is now also moving onto developing data sets for a wider range of meetings. Once implemented, this will be a significant improvement to governance and assurance.

The current challenge lies with the narrative reports. These are frequently not assurance driven and are occasionally multifunctional. This means the same report is used to explain operational challenges to an operational group and also used to provide assurance to Board/committee. Consequently, these reports tend to heavily lean towards operational information and are light on impact or outcomes. It is unlikely that a paper outlining the operational issues is going to sufficiently and succinctly assure the Trust Board that the oversight of mitigation and controls are effective. They also don't currently identify improvements or link to the patient/staff voice.

There also appears to be a culture where Board papers are required to be presented elsewhere prior to Board. This could be driving the multipurpose function of the papers and it may help to review this requirement. The process needs to be managed so that the Trust is not exposed, but the Trust Board can add value. This often requires an issue to be presented differently for the Executive Management Team, who may require more information on input, and for the Board, who may only require information on impact.

Where papers can not be specific then there is an opportunity to maximise the potential within the front sheet. Currently, not every item has a front sheet and when included these are not consistently used. They need to draw attention to relevant points within the report so that Board/committee members can easily identify the assurance within the report. This will clearly link a generic report to the Board/committee's purpose. In addition, to ensure every agenda item is able to link to the risk register and strategic priorities there needs to be a front sheet for every item.

The Trust also needs to consider how it can improve the quality of assurance within the narrative. This is both for narrative reports but also when providing narrative for data. However, some of the reports are of a high quality. It may be helpful to ask these authors to support or mentor authors who are still developing their skills.

There is a high tolerance to late papers and committee chairs are extremely understanding. However, late papers significantly disempower the secretary and chair to ask for revisions to papers that do not meet the committee purpose. By building in a little extra capacity it gives the opportunity for lead directors to quality assure reports and when necessary, for the chair and secretary to ask for further refinement. Some corporate functions (such as Freedom to Speak Up, Infection Control), are required to have a direct line to the Board. This should never be compromised but there may be times where assurance can be strengthened by including a supplementary paper from the lead director.

The way the information is presented to Board/committee is also important. Individual directors and presenters may wish to consider this within their own development plans. The performance committee noted that papers containing paragraph numbers were easier to explain in a virtual meeting. Whilst a rigid house style would create new problems the Trust may wish to consider a number of principles for Board level papers, such as paragraph numbering, font, size of font choice. Considered choices will also help improve accessibility and therefore strengthen accountability.

Recommendations arising from quality of information

- **Where possible, consider specific assurance papers for Board/committees**
- **Front sheets to be consistently used across all committees and agenda items**
- **Trust to consider how to make improvements to the level of assurance within narrative reports**
- **Build in additional time to allow a proper quality assurance of papers and for the chair or secretary to seek further refinements**

- **Consider minimum formatting requirements/standards for Board level papers**

3.4 Theme 3: Scrutiny & Assurance

The level of discussion and subsequent questioning was good. The observed discussions felt informed. There were occasions where the answer could be regarded as defensive or deflective and individual directors may wish to consider how they manage this within their coaching/mentor relationships. But, overall, the answers were informative.

However, engagement in the discussion was not always equal by the membership or equal across all agenda items. At the Trust Board patient safety generated widespread engagement whilst finance gained the least. There was also a distinct drop in energy when discussing culture. In addition, executive directors tended to be quieter on out-of-portfolio discussions. Whilst this is understandable, engagement across the team leads to a more effective Board and there is visible collective ownership of the issues. At present there does not appear to be unified ownership of some important issues. These appear to be solely assigned to the functional lead. The lack of professional curiosity is subject to a warning notice by the CQC.

However, the main limiting factor appeared to be the level of information presented within the papers. As identified in the previous section, the information was not always assurance driven and at times made it difficult to draw a conclusion on assurance.

It may be helpful to identify what assurance is being sought prior to commissioning the reports. This could be clearly communicated in advance to the author and to the committee through the front sheet.

Recommendations arising from scrutiny & assurance

- **Consider how to maintain a balance of engagement right across the membership and across the agenda**

- **Authors to have clarity on what the assurance requirements are for the committee and this to be clear at committee**

3.4 Theme 4: Committee Organisation

There were very few common themes across the committees and committee level feedback has been given to individual committee chairs.

Time keeping was a common issue. Many committees and the Trust Board did not adhere to the timeframes on the agenda. There was evidence that the Board/committee agendas were being carefully constructed. Time appeared appropriately allocated to the level of risk or importance. Poor time keeping inevitably meant that some items were included in an overrun. This meant they were either rushed or were considered without the full membership (as team members had been required to leave the meeting).

Recommendations arising from committee organisation

- **Chairs to ensure meetings run to schedule**

3.5 Theme 5: Link to Trust Business and Strategic Priorities

The wider linkage to Trust business and the strategic priorities is a work in progress. There were visible efforts to strengthen a number of links and this is evidenced by the revised Board Assurance Framework and several front sheets making links to other risks. However, the link to improvement is not always made.

The links between the committees were not always evident, especially during discussion. Whilst all the functional elements of quality, safety, workforce, strategy, risk come together at Trust Board there does need to be linkage at committee level. This appeared to be dependent upon membership and could be a symptom of there not being collective ownership of some of the issues. Therefore, until the development programme releases more collective responsibility, the membership needs to be reviewed to ensure there are strong links across all the elements.

One of the key challenges is to ensure the work of the Board and sub committees also connects with the staff voice. This is a real challenge, but the Board needs to be confident the priorities of the Board are aligned to the concerns of staff. The Trust does acknowledge the need to improve connectivity to the staff but at the point of the review this was not a consistent feature. Addressing staff concerns is subject to a warning notice by the CQC.

The meeting frequency needs review. Specific recommendations have been made for the Performance Committee and Trust Board, but it would be prudent to review the cycle of business and the necessary frequency at the earliest opportunity. The Trust needs to consider if the current cycle is able to sufficiently assure the current pace and workload.

Recommendations arising from link to Trust business

- **Review the committee membership to ensure strong links across corporate assurance processes**
- **Consider how to strengthen the link to the staff voice**
- **Review the frequency of Board/committees**

3.6 Theme 6: General Recommendations (or non-themed)

A development programme is an essential ingredient for a Board becoming, and remaining, effective. This needs to include statutory updates, such as health & safety and also needs to include issues based on a need assessment. From the effectiveness review it appears that there is a need to include work that will assist in developing a collective responsibility across the team.

In addition, the team of directors sets the culture for the organisation. This is understood, but progress seems slow and there is an opportunity for the Board members to consider their collective and individual role. The priorities set by the Board sends a signal to staff on what matters, the language used by the Board and the way the Board discusses issues are key influencers and the way the Board engages with clinicians, mechanics, cleaners will determine how they feel valued in the organisation. It would help the Trust to include culture within the development plan.

General recommendations

- **Undertake a needs analysis for Board Development (this could arise from the Part 2 well-led assessment)**
- **Develop collective responsibility within the development sessions**
- **Develop culture awareness within the development sessions**

4. Individual Board/Committees

A detailed report has been provided to each committee chair and secretary. To help focus the improvement work the following section gives a brief overview of the individual Board/committees and includes the conclusion/summary contained within the individual committee report.

The following table utilises the Care Quality Commission ratings in establishing an easy reference summary as to the effectiveness observed on the day of that particular Board/committee.

Table 1 – Individual Board/committee effectiveness

Trust Board		*Requires Improvement/Good*
Performance Committee		*Ineffective*
Finance & Investment Committee		*Good*
Workforce & Well-Being Committee		*Ineffective*
Quality & patient Safety Committee		*Requires Improvement*
Audit Committee		*Effective*

4.1 Trust Board

The Trust Board was observed on 29 September 2022 by Steve Lennox, NHS England Improvement Director, Sinthujaah De Silva, NHS England Deputy Director of Intensive Support, Louise Pramas, NHS England Culture Transformation Lead, and Samantha Riley, NHS England Director of Making Data Count.

The Trust Board is clearly on an improvement journey and the observed Board was significantly more effective than the two previous Boards. There was a new agenda format which helped focus the items and generated a discussion that felt informed and constructive. However, the challenge is at times unequal and there is an opportunity to demonstrate stronger unitary accountability by considering how the Board can be fully engaged more of the time.

There has been rapid improvements to data quality in the Integrated Quality Report and improvements to the Board Assurance Framework. The biggest gain now is to improve the quality of the narrative. The narrative reports are not always assurance driven. Improvements in this area will help the Board fulfil its purpose and in particular strive for continuous improvement across the service.

Also, the functions of a Board can be divided into three domains: strategy, accountability, and culture. These functions will be considered as part of the well-led review, but the Board may wish to consider undertaking some reflective work across those domains as part of the Board's development work.

4.2 Performance Committee

The performance Committee was observed on 13 October 2022 by Steve Lennox, NHS England Improvement Director.

There was plentiful discussion at the observed committee, and it was clearly helpful to those attending the committee, but it was unstructured. The papers had previously been reviewed at Trust Board and as performance was not strongly considered within the context of quality, safety, workforce and finance, it was difficult to see how the committee added real value to the business of the Trust.

A previous model placed performance in another Board Committee. This was changed to increase the focus on performance. A dedicated performance committee needs strong discipline as it runs the risk of straying into executive territory by considering operational issues in detail.

It has been recommended to the Trust that the Board review how they gain assurance on operational performance.

4.3 Finance & Investment Committee

The Finance and Investment Committee was observed on the 8 September 2022 by Steve Lennox, NHS England Improvement Director and Matthew Fox, NHS England Director (Finance) of Intensive Support.

The observed committee was good. The membership was informed and able to contribute to the discussions. Attempts were made to link to other areas of Trust business, especially patient safety. The committee had solid foundations from which it can build a high functioning and effective committee.

Most of the specific recommendations for this committee arise out of connectivity to other corporate workstreams, especially the risk register and this is easily addressed.

4.4 Audit Committee

The Audit Committee was observed on 22 September 2022 by Steve Lennox, NHS England Improvement Director.

This was the most effective of the observed committees and it comprehensively delivered the purpose identified within the Terms of Reference. This committee was only limited by the quality of information. There was a focus on assurance and a real effort to link discussion to the risk register and other corporate business. There was a business culture to the meeting that was reflected within the organisation and the preparation of the committee members. Everyone appeared briefed and the discussions reflected a thorough understanding of the agenda items.

There are four recommendations for this committee and only one is directly related to this committee.

4.5 Workforce & Wellbeing Committee

The Workforce and Wellbeing Committee was observed on 26 August 2022 by Steve Lennox, NHS England Improvement Director and Anna Lynch, NHS England Senior Manager. This was the first committee to be observed as part of the review.

Even though there are eighteen recommendations for this committee, the committee has good foundations. There is evidence of energy, commitment, and drive from everyone on the committee.

Most of the recommendations arise out of a lack of structure (and this is not isolated to the Workforce and Wellbeing Committee) and this is easily addressed. The installation of a carefully crafted framework will ensure the disconnect can be partially bridged. Once a structure is in place it should be possible to have clearer sight on the required assurance and this will help structure the assurance given to the committee.

4.6 Quality & Patient Safety Committee

The Quality & Patient Safety Committee was observed on 15 September 2022 by Cathy Geddes, NHS England Improvement Director and Simon Elliott NHS England Deputy Improvement Director.

The observed committee demonstrated that there was desire to gain assurance on issues pertaining to quality and patient safety in the Trust. However, the preparation of the committee agenda, papers and presenters had limiting factors that need to be reviewed.

The committee also did not comprehensively connect across quality, finance and workforce.

5. Conclusion

The improvement journey for the Board/committees is evident and is starting to deliver results. However, there are a number of corporate challenges that will limit the ability to be fully effective if they are not addressed. The most significant is the linkage across functions and the ability to demonstrate collective ownership of the issues.

The other limiting factor is the quality of the narrative information. There has been significant progress in data quality. This can now be enhanced by making improvements to the supporting narrative and by improving the assurance contained within narrative reports.

If these two challenges can be overcome, the Board/committee structure will have made the biggest gains in its journey to being effective.

6. Appendix A – Recommendations Prioritised

To assist with prioritisation, the recommendations contained within this report are listed below with an indication of priority.

	Short Term <3months	Medium Term 3-6months	Long Term >6months
Board Governance			
• Develop Terms of Reference for the Trust Board	✓		
• Consider a house style for the recording of all minutes and aim for consistency in language regarding assurance		✓	
• The cycle of business to be reviewed at every Board/committee meeting and the reason for any deferrals to be clearly recorded	✓		
Quality of Information			
• Where possible, consider specific assurance papers for Board/committees		✓	
• Front sheets to be consistently used across all committees and agenda items	✓		
• Trust to consider how to make improvements to the level of assurance within narrative reports			✓
• Build in additional time to allow a proper quality assurance of papers and for the chair or secretary to seek further refinements	✓		
• Consider minimum formatting requirements/standards for Board level papers	✓		
Scrutiny & Assurance			
• Consider how to maintain a balance of engagement right across the membership and across the agenda			✓
• Authors to have clarity on what the assurance requirements are for the committee and this to be clear at committee		✓	
Committee organisation			
• Chairs to ensure meetings run to schedule	✓		

Link to Trust Business			
• Review the committee membership to ensure strong links across corporate assurance processes	✓		
• Consider how to strengthen the link to the staff voice		✓	
• Review the frequency of Board/committees	✓		
General Recommendation			
• Undertake a needs analysis for Board Development (this could arise from the Part 2 well-led assessment)	✓		
• Develop collective responsibility within the development sessions			✓
• Develop culture awareness within the development sessions	✓		

7. Appendix B – All recommendations from all six observed Board/committee meetings

To assist in directing the improvement the recommendations arising from the observational exercises have been grouped into 6 themes. Not all recommendations sit precisely within a theme and there is overlap.

Key to Themes

	Committee Governance		Quality of Information		Scruitiny & Assurance		Committee Organisation		Link to Business		Other/ General

Table of Board/Committee Recommendations

Trust Board	Workforce Committee	Quality & Patient Safety Committee	Finance & Investment Committee	Audit and Risk Committee	Performance Committee (Ref PC)
1. Consider Terms of Reference for the Trust Board. Clearly identifying the aims of the Board and referencing them as appropriate in the operation of the Board.	1. To ensure the structure of the agenda is aligned to the organisation risks	1. Review committee membership to ensure robust linkage across corporate functions	1. All authors to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	1. To ensure the minutes are a factual, concise summary of the discussion and try and aim for consistency across the committees.	1. To ensure the cycle of business is explicit to the whole membership and any ommissions are recorded and carried forward
2. To ensure the views of the council of governors is expressed and considered at the Board	2. To ensure the assurance method is appropriate to the level of assurance required	2. Chair to introduce a Commiittee Planning Meeting with other Non-Exeutive Directors to agree the agenda, timings, papers and Key Lines of Equiry	2. To ensure the cycle of business is explicit to the whole membership and any ommissions are recorded and carried forward	2. All authors to consider the assurance required and to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	2. To ensure the minutes identify the committee's conclusion regarding assurance on each item
3. To ensure the cycle of business is explicit to the whole membership and any omissions are recorded and carried forward	3. To ensure the cycle of business is explicit to the whole membership and any ommissions are recorded and carried forward	3. Introduce a rolling cycle of Committee Business ot ensure the committee addresses all topics.	3. Consider how the BAF (specifically any financial risks) can structurally link to the work of the committee.	3. Consider if a gap analysis against the draft best practice guidance would help strengthen audit committee governance.	3. Where appropriate, the committee to ensure the discussion is linked to quality, safety, workfrorce, finance and strategy.

4. Individual authors, the Chair and the Secretary to ensure papers adequately address the need to assess, monitor and drive improvements.	4. To ensure the minutes are a factual, concise summary of the discussion	4. To ensure the structure of the agenda is aligned to the organisation risks – use the relevant BAF risks to shape the agenda	4. Consider how items are appropriately escalated up and down the organisation.	4. To consider how the escalation report can close the loop on assurance.	4. Clearly identify in the annual cycle of work where a review of data quality takes place.
5. It is recommended that further Board development takes place so that members can demonstrate that they understand how the Board sets the culture and are able to identify their personal contribution to the aim of transforming the culture.	5. All authors to consider the assurance required and to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	5. Ensure all actions are clear, with a Lead and timescale for delivery stipulated.	5. The Exec team need to consider where the joining up of finance, performance and quality occurs and how this reports into the governance stream.		5. It is recommended that the assurance deep dives are restructured to include a diagnosis of the issue, the potential solution, the actions to address the solution and progress to date. The assurance piece also needs to include the effectiveness of the oversight/governance process.
6. Review the recording of the Trust Board and make the necessary adjustments.	6. The committee to consider how the dashboard can be maximised to provide assurance on the BAU oversight and also on the items on the agenda.	6. Ensure all papers have front sheets that provide a summary of key issues, action required from Committee members, links to Corporate objectives and BAF risks and a level of assurance being provided.	6. Consideration needs to be given as to how the financial detail can be presented so that it is clear to existing and new committee members.		6. Consider a house style of paragraph numbering for all Board/Committee reports.
7. Consider the addition of a Front Sheet for the Patient Story that clearly outlines any links to already recorded risks, BAF risks. The reason for bringing this story to the Board and how it supports the Trust's priorities and what quality improvement have been made.	7. Linked to recommendation 5, the chair to consider what assurance is required from subject matter leads in advance of documentation being supplied.	7. Lead Executives to ensure they have read all papers that they are lead for prior to papers coming to Committee and that key risks and mitigations are clear within papers when appropriate.	7. Check air ambulance contract monitoring is captured on the risk register and consider how discussions that are risk based are cross referenced against the risk register.		7. Review the committee membership with referenece to clinical representation.

8. In the summary of a discussion, the Chair to make it explicitly clear how any identified assurance gaps will be addressed.	8. All authors must address the risks associated with their assurance report	8. Use standardised SPC methodology and analysis when presenting data.	8. Consider where strategies are published and how all Board members are updated on delivery and how accountability is demonstrated to the public.		8. It is recommended that the Board review how they gain operational assurance.
9. The chair to consider if the introduction of a disciplined framework to questions and answers will further strenthen the operation of the Board.	9. The Chair and Trust Chair to consider if quarterly meetings offer the necessary assurance for the Board.	9. Training to be given to senior managers preparing and presentng papers to Trust Board Committees. Writing for assurance rather than reassurance.	9. Ensure the executive team understand the reason for the patient level costing and why this is higher than the benchmarked services in the report.		
10. It is recommended that personal engagement is identified in the Development Need Analysis of the Board and addressed through the development plan.	10. The Chair to consider if the Director of Quality & Nursing needs to be a core member of the committee. If not, then consideration needs to be given as to how Health & Safety connects with the committee.				
11. It is recommended that the Board reviews its current frequency.	11. The Chair to consider how the committee can champion the corporate values (an opportunity to lead the way).				
	12. To ensure papers are assurance driven.				
	13. The Board development programme to include the culture of challenge within its development plan				
	14. Consider how the committee connects up and down to the Trust Board.				

	15. Consider how the committee can connect with the staff voice and as a priority can seek assurance that the issues important to staff are being progressed.				
	16. To undertake a reflective exercise to consider if the committee has a culture of tolerating poor compliance.				
	17. For authors to consider how their report connects with the wider system and any national initiatives.				
	18. To consider how the escalation report can close the loop on assurance and consider introducing a front sheet.				

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	66-22

Name of meeting	Trust Board
Date	15.12.2022
Name of paper	Board Development
Strategic Goal	Delivering Quality / Focus on People
Lead Director	Chairman
Report Author	Peter Lee, Company Secretary

Board Development 2022/23
In July, using the feedback from the Well Led Review, the Board agreed the areas of development to be prioritised for the remainder of the year. The Chair's reports to the Board since then has included references to this development:

Making Data Count	NHS England
NHS Leadership & Culture Programme	NHS England
Effective Challenge / Holding to Account	NHS Providers
Improvement Journey	Internal
Joint Board / COG – Priorities for 2023/24	Internal
Board Effectiveness Review	NHS England

Emerging from the session on the NHS Leadership & Culture Programme, which the Board has agreed to take forward (the first ambulance trust to do so), there was agreement that the Board needs to be really clear about its role in setting the Trust's culture. It is therefore proposed that this is the priority for Board development over the next three months.

The Trust's Improvement Director has helped to engage the NHS England Culture Transformation Lead to support the Board with this. The plan will be to use Our Leadership Way framework developed by the NHS Leadership Academy. This sets out the compassionate and inclusive behaviours all leaders should have at every level. The detail of the programme will be developed during December / early January, but there will be five sessions over three meetings on 31 January, 2 February and 2 March, covering the following:

- Introduction: Collective and Individual Responsibilities
- Our Personal Experiences (all Board Members talking about their experience of good and bad culture)
- Becoming more compassionate
- Becoming more curious
- Becoming more collaborative

Board Development 2023/24
In January 2023 there will be a workshop facilitated by the Improvement Director, for the Board to work through the outputs of the Well Led Self Assessment that has been undertaken during November and December. This will help to determine the areas of the Well Led Framework that

the Board has identified as requiring improvement and in turn this will inform the areas of development to be prioritised for the remainder of the year. The resultant Board Development Plan for 2023/24 will then come to the Board meeting in March, for approval.	
Recommendations, decisions or actions sought	The Board is asked to: 1. Support the plan to prioritise its development time in January February and March 2023 for Culture and Leadership, supported by NHS England. 2. Support the intention in January to use the outputs of the Well Led Self- Assessment to determine the Board Development Plan for 2023/24. The plan will come to the meeting in March for decision.

Southeast Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee Escalation Report

Overview of issues covered at the meeting 07.12.2022

Item	Purpose	Link to BAF Risk
External Audit / Annual Report	To seek assurance on the approach to the development of the Annual Report and the External Audit Plan	N/A
There is a clear plan in place for the development of the Annual Report, and this is being adjusted to reflect the national timetable recently confirmed. In light of the governance and risk management challenges in the past year, the committee asked to see in March an early draft of the Annual Governance Statement. KPMG provided its indicative External Audit Plan and summarised the key issues and risks. The plan was supported and the committee is confident that the financial statements will be produced by the finance team in good time. As has been the case since 2020, there is no requirement to audit the Quality Account. However, the committee supported the plan outlined by the Director of Quality and Nursing to ensure external assurance is provided on the quality priorities.		
Internal Audit Plan	To receive the outcomes of the internal audit reviews most recently completed	Risk 15 - ETD
Since the last meeting, two reviews were completed in line with the annual plan. Data Quality and AQIs received Reasonable Assurance. However, there was a Partial Assurance outcome for the review into Stat Man Training. The committee expressed some concerns about the gaps in control identified and noted that these are being picked up by the Workforce & Wellbeing Committee (WWC) which will oversee delivery of the management actions – please refer to the separate WWC report to the Board.		
Counter Fraud	To seek assurance that the Trust has effective counter fraud arrangements.	N/A
The committee continues to be assured with the counter fraud arrangements in place. It explored once more the ongoing issue related to staff working in secondary employment while sick, and challenged whether more could be done, pro-actively. There is an IA review of policy management in Q4 and the committee asked RSM to ensure it specifically covers the policies related to secondary employment and working while sick, to ensure we are doing all we reasonably can.		
Risk Management	To seek assurance that our risk	Risk 257 – Improvement Journey

	management process is effective.	
Risk management is a significant feature of the Warning Notice and so a key priority within the Improvement Journey. The committee received a new risk report, which is significantly improved and helps to demonstrate the progress we are making to strengthen how we manage risk. However, the committee challenged the executive to go further, including in how we describe our risks and use patient quality as the golden thread. Also in how we use the risk register to identify systemic risks, so that we can better identify where we need to find more strategic solutions. Overall, while the committee acknowledges the good progress being made it thinks the risk to patient quality and staff quality could be more overtly described. It also asked that a Board risk seminar is arranged in Q4, to give the opportunity to the Board to consider its view on the main risks, so that this can be compared to what is recorded in the risk register.		
Board Assurance Framework	To seek assurance that the evolving BAF is adequately aligned and reflective of the current principal risks.	Risk 257 – Improvement Journey
The committee is confident with the way the BAF is developing, with now a much clearer alignment to the Improvement Journey and Integrated Quality Report. In light of the discussion above (risk management) it took the opportunity explore how the BAF risks are described, and whether the golden thread of quality could be drawn out further still. The committee is assured by the way the BAF is being used by the Board and its committees to ensure the right areas of focus.		
EPRR Annual Assessment	To receive the outcomes of the internal audit reviews most recently completed	N/A
The annual EPRR assessment against the EPRR Core Standards and the Interoperable Capabilities was reviewed at this meeting and the committee is assured by the overall rating of 'Substantial Compliance'. An improvement from the assessment in 2021/22 (Partially Compliant). A copy is provided for the Board's information – Appendix 1. The committee also received a paper outlining how the implications of the review into the Manchester Bombing will be taken forward. Like many trusts, there has been a gap in EPRR testing / exercises during COVID, and so our response is reviewing how we close these gaps and the related resource requirements. In the meantime, there is a risk in our capability to respond should a similar incident occur locally, but the committee agreed in the assessment of the executive that this risk (in terms of likelihood) is relatively low on the basis that such incidents are very rare. The committee will receive an update at its next meeting.		
IT Critical Incident	To seek assurance that the Trust has effective counter fraud	N/A

	arrangements.	
The Chief Finance Officer provided a good overview of the emerging findings from the IT post-incident review. The response to this incident was really good, demonstrating the effective implementation of our business continuity plans. The final report will be provided early in the New Year. This will be combined with the EPRR investigation and there is also a plan to seek external support to test the resilience of our systems, as an additional layer of assurance. Although no patient harm has been identified to-date, the separate harm review will be reviewed by the Quality and Patient Safety Committee (QPSC).		
Operation Carp	To seek assurance that the Trust has an effective speaking up culture and systems in place to ensure investigation and learning.	N/A
The committee received an update against the actions agreed from this external review. It is assured with the governance underpinning the improvement plan, and as the impacts fall within the purview of QPSC, this committee will continue to monitor implementation.		

Specific Escalation(s) for Board Action	For the Board's awareness, the committee will be seeking further assurance related to risk management in the following areas in particular: 1. Datix – that the system is working effectively and that this helps to inform decision making / learning. 2. How we establish systemic risks from the risk register 3. The language we use when describing risk does justice to the underlying thinking, using quality as the golden thread.
	The committee overran and so will be holding an extraordinary meeting in January to receive the scheduled reports on FTSU and Information Governance.

		Agenda No	70-22

Name of meeting	Audit Committee
Date	07/12/22
Name of paper	EPRR Assurance Update
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Dave Williams, Head of Resilience & Specialist Operations

In the EPRR assurance process of 2022-23, SECAmb received an overall rating of 'Substantially Compliant' against the EPRR Core Standards and the Interoperable capabilities. This is a significant improvement from the 2021/22 rating of 'Partially Compliant'.

From the findings an improvement plan has been developed that sets out actions against all core standards where full compliance has yet to be achieved.

The assurance process was led by Surrey Heartlands CCG and will be ratified by NHS England in December 2023.

Progress against the plan is monitored via the Resilience Forum where there is cross-directorate and CCG/ICB representation; the next Resilience Forum meeting is on 21 December.

This paper provides the overall rating that was achieved by SECAmb in 2022/23.

Recommendations, decisions, or actions sought	For Assurance

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

EPRR Statement of Compliance (EPRR Core Standards and Interoperability)
The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2022/23**, **South East Coast Ambulance Service NHS Foundation Trust** has been required to assess itself against these core standards. The outcome of this self-assessment shows that against **53** of the core standards and **163** of the Interoperable Capability Core Standards which are applicable to the organisation, **South East Coast Ambulance Service NHS Foundation Trust;**

- is fully compliant with 52 of these EPRR core standards; and
- is fully compliant with 154 of these Interoperable Capability core standards
- will become fully compliant with 53 these core standards by September 2023
- will become fully compliant with 163 of these Interoperable Capability core standards by September 2023

The improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

The overall rating is: **Substantially Compliant** on both elements of the Core Standards.

Emma Williams, Executive Director of Operations (AEO), South East Coast Ambulance Service NHS Foundation Trust, 23/10/22

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

The rationale for this assessment is contained in the table below for those standards that were assessed to be PARTIAL

Ref	Standard	Rating	Commentary
24	Training & Exercising – Responder training	Partial	Agreement with the organisations self-assessment
Deep Dive – Shelter and Evacuation			
12	Equalities & health inequalities	Partial	Agreement with the organisations self-assessment
Interoperability			
H8	HART – Six operational HART staff on duty	Partial	Agreement with the organisations self-assessment
H25	HART – Attendance at strategic sites of interest	Partial	
H32	HART – Equipment asset register	Partial	
M5	MTFA – Ten competent staff on duty	Partial	
M12	MTFA – Effective deployment policy	Partial	
M23	MTFA – 10 minute response time	Partial	

Ref	Interoperability	Rating	Commentary
B24	CBRN – Model response locations – deployment	Partial	Agreement with the organisations self-assessment
C27	C2 – Assessment of commander competence and CPD evidence	Partial	
C31	C2 – Loggist – CPD	Partial	
J8	JESIP – Awareness of JESIP - Responders	Partial	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	68-22

Name of meeting	Trust Board
Date	15 December 2022
Name of paper	Chief Executive's Report

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

A. Local Issues

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

3 As part of its weekly meeting, the EMB regularly considers quality, operations (999 and 111) and financial performance. It also regularly reviews the Trust's top strategic risks.

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

- Received a presentation from the Chair on its work to start a review of the Trust's clinical strategy, following the establishment of the Clinical Advisory Group
- Agreed the immediate next steps for the Leadership and Culture Programme
- Reviewed plans to ensure winter resilience
- Agreed some interim measures to ensure financial control in year, while we develop sustainable plans for 2023/24 and beyond
- Reviewed the issues underpinning high sickness, as directed by the Board – details are in the IQR
- Sought assurance on the plan to deliver flu vaccinations
- Agreed a new risk management policy and supported the development of a new risk report.

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

6	**Engagement** During the past couple of months, I have been pleased to attend a number of key system meetings including the South East Regional Senior Leadership Event, the Sussex Health and Care System Leadership Forum, a National System Leadership event and the Health and Care Women Leaders Network Session hosted by NHS Confederation.
7	These events have provided valuable opportunities to grow our voice within the wider NHS system to support improved patient pathways, reduce hospital handover delays and develop new partnerships.
8	On 15 and 16 November, I was attended the national NHS Providers annual conference. During the conference, it was good to hear from Steve Barclay, the new Secretary of State for Health that his priorities include supporting and growing the workforce. He also confirmed the Government's commitment to deliver the £500m of additional national funding to support adult social care and health partners to reduce delayed discharges in hospitals, with recognition that this is contributing to delayed ambulance response times and handover delays at Emergency Departments.
9	**Recognising the achievements and long service of our colleagues** I was very pleased to join staff and volunteers at each of our three annual awards ceremonies in October, where we celebrated the long service and special achievements of our colleagues.
10	It was extremely humbling to see the number of years' service people have given to both SECAmb and the wider NHS. With awards recognising volunteer service of 10 years or more through to 40 Years' long service awards, each and every award winner should be very proud.
11	We were pleased to be joined at each service by each county's Lord Lieutenant or Deputy Lieutenant as they represented, for the first time, His Majesty The King, following the death of Queen Elizabeth II, to present Queen's Medals for Long Service and Good Conduct.
12	There was a real range special achievements recognised and it was an honour to present Chief Executive Commendations across a number of categories tied to the Trust's values including Clinical Excellence, Exceeding Expectations, Demonstrating Compassion and Respect and Voluntary Service.
13	**Showing support for the Royal British Legion's Poppy Appeal** I was pleased that, this year, we were once again able to show our support for the Royal British Legion's Poppy Appeal with a special design featuring on the side of 24 of our ambulances.
14	The Trust is proud of its strong links to the armed forces and has many staff who previously served and some who continue to serve as reservists. We are committed to employing and supporting those with a current or previous roles in the armed forces and I am proud that earlier this year we achieved an Armed Forces Sliver Award.

	B. Regional Issues
15	**IT outage** On 10 November 2022 we declared a Critical Incident following IT issues which resulted in the loss of the Crawley Network which initially impacted on the CAD and Telephony. We moved to paper CAD and backup telephony and the outage also affected a number of our corporate IT systems.
16	Following initial investigation and stabilisation work by our IT team, we moved back onto our CAD system on 11 November operating it as a standalone system at our East Emergency Operations Centre in Coxheath, Kent. We were also able to resume use of our corporate systems at that point and managed the incident from that point onwards as an internal Business Continuity Incident (BCI).
17	On 18 November following an extensive testing period to ensure all our systems were stable, we were able to stand down the BCI with all systems returned to normal working.
18	As part of our debrief and post-event processes, extensive investigation work has been carried out to establish the root cause of the outage which has subsequently been identified as failures in the hardware (switches and firewalls) system. The affected hardware has been replaced as part of the work undertaken in the period immediately following the outage.
19	We have also worked hard to identify any patient safety issues as a result of the outage. Our initial findings have not identified any identifiable patient harm so far although a more extensive look-back exercise is underway.
20	**Latest CQC report published** On 26 October 2022 the Care Quality Commission (CQC) published it's most recent report on SECAmb.
21	The inspection took place in August and looked at SECAmb's urgent and emergency care, as well as our resilience teams. The most recent report saw our overall rating move from 'Good' to 'Requires Improvement' and the individual rating for Caring remain as 'Good'.
22	The inspection also checked on progress in meeting the requirements from the well-led inspection which took place in February. We were pleased that the care provided by staff was recognised with a 'Good' rating and that inspectors found that Trust leaders were showing a sense of urgency in prioritising the issues which had previously been identified.
23	I know that there is much to do to get the Trust to where it needs to be and we are working closely with staff as well as partners both regionally and nationally to make the necessary improvements highlighted in the report through our Improvement Plan. We have already taken concerns around our culture and leadership extremely seriously and we are committed to making further improvements to ensure we

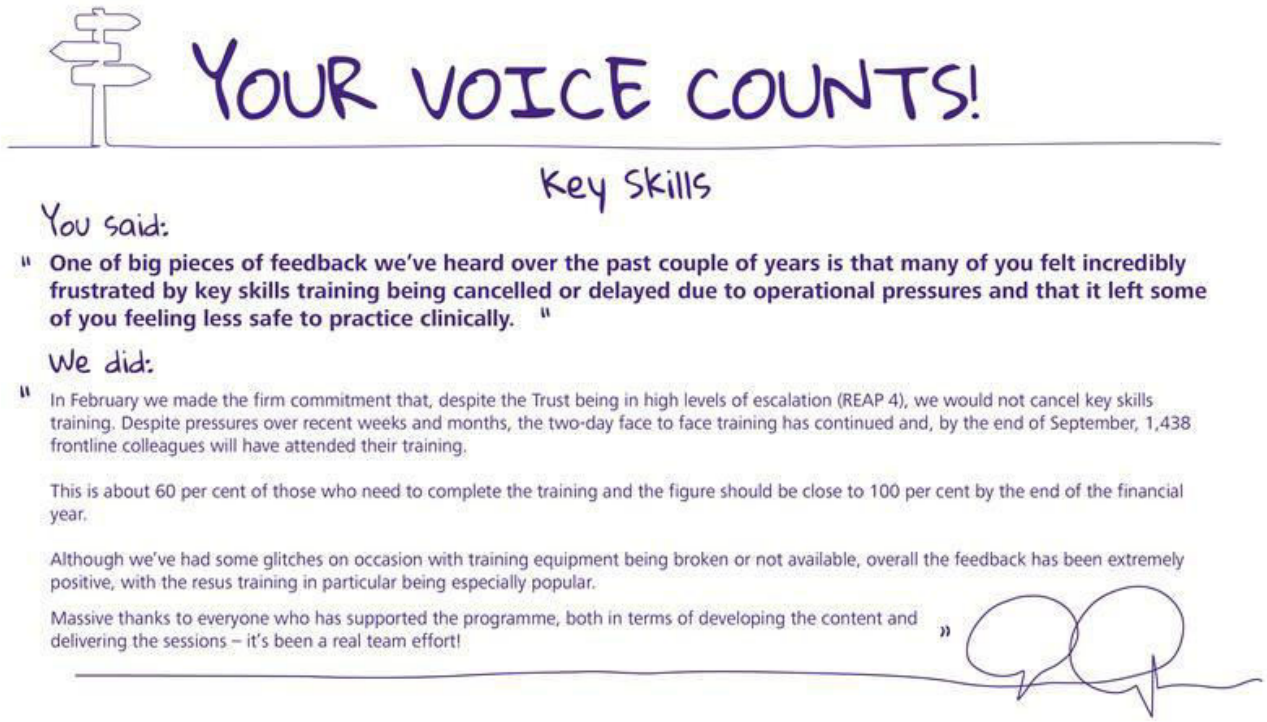
24	improve our response to patients and the working lives of our staff.
	Medway Make Ready Centre update
25	Construction work is continuing on our new multi-purpose ambulance, 999 and NHS 111 centre in Gillingham, which, once completed, will include 999 and 111 call centre operations as well as a Make Ready Centre – the only one of its kind to bring all three functions together under one roof.
26	The work is progressing well, however final completion is now expected to be in early February 2023 rather than late December 2022 as originally planned, due to a range of external factors outside of our control.
27	As a result of this, the phased relocation of the operational, fleet, 111 and EOC teams has been delayed and is now anticipated to take place between March and July 2023.
28	Consultation work with the staff affected by the move is continuing, as well as work to ensure ideas and suggestions from local staff are included in the personalisation of the building.
	NHS Staff Survey
29	This year's annual national NHS Staff Survey ran from 30 September to 25 November 2022 and, for the first time, bank colleagues were also able to take part.
30	We worked extremely hard to encourage as many colleagues as possible to participate, with regular reminders from myself, toolkits for managers to encourage local take-up and regular sharing of 'You Said We Did' examples, highlighting where staff feedback has been used to make changes and improvements (see Appendix A for an example).
	New Falls Service
31	I have been very pleased to see the roll out during the Autumn of a new clinical pathway aimed at reducing the length of time someone who has fallen waits for a response.
32	Falls make up a significant number of 999 calls but often, with little or no injury, can be triaged as lower category calls. However, we know that delays to such calls, as crews are sent to higher priority incidents, can lead to more harmful impacts for patients and have recognised that we needed to take a different approach to responding to such patients.
33	Following a successful trial in the Gatwick and Hastings & Polegate operating units, the new pathway sees our volunteer community first responders, (CFRs), make initial assessments of appropriate patients who call 999 after suffering a fall.
	The proof-of-concept trial saw 33 specially-trained and additionally-equipped CFRs, who previously only responded to serious emergencies, also responding to calls to falls patients, following triage at the Trust's Emergency Operations Centres, (EOCs). To date, more than 150 patients have already benefitted from the scheme.

34 35	CFRs on the Community Falls Team provide immediate care to reduce risks and, if safe to do so, will assist patients from the floor using specialist lifting equipment. The team is fully supported remotely by Trust clinicians at each stage as needed. The patient then receives a follow-up call from a Trust clinician later that day. If the patient's condition is more complex, an ambulance is dispatched to back up the CFR. The initiative will begin to roll out across our region from January 2023, led by the Community Resilience Team.
	C. National Issues
36 37 38 39	**Industrial Action** As we will all have seen via the national media, a number of trade unions have been undertaking industrial action ballots as part of a national pay dispute which impacts NHS organisations across the country. As I write this, we have been informed by our local GMB branch that, following a ballot of their members, they are intending to undertake industrial action on 21 and 28 December. We have been informed by the RCN that, although they had reached the required threshold in SECAmb to undertake industrial action, their members within SECAmb will not participate in the industrial action planned by the RCN during December. Unite and Unison have not, at present, met the required threshold to undertake industrial action within SECAmb. We will continue to work together with our trade union colleagues to make sure the safety of our patients isn't compromised while our staff exercise their right to take strike action.
	D. Escalation to the Board
40 41 42 43	**Improvement Journey** Delivery of our Improvement Journey has continued through October and November, with a continuing focus on addressing the Warning Notices, issued previously by the CQC and which expired on 18 November. At the Executive Management Board we have discussed our emerging Patient to Board Patient Safety and Performance Assurance Framework, having received a new version of the operations escalation report, as well as a second iteration of an EMB quality dashboard. We have also spent time with the Senior Management Group, developing our Strategic Priorities for 2023/24. We are also starting to develop the foundations to transition beyond the regulatory drivers for the Improvement Journey, and build on the progress made to develop a sustainable, organisation-wide approach to continuous improvement to ensure we deliver our Strategic Priorities. **Operational Performance** All ambulance services remain under significant pressure at present as does the wider NHS system and we are starting to see noticeable increases in demand on our 999 and 111 services as a result of the recent cold weather and concerns around Strep A.

44	We continue to work hard to ensure that we provide as responsive a service as possible to our patients although recognise there are periods when the peaks in demand we experience outstrip the resources available to us. This is being exacerbated at present by increasing levels of staff sickness.
50	We continue to perform well compared to our peers nationally, although our 999 call answer times remain an area of concern.
51	Our REAP Level is regularly reviewed and on 6 October, we decided to move from Level 3 to Level 4, reflecting the growing pressure both our 999 and 111 services remain under. Our REAP level will continue to be reviewed by the Senior Management Team on a weekly basis and adjusted, if needed.

APPENDIX A

'You Said We Did' examples:



YOUR VOICE COUNTS!

Key Skills

You said:

" **One of big pieces of feedback we've heard over the past couple of years is that many of you felt incredibly frustrated by key skills training being cancelled or delayed due to operational pressures and that it left some of you feeling less safe to practice clinically.** "

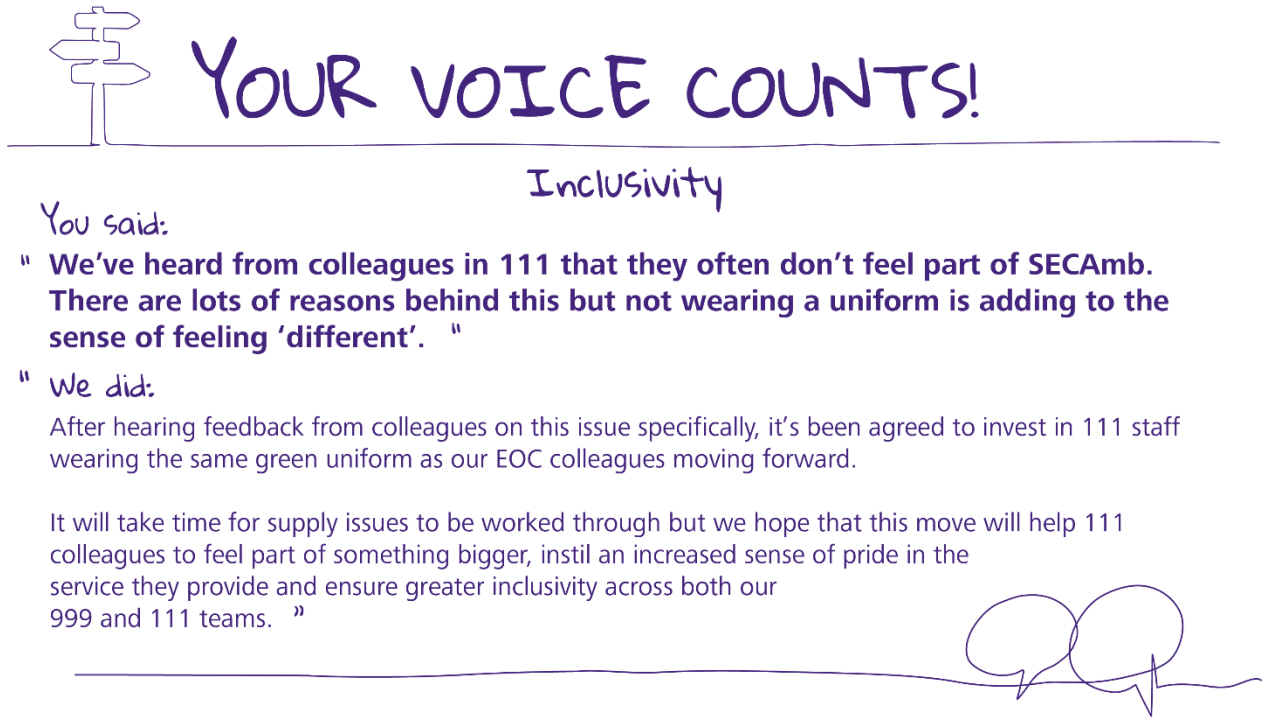
We did:

" In February we made the firm commitment that, despite the Trust being in high levels of escalation (REAP 4), we would not cancel key skills training. Despite pressures over recent weeks and months, the two-day face to face training has continued and, by the end of September, 1,438 frontline colleagues will have attended their training.

This is about 60 per cent of those who need to complete the training and the figure should be close to 100 per cent by the end of the financial year.

Although we've had some glitches on occasion with training equipment being broken or not available, overall the feedback has been extremely positive, with the resus training in particular being especially popular.

Massive thanks to everyone who has supported the programme, both in terms of developing the content and delivering the sessions – it's been a real team effort! "



YOUR VOICE COUNTS!

Inclusivity

You said:

" **We've heard from colleagues in 111 that they often don't feel part of SECAmb. There are lots of reasons behind this but not wearing a uniform is adding to the sense of feeling 'different'.** "

" We did:

After hearing feedback from colleagues on this issue specifically, it's been agreed to invest in 111 staff wearing the same green uniform as our EOC colleagues moving forward.

It will take time for supply issues to be worked through but we hope that this move will help 111 colleagues to feel part of something bigger, instil an increased sense of pride in the service they provide and ensure greater inclusivity across both our 999 and 111 teams. "

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	69-22

Name of meeting	Trust Board
Date	15.12.2022
Name of paper	Board Assurance Framework
Strategic Goal	All
Author	Peter Lee, Company Secretary

There have been some revisions to the BAF since the version that came to Board in September, as set out, including further alignment with the strategic goals and the priorities within the Improvement Journey and metrics in the IQR.

The BAF is received by the Board as one of three primary documents, along with the Integrated Quality Report and Improvement Journey. These documents are also be used by Committee Chairs to help ensure meetings take a risk-based approach to where it should focus. This is reflected in the committee reports to the Board, which reference the related BAF risk.

The BAF was reviewed by the Audit & Risk Committee on 7 December; see its report to the Board (agenda item 67-22).

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

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

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

Board Assurance Framework
Section A: Strategic Direction

1. Strategic Goals / Corporate Priorities

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

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

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

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

1.3. These priorities are in the process of review in line with the business planning cycle for 2023/24 and will be covered in the Improvement Journey report to Board on 15 December 2022.

Board Assurance Framework
Section B: BAF & Risk Overview

2. Introduction: The BAF

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

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

2.3. This BAF sets out the principal risks and how they could impact on the strategic goals. The detail of each risk is set out in Appendix A.

2.4. Section C provides context by identifying the vehicles and mechanisms for maintaining oversight of delivery.

3. Risk Management

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

3.2. A Board session was held on 1 December to review progress with risk management, specifically in relation to the Warning Notice. This helped to provide further understanding of the process of risk management.

3.3. Section E has been added to outline the Trust's extreme risks within the corporate risk register. These are risks that are deemed to not explicitly affect the strategic priorities but as they score 15 or above, they are the highest (non-BAF) risks on the risk register.

4. Structure of the BAF Risk Report

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

4.2. The Board agenda has been organised against the strategic goals and committee agendas reflect how they align with the specific BAF risks. This is used in the planning for each meeting and confirmed in the related escalation report to the Board.

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

Table 1: Strategic Goals

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

Board Assurance Framework
SECTION C: Oversight & Delivery

5. Oversight & Delivery

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

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

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

Board Assurance Framework
SECTION D: Risks

6. BAF Risks

6.1. The Board Assurance Framework has ten strategic risks. Following the review by the committee in September a distinct Culture risk has been added.

6.2. Each strategic risk has been reviewed by the lead Executive Director and updated to ensure identified actions are appropriate and have appropriate timeframes.

6.3. The Risk and Assurance Group meets weekly and reviews all risks on the risk register and reports to SMG. The separate Risk Management Report is provided to the committee and a version of this is now received by EMB, each month.

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

6.5. In this version each risk has included a section cross referencing to the relevant SPC chart from the IQR, where applicable. Appendix Key to the SPC icons is below.

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

6.7. Section E includes the non-BAF ‘extreme’ scoring risks.

6.8. Risk 257 (Improvement Journey) will be reviewed following the meeting with the CQC on 18 January 2023, when the Board will be presenting the progress made against the Warning Notice. This review will include consideration to how the Improvement Journey becomes the mechanism by which the Trust delivers against its Strategic Goals on a sustainable basis. Noting the current governance was setup to deliver against the regulatory obligations, which will not be an appropriate or sustainable approach going forward in the context of delivering improvement against a strategic framework.

BAF Dashboard

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

Risk ref	Thematic Risk Title	Oversight Committee	Strategic Goal Impacted					Initial risk	Current Risk (Current Position)								Change	Target score	Target date
			1	2	3	4			Sep 21	Nov 21	Jan 22	Mar 22	May 22	Aug 22	Sep 22	Dec 22			
14	Operating Model	QPS	✓	✓	✓	✓		20	20	20	16	16	16	16	20	20	⇔	08	Mar-24
255	Workforce – Recruitment	WWC	✓	✓	✓	✓		20						16	16	16	⇔	04	Mar-23
13	Workforce – Retention	WWC	✓	✓	✓	✓		16	16	16	12	12	12	16	16	16	⇔	08	Mar-24
Tbc	Culture & Leadership	WWC	✓	✓	✓	✓		16								16	NEW	08	Mar-25
17	Integration of 111 & EOC	QPS/FIC			✓	✓		16			16	16	16	16	16	16	⇔	08	Oct-22
256	Quality Improvement	QPS		✓				16						12	12	12	⇔	04	Jun-23
257	Improvement Journey	All	✓	✓	✓	✓		12						08	12	12	⇔	04	Jan-23
15	Education Training & Dev	WWC	✓	✓				16	16	12	12	12	12	09	09	09	⇔	06	Mar-23
16	Financial Sustainability	FIC	✓	✓	✓	✓		16	16	16	16	12	12	16	16	16	⇔	08	Mar-23
71	Cyber Attack	FIC		✓		✓		16							12	12	⇔	09	TBC

BAF Risks

	BAF Risk ID 14 Operating Model	Target Date: March 2024

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

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Report Metrics for Assurance	Variation	Assurance
▪ Responsive Care priority within the Improvement Journey focusses on key actions to improve processes / use of resources, such as H&T, JCT (see Improvement Journey Update) ▪ Use of REAP and SMP to help match resource with demand ▪ Integrated Plan agreed with commissioners to increase clinical workforce to 2555 WTE ▪ Performance Cell capability is helping to forecast resource gaps / trajectory against ARP	**999-9 "**Hear and Treat"		
	999-11 "JCT Allocation to Clear at Scene Mean"		
	999-11 "JCT Allocation to Clear at Hospital Mean"		
	999-2 "Cat 1 Mean"		
	999-4 "Cat 2 Mean"		
	WF-1 "Number of Staff WTE"		

Gaps in Control
▪ Slow progress moving to a more virtual model ▪ Stated actions help to improve the current approach / contribute to future model but we haven't yet agreed the vision for a new operating model, internally or in collaboration with system partners.

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress

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

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

Underlying Cause / Source of Risk:		
Risk that we do not achieve the recruitment plan to increase our frontline workforce to 2555 WTE, as set out in the 2022/23 Integrated Plan. This will result in consistently being unable to provide the target operational hours and therefore will impact adversely on patient care and staff wellbeing. The risk also exists within our call centres due to the re-opening of Gatwick Airport post-pandemic and the move to Medway impacting colleagues moving from Coxheath to the new Medway site in 2023. EMA call-handler recruitment significantly increased due to high attrition and the 2022/23 plan targets.	**Accountable Director**	Executive Director of HR
	Committee	WWC / Performance
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**04** (Consequence 4 x Likelihood 1)

Controls in place (what are we doing currently to manage the risk)	**Integrated Quality Report Metrics for Assurance**	**Variation**	**Assurance**
▪ Integrated Workforce Plan monthly monitoring of projected position ▪ Additional Recruitment Events ▪ International Recruitment ▪ Increasing capacity of compliance checks driving delays in EMA recruitment	**WF-1** "Number of Staff WTE"		
	WF-3 "Time to hire"		
	999-12 "999 Frontline Hours Provided %"		

Gaps in Control

The Trust is currently 128 WTE behind on its frontline workforce plan for the month of October. The projected shortfall by the end of the year is projected to be 33 WTE against the plan of 2555 WTE due to the mitigating actions taken through AAP recruitment. Our EMA establishment is currently 51 WTE behind plan, with a projected shortfall of between 49 and 72 WTE against an requirement of 277 WTE by end of the FY.

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) October Integrated Plan: 128 WTE below plan (999 frontline) (-) October Integrated Plan: 51 WTE below plan (EOC EMA) (-) On road hours significantly below target (-) Higher than normal turnover in EOC and 111 (+) Time to Hire has seen a reduction with special cause variation (+) Projected WTE position for end of FY is mitigated for 999 frontline (-) Impact on call handling performance due to projected 49 to 72 WTE shortfall against 277 WTE end of FY plan	

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**
(P&C-7) To compensate against the additional attrition and known gaps in the recruitment pipeline there has been additional recruitment events held to recruit external AAPs.	Director of HR	31.03.2023	To date there have been 85 successful candidates offered a position (Includes already started, 54 yet to start on a course and 13 have a TBC date)

(P&C-7) International paramedic recruitment - these candidates have a longer turnaround time from offer to start and any offers made going forwards will not likely start within this financial year.	Director of HR	31.03.2023	Offered to ~~3~~4 candidates so far (five started), with aim to offer 75 by 31.03.2023.
Proposal to utilise NQPs within the EOC if they have not yet obtained a C1 licence. This will enable the Trust to retain these staff and reduces the risk of candidates accepting offers at neighbouring services who accept NQPs without a C1 licence. This will also bolster the 999 clinical workforce teams' capacity over the winter period and increase hear and treat rates.	Director of Operations Medical Director	tbc	
In terms of recruitment process for EMA, a significant capacity gap has been identified which is severely affecting the compliance checking process due to significantly more EMAs in the recruitment pipeline than normal. We currently are recruiting more than four times the normal of staff in this area. This has been escalated to the CFO to ensure funding can be made available to fund additional temporary capacity in the compliance check team, which will clear the current outstanding cases by April 2023.	Director of HR	Tbc	

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

	BAF Risk ID 13 Workforce Retention	Target Date: March 2024

Underlying Cause / Source of Risk:		
Risk of higher than planned turnover and loss of senior paramedics to primary care and other parts of health system, which will lead to the deskilling of the workforce and an inability to upskill the remaining workforce.	**Accountable Director**	Executive Director of HR
	Committee	WWC / Performance
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Report Metrics for Assurance	Variation	Assurance
▪ Work in partnership with six higher education institutions (HEIs) for pre-registration paramedic education programmes ▪ Clinical Education Strategy & Delivery Plan ▪ Workforce Plan agreed as part of the Integrated Plan ▪ Raised at system assurance meeting and ICB Chief People Officer Meeting. ▪ Retention Plan agreed / reviewed by WWC	**WF-1** "Number of Staff WTE"		
	WF-48 "Annual Rolling Turnover Rate %"		
	WF-49 "Sickness Absence %"		

Gaps in Control
▪ The Trust has not agreed its strategic approach to clinical portfolios ▪ There is no ICS/System workforce plan

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Shortfall of paramedics / High attrition (-) Additional Roles Reimbursement Scheme could lead to a potential increased attrition of paramedics (-) Retention issues within paramedics/EOC/111 (+) increase in direct entry students converted to employees	Need greater visibility of the effective implementation of the retention plan

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

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

NEW	**BAF Risk ID TBC** Culture & Leadership	**Target Date:** **March 2025**

Underlying Cause / Source of Risk:	**Accountable Director**	Executive Director of HR
Culture of bullying, sexual misconduct and poor/underdeveloped management and leadership practice resulting in poor employee experience, a high number of employee relations and FTSU cases as well as affecting staff turnover negatively. Culture is insufficiently open and transparent and this leads to insufficient focus on staff concerns which can impact upon patient and staff safety.	**Committee**	WWC
	Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)	**Integrated Quality Report Metrics for Assurance**	**Variation**	**Assurance**
• Commenced NHS Culture and Leadership Programme including appointment of a new Programme Director (Cultural Transformation) • Implementing Just and Restorative Culture methodology • Implementing programme of early resolution/mediation training for managers, unions and HR • Trust Board development programme proposal to be presented at Dec 22 Trust Board • Programmes of management development to improve management practice (under collective brand of Made@SECAmb) • Increase in resourcing for FTSU service	**WF-44** "Grievance mean case length days"	↘	
	WF-41 "Count of Until it Stops (Sexual Safety) Cases"	↗	

Gaps in Control
▪ Insufficient data reporting with clear plans to address leading to lower visibility ▪ Insufficient resourcing in culture improvement work ▪ People strategy not developed yet

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) protected time to attend key skills and management development (+) Employee relations data reviewed regularly at SMG and by HRBPs (+) regular reporting of ER and FTSU cases to commence to Leadership Team, WWC and Trust Board to improve visibility and monitor progress/highlight areas of concern (-) WRES, staff surveys, quarterly national pulse surveys (-) Exit interview data (+) Statutory and mandatory/keys skills training (+) Appraisal rates	Prioritisation of other issues cf. culture at Board and WWC Currently FTSU data is not currently reported routinely to senior/top leadership meetings

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

(P&C-7) Role specific Staff Survey/Exit Interview action plan for Paramedics and Urgent Care	Director of HR	31.12.2022	Retention Plan to be reviewed at EMB SMG on 21.09.2022
(P&C-7) Development opportunities for Paramedics to progress to Paramedic Practitioners and Critical Care Paramedics. As a minimum we recruit to our budgeted FTE for Paramedic Practitioners and Critical Care Paramedics	Director of HR	30.03.2024	Retention Plan to be reviewed at EMB SMG on 21.09.2022
(P&C-8) Development of a People Strategy and related plans	Director of HR	TBC	
(P&C-5) Delivery of the NHS Culture and Leadership Programme	Director of HR	TBC	
Implement the Just and Restorative Culture methodology and principles	Director of HR	TBC	

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

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

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Report Metrics for Assurance	Variation	Assurance
• Continue to engage with NHSE directly to seek responses and answers to the concerns and issues raised to date. The NHSE Integrated Urgent Care (IUC) central team has devolved responsibility for the implementation and communication of SVCC to the NHSE regional leads. As such, KMS 111 Head of Service has been in regular contact with the regional NHS E team (and national NHS E IUC Leads, when necessary, i.e., for telephony, commissioning, clinical and medical). • We have full attendance at the three original NHSE national SVCC engagement sessions, in addition to all local NHSE SVCC meetings covering the three workstreams. • Raised concerns via the AACE national forums. • The Associate Director for IT has escalated his concerns and issues through to the national team. Internally, the Associate Directors for IT and for Integrated Care continue to work closely to ensure that SECAmb is fully compliant with the expectations of NHSE regarding the IT and subsequent operational implementation of SVCC. • Implementation has been deferred to at least October 2022 – this is subject to funding that is yet to be agreed.	**111-2** "111 Calls Answered in 60 Seconds %"		
	999-1 "999 Call Answer Mean"		

Gaps in Control

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Work with commissioners to close the funding gap	Director of Finance	Ongoing	

Re modelling the interface between 111 and EOC in terms of call handling and CAS	Director of Operations	TBC	TBC

	BAF Risk ID 256 Quality Improvement	Target Date: June 2023

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

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

Gaps in Control
No Quality Improvement Methodology In place

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
(QI-8) QI Strategy, Vision, Aims and Objectives to be developed	Director of Quality	April 2023	Approach to be agreed at the Board development session on 15 December
(QI-8) Training plan to be established and underway	Director of Quality	April 2023	

(QI-8) Coordinated learning infrastructure/framework in place – see QI workstreams within the Improvement	Director of Quality	April 2023	
Board QI session	Director of Quality	15.12.2023	Scheduled

	BAF Risk ID 257 Improvement Journey	Target Date: January 2023

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

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Report Metrics for Assurance	Variation	Assurance
▪ Improvement Plan is on place – re-prioritised to ensure focus on the Warning Notice and Must Dos. ▪ Monthly Board meetings established to assure delivery of the Plan. ▪ A programme of IJ deep dives at each committee ▪ External support accepted – HR Review; Finance Review; SI / Harm Review. ▪ Quality Summit held ▪ Application for NHSE/I funding and internal business case approved / recruitment made ▪ Improvement Journey Steering Group now chaired weekly by Director of Planning and Business Development. ▪ The programmes have been re-baselined and following a freeze on the 9th September there's a clear plan and focus on collating of evidence. ▪ Additional support is being drafted to help address the gap in communications / engagement with the programme. ▪ People and Culture Programme has been put under additional support under the internal "intensive support", this includes creating capacity within DDHR to lead on the programme and allocation of a dedicated PM ▪ A targeted register of evidence has been produced to support focus on outcomes by the expiry of the S29A (Warning Notices) ▪ 3 peer-review sessions have taken place in November, an internal session with colleagues who have not been close to the programme, an external with system partners, and a full Board Development Day, reviewing the progress made against the WN. Peer-review mechanism will be embedded, with external partners. ▪ Current governance structure will continue until the 31st of March following expiry of the Warning ▪ Re-structured Board Agenda aligned to Trust Priorities and Improvement Journey Notices, with a focus on Must Do, Should Do and RSP deliverables. ▪ Committee Deep Dives	N/A		
Gaps in Control			

- Resourcing gaps and capacity constraints identified across the IJ programmes, in particular with delivery leads, not yet closed. Agency project managers have not been retained beyond December due to not meeting the skills required by the programme.
- As the programme transitions from Warning Notice focussed to Must Do, Should Do and RSP, there's some 50 different deliverables that are being mapped out by the programme leads. The Board must seek assurance on how it will maintain oversight of these during this next phase as well as supporting an eventual transition to a Strategically led Improvement Journey.
- Sustainability of the current governance arrangements for oversight.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Report to Board in December (+) Board Development Day on 1st December (+) Deep dive sessions completed at committees	

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
(IJ Portfolio) Mock Inspection	Director of Quality	Sept/Oct	A schedule of mock CQC inspections will carry on following a pre-defined scheduled, covering Polegate and Hastings on the 28th of September, Banstead, and Gatwick, on the 12 and 13th of October. A mock inspection was only conducted at Gatwick due to short notice cancellation from some key partners. Feedback from the Gatwick visit has been shared with the OUM. Polegate and Hastings will be conducted in Jan 2023 and Banstead in Feb 2023. There will be a programme of quality surveillance visits developed with the Sussex ICB Quality team from April 2023.
(QI-1) Improved reporting to Board to show impact of the actions on our people and patients	Director of Planning	Ongoing	Updated report scheduled for Board 25.08.2022. Updated IQR in line with Make Data Count Board Development. Updated reports to Board in September based on deliverables.
Preparation for expiry of the S29A Warning Notices	Director of Planning / Director of Quality	15.10.2022	Preparation for CQC re-inspection, inclusive of focus sessions on the evidence produced to address each WN shared with entire leadership team. Self-assessment to be conducted by all Board and Senior Managers through October. Board Development and Peer review completed through November against the Warning Notices.
Board Well Led Self-Assessment	Chairman / Company Secretary	January 2023	A well led self-assessment is underway with a Board workshop to be held in January date tbc, facilitated by the NHSE Improvement Director.
Board Reporting Framework to be updated to provide assurance against Must-Do, Should-Do and RSP actions	Director of Quality / Director of Planning	February 2023	Improvement Journey Programme Leads workshop held on 5.12.2022 to review and align progress of each deliverable package against the relevant group. Weekly Steering Group oversight to be retained.
Development of the sustainable models of continuous improvement to support the transition from a compliance driven improvement plan to a strategic driven improvement plan	Director of Quality / Director of Planning	31.03.2023	Programme leads for the current delivery groups, current Improvement Journey leads and Deputy Director of Quality Improvement are developing an initial draft of a business case for 23/24. The focus will be in having a structure that enables and supports improvement to happen locally, whilst retaining central visibility for assurance on progress against strategic goals.

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

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

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Report Metrics for Assurance	Variation	Assurance
• Key Skills delivery programme • Management development programme started in July 2022 • Clinical Education Strategy • Workforce / Integrated Planning & Training gap analysis • Training Plan 2022/23 • Monthly core skills (stat/man) training compliance reporting on Power BI • Agreed increased abstraction levels from 29% to 33% for 2022/23 • Adopted no cancellation approach to key skills	**WF-6** "Statutory & Mandatory Training Rolling Year %"		
	WF-40 "Appraisals Rolling Year %"		
	999-12 "999 Operational Abstraction Rate %"		

Gaps in Control
• Education, Training and Development (ETD) Strategy

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

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

	BAF Risk ID 16 Financial Sustainability	Target Date: March 2023

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

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Reports Metrics for Assurance	Variation	Assurance
▪ For 22/23, the Trust has mitigated an original planning gap of c.£40m with non-recurrent funding from national allocations. ▪ Funding for the 2022/23 Integrated Plan for 2555 WTE, which improves ARP but does not achieve the standards. ▪ The Trust has reviewed the likely financial outcome for 2022/23 and without remedial action the Trust would have an £8m deficit. The remedial action plans are underway with each directorate to deliver recurrent savings in year to significantly reduce the likely deficit to circa £2m	**WF-1** "Number of Staff WTE"		
	F-9 "Income (£000s) YTD"	NA	NA
	F-10 "Operating Expenditure (£000s) YTD"	NA	NA
	F-6 "Surplus/Deficit (£000s) Month	NA	NA

Gaps in Control
▪ The stated controls are in year measures and unlikely to improve long term sustainability ▪ The ICS systems in Sussex and Kent have communicated to the Lead Ambulance Commissioner (Surrey ICS) that they will not commit to further funding for 23/24 without understanding the demand and capacity issues. Without rectification and agreement from the systems as to how to manage demand is required. The gap will likely increase if supply side measures (increasing WTE) is the primary solution. ▪ We have commenced the 2023/24 planning round and are intending to achieve 80% of financial & operational planning by the end of December 2022.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) financial management: achieving plan (-) underlying funding gap / deficit (-) Cost Improvement Plan	We don't currently have a plan for addressing long term sustainability. The plan is under development, and we will report to the Board early in the New Year.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Financial diagnostic by NHS Improvement Director underway looking at internal and external issues.	Chief Finance Officer	September	The report has been shared with the Board.
Discussion with commissioners about how to ensure longer term planning	Chief Finance Officer	Ongoing	

Sustainability & Partnerships Programme within the Improvement Journey established	Chief Finance Officer	Ongoing	Programme now in operation and delivering in line with the S&P plan.

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

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

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

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

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Privilege access management (PAM) implementation, starting with suppliers, then internally	Director of Finance	TBC	Most suppliers are now working with the system and adjustments are being worked through with them to ensure it is fully meeting their needs before moving to internal staff.
An action card is being developed to cover single device or user cybersecurity incidents	Director of Finance	25.11.2022	
An action card is being developed to cover Trust wide cybersecurity events.	Director of Finance	25.11.2022	

Board Assurance Framework
SECTION E: Non-BAF Extreme Risks

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
28	**Drug Seeking Behaviour via 111 Electronic Prescribing Service (EPS)** *There is a risk that people seeking to obtain high risk and/or addictive medications are being enabled as a result of no mechanisms to identify this drug seeking behaviour which may lead to significant patient safety risk and Trust liability.*	15	15	06	Chief Pharmacist
29	**EPRR Incident Response** *There is a risk that the Trust's response to an incident of an EPRR nature will fall short of the requirements outlined in the Major Incident Plan and NHS EPRR Framework.* *These incidents include but are not limited to: significant or major incidents, transport accidents, multi-site incidents or business continuity incidents.*	20	16	06	Head of EPRR
136	**Process of tagging medicines pouches is not working effectively** *There is a risk medicines will not be available for the patient if paramedics are incorrectly completing paperwork following their daily assurance checks. Incomplete or incorrect paperwork leads to pouch tagging errors and there is a risk that the medicine will not be in the right place at the right time for the next Paramedic and patient due to incorrect tagging.*	15	15	03	Chief Pharmacist
16	**Climate Change** *As a result of greenhouse emissions, global warming will increase the temperature of the earth over the coming decades. Amongst many impacts this will lead to, climate change is likely to become the biggest healthcare emergency of the 21st Century. This will impact our operating model both on the types of conditions we attend to (i.e. extreme weather), as well as our infrastructure and how we deliver care (i.e. changing our fuels and consumables to meet mandated carbon-reduction targets).*	15	15	10	Director of Planning
273	**Industrial Action** *Trade unions are balloting nationally in response the pay award for 2022/23 – in the event of strike action or industrial action short of strikes this could significantly disrupt service provision.*	16	16	08	Director of HR

Appendix 1 - Risk Scoring

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

Low Moderate High Extreme

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

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

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

Appendix 2 - SPC Icon Description

				
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
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				Special cause variation where **UP** is neither improvement nor concern.
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NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – December 2022

Reporting Period: September – October 2022

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

Contents

Improving Quality of Information to Board - December 2022

- Following additional Board development sessions with NHSE, we have done further improvements to our IQR.
  - Control Limits have been recalculated for metrics where there are clear signs of process change.
  - Assurance grids have been introduced for every pillar of the Improvement Journey.
  - Addition of Bullying and Harassment Metrics added in under Employee Experience and Suspensions in People and Culture. This will strengthen the Board's visibility to some of the key metrics that help us assure how swiftly we are addressing ER cases.
  - A technical Narrative has been added to the side of each SPC chart, to help the data trends be better understood.
  - Operational Narrative training has been delivered to the Trust in sessions both in September and November.
  - Board timetable has been updated to ensure there's sufficient time to develop a quality report.
  - Several metrics have been updated and included in the report, including: Safeguarding Level 3, Harm, Call handling performance in 999 and 111.
  - Where appropriate, both annual rolling and monthly SPC charts are provided to see the trends better (i.e. in areas like attrition).
  - The executive summary matrix has been included for all section, included of a breakdown of the key areas of assurance under each key pillar (see next slide).
  - Performance benchmarking has been included against other Ambulance providers for the month of October.
- In addition, the BAF Risk report now includes a direct link to the key assurance metrics and SPC icons to strengthen how the reports are considered together.
- After 3 cycles of iterative continuous improvement of the IQR, there will be a pause in technical development to enable the BI team to focus on the development of more detailed Quality Dashboards to support divisional and regional level discussions, which will support the Trust in its development of a strong Patient to Board Quality and Performance Assurance framework. This will mean effectively using SPC charts in line with the IQR methodology across all levels of the organisation.
- The focus for Board improvement for the Board in January will be to strengthen the narrative even further, before any further changes are done.
- The focus will also shift during the upcoming period to start on-boarding key data sources to the data warehouse, as we remain with 75% of data not being available, which creates a data quality and validation risk. The priority datasets will be Datix and workforce systems.

Alignment Framework

Improvement Journey

Quality Improvement

We listen, we learn and improve

QUALITY IMPROVEMENT

- *SI, Incidents and Harm*
- *Patient care – Cardiac*
- *Patient care - Stroke*
- *Medicines Management*
- *Safeguarding*
- *Safety in the workplace*
- *Patient Experience*

Responsive Care

Delivering moderns healthcare

RESPONSIVE CARE

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

People & Culture

Everyone is listened to, respected and well supported

PEOPLE & CULTURE

- *Employee Experience*
- *Culture*
- *Workforce*
- *Wellbeing*
- *Development*

Sustainability & Partnerships

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

SUSTAINABILITY & PARTNERSHIPS

- *Delivery against Plan*

IQR Themes

Icon Descriptions

				
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Quality Improvement

QUALITY IMPROVEMENT

Summary

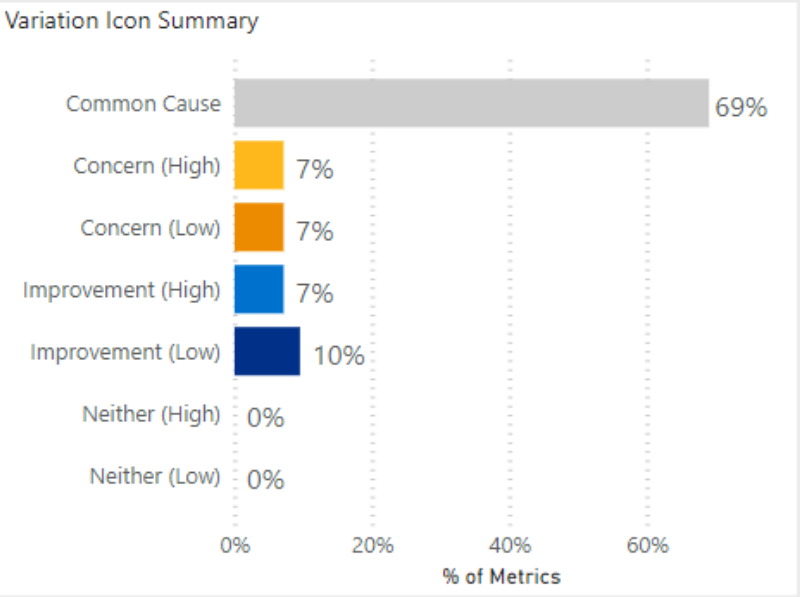
October 2022

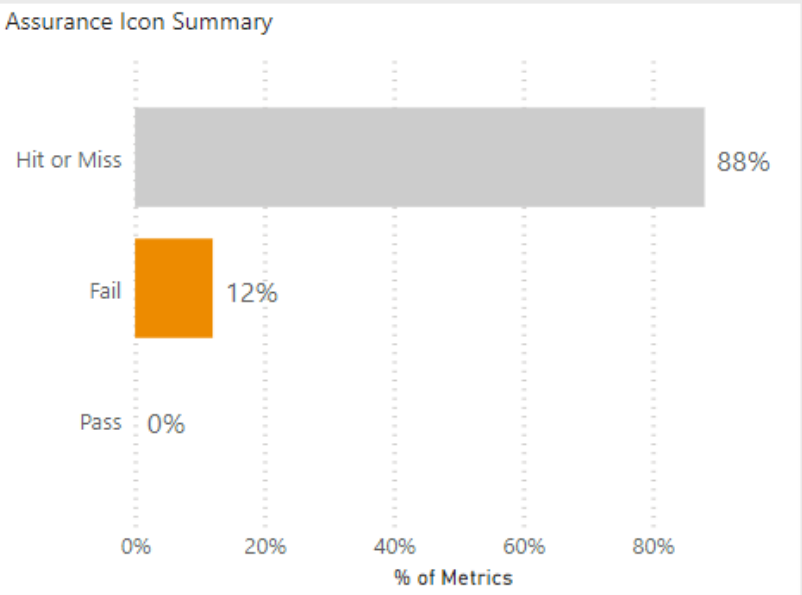
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Sepsis Care Bundle % **Acute STEMI Care Bundle Outcome % Organisational Risks Outstanding Review %		Complaints per 1000 999 Calls Answered Health & Safety Incidents Outstanding Actions Relating to SIs, Outside of Timescales Required NHS Pathways Audits Completed (EMA) %
Common Cause		Cardiac Survival Utstein % Cardiac Survival ALL % Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Stroke - Call to Hospital Arrival Mean Hand Hygiene Compliance % Safeguarding Training Completed (Children) Level 2 % Deep Clean Compliance %	Compliant NHS Pathways Audits (EMA) % Number of CD Breakages	Number of Medicines Incidents Number of Datix Incidents Number of Incidents Reported as SIs Manual Handling Incidents Proportion of Complaints Relating to Crew Attitude % Number of Complaints Number of Compliments
Special Cause Concern		Complaints Reporting Timeliness % Duty of Candour Compliance % Medicines Management % of Audits Completed Single Witness Signature Use CDs Non-Omnicell	Single Witness Signature Use CDs Omnicell	Violence and Aggression Incidents (Number of Victims - St...

Not included: Metrics that are not on a story board, metrics with common cause variation with hit or miss assurance and metrics with common cause variation without a target.

QUALITY IMPROVEMENT

Overview (1 of 3)





Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Oct-2022	137		72.42	144.68	216.95		
Number of CD Breakages	Quality Improvement	Oct-2022	14	0	2.4	17.47	32.55		
Number of Datix Incidents	Quality Improvement	Oct-2022	1542		904.87	1371.11	1837.34		
Number of Incidents Reported as SIs	Quality Improvement	Oct-2022	5		-5.11	5.53	16.17		
Duty of Candour Compliance %	Quality Improvement	Oct-2022	50%	100%	50.96%	88.79%	126.62%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Oct-2022	101		47.46	92.68	137.9		
Number of RIDDOR Reports	Quality Improvement	Oct-2022	11		-0.42	11.84	24.11		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Oct-2022	22		50.01	78.38	106.76		
Health & Safety Incidents	Quality Improvement	Oct-2022	25		11.28	30.79	50.3		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Aug-2022	33	0	3.03	24.65	46.26		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Aug-2022	85	0	-19.97	44.71	109.38		
Medicines Management % of Audits Completed	Quality Improvement	Oct-2022	76.1%	100%	76.66%	90.33%	104%		

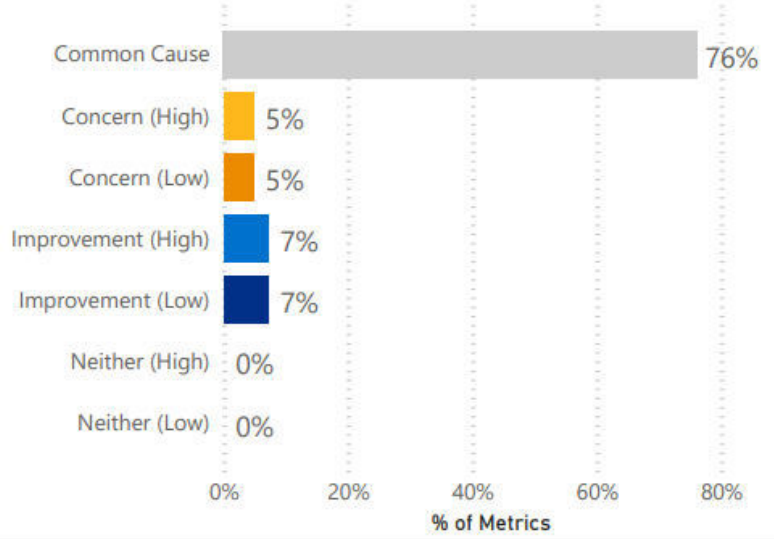
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Oct-2022	0%		-0.14%	0.04%	0.21%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Oct-2022	55%		6.68%	33.72%	60.76%		
Complaints Reporting Timeliness %	Quality Improvement	Oct-2022	25%	95%	39.82%	75.73%	111.64%		
Number of Complaints	Quality Improvement	Oct-2022	56		34.97	83.74	132.5		
Complaints per 1000 999 Calls Answered	Quality Improvement	Oct-2022	0.09		-0.46	0.26	0.99		
Number of Compliments	Quality Improvement	Oct-2022	125		110.45	169.47	228.49		

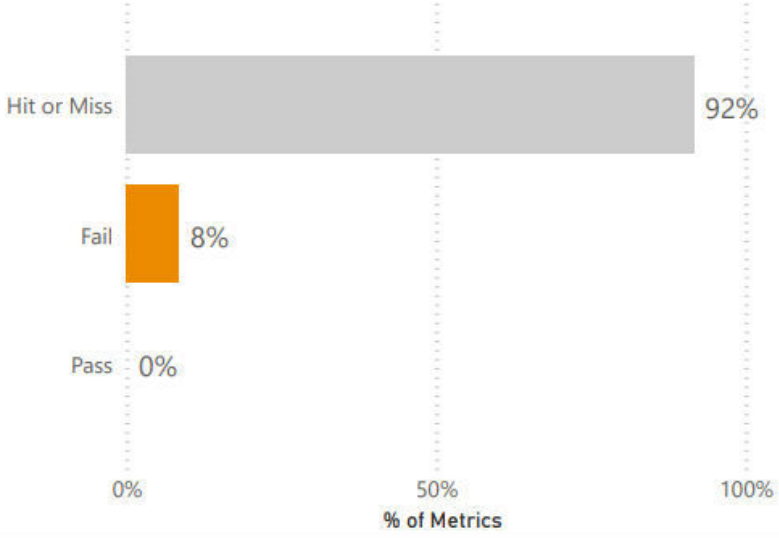
QUALITY IMPROVEMENT

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Aug-2022	35.1%	45.1%	26.57%	46.24%	65.91%		
Cardiac ROSC ALL %	Quality Improvement	Aug-2022	19.4%	23.8%	16.12%	24.92%	33.71%		
**Sepsis Care Bundle %	Quality Improvement	Sep-2022	87.1%	85%	80.33%	85.28%	90.23%		
Cardiac Survival Utstein %	Quality Improvement	Jul-2022	34.2%	25.6%	10.42%	27.84%	45.25%		
Cardiac Survival ALL %	Quality Improvement	Jul-2022	14.2%	9.6%	4.21%	10.56%	16.91%		
Cardiac Arrest - Post ROSC %	Quality Improvement	Aug-2022	72.2%	76.8%	58.6%	74.88%	91.15%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Sep-2022	69.8%	64.7%	50.35%	63.71%	77.06%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Jun-2022	02:22:00	02:22:00	02:11:20	02:29:04	02:46:48		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Jun-2022	03:19:00	03:14:00	02:52:26	03:29:19	04:06:12		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Jun-2022	01:40:00	01:29:00	01:22:58	01:38:45	01:54:32		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Jun-2022	02:33:00	02:20:00	02:03:32	02:33:30	03:03:28		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Sep-2022	98%	96.3%	94.66%	96.91%	99.15%		
Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Aug-2022	94%	93.8%	84.04%	90.98%	97.93%		
Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Aug-2022	76.5%	77.9%	68.36%	78.79%	89.23%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Oct-2022	105%		72.22%	97%	121.78%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Oct-2022	84%	100%	74.47%	85.25%	96.03%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Oct-2022	90%		80.77%	92.95%	105.13%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Oct-2022	102%		83.13%	98.25%	113.37%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Oct-2022	75.2%		25.52%	65.07%	104.62%		

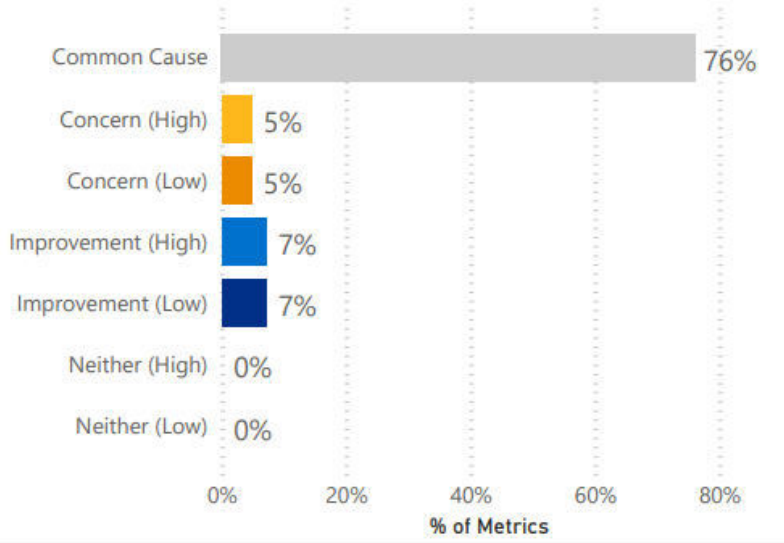
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Oct-2022	86%	90%	75.3%	87.27%	99.24%		

QUALITY IMPROVEMENT

Overview (3 of 3)

Variation Icon Summary



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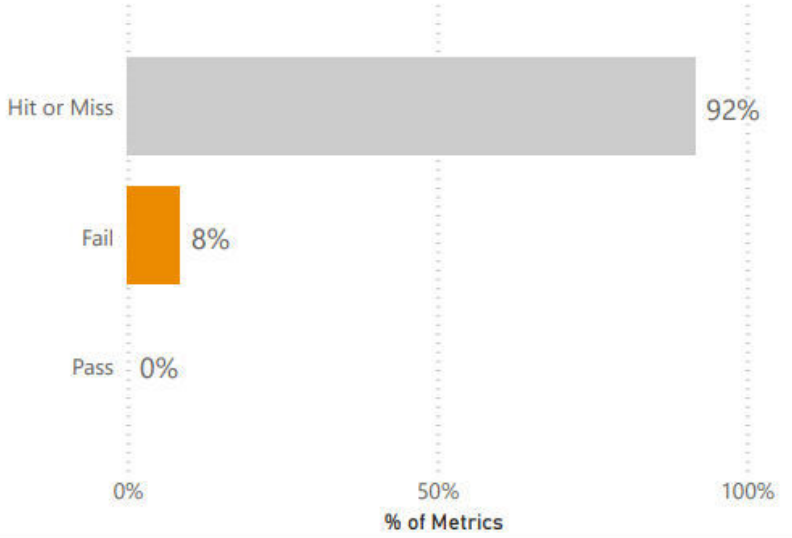


Health & Safety

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Sep-2022	82%	85%	81.74%	83.77%	85.8%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Sep-2022	51.1%			50.55%			
Manual Handling Incidents	Quality Improvement	Oct-2022	35		7.53	27.55	47.57		

QUALITY IMPROVEMENT

SIs & Incidents

QS-2
Dept: Quality & Safety
IP: Quality Improvement
Latest: 5

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

QS-1
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1542

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

QS-17
Dept: Quality & Safety
IP: Quality Improvement
Latest: 22

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

QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 101

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

Summary

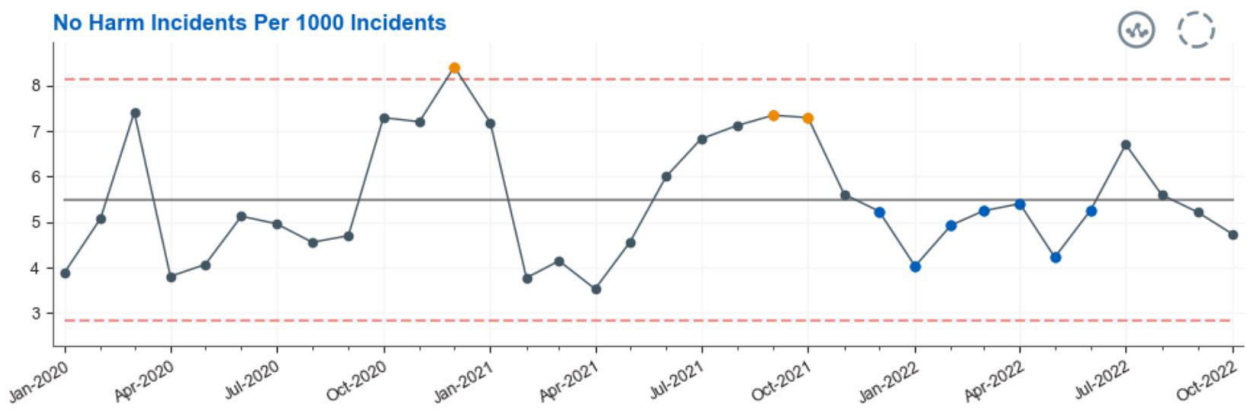
- **SIs**: There is no special cause variation in the trend of number of incidents reported as SIs. The two prominent themes arising from SIs are delayed dispatch/attendance due to system-wide pressures on capacity, and EOC call handling.
- **Datix Incidents:** There are 2 special cause variations indicated on Datix incidents table (Jan & March 2022). These reflect incidents related to system wide pressures (often cited as winter pressures) on capacity and demand. All breached datix incidents from 2019 to April 2022 have been closed. There are controls and escalation in place to manage breached incidents.
- **Outstanding SI Actions:** Improvements continue as depicted above with total numbers significantly reduced and remaining consistent thereby indicating no additional breaches coming on stream.
- **Violence and Aggression incidents:** Increase in incidents continues to be reported, as processes that have been put into place to respond to staff when subjected to violence or aggression are proving effective. It is expected this trend will continue as awareness is raised and there is an increase in the confidence in reporting these incidents.

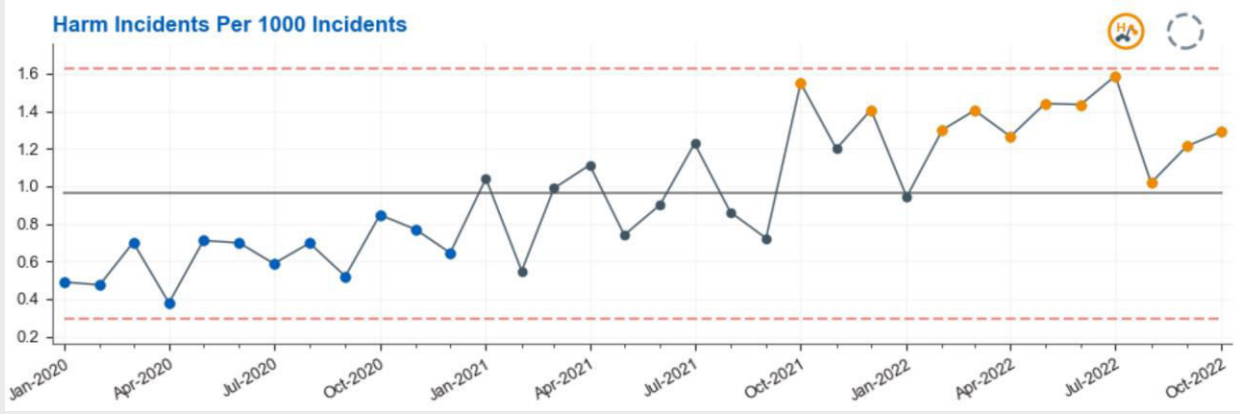
What actions are we taking?

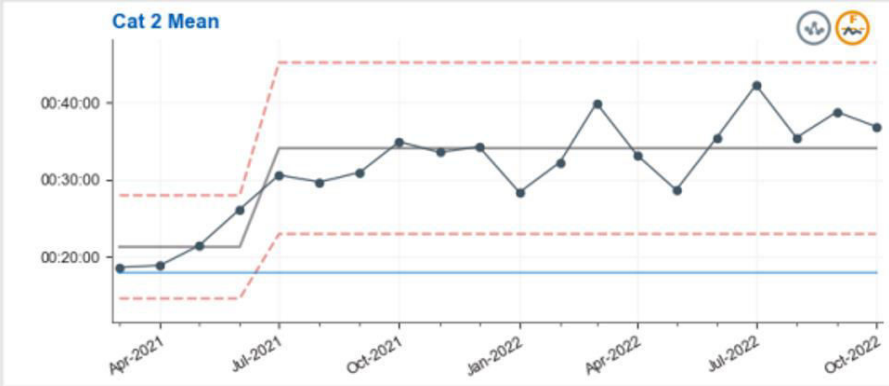
- **SIs:** Scoping across other ambulance services on incidence rates of SIs will be undertaken in order to ascertain a benchmark. Joint directorate work has been focused on 'keeping patients safe in the stack', reporting into QPSC for oversight on progress, and linking into the QI developments in order to coordinate efforts across QIG and RCG, identifying priority of schemes and set timelines.
- **Datix Incidents:** Targeted approach being taken to address prominent themes (e.g Pharmacy interface with 111), and operating areas dealing with increased numbers of local investigations. Monthly datix web training initiated from June 2022 in addition to bespoke training.
- **Outstanding Actions:** Targeted approach to final closures of breached actions, with continued focus on upstream actions to ensure situation does not recur. This is ab ongoing process overseen by SI Coordinator and SIG. Target is zero outstanding actions by end of D
- **Violence and Aggression incidents:** Previously the 111 Call centre in Ashford had a low number of reports, the 111 SLT have run a campaign to increase awareness of reporting violence and aggression incidents. This is also to occur in Crawley in the coming months. We have instigated a violence reduction working group in September to interrogate the data. The target is to work towards compliance of the NHS Violence Reduction Standards. As this requires culture change, we expect 18 months+ before we see the full effect of the actions.

QUALITY IMPROVEMENT

Harm







999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:36:54
Target: 00:18:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

- High special cause variation for harm (incidents graded as Low/moderate/severe/death) but 85% of these were graded as LOW indicative of an improving reporting culture in the organisation.
- In all harm reporting (including No Harm) there has been an 9.6% increase in reported incidents on Datix this year compared to previous, this significant shift being prominent those incidents graded as no harm/low harm and near miss. The categories driving these variations are; 16% reported issues with other health care providers, the majority of these being 111 Pharmacy issues (whereby community pharmacies fail to follow agreed pathways of referral into the service); 15.8% relate to 111/KMS/CAS being driven by issues with clinical tail audits and with triage; 7.9% are in relation to vehicle related incidents.
- Cat 2 Mean showing common cause variation and is continuously failing the target of 18 minutes. This is reflected in predominant theme within SIs investigated.

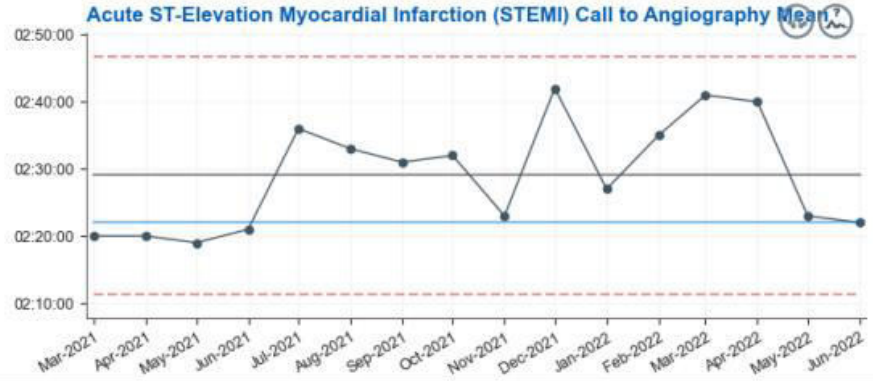
What actions are we taking?

- There is a sustained significant reduction in breached Datix with targeted approach in place to support Operating Units identified as holding backlogs. Datix being held up by external partners also being targeted with Quality leads involved.
- EOC/111 QUAPS discussed top 5 themes and are to escalate Pharmacy issues with ICB Pharmacy Leads as progress not being made in improving this position.
- Clinical tail audits and triage: this will remain high reporter in 111 as encouraged by the service in order to audit and develop improvement actions on ongoing basis. All incidents are associated with no/low harms.
- Vehicle related incidents are also likely to remain at this rate as the process for reporting into My App requires entry into Datix for reference number – majority no/low harm.

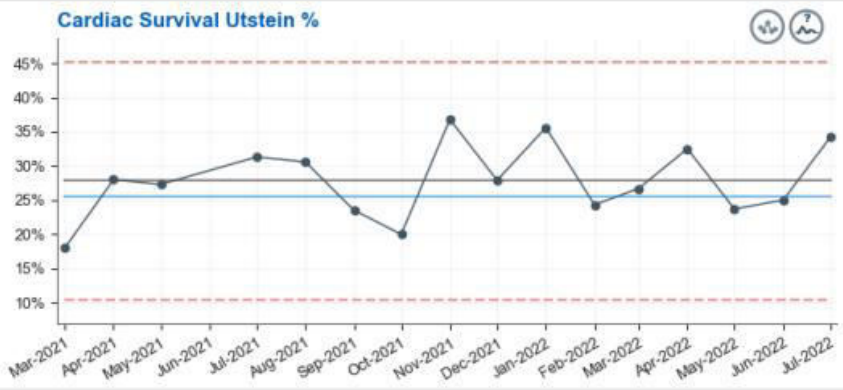
QUALITY IMPROVEMENT

Impact on Patient Care - Cardiac

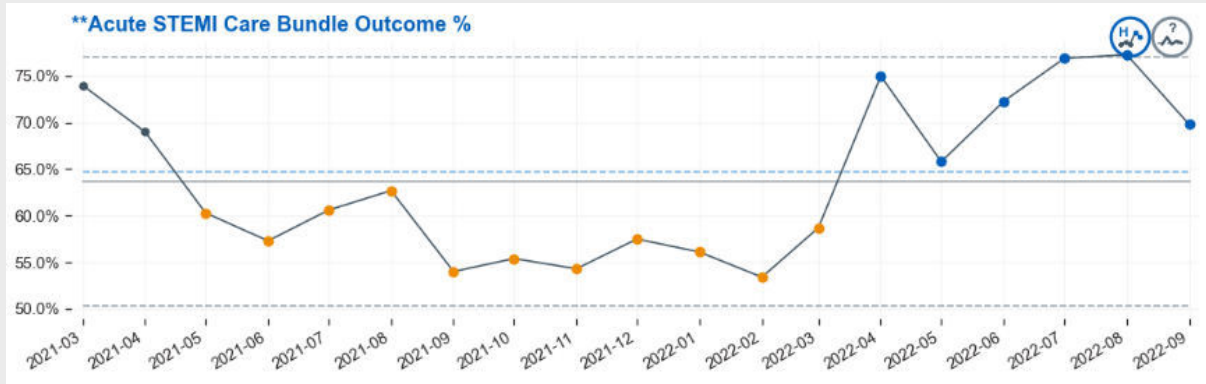
M-4
Dept: Medical
IP: Quality Improvement
Latest: 14.2%
Target: 9.6%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



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



M-3
Dept: Medical
IP: Quality Improvement
Latest: 34.2%
Target: 25.6%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



Summary

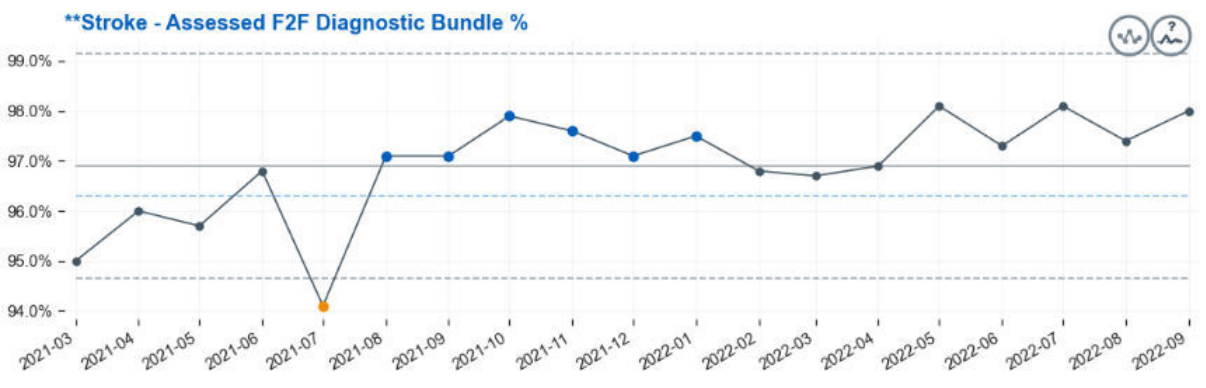
- **Cardiac Arrest Survival** – the annual report is due to be presented to Trust Board in Q4 and that will provide the Board will greater insight and benchmarking against other Ambulance Trusts.
- **STEMI Call to Angiography** - common cause variation: part of this is delay to arrival on scene.
- **Acute STEMI Care Bundle Outcome:** Improvement in compliance since June 2022 which may reflect the inclusion of IV Paracetamol as suitable analgesic.

What actions are we taking?

- **STEMI Call to Angiography** - There is ongoing QI work to reduce time on scene:
- OU level on-scene audit data via BI is in progress and should provide individual staff level information about times on scene for follow-up by OTLs.
- All clinical guidance, CPD, and Keyskills material emphasises reducing time on scene.
- Time to decision making for acceptance is not generally documented – however there is ongoing work with the pPCI centres to reduce this as much as possible and internal SECAmb guidance states staff should seek advice from the Critical Care desk in cases of delay.
- **Acute STEMI Care Bundle Outcome:** The South East Cardiac network has raised concerns that the current STEMI care bundle increases on scene time, and has recommended alternative measures, these are due for discussion at NASMeD on 13/12.

QUALITY IMPROVEMENT

Impact on Patient Care – Stroke



Summary

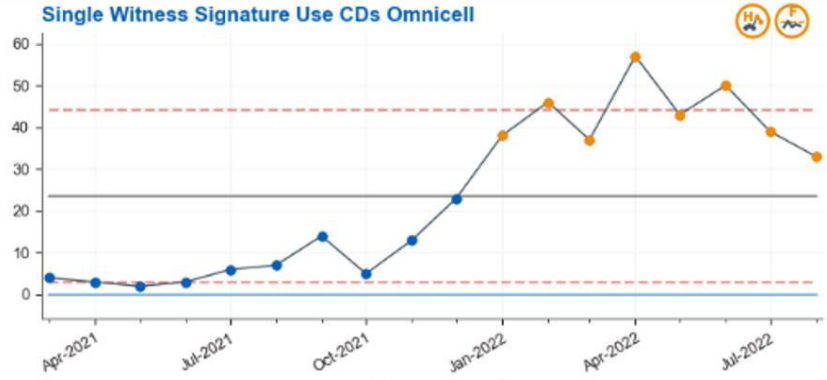
- **Stroke** - We are not meeting the national targets for Stroke patients due to overall delays in arrival at scene.
- However, once we arrive with the patient, our compliance against the Diagnostic Bundle has been above target since August 2021. Whilst there's no special cause variation identified, it's recommended that limits will be re-calculated from August 2021, which is likely to indicate the target is being consistently met.

What actions are we taking?

- **Stroke** - ongoing 2 year UCL evaluation of stroke telemedicine to evaluate if stroke telemedicine extends time on scene. Inconsistency between pPCI metric (call to balloon) and stroke (call to door) has been raised at national level. Mean time on scene for stroke generally across SECAmb is within reasonable parameters (approximately 30 minutes). This will be added in the next IQR as it has been identified as a key indicator for quality of care in one of our clinical priority areas.
- It is not possible to make any more improvements without addressing our C2 performance as a whole.

QUALITY IMPROVEMENT

Medicines Management



MM-3

Dept: Medicines Management
IP: Quality Improvement
Latest: 33
Target: 0
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 14
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 76.1%
Target: 100%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Summary

- **Single Witness Signature:** The reporting changed from looking at inappropriate signatures to looking at all signatures initially and then determining the inappropriate ones, which has caused a significant fall in performance.
- **Audits Completed:** There has been a significant drop in compliance of these weekly audits. In January 2022, the OI hub that previously oversaw this activity closed. The responsibility to complete audits has now moved to the OTLs. Due to capacity and turnover of OTLs the number of audits being undertaken has reduced.
- **Number of CD Breakages:** The number is consistent and has not significantly changed in recent months.

What actions are we taking?

- **Single Witness Signature:** Single Signature paper to be presented on 12th December. Chief Pharmacist will be monitoring this activity as this is of concern. We have identified any outliers by OU and individual and are working with local management teams where outliers have been identified.
- **Audits Completed:** Medicines are aware of the stations that are not compliant and reporting into the monthly Medicines Governance Group (MGG) meeting and would expect to see improvement by January. A TNA was presented to Teams A on 28/11, a further meeting is planned 14/12 to agree abstraction for OTL training.
- **Number of CD Breakages:** MGG receives a report bi-monthly on this identifying outliers by station and individual

QUALITY IMPROVEMENT

Medicines Management - Incidents

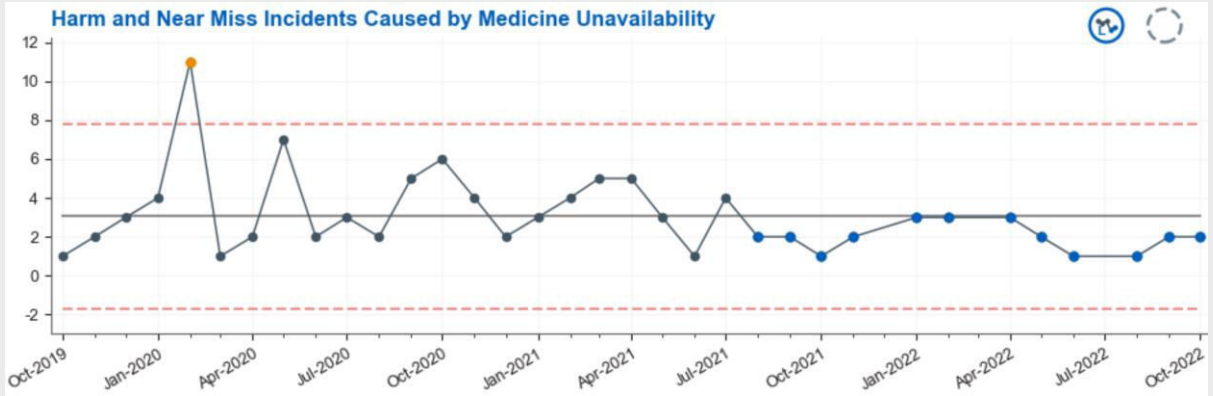
MM-1

Dept: Medicines Management

IP: Quality Improvement

Latest: 137

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



Summary

Medicines Incidents:

- There is no special cause variation in the trend of medicines related incidents. We have seen a consistently improving picture in the Harm and Near Miss incidents caused by medicines unavailability.

Harm & near miss incidents:

- This is common cause variation and remains reassuringly low, the likelihood of patient harm is low.

What actions are we taking?

Medicines Incidents:

- The Medicines Governance & Comms team have planned a Medicines Safety Week for the 14th November to remind staff to report on incidents, including near misses.

Harm & near miss incidents:

- The unavailability of any medicines constitutes a risk, this is primarily due to the tagging process and the capacity of the medicines bags. A pouch review is part of the medicines governance action, resource needs to be identified to undertake this review which is planned to commence in Q1 2023/24

QUALITY IMPROVEMENT

Safeguarding

QS-8
Dept: Quality & Safety
IP: Quality Improvement
Latest: 82%
Target: 85%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

QS-8
Dept: Quality & Safety
IP: Quality Improvement
Latest: 51.1%

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

Summary

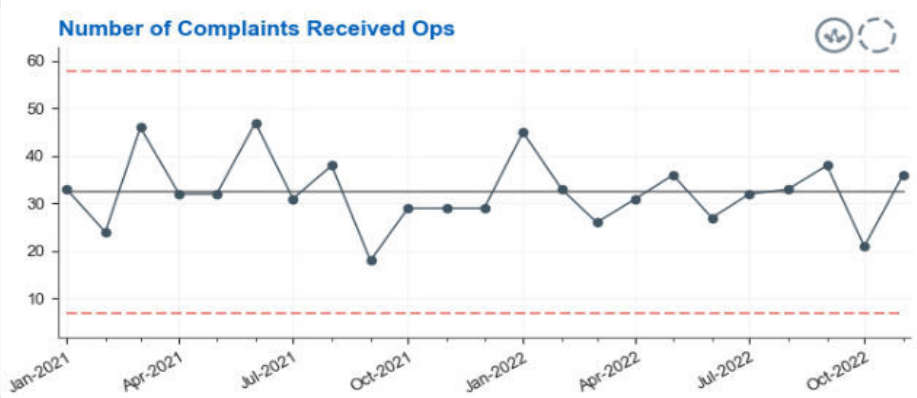
- **Level 2:** Remains within target range with expected increase in April due to new starters when training recommences as planned.
- **Level 3:** Re-commenced level 3 training Aug 2022, trajectory set at 85% (minimum commissioned) to reach by end of March 2023 .

What actions are we taking?

- **Level 2:** An exercise in June 2022 contacting non-compliant staff and found this didn't reflect the true picture of compliance. Discussions have taken place with Organisational Development to rectify this issue – this is ongoing and to be monitored again in Dec. 2022. To clarify with Learning Development before year end for reporting parameters as there may be an option to exclude staff who are in post less than 6 months and staff that can be included as undertaken training within their other employment (e.g. sessional GPs).
- **Level 3:** There are 14 L3 teaching sessions offered to March 2023 with the possibility of adding a few more session or overbooking session. Sessions to the end of December 2022 is fully booked and the safeguarding team is offering bespoke training to areas such as our 111. A trajectory for training compliance is established and monthly compliance data shared with Operating Units Managers.

QUALITY IMPROVEMENT

Patient Experience



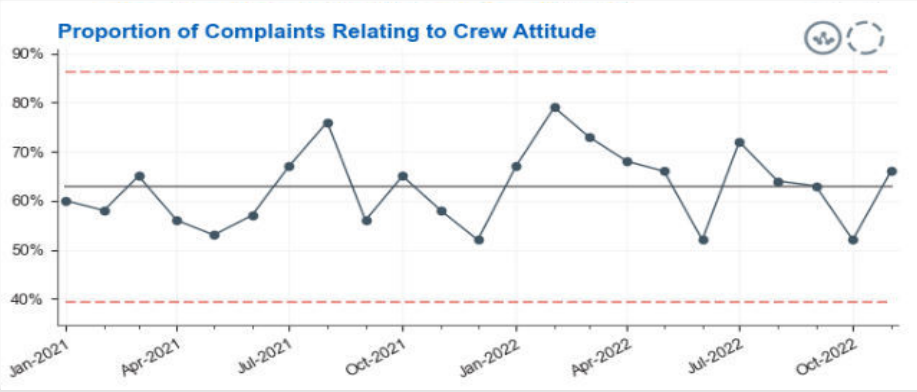
QS-5

Dept: Quality & Safety
IP: Quality Improvement
Latest: 56

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

QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 25%
Target: 95%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



QS-10

Dept: Quality & Safety
IP: Quality Improvement
Latest: 55%

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

QS-3

Dept: Quality & Safety
IP: Quality Improvement
Latest: 50%
Target: 100%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Summary

- No significant statistical variation in the total no. of complaints received or the proportion of complaints relating to staff attitude.
- Special cause reduction noted regarding reporting timeliness of complaints. This has coincided with the team focusing on reducing the number of breached complaints. We expect this to improve from Jan 2023.

Duty of Candour:

- The reduction in compliance over past two months has occurred within incidents graded as moderate or severe harm (not complaints) and is due to issues including paucity in team numbers due to sickness and vacancies and the information required not being available to undertake the duty of candour, e.g., no next of kin details on EPCR or delay from coroners.

What actions are we taking?

- Scoping exercise to better understand possible target levels for consideration in relation to the total no. of complaints received
- Alternative duties member of staff to assist with EOC complaints backlog, plan to clear and be up to date by end of December
- Implementation of a complaints and compliments dashboard that provides a deeper analysis of data to drive improvement. Whole organisational complaint data is now shared and critically discussed at Team B meetings to promote organisational learning and constructive challenge.

Duty of Candour:

- Team capacity strengthened through additional resources; process of contact being robustly applied; Allocation of investigators refined and strengthened; legal team are in discussion with SI Lead regarding the release of NOK from coroners.

QUALITY IMPROVEMENT

Safety in the Workplace

QS-20

Dept: Quality & Safety
IP: Quality Improvement
Latest: 25

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

QS-7

Dept: Quality & Safety
IP: Quality Improvement
Latest: 86%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

QS-22

Dept: Quality & Safety
IP: Quality Improvement
Latest: 35

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

QS-19

Dept: Quality & Safety
IP: Quality Improvement
Latest: 89%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

- Signs of a sustained improving trend in the number of health and safety incidents, though paramedics continue to be the most affected occupation.
- No special cause variation in the number of manual handling incidents, with the vast majority of incidents still occurring during patient transport. During Sep and Oct 2022, the most prevalent body areas effected by manual handling injuries were back and shoulder.
- Hand hygiene compliance and deep clean compliance have not seen any special cause variation in the most recent 6-month period, aim is to move from hitting or missing target to consistently hitting target. For hand hygiene one of the elements of non-compliance is still staff not having hand gel on them at all times.

What actions are we taking?

- Incident trends will continue to be monitored at Health & Safety Committee and regional Health & Safety meetings.
- The Health and Safety team will review training being offered on manual handling to target group most affected in partnership with Clinical Education.
- Staff who are required to carry out hand hygiene audits have been trained and being supported in how to correctly complete the audits. The ICP team will meet with OTLs to review all IPC audits and agree any actions – first meeting scheduled for 12th Dec 2022.
- Fortnightly meetings are taking place to identify and target for deep cleaning any areas where non-compliance is flagged.
- Limits for the Deep Clear compliance will be re-calculated to remove the variation caused by an outlier data point in August 2021, which was driven by a change in reporting following the new Make Ready contract.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

October 2022

Pass | Hit and Miss | Fail | No Target

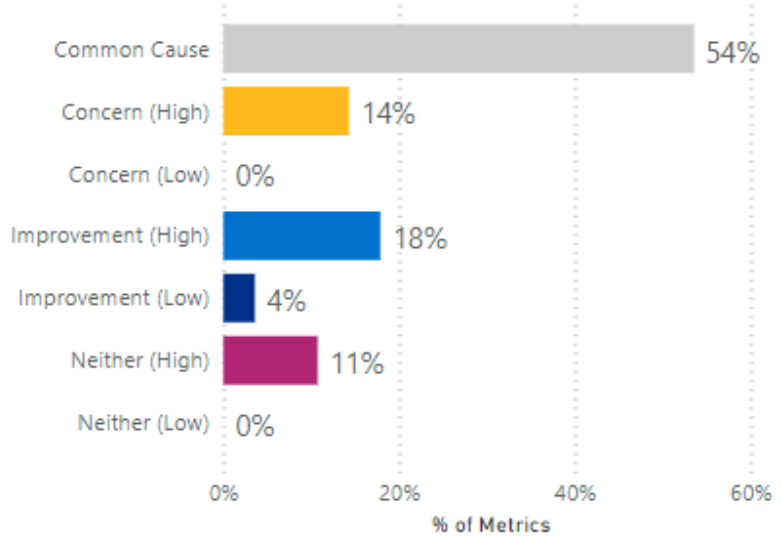
Special Cause Improvement		Number of Staff WTE (Excl bank and agency)	Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Current licence details held for Operational Staff %	Number of Staff Headcount (Exc bank and agency) Whistleblowing
Common Cause	DBS Compliance %		Sickness Absence % 999 Frontline Late Finishes/Over-Runs %	Turnover Rate % Individual Grievances Open Count of Grievances Closed % of Meal Breaks Taken Freedom to Speak Up: Total Open Cases Suspension Closures Number of Wellbeing Hub Referrals
Special Cause Concern		Vacancy Rate %	Annual Rolling Turnover Rate	% of Meal Breaks Outside of Window Disciplinary Cases

Not included: Metrics that are not on a story board, metrics with common cause variation with hit or miss assurance and metrics with common cause variation without a target.

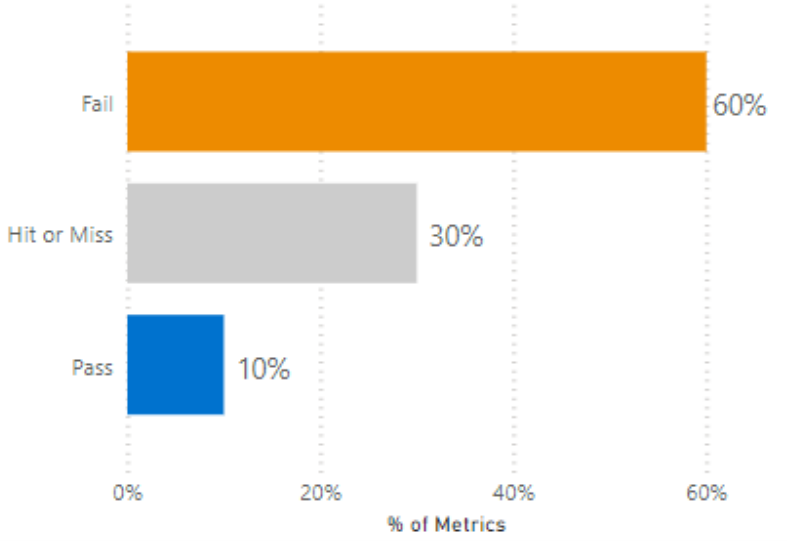
PEOPLE & CULTURE

Overview (1 of 2)

Variation Icon Summary



Assurance Icon Summary



Workforce

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Oct-2022	3992.85	3946.96	3886.39	3935.1	3983.8		
Number of Staff Headcount (Exc bank and agency)	People & Culture	Oct-2022	4402		4282.79	4335.84	4388.89		
Vacancy Rate %	People & Culture	Oct-2022	4.4%	5%	-0.37%	2.81%	5.99%		
Turnover Rate %	People & Culture	Oct-2022	1.6%		0.98%	1.44%	1.9%		
Annual Rolling Turnover Rate	People & Culture	Oct-2022	18%	15%	16.58%	17.58%	18.58%		
Sickness Absence %	People & Culture	Oct-2022	8.6%	7%	7.48%	9.3%	11.12%		
DBS Compliance %	People & Culture	Oct-2022	100%	100%	100%	100%	100%		
Current licence details held for Operational Staff %	People & Culture	Oct-2022	96.7%	100%	87.65%	93.37%	99.1%		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Oct-2022	72.6%	95%	57.46%	67.34%	77.23%		
Appraisals Rolling Year %	People & Culture	Oct-2022	49.4%	85%	30.47%	38.26%	46.05%		

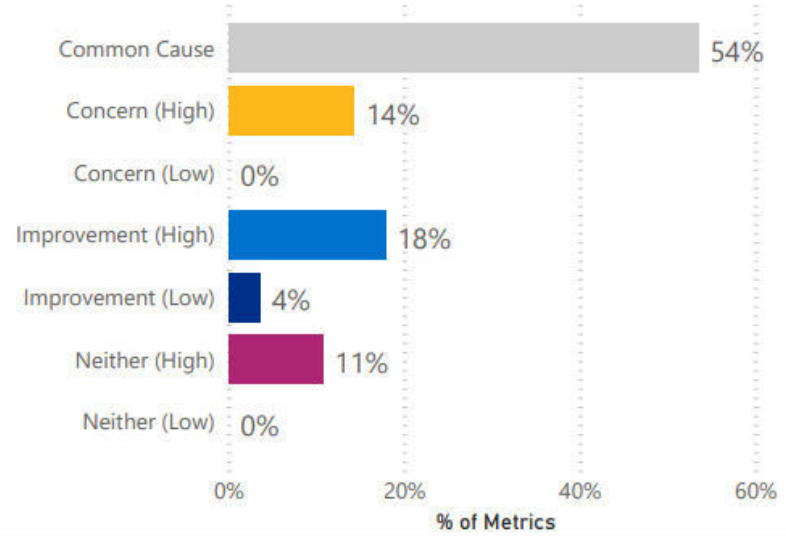
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Oct-2022	55.2%	5%	45.16%	51.94%	58.73%		
Average Late Finish/Over-Run Time	People & Culture	Oct-2022	00:46:00		00:36:20	00:41:53	00:47:25		
% of Meal Breaks Taken	People & Culture	Oct-2022	96.8%		96.51%	97.98%	99.45%		
% of Meal Breaks Outside of Window	People & Culture	Oct-2022	61.8%		34.37%	56.55%	78.73%		

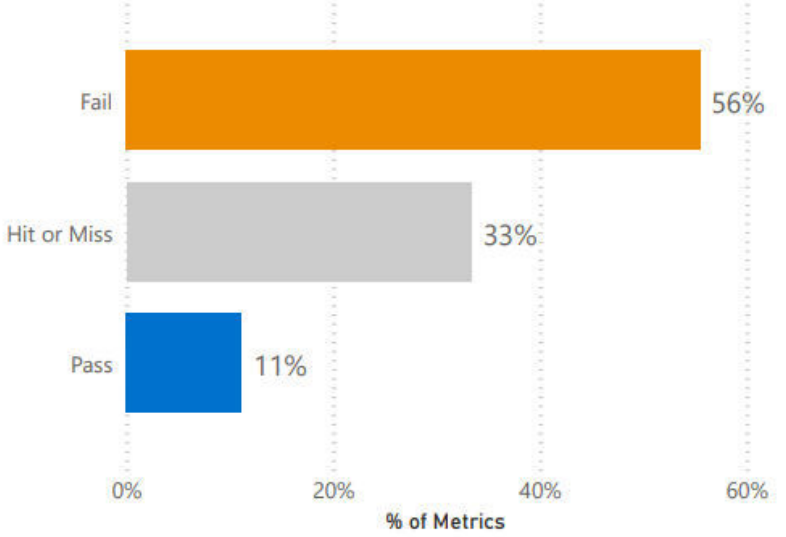
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

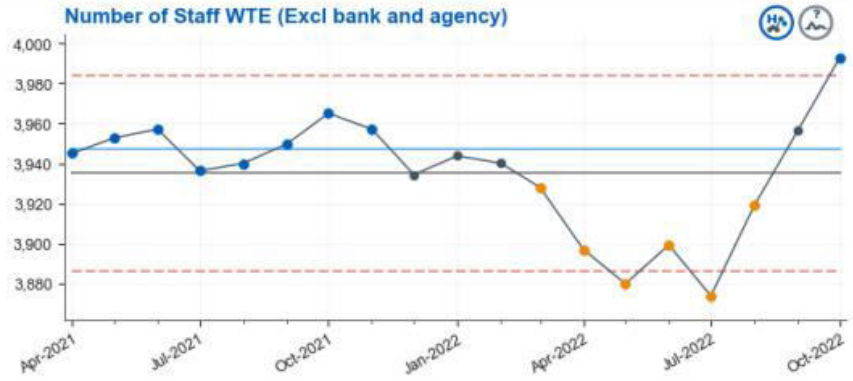
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Oct-2022	16		0.44	9.89	19.35		
Collective Grievances Open	People & Culture	Oct-2022	3		-1.19	1.47	4.13		
Count of Grievances Closed	People & Culture	Oct-2022	6		-1.61	9.47	20.56		
Grievances Mean Case Length (Days)	People & Culture	Oct-2022	78.06		3.09	81.43	159.77		
Bullying & Harrassment Internal	People & Culture	Oct-2022	7	0	-3.36	2.84	9.05		
Whistleblowing	People & Culture	Oct-2022	0		-0.73	0.16	1.04		
Disciplinary Cases	People & Culture	Oct-2022	10		-2.02	4.63	11.28		
Freedom to Speak Up: Total Open Cases	People & Culture	Oct-2022	23		7.94	26.26	44.59		
Freedom to Speak up: Cases Opened in Month	People & Culture	Oct-2022	19		-2.83	7.37	17.57		
Freedom to Speak up: Cases Closed in Month	People & Culture	Oct-2022	14		-5.15	4.89	14.94		
Policies & Procedures Outstanding Review %	People & Culture	Sep-2022	65.6%	0%		36.93%			
Count of Until it Stops Cases	People & Culture	Oct-2022	13		-3.08	4.28	11.63		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Oct-2022	111		27.51	104.65	181.79		

PEOPLE & CULTURE

Workforce (1 of 3)

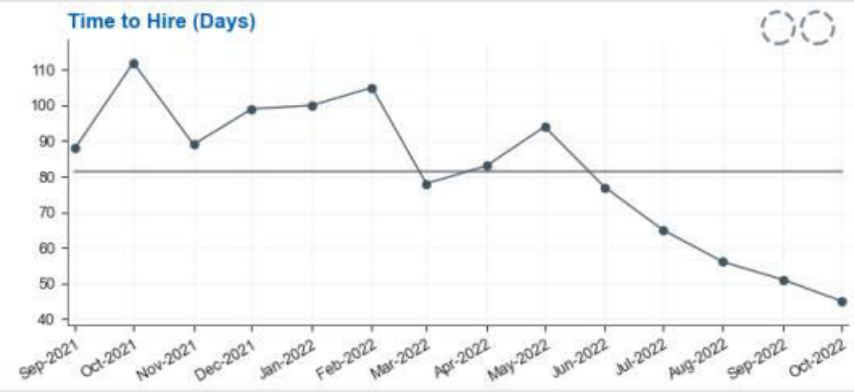


WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 3992.85
Target: 3946.96
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

WF-4

Dept: Workforce HR
IP: People & Culture
Latest: 4.4%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



WF-43

Dept: Workforce HR
IP: People & Culture
Latest: 45

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

Summary

- The deviations in number of staff WTE and vacancy rate are the mechanistic effect of agreeing an increase in FTE establishment for front-line operations and contact centres (please see slide 27).

Time to hire

- Despite not having sufficient data points to generate a full SPC, the time to hire is showing a significantly improved picture and we can consider it special cause variation following significant recruitment drive in-year.

What actions are we taking?

- The narrative on slide 27 provides the detail on recruitment plans to meet the new FTE establishment.

PEOPLE & CULTURE

Workforce (2 of 3)

WF-48

Dept: Workforce HR
IP: People & Culture
Latest: 1.6%

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

WF-7

Dept: Workforce HR
IP: People & Culture
Latest: 18%
Target: 15%
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

Summary

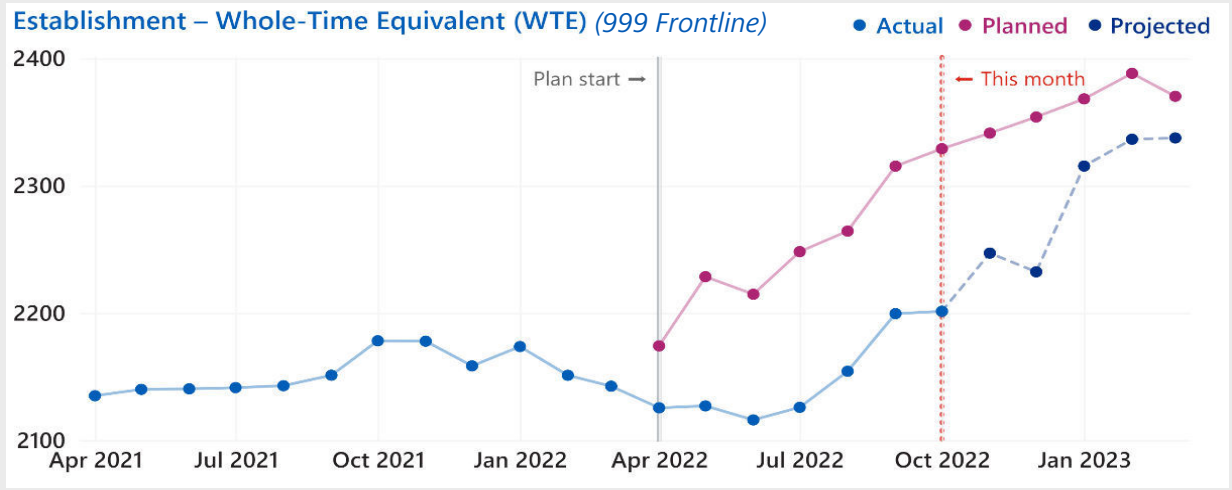
- Since the decline in COVID-19 and the implementation of the Government's plan to return to normal we have seen an increase in turnover.
- Our exit interview data is telling us that our people seek a better work life balance, better health and wellbeing, and more development opportunities.

What actions are we taking?

- Retention will be supported by the wider People Improvement Journey, Culture Programme, and Leadership Development. As well as Freedom to Speak Up and our Listening Toolkit.
- A retention plan was approved by Leadership Team and WWC in November. There are a number of agreed actions that support 111 and EOC as our greatest areas of opportunity.
- A communication and engagement process is now underway to ensure all managers understand their role in improving retention. The October annual turnover rate in EOC East is 40%, EOC West is 42.5% and 111 Urgent Care is 42% and the plans are expected to reduce these to 10% by May 2023. Oversight of this plan will be WWC.
- Recruitment selection processes are being reviewed to ensure that the right people are selected for roles of high turnover such as EOC and 111. It is planned that improved testing for resilience will be introduced for Q1 2023/24.

PEOPLE & CULTURE

Workforce (3 of 3)



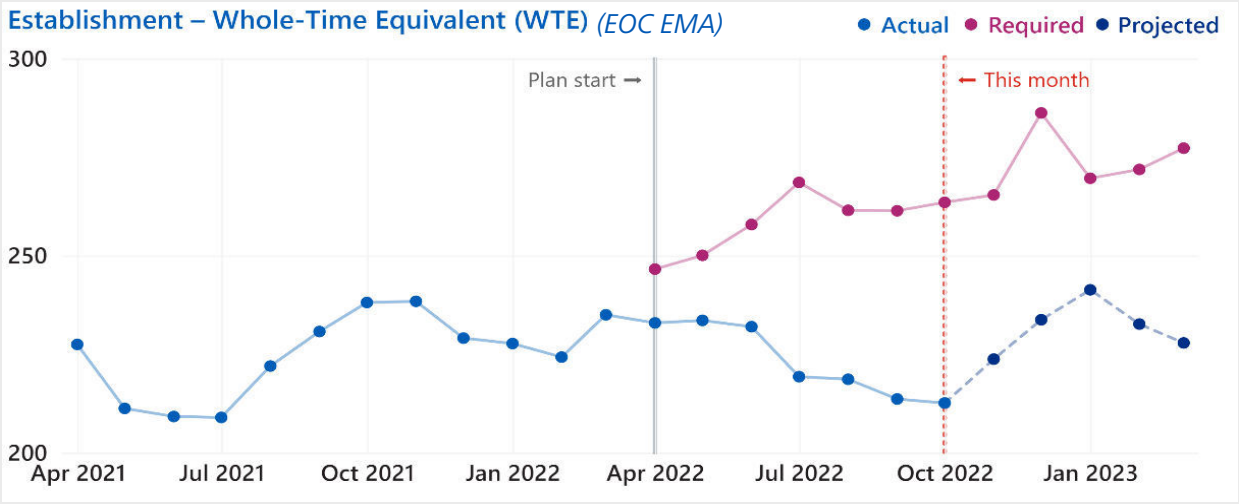
Summary – 999 Frontline

The Trust is currently 128 WTE behind on its frontline workforce plan.
This gap will reduce to 33 WTE by the end of the year due to mitigating action being taken through alternative recruitment routes, in particular international AAP/Technicians from Ireland.
This will form the starting position of the workforce plan for next year.

Frontline attrition has also stabilised and is closely following the plan of around 20 leavers/month.

Mitigating actions – 999 Frontline

The deviations against plan are due to attrition in Q1 being above plan and recruitment targets not being met with a total of 209 NQPs and experienced international paramedics recruited vs 245 in the plan.
Mitigation has been taken in the form of increased AAP recruitment with 133 new starts expected in Q4, helping recover from the Q1 increased attrition position.
The retention related actions have been described in the previous slide.



Summary – EOC EMA

EMA establishment is currently 51 WTE below the planned levels this month. Of the 51 WTE gap, 39 WTE is attributed to attrition in excess of the plan for this year. If attrition falls back in line with the plan, the current projection puts the Trust at 49 WTE below the required levels of 277 WTE by the end of the financial year. However, if attrition continues at the current rate, the Trust could expect to lose an additional 23 WTE. This would put the EMA workforce forecast at 205 WTE against a requirement of 277 WTE.

EMA attrition has been 63% higher than planned this year with 99 WTE vs 60.5 WTE by October 2022.

Mitigating actions – EOC EMA

In terms of recruitment process, a significant capacity gap has been identified which is severely affecting the compliance checking process due to significantly more EMAs in the recruitment pipeline than normal. We currently are recruiting more than twice the normal of staff in this area, but these numbers are not being realised into delivery sufficiently quickly at present. Action has been taken by the HRD and CFO to ensure optimisation of the check process and funding will be made available to add additional temporary capacity in the compliance check team, which will clear the current outstanding cases by financial year end. In addition, a small cadre of individuals within EOC are staying connected with applicants as they progress throughout the process to reduce the risk of dropout.

PEOPLE & CULTURE

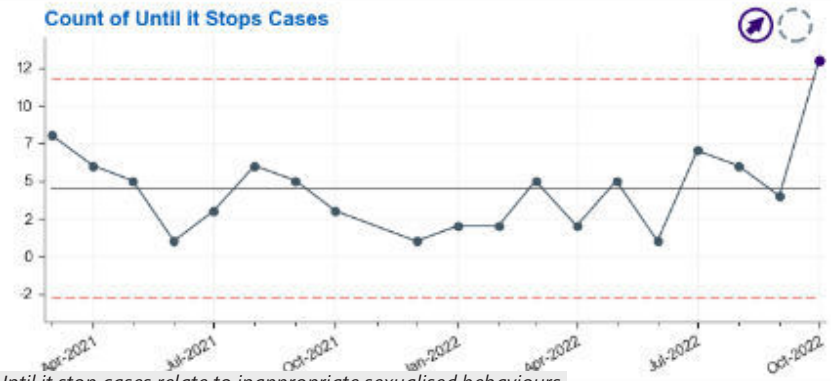
Culture (1 of 2)

QS-27
Dept: Quality & Safety
IP: People & Culture
Latest: 23

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

WF-10
Dept: Workforce HR
IP: People & Culture
Latest: 16

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



WF-41
Dept: Workforce HR
IP: People & Culture
Latest: 13

Special cause variation where UP is neither improvement or concern

WF-42
Dept: Workforce HR
IP: People & Culture
Latest: 6

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

Note: Until it stop cases relate to inappropriate sexualised behaviours

Summary

- There is significant work ongoing to address the culture of bullying and harassment however, it is still too early to measure its impact. FTSUG advised that more staff are having a positive experience from raising concerns.
- In October we saw an additional 7 Until it Stops cases opened, with a larger increase of 39 grievance cases opened in both September and October; these are now going through the investigatory process. Of the 39 cases, just over 40% relate to poor/unfair treatment and just under 20% related to Employment Tribunals where ET applications have been lodged prior to the conclusion of any internal mechanisms.

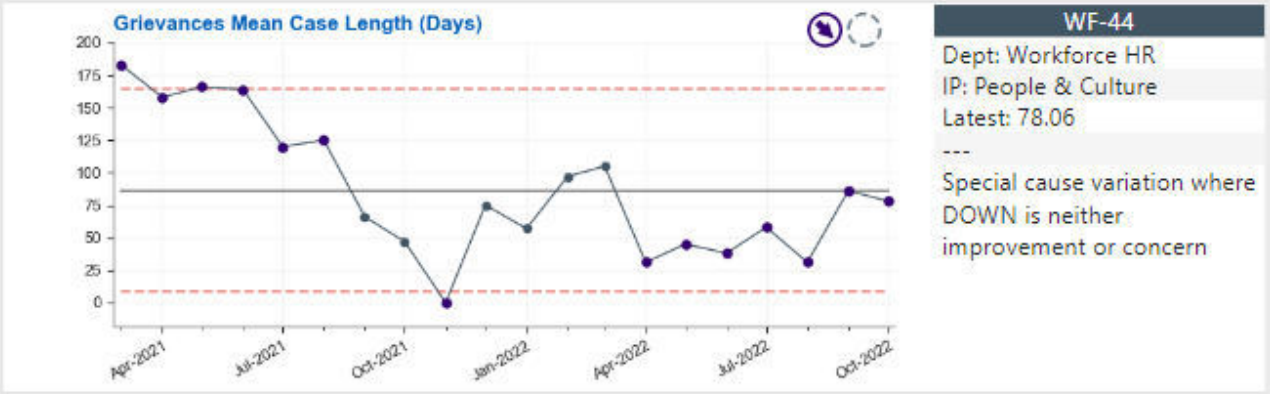
What actions are we taking?

- Freedom To Speak Up (FTSU): We have now appointed 2 additional FTSU support WTEs to address the historic under resourcing in the department which will help us better support our colleagues. The review of the FTSU governance and reporting has now been undertaken, resulting in the implementation of a new data recording process which will allow for anonymised information to be shared from a centralised location. This new process, which is a work in progress, will allow us to work towards improved reporting capabilities, giving us greater detail on the cases and themes.
- FTSU training is now available Trust wide with tailoring towards all staff levels. This will aid in our culture journey, providing guidance on all FTSU matters and processes along with available alternatives where appropriate.

(continued in next slide Culture 2 of 2)

PEOPLE & CULTURE

Culture (2 of 2)



Note: Until it stop cases relate to inappropriate sexualised behaviours

Summary

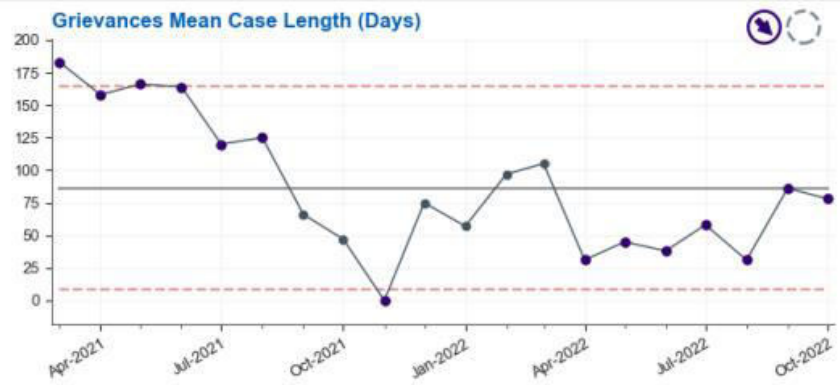
- Whilst employee relations cases have continued at a high level, the analytics assessing performance on individual cases are proving helpful in identifying the most urgent and longer-standing cases.
- As a Trust, we presently have insufficient numbers of well-trained internal Investigation Managers for the current volume of ER cases.
- We are currently seeking temporary additional capacity from the CSU, to support the organisational moves planned to the new Medway facility.

What actions are we taking?

- Further work will be undertaken from March 2023 to implement a Triage system into our Dignity @ Work Policy where all grievance cases will be presented to an independent MDT Panel. As part of the complete response within the Culture and Leadership Programme, we are aiming for an 80% reduction of cases on the 2022 volume by 2025/26 so that there are no more than 20 open grievance cases at any one time.
- Fundamentals, and other leadership development training, is under way and our plan is to monitor the effectiveness and impact of this – particularly the areas where it is most needed, in the leadership of field ops and EOC/111. Three cohorts of 12-14 people each have taken place now with a further 24 planned.
- 370 managers have now attended the sexual safety training sessions have been procured to enable all managers to attend – currently 131 remain to attend. An evaluation plan for the training has also been developed and will be implemented in Q4.22/23.

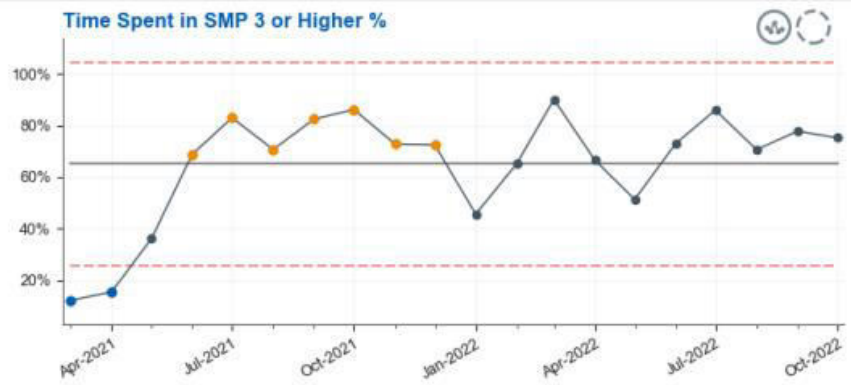
PEOPLE & CULTURE

Employee Experience



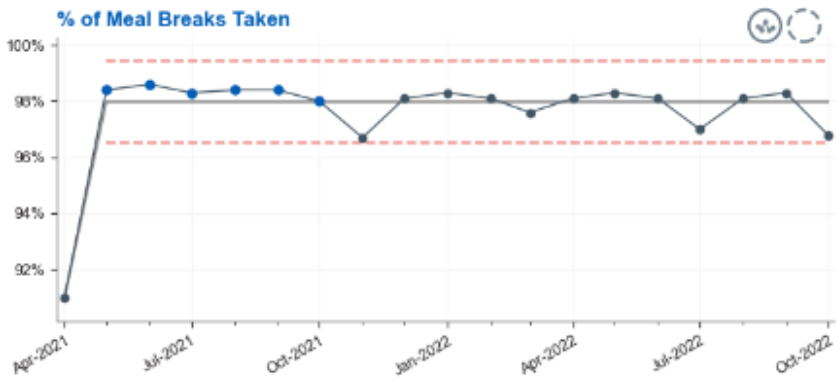
WF-44
Dept: Workforce HR
IP: People & Culture
Latest: 78.06

Special cause variation where DOWN is neither improvement or concern



999-14
Dept: Operations 999
IP: Quality Improvement
Latest: 75.2%

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



999-27
Dept: Operations 999
IP: People & Culture
Latest: 96.8%

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

999-15
Dept: Operations 999
IP: People & Culture
Latest: 55.2%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them. This is biased towards frontline road staff, and we will be developing further Employee experience dashboards to cover call-centres and corporate colleagues as part of our 23/24 IQR development roadmap.

What actions are we taking?

- Continued focused work by the whole HRBP function on the grievance policy and process, from greater support for informal resolution though the investigation and hearing phases. Two examples; (1) an area of highest grievances in the Trust was in 111, sustained focus by the HRBP with the senior management of EOC/111 has reduced the number of grievances and (2) The Trust has commissioned and delivered external mediation training, with 12 new accredited mediators now supporting informal resolution.

What actions are we taking? (cont.)

- The capability to improve the meal break and late sign-off metrics is directly related to increasing the resource availability in relation to demand received. Actions to contributing to this are located in the Responsive Care slides below, focusing abstraction management, review of demand, recruitment and retention. In the longer-term better alignment of rotas to demand and the development of a new clinical care model should result in improvement in these measures. To note: whilst there are policies/procedures in place to support shift end working, additional changes could be added to positively impact over-runs, however this would have an impact on overall capacity and therefore patient safety/care.
- The Trust's Clinical Safety Plan (CSP) and Welfare Policy have been reviewed and updated, to provide a better framework for the Trust to mitigate clinical risk during times of elevated surge. The CSP includes additional actions that were developed alongside the SMP and risk assessed to support patients and the wider service at times of significantly increased pressure.

PEOPLE & CULTURE

Employee Sickness

WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 8.6%
Target: 7%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

WF-25
Dept: Workforce Wellbeing
IP: People & Culture
Latest: 111

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

Summary

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

- Senior HR and Operational Managers have been meeting each OU on a 5 weekly basis to review absence management. These meetings have been positively welcomed by all parties and have been able to provide Executives with confidence that the policy is being carried out consistently across ops.

What actions are we taking?

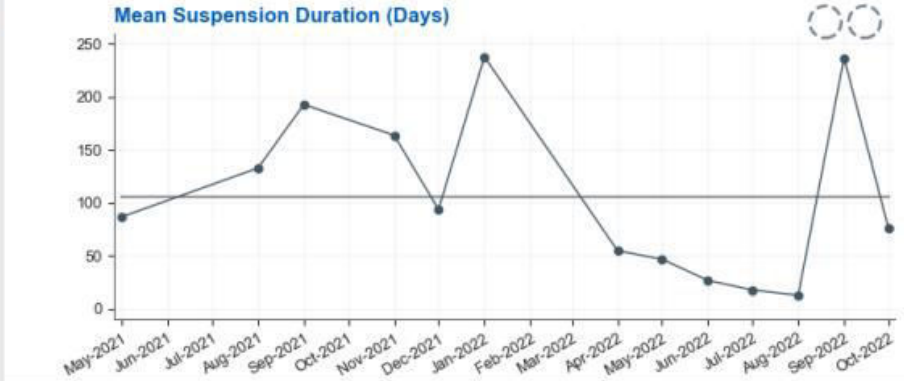
- Those colleagues on Alternative Duties Pathway 3 have all been placed on sickness absence pending updated Occupational Health reports, so we expect sickness to rise slightly for approximately 8 weeks whilst theses reports are processed and acted upon.. As COVID has accounted for approximately 4% of absence, we expect to see a significant improvement in sickness absence by February 2023.

PEOPLE & CULTURE

Employee Suspensions

WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 16

Special cause variation where UP is neither improvement or concern



WF-47
Dept: Workforce HR
IP: People & Culture
Latest: 76.21

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

WF-45
Dept: Workforce HR
IP: People & Culture
Latest: 2

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

Summary

- The increase in suspensions are predominantly due to bullying and harassment and sexual misconduct cases, the impact of this is too early to indicate.
- As a trust we have made improvements to ensure psychological safety of these allegations being taken seriously, whether there is a link to the management training being conducted through Sexual awareness courses
- This will be reviewed on a monthly basis to establish clear understanding of why we have had such an increase in suspensions within the Trust.

What actions are we taking?

- Weekly reviews of all suspended staff by HRD and Ops Director and HRBPs who report and provide assurance that cases are being managed as proactively as possible.
- This has proven to be a robust process for the Trust.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 72.6%
Target: 95%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

WF-40
Dept: Workforce HR
IP: People & Culture
Latest: 49.4%
Target: 85%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

Summary

- Appraisals: Despite being far from the target of 85% we are seeing an increase in appraisals driving an increase in the rolling year completion rate. A significant rolling year on year increase from October 21 (<30%) to October 22 (49.4%) is demonstrating improvements.

- Statutory & Mandatory training: An internal audit into statutory and mandatory training was recently undertaken in Aug/Sep 2022. The conclusion of the internal audit deemed that controls in place at the Trust to manage statutory and mandatory training are deficient. Three areas of good practice were identified; Key Skills training, training delivery during/post COVID and training alignment with the NHS Core Skills Training Framework (CSTF).

What actions are we taking?

- Appraisals: Currently, we have 30% remaining to reach our annual 80% rolling year target with 30% of the financial year remaining. Those areas which are currently below the trajectory required will receive additional focus and monitoring through Teams A and B. Additional support is being provided by L&OD as needed on the technical aspects of using the new appraisal system.

- Statutory & Mandatory training: A statutory and mandatory training improvement action plan. This includes 8 management actions with a completion date of the end of Q1 2023 including the development of a Statutory & Mandatory Training Policy with clear roles and responsibilities. The governance of the improvement action plan will be by the Education Training & Development Group and statutory and mandatory training compliance will be reported regularly to SMG, EMB and WWC agenda.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

October 2022

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

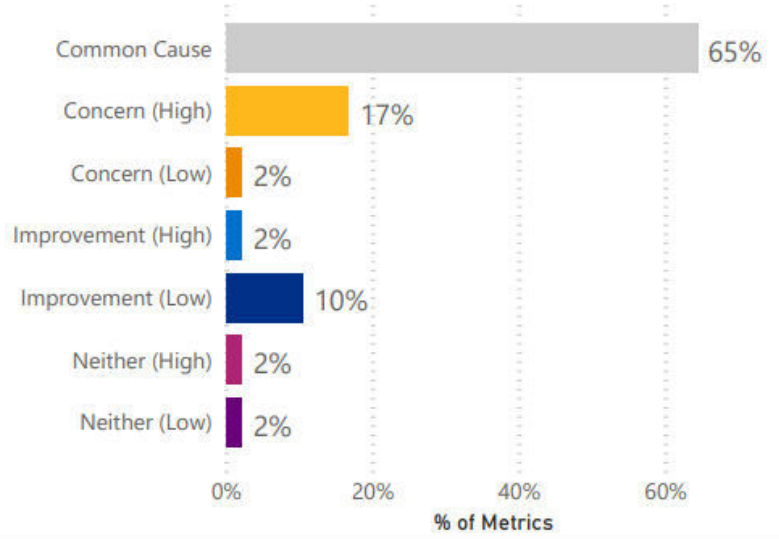
Special Cause Improvement (H, L)	111 to 999 Referrals (Calls Triaged) %			Critical Vehicle Failure Rate (CVFR) Proportion of Wrap Up Times > 15 minutes 999 Referrals A&E Dispositions Ambulance Validation %
Common Cause	Cat 1T Mean	Hear & Treat % A&E Dispositions %	999 Frontline Hours Provided % See & Treat % See & Convey % Average Wrap Up Time 111 Calls Answered in 60 Seconds % 111 Calls Abandoned - (Offered) % Cat 1 Mean Cat 2 Mean Cat 2 90th Centile Cat 3 90th Centile Cat 4 90th Centile	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean ECAL Mean Response Time Incidents Cat 2 Proportion (Cat 1-4) Duplicate Calls % 999 Calls Answered Incidents
Special Cause Concern (H, L)	Cat 1T 90th Centile	999 Call Answer 90th Centile 999 Call Answer Mean Responses Per Incident 999 Operational Abstraction Rate %	Cat 1 90th Centile	FFR Attendances Number of Hours Lost at Hospital Handover Hours Lost at Handover as a Proportion of Provided Hours...

Not included: Metrics that are not on a story board, metrics with common cause variation with hit or miss assurance and metrics with common cause variation without a target.

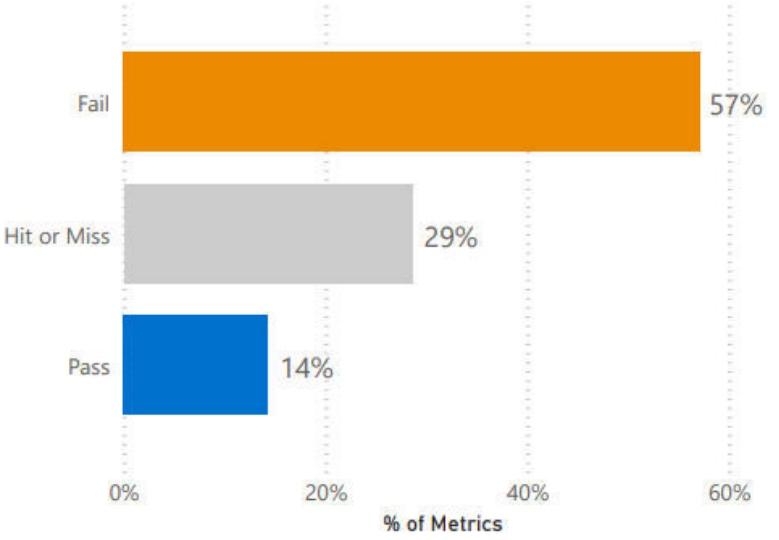
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

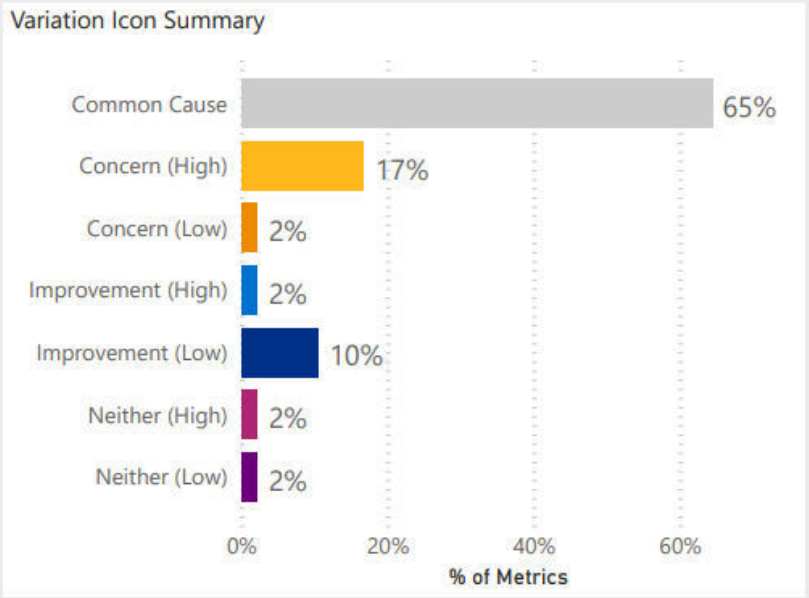
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Apr-2022							
Section 136 Mean Response Time	Responsive Care	Oct-2022	00:30:12		00:09:56	00:26:46	00:43:36		
Cat 1 Mean	Responsive Care	Oct-2022	00:09:40	00:07:00	00:08:07	00:09:02	00:09:56		
Cat 1 90th Centile	Responsive Care	Oct-2022	00:17:40	00:15:00	00:15:10	00:16:23	00:17:37		
Cat 1T Mean	Responsive Care	Oct-2022	00:11:45	00:19:00	00:09:50	00:11:00	00:12:10		
Cat 1T 90th Centile	Responsive Care	Oct-2022	00:22:09	00:30:00	00:18:24	00:20:13	00:22:02		
Cat 2 Mean	Responsive Care	Oct-2022	00:36:54	00:18:00	00:22:58	00:34:06	00:45:13		
Cat 2 90th Centile	Responsive Care	Oct-2022	01:15:32	00:40:00	00:44:50	01:09:35	01:34:20		
Cat 3 90th Centile	Responsive Care	Oct-2022	06:52:54	02:00:00	03:00:02	06:38:57	10:17:52		
Cat 4 90th Centile	Responsive Care	Oct-2022	09:22:59	03:00:00	04:04:34	08:24:42	12:44:49		
HCP 3 Mean	Responsive Care	Oct-2022	03:08:56		01:31:51	03:08:40	04:45:29		
HCP 3 90th Centile	Responsive Care	Oct-2022	07:02:15		02:48:11	07:08:19	11:28:27		
HCP 4 Mean	Responsive Care	Oct-2022	03:53:12		02:10:57	04:00:14	05:49:30		
HCP 4 90th Centile	Responsive Care	Oct-2022	09:14:35		04:14:51	08:58:01	13:41:11		

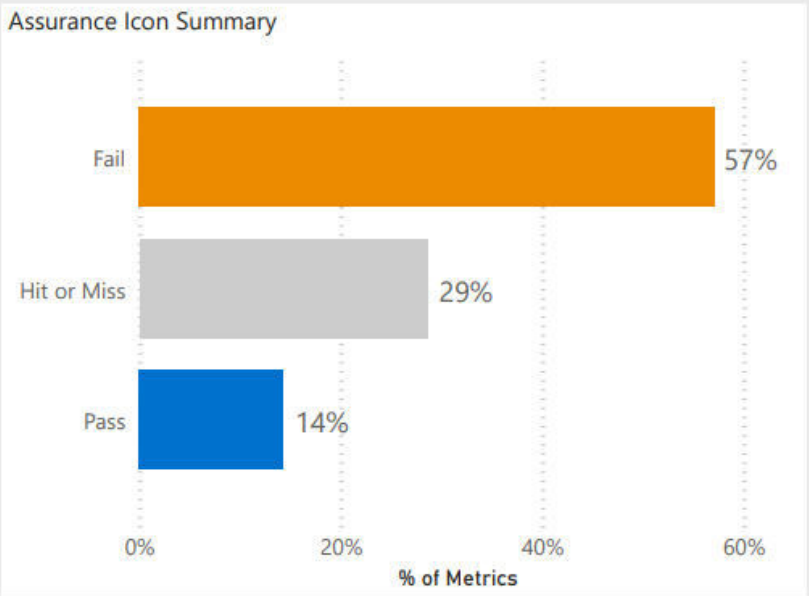
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Oct-2022	24.5%		21.31%	25.69%	30.07%		
999 Calls Answered	Responsive Care	Oct-2022	74817		59677.03	78232.13	96787.22		
999 Call Answer Mean	Responsive Care	Oct-2022	00:01:10	00:00:05	00:00:10	00:00:28	00:01:05		
999 Call Answer 90th Centile	Responsive Care	Oct-2022	00:03:33	00:00:10	00:00:29	00:01:31	00:03:32		

RESPONSIVE CARE

Overview (2 of 3)





Utilisation

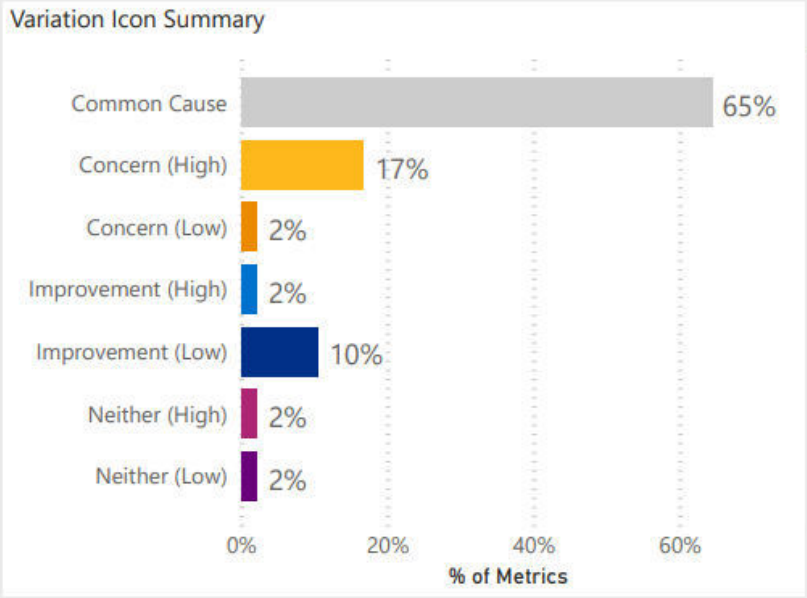
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Oct-2022	88.2%	100%	83.57%	89.3%	95.03%		
Provided Bank Hours %	Responsive Care	Oct-2022	0.6%		0.02%	0.71%	1.39%		
Provided Overtime Hours %	Responsive Care	Oct-2022	9.1%		7%	10.74%	14.47%		
Provided PAP Hours %	Responsive Care	Oct-2022	5.7%		4.22%	5.59%	6.96%		
999 Operational Abstraction Rate %	Responsive Care	Oct-2022	35.9%	28%	25.03%	32.91%	40.78%		
999 Remaining Annual Leave FY	Responsive Care	Oct-2022	27%			42.34%			
Vehicles Off Road (VOR) %	Responsive Care	Oct-2022	11.8%		7.56%	10.88%	14.21%		
% of DCA vehicles off road (VOR)	Responsive Care	Oct-2022	12.6%			12.39%			
% of SRV vehicles off road (VOR)	Responsive Care	Oct-2022	5.6%			7.02%			
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Oct-2022	150		102.95	220.55	338.15		
Number of RTCs per 10k miles travelled	Responsive Care	Oct-2022	0.24			0.71			
% of planned vehicle services completed	Responsive Care	Oct-2022	87%			75.75%			
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	May-2022	95%	95%		94.71%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Oct-2022	63.4%		57.41%	62.28%	67.15%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Oct-2022	6.7%	13%	7.4%	8.32%	9.24%		
Incidents	Responsive Care	Oct-2022	60429		55228.97	62091.35	68953.73		

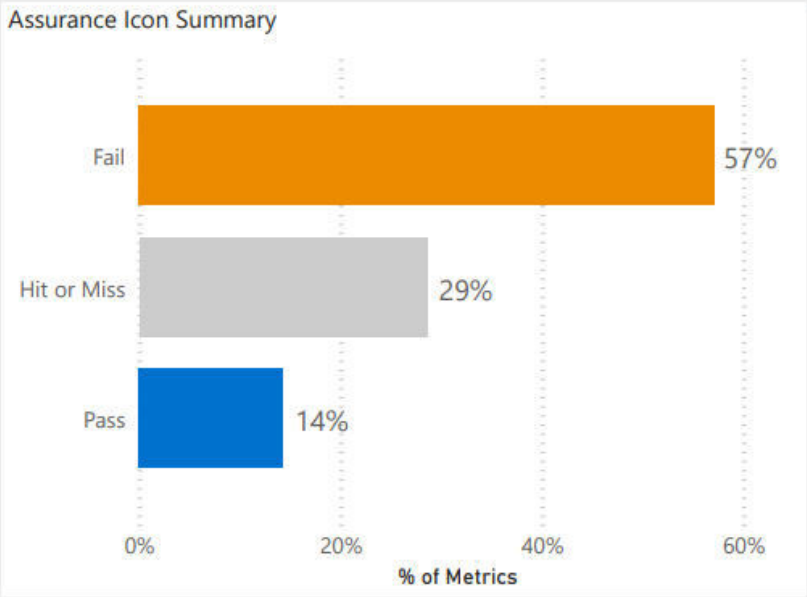
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Oct-2022	107912		88128.82	118002.3	147875.78		
111 Calls Answered in 60 Seconds %	Responsive Care	Oct-2022	20.6%	95%	7.07%	33.1%	59.13%		
111 Calls Abandoned - (Offered) %	Responsive Care	Oct-2022	23.2%	5%	5.02%	18.22%	31.42%		
999 Referrals	Responsive Care	Oct-2022	5129		5851	7356.7	8862.4		

RESPONSIVE CARE

Overview (3 of 3)





999 Frontline

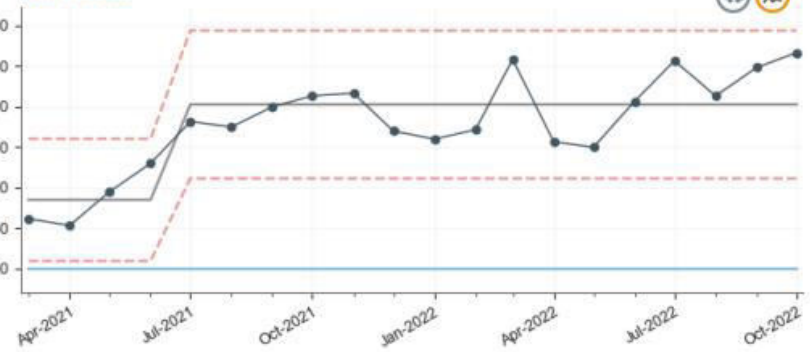
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Oct-2022	01:17:39		01:16:03	01:17:40	01:19:18		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Oct-2022	01:58:21		01:52:54	01:55:41	01:58:28		
Responses Per Incident	Responsive Care	Oct-2022	1.11	1.09	1.08	1.09	1.1		
CFR Attendances	Responsive Care	Oct-2022	1547		948.93	1358.15	1767.37		
FFR Attendances	Responsive Care	Oct-2022	221		131.06	293.6	456.14		
ECAL Mean Response Time	Responsive Care	Oct-2022	00:24:03		00:21:39	00:23:28	00:25:18		
Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	Responsive Care	Jan-2022	30.2%			30.8%			
Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	Responsive Care	Jan-2022	17.9%			47.73%			
Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	Responsive Care	Jan-2022	51.8%			21.46%			

111/999 System Impacts

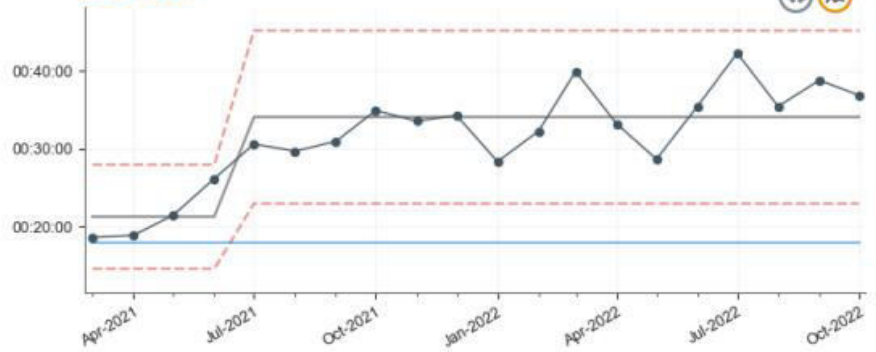
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Oct-2022	9.6%	10%	7.78%	9.66%	11.54%		
See & Treat %	Responsive Care	Oct-2022	31.9%	35%	30.25%	31.72%	33.19%		
See & Convey %	Responsive Care	Oct-2022	58.3%	55%	56.48%	58.92%	61.36%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Oct-2022	2%		1.04%	1.46%	1.88%		
Number of Hours Lost at Hospital Handover	Responsive Care	Oct-2022	5295.3		2675.64	3989.14	5302.64		
Average Wrap Up Time	Responsive Care	Oct-2022	00:17:17	00:15:00	00:17:03	00:17:33	00:18:03		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Oct-2022	46.9%		46.07%	49.86%	53.65%		
A&E Dispositions %	Responsive Care	Oct-2022	8.7%	9%	7.49%	8.7%	9.91%		
A&E Dispositions	Responsive Care	Oct-2022	6694		7032.57	8658.95	10285.33		
Clinical Contact %	Responsive Care	Oct-2022	48.3%		46.02%	48.65%	51.28%		
Ambulance Validation %	Responsive Care	Oct-2022	95.9%		91.98%	95.55%	99.12%		

RESPONSIVE CARE

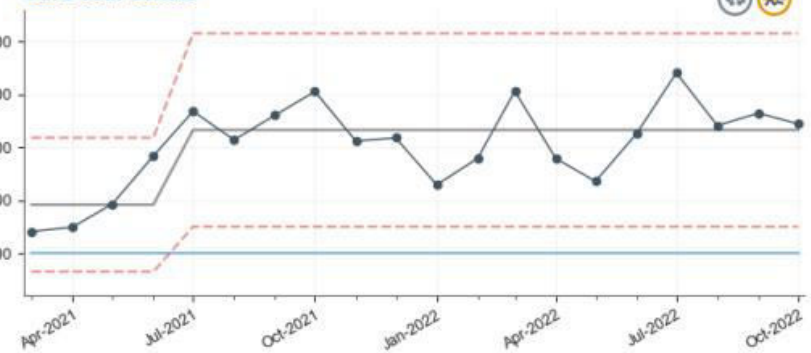
Response Times



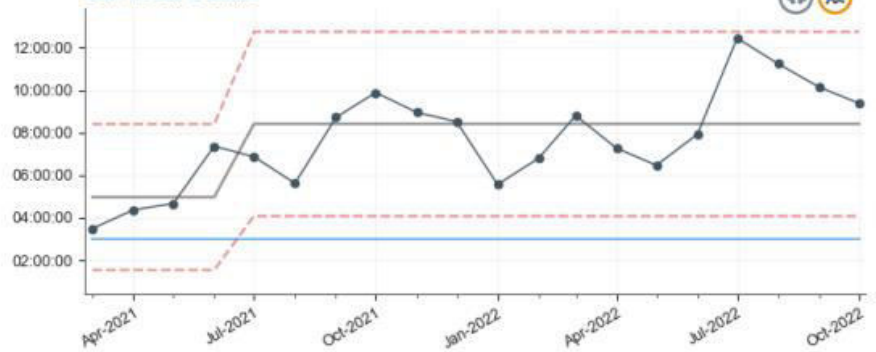
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:09:40
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:36:54
Target: 00:18:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-5
Dept: Operations 999
IP: Responsive Care
Latest: 06:52:54
Target: 02:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-6
Dept: Operations 999
IP: Responsive Care
Latest: 09:22:59
Target: 03:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

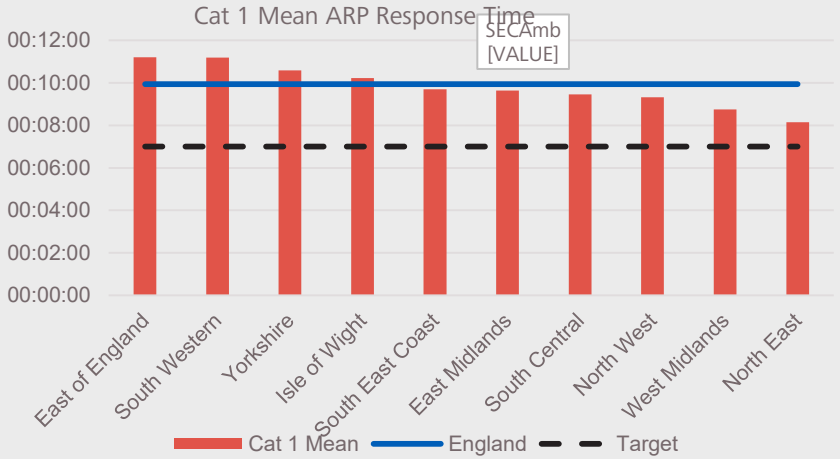
Summary

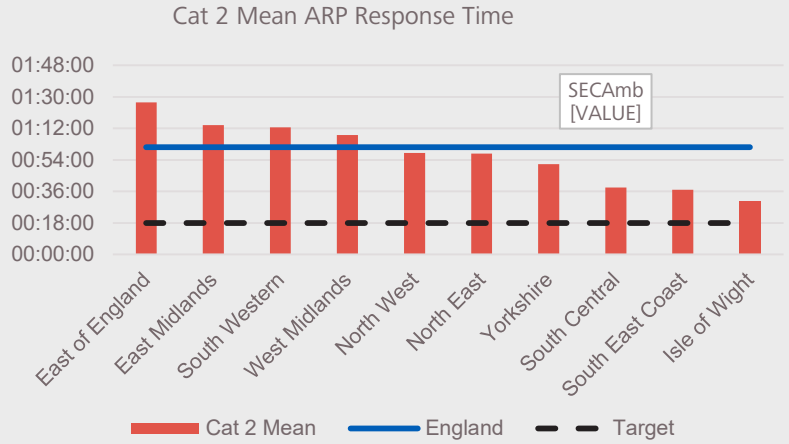
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- This performance has been strongly impacted by the fluctuating demand and resource availability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

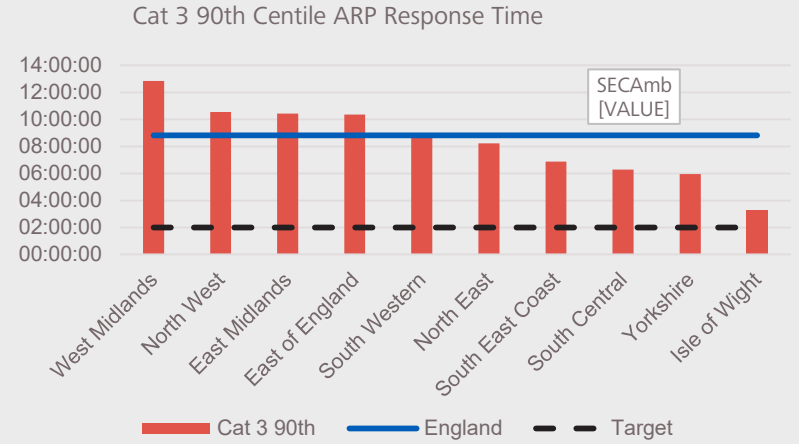
What actions are we taking?

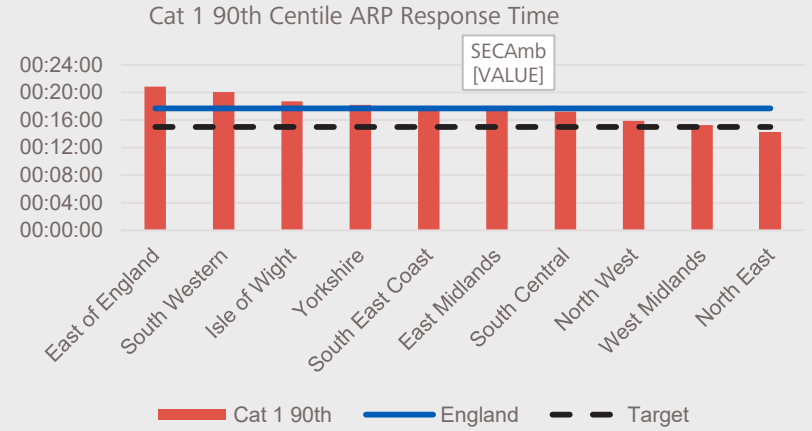
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (95.98% for Oct).
- A specific programme of improvement initiated with focus on optimising Hear and Treat for 999, changes to the operating model and policies and processes to maximise the level of clinical intervention prior to ambulance dispatch. This work is overseen via the RCG workstream with a specific QI project on the EOC clinical component.
- Increased clinical staffing in EOC to maintain patient safety and support ambulance dispatch decision-making
- Focus on optimising resources through maintenance of overtime (9.1% Oct – a decrease from Aug & Sept) and abstraction management (35.63% in Oct - a decrease from Aug & Sept at over 37%).
- Continued engagement on a local and strategic level regarding hospital handover process to minimise lost hours where possible (7,437.48hrs for Oct – an increase on Aug & Sept).
- As the current operating model and our processes are not capable, the Board has agreed that one of its strategic objectives for 23/24 will be to do a full review of our clinical strategy, which has already started by the Clinical Advisory Group, to inform the vision for a sustainable care delivery model.

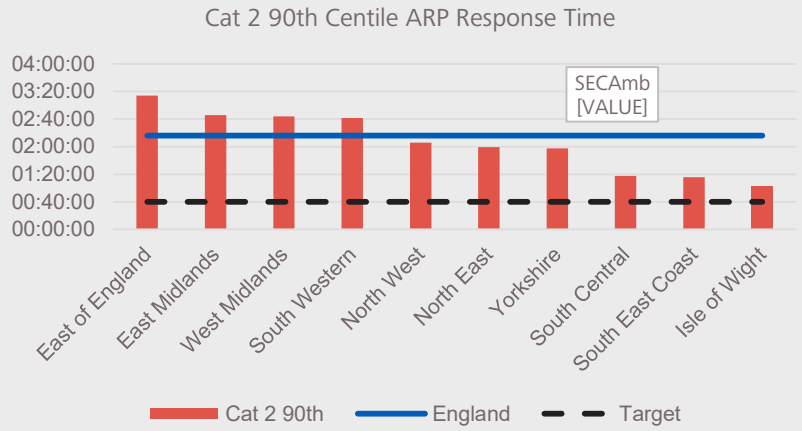
ARP Response Time Benchmarking (October 2022 Data)

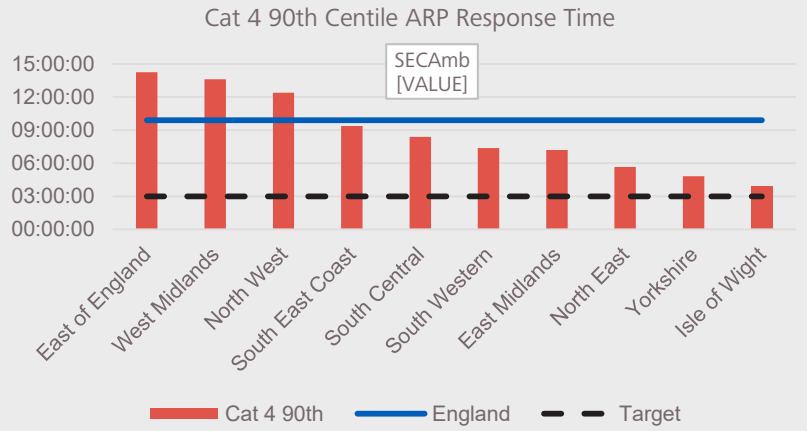












Summary

- Despite failing to achieve our ARP Standards, we are delivering above England average across all response times.
- In particular, our C2 Mean is the second quickest response time, with C2 being the largest cohort of patients we see (over 60%) who are most unwell.
- Our 999 call-answer time (next slide), however has declined to 70 seconds with special cause variation in October. This is due to the EMA workforce shortfalls as shown in the Workforce section of the IQR, where we are currently 51WTE short against a plan of c. 260 for October. Details on the action in place can be found in the workforce section above (slide 27).

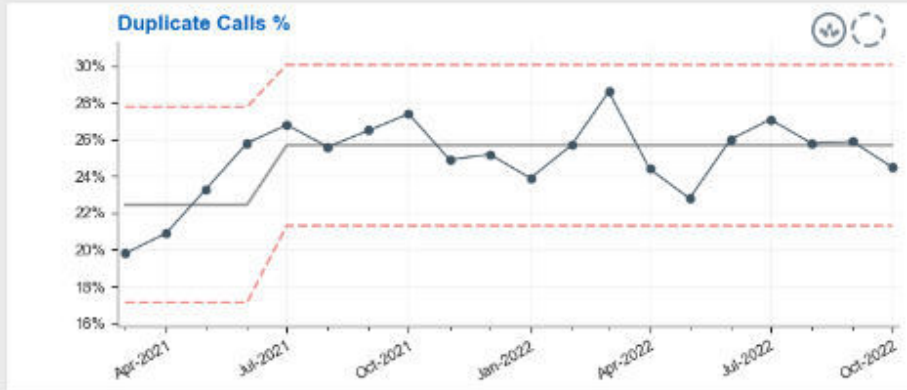
RESPONSIVE CARE

EOC Emergency Medical Advisors

999-10

Dept: Operations 999
IP: Responsive Care
Latest: 74817

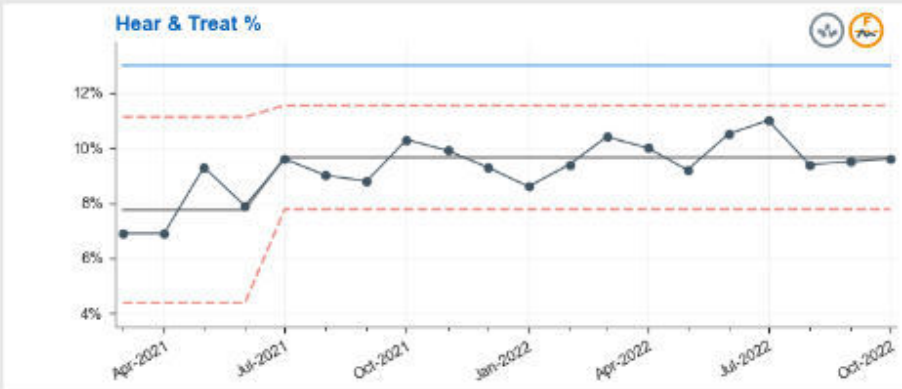
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-33

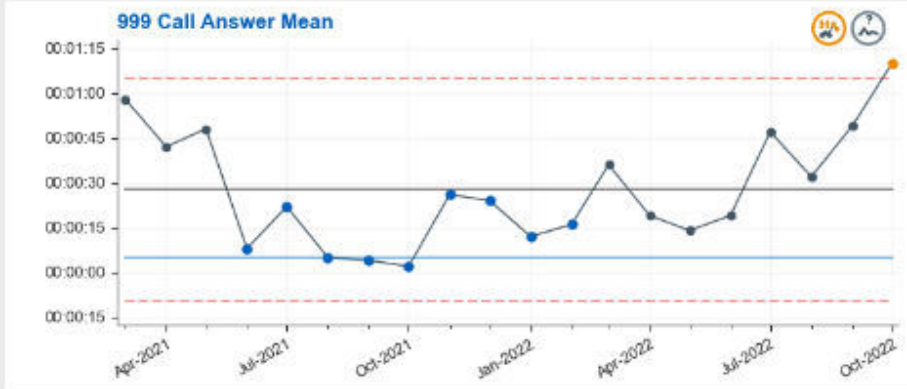
Dept: Operations 999
IP: Responsive Care
Latest: 24.5%

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



999-9

Dept: Operations 999
IP: Responsive Care
Latest: 9.6%
Target: 13%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-1

Dept: Operations 999
IP: Responsive Care
Latest: 00:01:10
Target: 00:00:05
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

Summary

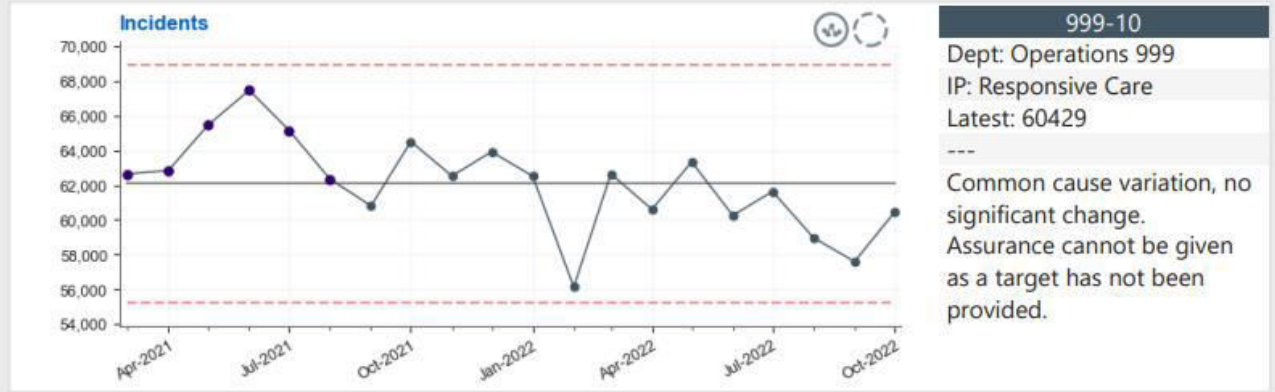
- This narrative relates to the overall efficiency and effectiveness of the call-taking functions within EOC.
- Call answer mean time has shown a steeper increase in the past two months leading to the special cause variation being noted – this is strongly aligned to the EMA resourcing levels over the same period.
- Over the duration of the past 6 months, there has been no significant changes in levels of either ***calls answered*** or ***duplicate calls***. The usual reason for the increase in duplicate calls relates to patients calling back if there has been a perceived or real delay in response, sometimes including a change/worsening of patient condition. This is primarily due to reduced staffing levels over this period as well as a decrease in overall call-answering efficiency as new staff y became proficient.
- Increasing levels of EMA sickness and attrition are due in part to internal career progression but also increasing pressures on staff in EOC operating at high levels of SMP for sustained periods
- ***Hear and Treat*** performance is demonstrating fluctuating performance over the previous year, consistently around 10%, rather than an improving trend.

What actions are we taking?

- EMA establishment is currently 51 WTE below the planned levels this month. Of the 51 WTE gap, 39 WTE is attributed to attrition more than the plan for this year. EMA attrition has been 63% higher than planned this year with 99 WTE leaving against a plan 60.5 WTE by October 2022. The end of year target is 277WTE and dependent on attrition v recruitment rate, the Trust could fall short of this by circa 50WTE.
- Year to date the Trust has recruited 72 EMAs, with a further 54 in the pipeline before the end of this financial year. Recognition of increasing recruitment challenges in the Gatwick area and the impact on the move to the new site in Gillingham due mid-2023.
- Review of 111 HA "Dual-skilling" training, to facilitate easier transition of HAs to support handle 999 call handling
- Ongoing focus on sickness management, to address the high levels of absence amongst EMAs
- Focus on improving AUX time – close monitoring via EMA Team Leaders. This has been added to their workplan.
- Hear & Treat is a specific workstream within the Improvement Journey Programme – supported by a detailed action plan including learning from other Trusts. Our target is to achieve 13% by year-end, and a deep dive was conducted at Performance Committee in November. A follow-up review of this target will be done in Q4, recognising the challenges in delivery to day and the need to adopt a more robust QI methodology to improvement following a review with the new Deputy Director of QI.

RESPONSIVE CARE

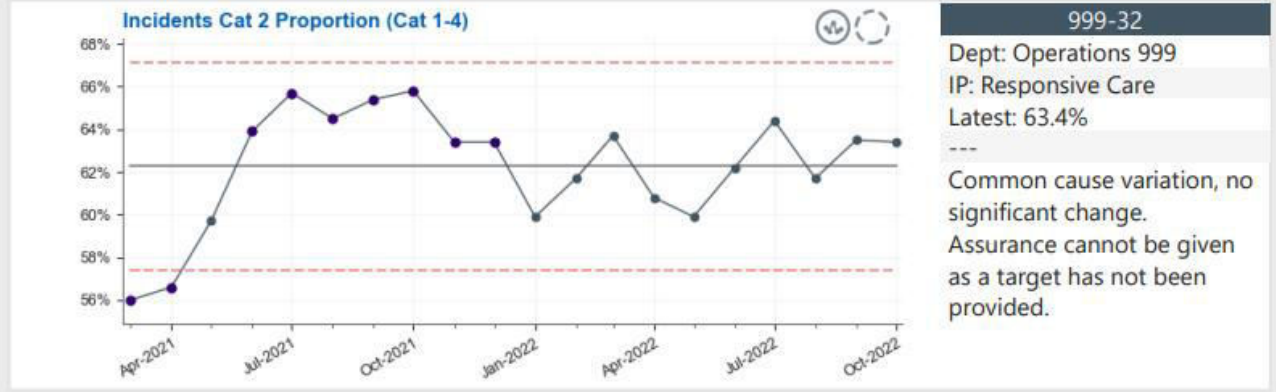
Utilisation



999-10
Dept: Operations 999
IP: Responsive Care
Latest: 60429

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

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 88.2%
Target: 100%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-32
Dept: Operations 999
IP: Responsive Care
Latest: 63.4%

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

111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.7%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Summary

- There are multiple contributors to 999 demand, and where possible actions are taken to reduce inappropriate call volumes arriving in the 999-service line:
- From the Trust's 111 service, there is a very high revalidation rate for all calls being proposed to be passed to 999 (consistently above 95%) which is resulting in the reduced referral rate from 111.
- From the above, since May 2021, there has been very significant fluctuations in **frontline hours** provided – this has directly impacted on the Trust's ability to respond physically to incidents, hence the trend seen of a slow reduction in total number of incidents managed.
- Frontline hours impacted by high abstraction levels, mainly driven through sickness. For Q1 the **attrition** has been double that planned, further creating a gap between planned resources and available resources - currently the Trust is 128 WTE behind on the workforce plan due to deferrals in start dates for new candidates, excess attrition earlier in the year and lower than planned ECSW recruitment

What actions are we taking?

- Continued effective clinical validation of non-emergency ambulance calls from Kent, Medway and Sussex's 111 service, significantly above the contractual requirements to protect 999 - (95.98% for Oct)
- Continued focus on optimising resources through abstraction management and optimisation of overtime to provide additional hours.
- Increased focus on optimising clinical resourcing between 111 and EOC in real-time, coordinated by the Trust's Operations Managers Clinical (OMC) to mitigate risk and optimise clinical validation across 111 and 999

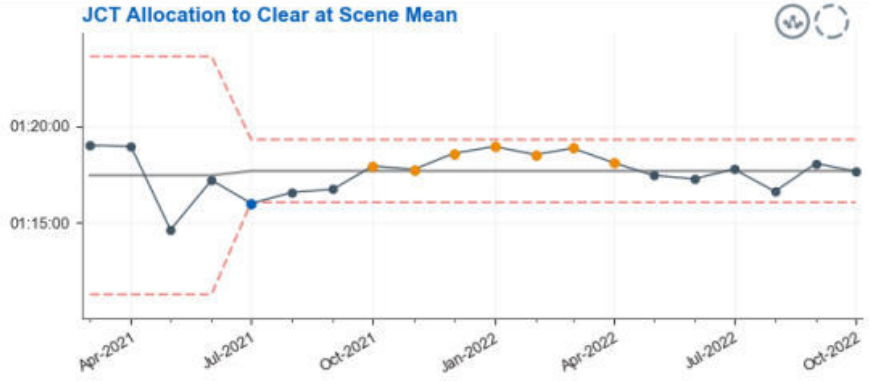
RESPONSIVE CARE

999 Frontline

999-17
Dept: Operations 999
IP: Responsive Care
Latest: 1.11
Target: 1.09
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

999-13
Dept: Operations 999
IP: Responsive Care
Latest: 00:24:03

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



999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:17:39

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

999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:58:21

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

Summary

- The efficiency of front-line clinical staff whilst on scene directly contributes to the ability of the Trust to respond to incidents.
- The data within this summary is designed to provide a coordinated suite of indicators demonstrating a number of metric trends. For example, the Paramedic Practitioner hubs are available for front-line staff to be able to reach out for supportive decision-making discussions.
- **Job cycle time** (JCT) provides a single metric between two points in the incident journey and is directly impacted by a number of activities including running time to the incident (local or distant depending on demand and resource availability) and duration of time spent on scene. The latter is usually dependent on the patient's presenting complaint where often the sickest patients are moved from scene more quickly whereas the lower acuity incidents may required longer to make referrals for ongoing care within the community.

What actions are we taking?

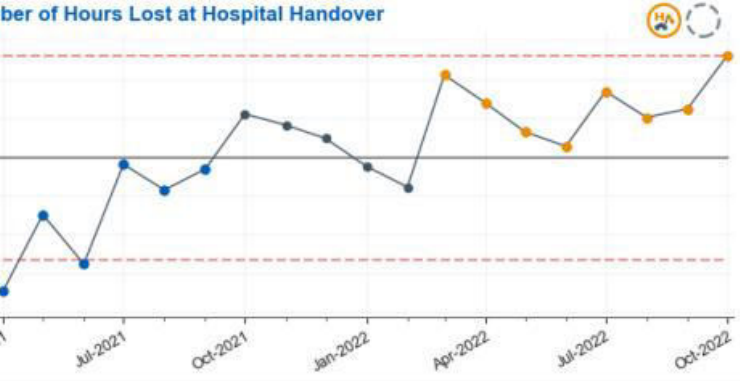
- The Trust commissioned an external AACE review of the Dispatch function, and the recommendations are currently being worked up as part of the Responsive Care Group plan. This has resulted in a prioritisation matrix assessing all recommendations and proposing an implementation plan/approach and timeline.
- Continued focus on delivery of Paramedic Practitioner hubs to ensure optimal response to ECALs from crew staff, also support to work with OOH GP/primary care call-backs
- The Trust has changed its HCP line process within its 111 service, to prioritise call answering for crew call-backs in Kent and Sussex during the out of hours period, to facilitate more rapid access to GP support and to reduce on-scene times

RESPONSIVE CARE

111/999 System Impacts

111-5
Dept: Operations 111
IP: Responsive Care
Latest: 8.7%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

999-9
Dept: Operations 999
IP: Responsive Care
Latest: 31.9%
Target: 35%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-24
Dept: Operations 999
IP: Responsive Care
Latest: 5295.3

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

999-31
Dept: Operations 999
IP: Responsive Care
Latest: 00:17:17
Target: 00:15:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

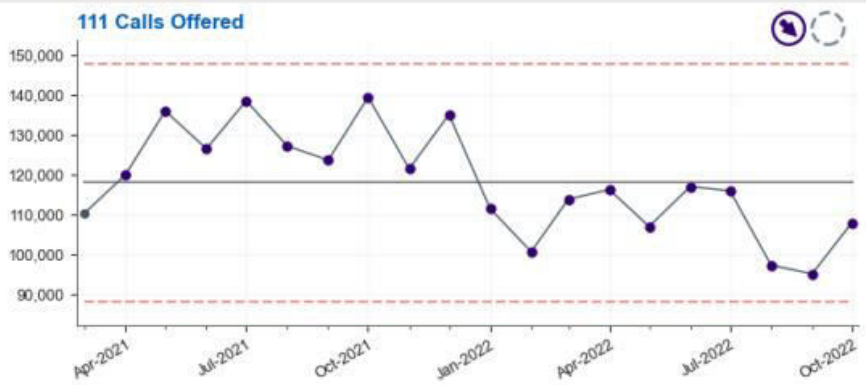
- SECAmb services (999 and 111) are key components of the emergency and urgent care health system in the SE region – this narrative provides an overview of the metrics which describe this component
- The ***111 to ED dispositions*** have been maintained at a very low level since the introduction of ED disposition revalidation, significantly better than the national average
- The introduction of "111 First" supported by Direct Appointment Booking (DAB) has resulted in the KMS 111 service facilitating smother patient pathways across the region, leading NHS E % DAB national performance
- In comparison, the level of **see & treat** provided has decreased since the start of the Covid Pandemic, below the 35% target, however further work is ongoing regarding promoting and recording of the use of care pathways as an alternative to Emergency Departments.
- ***Wrap-up time*** had shown some improvements but this has not been sustained resulting in a performance that is still in excess of the target.

What actions are we taking?

- Maintain 111 to ED revalidation, to support improved outcomes for system partners, particularly when they are under pressure through appropriate DoS management – this is monitored within the Trust and through contract meetings with commissioners
- Local teams continue to engage with local systems to understand and be able to access community pathways of care. Additional work has been commenced ahead of winter regarding enhanced care to elderly fallers.
- Continued partnership working with hospitals relating to hand over time, both on a local and strategic level, monitored at the weekly (Friday) system (Commissioners + SECAmb + NHSE) calls. More recently the collaborative working in the Kent ICB and their winter command cell has contributed to a reduction in lost hours at Medway Maritime Hospital from 883.18hrs in October to 327.58hrs in November. To note: as a Trust, SECAmb has significant lower handover times across all hospitals and the whole geography than many other English ambulance services.

RESPONSIVE CARE

111



111-1

Dept: Operations 111
IP: Responsive Care
Latest: 107912

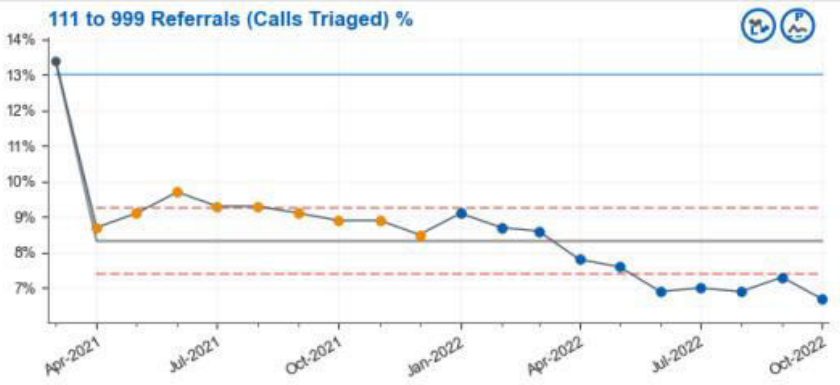
Special cause variation where DOWN is neither improvement or concern

111-2

Dept: Operations 111
IP: Responsive Care
Latest: 20.6%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

111-3

Dept: Operations 111
IP: Responsive Care
Latest: 23.2%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



111-4

Dept: Operations 111
IP: Responsive Care
Latest: 6.7%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Summary

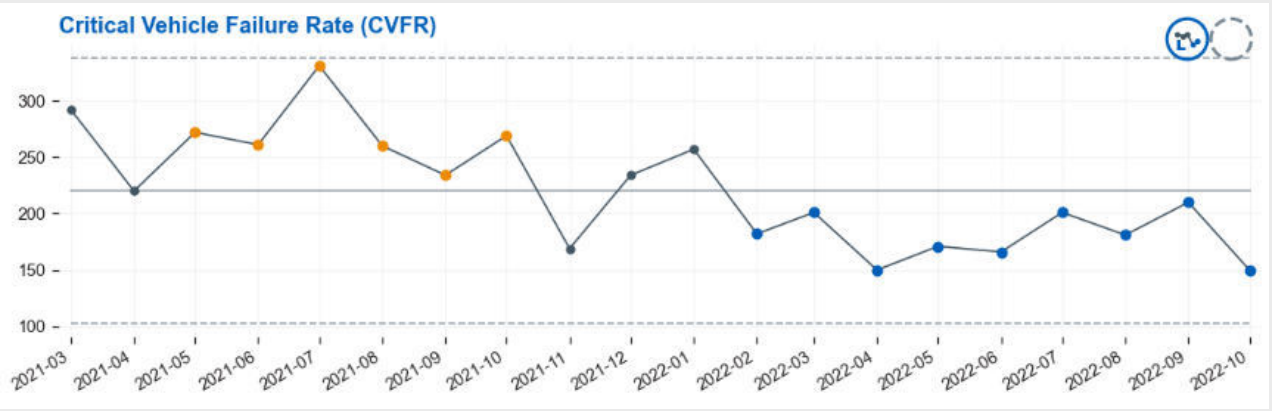
- The call activity and demand in 111 is significantly above that which SECAmb is contractually commissioned and remunerated for however this is impacted by the % of abandoned calls and therefore potential duplicates.
- The service's responsiveness remains poor, as reflected in the sustained low level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

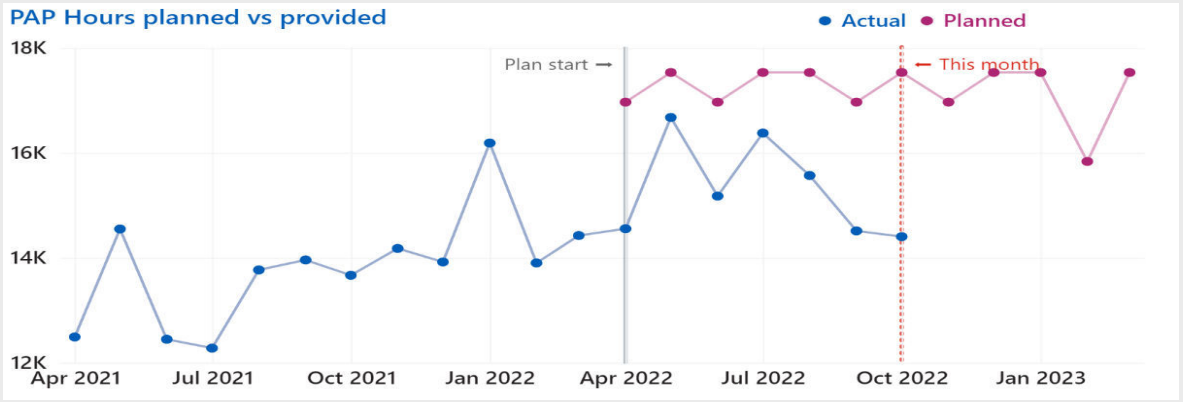
What actions are we taking?

- Trust has been successful in negotiating a new financial settlement for the 111 service during Q2 2022 (£9.3m), which has enabled the Trust to recommence recruitment and training of staff into early 2023 to fulfil the requirements to be part of the regional Single Virtual Contact Centre (SVCC)
- The service continues to protect the wider healthcare economy by being a benchmark nationally for 999 and ED validation, in addition to Direct Appointment Booking (DAB).
- The Trust has been working with NHS E to secure additional support from an established 3rd party 111 provider, to support performance delivery across Dec and Jan of 2022/23 on a 18hrs per day, 7-days a week basis – this is in the final stages of approval.
- A 111 HA "Hybrid working" pilot has been successful, with an expansion planned for Q4 of 2022/23, subject to a subsequent BC being approved. This will reduce attrition and improve staff working flexibility

RESPONSIVE CARE

Support Services
Fleet and Private Ambulance Providers





Summary

Fleet

- The VOR mean at 11% is within the planned contingency and on target.
- The planned vehicle services does not have sufficient data points to develop the SPC limits, however the downward trend and in particular the July and August is indicative of challenges especially within the West following the Chertsey flooding and challenges in delivery of planned maintenance for non-MRC sites.
- The Vehicle Maintenance Team has also been under sourced due to challenges in recruitment.
- The critical Vehicle Failure Rate is showing a consistently downward trend which is correlated with the fleet replacement plan and it's proposed that the limits be re-calculated from February 2022 when the initial replacement cycle started in line with the Fleet Strategy.

Private Ambulance Providers:

- The main driver for the drop in performance is due to one of our largest PAP providers who account for 40% of the contracted PAP activity has been under delivering against their contracted SLA.

What actions are we taking?

Fleet

- Following re-gaining access to Chertsey in September, the maintenance completions has been recovered, with a focus on clearing backlog ahead of Winter pressures.
- Vehicle Maintenance Technicians hours are being backfilled by additional overtime by managers. A benchmarking of salaries vs the market is underway, and we have started advertising outside of NHS Jobs and targeting sites that are more popular with the engineering community.
- The replacement cycle is on-going for new vehicles, we expect to see the CVFR continue to reduce as the oldest fleet is removed, before we set specific targets. The fleet strategy is due a review in Q4 of 2022/23 following assessment of the impact of the National Specification (fiat).

Private Ambulance Providers

- We have issued a contract warning notice to the supplier who is underperforming, and their improvements are being monitored through monthly contract review meetings. A timeframe of 4 months has been given for improvement.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

ID	Metric	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£23450.50	£24049.10	£25088.10	£24865.50	£24640.50	£28750.10	£22741.10	£23107.80	£29732.80	£24477.20	£25014.60	£26914.10	£24427.40	£24405.00	£22.40		
F-9	Income (£000s) YTD	£169461.90	£193511.00	£218599.10	£243464.60	£268105.10	£296855.20	£22741.10	£45848.90	£75581.70	£100058.90	£125073.50	£151987.60	£176415.00	£170926.00	£5489.00	£305150.10	£134224.10
F-2	Operating Expenditure (£000s) Month	£24300.60	£24785.10	£26396.10	£25269.10	£24949.00	£25280.70	£25308.00	£25680.00	£24694.40	£24916.90	£25431.00	£26753.10	£25694.30	£25021.00	£673.30		
F-10	Operating Expenditure (£000s) YTD	£175110.60	£199895.70	£226291.80	£251560.90	£276509.90	£301790.60	£25308.00	£50988.00	£75682.40	£100599.30	£126030.30	£152783.40	£178477.70	£172971.00	£5506.70	£304560.30	£131589.30
F-3	Capital Expenditure (£000s) Month	£395.11	£2905.10	£2476.90	£2428.81	£0.00	£11423.73	£1055.46	£1769.56	£1629.39	£2403.24	£1558.40	£3060.10	£1327.92	£2750.00	£-1422.08		
F-14	Capital Expenditure (£000s) YTD	£6305.18	£9210.27	£11687.18	£14115.98	£14115.98	£25539.71	£1055.46	£2825.02	£4454.41	£10088.65	£11647.05	£14707.15	£16035.07	£24135.00	£-8099.93	£33411.52	£9276.52
F-4	Cost Improvement Plan (CIP) (£000s) Month	£161.00	£250.84	£181.32	£963.31	£392.69	£1676.00	£83.87	£124.50	£160.00	£163.63	£0.00	£0.00	£264.00	£577.00	£-313.00		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£1229.00	£1479.84	£1661.16	£2624.31	£3017.00	£4693.00	£83.87	£208.37	£368.37	£632.00	£632.00	£632.00	£896.00	£2218.00	£-1322.00	£5598.00	£3380.00
F-6	Surplus/Deficit (£000s) Month	£-850.10	£-736.00	£-1308.00	£-403.60	£-308.50	£3469.40	£-2566.90	£-2572.20	£5038.40	£-439.70	£-416.40	£161.00	£-1266.90	£-616.00	£-650.90		
F-7	Cash Position (£000s) Month	£46592.00	£45791.00	£43638.00	£47832.00	£53937.00	£62555.00	£52948.00	£45599.00	£44224.00	£40728.00	£41594.00	£38072.00	£34498.00	£39176.00	£-4678.00	£39176.00	£0.00
F-8	Agency Spend (£000s) Month	£154.98	£192.19	£255.95	£284.74	£170.08	£445.26	£352.65	£338.74	£597.00	£558.40	£378.25	£313.16	£290.53	£448.00	£-157.47		
F-16	Agency Spend (£000s) YTD	£1430.87	£1623.06	£1879.01	£2265.41	£2435.49	£2880.75	£352.65	£691.39	£1288.39	£1846.78	£2225.04	£2538.20	£2828.73	£3136.00	£-307.27	£5498.00	£2362.00

Summary

The Trust's financial performance for the 7 months to 31 October 2022 was £0.6m lower than plan due to the impact of lower 999 income as a result of the block contract values being less than expected. 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
3.the Trust meets the requirement to deliver 111 Single Virtual Contact Centre (SVCC) requirement.

At month 7, specific areas of concern that will impact the Trust financial forecast position are:

1.Delivery of its financial recovery plan, including being able to deliver its efficiency target and reducing current expenditure run rates.
2.Ability of the Trust to meet its recruitment and retention targets
3.The impact of 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.Ability within 111 to change the service offering quickly enough to meet the new service specification agreed by the Operations Director.

What actions are we taking?

The Trust continues is engaged in a financial recovery plan to deliver its plan, including ongoing cost control. This is to include:

a. Executive Director challenge review meeting scheduled from 24-30 November 2022 focused on
   i. To deliver the financial plan
   ii. Improvement of financial forecasts through deep dive of current run-rates
   iii. Analysing current vacancies
   iv. Efficiency plan delivery
   v. Stopping unfunded and non-essential business cases.
b. Review and analysis of balance sheet provisions

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Appendix

Appendix 1: Glossary

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations
F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

Improvement Journey – December Board Report

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: 15th December 2022	**Next update due:** 2nd February 2023	

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 were initially 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 reports in June and August 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 approach to continuous improvement – it is the aim of the Trust that any improvement 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. The Trust has now commenced the transitional period focused on implementing and developing a "Patient-to-Board" approach to continuous improvement, ensuring anybody across SECAmb can be a part of our Improvement Journey.

1.1.7. This continuous improvement approach based on empowering those closest to patients to drive improvements will be a key enabler for the Trust to deliver its long-term strategic goals on a sustainable basis.

1.2. Summary since the last report (Board Report – November 2022 (reporting on 15.12.22))

1.2.1. Board Effectiveness / WN1 – During the month of November, the Executive Team have facilitated workshops with Senior Managers across the organisations as well as the Board and Councill of Governors to develop our Strategic Priorities for 2023/2024. The outcomes of the sessions were presented to the Public Council of Governors as a draft on the 5th of December and are presented to the Board for approval on the 15th of December. These priorities will be used to help guide the planning for FY23/24, and we will be using them as a bridge whilst we develop an updated strategy and vision for SECAmb.

1.2.2. Through Q4 we will be facilitating business unit and operating unit led planning sessions, helping us shift the focus from a centrally driven improvement journey to provide more local ownership and support to driving improvement.

1.2.3. The Clinical Advisory Group presented an initial draft of what a concept of a new Clinical Strategy could deliver for our patients and staff to the joint Senior Management and Executive Management Boards. We expect to progress our strategic work in Q4 as part of building the foundations of long-term sustainable improvement.

1.2.4. In the month of November, we have received the external committee effectiveness review led by the Improvement Director. The recommendations will be adopted by the chairs of each committee. The Improvement Director has also started an internal Well-Led review, ahead of an external Well-Led review the Board will be commissioning in 2023 as part of the RSP Exit Criteria.

1.2.5. Finally, the Board undertook a full Development Day build around reflecting on the Improvement Journey and changes it has been over the last 7 months. This followed an "effective challenge" session delivered by NHS providers and a detailed seminar on the changes done to our Risk Management processes and policies.

1.2.6. Quality of Information / WN2 – There has been continued evolution of the Integrated Quality Report, up to its 3rd iteration in the December Board. This now includes more detailed information around Harm, Culture and there has been a focus on improved narrative in line with the "Make Data Count" framework from NHSE, helping drive more specific discussion around areas of concern or improvement, as well as actions and accountability for these actions.

1.2.7. The BAF Risk report has also evolved to include key IQR metrics and associated SPC Icons. This is a further step in the journey of strengthening the quality of information the board receives.

1.2.8. The Executive Team have also made changes to the way risk and performance is overseen, with the development of an EMB quality, workforce and operational delivery report that it receives monthly, with greater granularity of detail down to operating unit level.

1.2.9. To support on-going effectiveness, governance reviews of corporate functions are

currently underway, following from the governance review undertaken throughout our clinical governance groups.

1.2.10. The development of Quality Dashboards to support better local management, decision making and timely triangulation and escalation of issues is now the focus of the Business Intelligence team, working alongside local operational and quality leads.

1.2.11. Risk, Clinical Governance and Quality Improvement / WN3 – The Deputy Director of Quality Improvement has joined the Trust in November. A proposal for developing a QI Strategy and embedding DMAIC and PDSA as core methodologies for improvement has been reviewed with senior management and executives, as is being presented in Part 2 of the Board in December.

1.2.12. The Quality Improvement, Data Science and Clinical Control Room Operations team held a scoping session to review the thematic outcomes of the harm reviews and identify next steps following the first Quality Summit. Out of the 6 key areas of risk, long waits and keeping patients safe on the stack is disproportionately where we hold the greatest level of risk. As a result, an initial QI project is being led by the joint group to test the application of the new continuous improvement methodologies at SECAmb.

1.2.13. The Risk Policy has been updated following a review of all 12+ risks by SMG and EMB, and close to 100% completion of risks reviewed by the newly established Risk Assurance Group (RAG). As a result, all 12+ risks are now regularly reported as corporate risks monthly to the Executive team, and the Board will see extreme and corporate risks within the BAF Risk report.

1.2.14. The review of the clinical governance review continues, with all 11 Quality Governance Group (QGG) TOR's having been reviews pending QGG ratification.

1.2.15. A learning from SIs forum has been established, coordinating and identifying learning from incidents and SI's.

1.2.16. All legacy SIs have now been closed, with the remaining breached SI's being from 2022.

1.2.17. People & Culture / WN4 – The Business Case for the Culture and Leadership Programme has been progressed pending final approval expected in December.

1.2.18. Completed external review recommendations issued. The Trust has recently appointed a Culture Transformation Programme Director to support delivery of the Culture Leadership Programme.

1.2.19. Over 350 managers have now completed the Sexual Safety workshops and there have been three cohorts of 12-14 people each on the first-line managers leadership development Fundamentals programme.

1.2.20. An external review of the HR and OD function has been completed in response to a request by the CQC. This was considered by the Executive Board in November 2022 and accepted in full. It also raised issues for action in respect of the quality of people management which form part of our management development plans. A full action plan has been developed in response to the review.

1.2.21.

1.2.22. Communications and Engagement – The Trust's Yammer platform went live on 1st December, which will help our people connect, engage, build communities and share knowledge. All staff and volunteers are automatically members of the main Team SECAmb community and colleagues have already been busy posting to the main group and also setting up specific communities for their teams and areas of interest.

1.2.23. Following positive feedback from staff, the Trust has continued to use the 'You Said, We Did' framework, listening to our people and demonstrating the changes made as a result of their involvement. Recent communications include raising concerns, violence and aggression, alternative pathways, leadership visibility, internal communications and tackling inappropriate behaviour.

1.2.24. The Trust is working with Hood & Woolf, a communications and engagement

consultancy, to ensure that core connectors across the organisation are able to articulate and have a sense of ownership of the key components of the Improvement Journey. Having undertaken a review and critique of current internal communications cascade mechanisms and channels, Hood & Woolf is supporting the Trust in developing an internal communications & engagement strategy and delivery plan for Board approval. Part of the recommendations will go hand in hand with the development of a strong strategic narrative in the new year to support the move towards our strategic goals and alignment behind a Vision for SECAmb.

2. Overall progress against outcomes

2.1. Progress against Warning Notices and Must-Dos

1.1.1. Overall progress against meeting the WN target evidence is **99**%, an increase from **60**% reported to the Board in October.

1.1.2. Overall progress against meeting the MD target evidence is **80**%, an increase from **54**% reported to the Board in October. Note, this does not include must-do actions assigned to the Trust within the August CQC report.

1.1.3. This is also not an indication of the impact of the actions taken. This report will iterate to provide a summary of progress against achieving the expected impact of the actions, rather than the completion of the actions themselves. This will be part of the shift to reporting against Must-Do, Should-Do and RSP actions, rather than the warning notices.

1.1.4. Progress against CQC deliverables is based on evidence submitted by each Improvement Journey programme as of 1st December - see appendix 1 for descriptions and appendix 4 for the detailed progress table.

Comparison on previous month

	Sep-22	Oct-22	Nov-22
Overall Progress against WN	42%	60%	99%
Overall Progress against MD	28%	54%	80%
Overall Progress against SD	n/a	n/a	n/a

Warning notice - S29A					Must-do actions				
Warning notice - S29A	*Forecast by Nov 2022*	Completion % Sep 2022	Completion % Oct 2022	Completion % Nov 2022	Must-do actions	*Forecast by Nov 2022*	Completion % Sep 2022	Completion % Oct 2022	Completion % Nov 2022
WN1	*75%*	40%	48%	100%	MD1	*30%*	25%	71%	71%
WN2	*60%*	30%	66%	100%	MD2	*40%*	57%	78%	100%
WN3	*70%*	40%	48%	97%	MD3	*50%*	40%	59%	88%
WN4	*40%*	57%	78%	100%	MD4	*70%*	40%	48%	97%
					MD5	*30%*	13%	20%	50%
					MD6	*70%*	40%	57%	99%
					MD7	*30%*	13%	63%	96%
					MD8	*30%*	0%	40%	40%

Above forecast target
<10% of forecast target
>10% of forecast target

1.1.5. A series of peer-review sessions, supported by internal subject matter experts and external parties, were completed through November to assure against the evidence submitted:

1.1.5.1. Between 24th October - 11th November, the Improvement Journey Portfolio Team validated approximately 364 items (WN1 – 143, WN2 – 127, WN3 – 108, WN4 – 102) of evidence provided by the individual programme delivery groups and executive leads.

1.1.5.2. Internal peer review sessions were followed by an external peer review of progress and associated evidence conducted on 14th November. Attended by representatives from the Trust's integrated care boards, NHS England and internal subject matter experts, this activity provided the executive leads and Improvement Journey Portfolio Team with a greater understanding of gaps within the existing portfolio and how to best articulate the journey to date. It was acknowledged that

whilst the Trust has lots of evidence demonstrating activities underway and those completed, we can improve how we articulate the story with more focus on positive impacts for our staff and patients.

1.1.5.3. The final component of the peer-review sessions undertaken through November was a Board development day undertaken on 1st December, focussed on the findings of the internal and external peer reviews for warning notices one to four. The purpose of this development session was to aid the Board and executive in highlighting areas for continued improvement and to shape the Improvement Journey plans beyond the expiry of the Section 29A warning notices. Through interactive participation, each Improvement Journey programme's executive lead and their NED counterparts presented where the Board and wider organisation were in February 2022, progress to date and opportunities for strengthening Board effectiveness. It was agreed that the Trust needs to concentrate on promoting a culture of continuous and sustainable learning and improvement. To enable this, the Trust Board and executive will need to consider its risk tolerance and appetite, ensure there is a robust compliance mechanism in place to maintain adherence to the CQC key lines of enquiry (and other regulatory requirements) and a commitment to supporting key enablers for continuous improvement.

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

1.2.1. The Improvement Journey Portfolio Team will be reviewing all outstanding regulatory requirements, including the RSP exit criteria, during the month of December, determining how these will be progressed within existing Trust functions and associated governance structures together with key success metrics, with assurance continuing to be provided through the Improvement Journey Steering Group to the Trust executive and Board.

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

1.3.1. Overall progress against achieving the RSM considerations is 82%, up from 77% as reported in October's Board report.

1.3.2. The in-progress actions are on track for completion in Q4 2022/23.

3. Improvement Journey Risks, Issues, and Interdependencies

					Pre mitigated (Gross Score)						Post mitigated (Target Score)		
Risk ID	**Risk Impact Category**	**Risk Title (short title)**	**Risk Cause and Effect (What might happen? What is the expected impact?)**	**Risk Owner**	**Impact (1-5)**	**Likelihood (1-5)**	**Overall Severity (1-25)**	**Risk response**	**Mitigations Action (risk manager and due date for each action)**	**Next Review Due Date**	**Impact (1-5)**	**Likelihood (1-5)**	**Overall Severity (1-25)**
R7	Quality People Reputation	Communications & Engagement	There is 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 implementation of an adapted engagement approach and digital community platform. 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).	06/01/2023	5	3	15
R9	Schedule Quality	Delivery	Current mechanisms to deliver the Improvement Journey are working against the programme, which could impact the success of the longer-term aim.	David Ruiz-Celeda	5	4	20	Treat	The approach is currently regulatory-driven and needs to move to be more strategically driven. The transition from the warning notice phase to the longer-term phase of delivering sustainable continuous improvement is being defined, covering the governance and assurance requirements, and mapping the remaining regulatory requirements across the programmes and the associated BAU structures.	06/01/2023	4	3	12
R10	Finance	Funding	There is uncertainty regarding continuation of external (NHSE) funding to support the Improvement Journey beyond March 2023.	David Ruiz-Celeda	4	4	16	Treat	Early assessment of needs and business case is currently being completed (due January 2023). NHSE Improvement Director has highlighted this risk to the NHSE regional team and has requested further clarification.	06/01/2023	4	3	12

R11	People	Delivery Resources	Resourcing and skills gaps are foreseen and identified as the Improvement Journey transitions beyond the initial compliance-driven phase to a continuous improvement approach, which could impact progress and delivery.	David Ruiz-Celeda	4	4	16	Treat	Programme mapping undertaken against Must-Do, Should-Do and RSP exit criteria, identifying appropriate oversight of delivery and interdependencies within existing governance. Outcomes are informing development of continuous improvement framework. Improvement Journey delivery leads, Deputy Director of QI and Associate Director of Strategic Partnerships are progressing plans to ensure continuity of the Improvement Journey. Interim senior delivery leads are supporting portfolio progress in the meantime.	06/01/2023	4	3	12
R8	Schedule Quality	People & Culture programme: intensive support	The People & Culture programme has not been updated to an appropriate mature standard where progress can be monitored and is not currently able to demonstrate significant improvement against the relevant areas highlighted by the CQC, i.e., WN4.	Ali Mohammed	5	4	20	Treat	The People & Culture Programme has been placed into intensive support to ensure additional support is made available to the programme team to deliver improvement against WN4 and the associated must-do actions. This includes creating capacity for the DDHR&OD to lead the programme, introducing an additional senior project manager to support business case completion and allocating a dedicated full-time project manager to the programme. Additionally, the Portfolio Steering Group is reviewing the programme's progress weekly against the intensive support checklist, with a weekly update provided to the CEO and EMB.	06/01/2023	4	2	8
R2	Schedule Quality	Demand	Due to operational demand or unforeseen service pressures, some portfolio delivery timeframes could be impacted.	All SROs	4	4	16	Tolerate	Weekly programme group and Portfolio Steering Group meetings are in place to keep to deadlines, ensuring ongoing assessment of unforeseen risks or issues and identification of appropriate controls and mitigations, with direct escalation to EMB as required. A fortnightly review of operational pressures is incorporated within the Joint Leadership Team meetings, considering any impact on the Trust's Improvement Journey.	06/01/2023	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 group and Portfolio Steering Group meetings are in place to monitor deadlines and progress. A monthly Trust Board report provides level 1 and 2 summaries and programme progress against warning notices and must-do's. PCG, RCG and QIG now have dedicated delivery lead and project support, with SPG having identified interim resources.	06/01/2023	4	2	8

4. Assurance and Actions for the reporting period ahead

4.1. Warning Notice 1

Progress (additive to October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) All CQC evidence regarding WN1 has now been submitted and validated. (+) Six-week (phase one) Sustainability & Partnerships programme plan completed and formal summary to be included in Board report for December. (+) The Executive Management Board has started to consider strategic priorities for 2023/24, with the commencement of the planning round. (+) Revised meeting and governance structure tested and implemented within Finance Directorate and to be shared with EMB to implement learning across all directorates as next step to ensuring push-assurance is met in all areas and to drive Board effectiveness. (+) Positive feedback received following a series of peer reviews, including external system partners, with a collective recognition of the progress made by the Trust to date and areas jointly identified for additional focus in the short term. (+) Improvement Journey delivery leads, Deputy Director of QI and Associate Director of Strategic Partnerships are progressing plans to ensure continuity of the Improvement Journey beyond the initial compliance-driven phase. (+) Clinical Advisory Group established and initial draft of the concept for the new Clinical Strategy presented to SMG and EMB. (+) External effectiveness review of Board and sub-committees conducted and completed during September, with recommended actions now embedded within committee work plans. (+) External communications consultancy initial review completed, finding that the Trust's communications mechanisms are appropriate and not the root cause of the challenges faced.	(-) Board effectiveness and stability may be impacted by upcoming changes in the executive team. (-) Plans are outstanding to ensure continuity of the Improvement Journey beyond the sprint phase. (-) Whilst improved, the quality and timeliness of Board/sub-committee papers require further development. (-) Board reporting still requires operating unit/function-level detail to ensure identification and monitoring of hot spots, particularly patient quality and harm. (-) Sustainability & Partnerships programme resource review ongoing. (-) There is no current plan for a programme of periodic internal "well-led" reviews, however, a Head of Quality & CQC Compliance has been appointed in November to develop the ongoing compliance framework, which will include an approach to "well-led" (-) Findings from the external communications consultancy have found that there is a gap in the Trust's approach to information cascading across the organisation, without a consistent team-briefing system, as well as a gap in consistent narrative around a vision for the organisation.	**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 October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) All CQC evidence regarding WN2 has now been submitted and validated. (+) Eleven Quality Governance Group (QGG) subgroups have reviewed and updated their ToRs (new format and aligned to the KLOEs) in readiness for QGG ratification (due December 2022). (+) Recruitment to internal Head of	(-) Extraordinary QGG meeting required to sign off eleven QGG subgroup ToRs. (-) BI team to arrange further training for Trust quality leads regarding the adoption of SPC metrics, their analysis and reporting. (-) Patient to Board reporting framework remains under development with	**Action 21:** Executive dashboard to be developed iteratively, demonstrating that progress and triangulation has started beyond the IQR at Board.

Quality & CQC Compliance completed with postholder commencing w/c 5th December 2022. (+) Internal Well Led self-assessment review commenced during Q3 in preparation for external review during Q4. (+) Quality Improvement programme metrics have been developed further, with five core metrics reviewed during each programme meeting, and are shared weekly. (+) Promotion of Making Data Count framework with system partners, identifying key metrics for ongoing UEC initiatives. (+) Further development of Patient to Board reporting arrangements with new sub-workstream added to the Quality Improvement programme to define the Performance & Quality Assurance Framework. (+) Continued evidence of committees/groups beginning to embed new changes through revised meeting formats, focused reporting and increased challenge.	trackable interdependency identified with Responsive Care programme. (-) Inability to provide assurance on regional/local performance and quality actions whilst the Performance & Quality Assurance Framework is developed. (-) Engagement of middle and first-line managers in developing Patient to Board quality governance and reporting remains a gap. (-) BI team continuing to develop the Quality Dashboard. (-) Dissemination of key messages from QPSC and QGG not yet fully embedded. (-) Medical Directorate data clinic deferred.	

4.3. Warning Notice 3

Progress (additive to October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) All CQC evidence regarding WN3, with the exception of WN3-5c (evidence of how learning from the patient journey mapping has been embedded in risk and harm management processes) has now been submitted and validated. (+) Five core metrics reviewed at each programme meeting - 1) breached SIs, 2) breached SI actions, 3) open incidents, 4) breached incidents and 5) progress with risk register reviews. (+) Quality Improvement programme SPC metrics developed and shared weekly. (+) Substantive Deputy Director for Quality Improvement commenced in early November 2022 and is currently progressing the Trust's proposed QI methodology. (+) *Learning from SIs Forum* established and co-ordinating identification and cascade of learning from incidents and SIs. (+) SI investigation buddy process now implemented to enhance investigation quality, timeliness and consistency. (+) 94% of risk register reviews (moderate and high risk) have now been completed. (+) All legacy SIs have now been closed; outstanding breached SIs are from 2022 only. (+) Programme lead identified to	(-) Survey to scope QI capability and capacity across the Trust is under development. Dissemination is delayed to January 2023 due to current staff survey and risk of survey fatigue. (-) Additional work required from the Q&N SLT and BI team to ensure consistent incident and harm metrics and reporting. (-) Healthwatch patient representative attending QGG delayed due to the work required to source suitable representation. (-) QGG deep dive required on No Send conditions to triangulate audit and risk data. (-) DCIQ training platform being updated due to gap regarding how to undertake/document risk reviews. (-) DCIQ training is outstanding for three executive leads due to updates required on the platform. (-) Delays to the approval of the Medicines Management Transformation Manager business case. (-) Serious Incident team capacity remains challenged. (-) Outstanding assurance that the quality governance is now effective.	.

manage the Patient Safety Incident Response Framework (PSIRF) implementation between November 2022 and September 2023. (+) Clinical Advisory Group fully established and leading on the refresh of the Trusts Clinical Strategy, clinical governance and learning from incidents. (+) Updated *Risk Management Policy* agreed at SMG and ratified at EMB. (+) All risk and action owners are now trained in DatixCloudIQ (DCIQ), except for three executive leads. (+) Key initiatives identified from September's Quality Summit. Planning meetings underway for next Quality Summit, scheduled for March 2023. This will revolve around keeping patients safe on the stack as a visible QI project using the DMAIC methodology. (+) Regular Trust attendance confirmed at the National Ambulance Service Patient Experience Group (NASPEG). (+) Operational managers are continuing to see fewer SIs and Datixs with less actions due to streamlining of central processes.		

4.4. Warning Notice 4

Progress (additive to October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) All CQC evidence regarding WN4 has now been submitted and validated. (+) Two workshops held with Non-Executive Directors to determine key People & Culture programme metrics required to provide sufficient assurance and monitoring on grievance case completion against case complexity. (+) Changes made to the ER database (live from 7th November 2022) for all cases opened up after that date. (+) Additional FTSU resource introduced and communicated to Trust. (+) FTSU 'follow-up' training completed by Trust Board members. (+) Completion of external FTSU review is now informing the Improvement Journey action plans for FTSU improvement over the next 12 months. (+) FTSU database transferred anonymously to the data warehouse, enabling BI reporting to be developed. (+) Culture Improvement Programme Director role appointed to support delivery of the Culture and Leadership Programme.	(-) Culture and Leadership Programme plan currently delayed pending business case approval. (-) Whilst workforce reporting frequency has improved, revised metrics have not yet been tested to provide assurance or understanding of case numbers, volume, complexity, or duration. (-) The BI and FTSU teams are working to ensure the collation and reporting of FTSU data can be automated moving forward. (-) Revised framework and policy for raising concerns (not just via FTSU) requires development. (-) Programme delivery lead is currently impacted by ongoing staff consultations and strike preparedness.	**Action 22:** Executive Lead to support progress of the Business Case for Culture and Leadership Programme to ensure delivery can commence (expected December). **Action 23:** Reporting for ER, FTSU and workforce metrics, inclusive of insights, to be completed and embedded into EMB, WWC and IQR reporting, following the development workshops in October. (part completed)

4.5. Must-dos and Should-dos

Progress (additive to October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) Evidence registry continues to provide visibility of target evidence for must-dos detailed within the June 2022 report and not covered within the WNs. (+) Improvement Journey Steering Group review of all must- and should-do requirements from the June and October (2022) reports planned for 5th December. (+) Recruitment to internal Head of Quality & Compliance completed with postholder commencing w/c 5th December 2022. (+) Initial must- and should-do tracker which identifies responsible persons, key metrics and reporting routes for all actions detailed within the June and October (2022) reports has been developed and populated.	(-) Generating must-do and should-do evidence associated within the June 2022 report has not been a priority whilst WN evidence was progressed. (-) Additional must- and should do actions detailed within the October (2022) report require mapping into the existing Improvement Journey programmes to BAU governance structures.	**Action 24:** This Board repot in February will change and adopt a slightly different structure to provide direct visibility of completion status against the Must, Should do and RSP, rather than focussing on the Warning Notices.

4.6. RSP Exit Criteria and System Assurance / Collaboration

Progress (additive to October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) National entry meeting with NHSE completed on 14th October 2022. (+) Mapping to the WN and MD actions demonstrates strong alignment between deliverables. (+) RSP progress tracking will commence w/c 5th December, with Improvement Journey Steering Group review planned. (+) RSP exit criteria tracker which identifies responsible persons, key metrics and reporting routes has been developed and populated. (+) NHSE review of Trust finances completed and presented to FIC on 26th September. (+) Financial self-assessment completed with external reviewers. Improvements will be built into the Sustainability & Partnerships programme. (+) Financial reforecast completed and actions will be embedded in recovery plan. (+) Sustainability & Partnerships programme reviewed to include financial delivery in-year, financial sustainability for future years and delivery of benchmarking information.	(-) Procurement remains an area of concern with the external review highlighting areas requiring immediate improvement. (-) Work is ongoing with integrated care boards to plan the transition of the lead commissioner/ICB function to Sussex ICC.	**Action 24:** This Board repot in February will change and adopt a slightly different structure to provide direct visibility of completion status against the Must, Should do and RSP, rather than focussing on the Warning Notices.

4.7. RSM Recommendations

Progress (additive to October report)	Gaps	Actions (continued from October report, p indicates previous action)
(+) High-level completion of recommendations with credible actions in place to complete 100% in Q4. (+) The Executive Management Board has started to consider strategic priorities for 2023/24, with commencement of the planning round. (+) Substantive Deputy Director for Quality Improvement commenced in early November 2022 and is currently progressing the Trust's proposed QI methodology.	(-) No mapping of "Better by Design" workstreams has been completed yet onto the Improvement Journey. (-) Uncertainty regarding continuation of external (NHSE) funding to support the Improvement Journey beyond March 2023.	**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 October report)	Gaps	Actions
(+) New reporting template provided to ensure consistency and structure of the reporting, for programmes to produce on a bi-weekly basis. (+) Programme reporting adapted to be outcome focused with identified metrics and summary capturing performance, changes, and impacts. (+) Groups to complete data clinics to ensure metrics are set and targets understood (+) Improvement Journey banners installed at each operational reporting base and the Improvement Journey booklet disseminated to Band 8s and above, outlining the overarching portfolio purpose. (+) Hood and Woolfe strategic communication delivery plan shared with next steps outlined, including a co-designed internal communication and engagement strategy – with staff, for staff. (+) Launch of Yammer the new digital community platform.	(-) 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 continuity and recruitment challenges for project resources. (-) Due to the different levels of maturity in the workstreams, there is little interdependency mapping possible at this stage. The need for localised resources to drive improvement across different areas (culture, improvement, quality, financial efficiencies) has been identified.	**Action 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.

5. Appendixes (updated 06.12.2022)

Appendix 1 - CQC deliverables - June 20

Appendix 2 - RSP SECAMB entry meeti

Appendix 3 - RSM internal audit recomm

Appendix 4 - CQC evidence progress tra

Appendix 5 - CQC Warning Notice outco

Appendix 6 - Board Pre-read Warning No

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	70-22

Name of meeting	Trust Board
Date	15 December 2022
Name of paper	Keeping Patients Safe - Executive Summary to the Board
Trust Priority Area	**Delivering Quality**
Author / Lead Director	Dr Fionna Moore, Executive Medical Director Robert Nicholls, Executive Director of Quality & Nursing Kirsty Booth, Business Support Manager Medical
Primary Board Papers	BAF Risks 14 Extreme/Corporate Risks 28, 34, 36, 136 Integrated Quality Report slides 7 to 19 inclusive Improvement Journey (pages 2, 3)

Risk:
Over the past few months, the Trust has reviewed and strengthened its risk management system and processes. A Risk Management Policy and Procedure was reviewed, updated, approved, and implemented on the 25th May 2022. However, review by the leadership team (Senior Management Group and Executive Management Board) recognised that further improvement was needed regarding the Trust's corporate risk register and in addition, making the policy more easily understood by all. As a result, a further change was made to the policy during October 2022 to the ratings of risk on the Corporate Risk Register. Risks that are rated high (12+) and extreme (15+) are now included on the Trust's Corporate Risk Register. In addition, the risk governance arrangement and escalation routes were made much clearer in the policy. The policy has been launched and there is a new risk management report that was presented to the Executive Management Group and the Audit Committee early December 2022.

The Trust has strengthened the Risk and Assurance Group (RAG) that was implemented in August this year. The group is now chaired by the Deputy Director of Quality and Nursing and has representation from senior staff from across the Trust. Risk owners present their risks at the monthly RAG meetings where there are discussions about the ratings, controls, and actions in place to mitigate the risk. The RAG is working with the Business Intelligence Team to agree an IQR metric to further support monitoring of assurances. Further work is planned in Quarter 4 of 2022/23 regarding raising the profile of risk management across the Trust.

Within Medical there are four extreme risks (28, 34, 36 and 136). Three of the four sit within the medicines portfolio, all mitigations that are possible are in place already. Two business cases (Relocation of Medicines Distribution Centre (MDC) and Transformation of Medicines Governance Team) are yet to progress to Business Case Group that will work to mitigate or remove the risk. Risk 28 is proposed for closure as this is now an issue; the Trust has evidence of drug seeking behaviour within the 111 EPS. This is being reviewed by Senior Management Group who will oversee the actions required to enable this risk to be closed.

Within Quality & Nursing there is one BAF Risk:
Risk 14 - BAF Risk - Patient Quality and Safety - Risk that our operating model is not suitably designed to ensure efficient and effective management of demand and patient need. The impact of this risk is represented in the trends from serious incidents highlighted in the IQR.

IQR:
Elements from the Medical Directorate within the IQR relate to medicines management (incident recording, audit and Controlled Drug oversight) and a limited set of clinical outcomes (Cardiac arrest survival, STEMI and stroke care). In view of concerns raised by interventional cardiologists around long on scene times contributing to delays to angiography, an escalation has been raised at NASMeD to review the current care bundle.

Data clinics are ongoing between the BI team and the Medical Directorate to develop the IQR content.

A deep dive to identify any outlying stations and individuals where single witness CD signatures are occurring will be presented at the December Medicines Governance Group.

The IQR for Quality & Nursing highlights the following areas:

The management of Serious Incidents (SI) and breached SI actions has been a focus for the Trust from April this year. At the end of October 2022 there were 22 remaining breached SI actions. There has been a steady downward trend suggestive that the controls that are in place are effective. As of 8th December 2022, there were only 9 breached open SI actions with a zero-target expected at the end of December 2022. The progress made has also been attributed to good cross directorate engagement to deliver the agreed timeline.

Regarding Serious Incident investigations, all outstanding backlog of actions from 2019 and 2021 have been closed. As of 8th December 2022, there were 9 outstanding breached SI reports – all reports have allocated investigators. The Serious Incident Group meets weekly to identify moderate to serious harm incidents in addition to completed SI investigations. There is escalation to the Director of Quality and Nursing and the Medical Director on SI breached cases and where there is uncertainty regarding whether cases meet the SI threshold.

Violence and aggression against our staff is high on the Trust's agenda and focus work is continuing to encourage staff to report incidents particularly in 111 and 999. The Trust is working towards developing a Violence and Aggression strategy to ensure it support our compliance with the NHS Violence Reduction Standards.

The number of datix incidents that breached the 45 days investigation timeframe over the period 2019 to 2021 has been cleared. The Board will receive a verbal update on the management of datix incidents.

The Patient Experience Team continues to work on the overdue complaints. Between September and October 2022, there were 67 overdue complaint responses outside the Trust's 35 working days response time. There are currently 32 breached complaints left from the outstanding 67 breached complaints. All other complaint responses are within the timeframe. The Complaints Team are actively engaging with the complainants where possible, and the team have given assurance that the December deadline will be achieved.

Delivering Duty of Candour (DoC) has been an issue due to capacity issues within the SI team coupled with lack of Next of Kin (NoK) details on ePCR. The Trust did not achieved completion of DoC within the stipulated 10 working days period. The SI team is working with the Legal team to improve the access to NoK information from the Coroners' offices.

Safeguarding Level 3 training is in place to April 2023; As of 1st December 2023, 1,654 clinicians out of a total of approximately 2,220 are in date with L3 Safeguarding training (74.77%). A further 130 (5.2%) have booked on to sessions up until the end of March 2023. Our level 2 training figures are being affected because new starters are not completing their training on induction. The Trust induction process to be reviewed so this becomes a mandatory requirement.

Safety in the workplace is continued to be monitored through the Health & Safety Working Group and regional subgroups.

Hand hygiene compliance continues to be an issue but is being actively monitored by both the IPC teams and IPC Champions. A position statement from AACE has been received on 'bare below the elbow' and has been published in the Trust.

Vehicle deep clean compliance continues to be a concern and is being actively monitored through contract meetings.

Improvement Journey:
QIG 1: All subgroup ToRs for groups that report to Quality Governance Group (QGG) have been reviewed and rewritten in line with the QIG. With the exception of Learning from Deaths subgroup ToR all are now approved.

QIG 5: Medicines Management. The common theme throughout the risks, IQR and improvement journey is the dependence on the capacity of the medicines governance team and relocation of the MDC. Below is the progress made so far:
The transformation Business Case (BC) is with the Finance teams awaiting their review before progressing.
The recruitment of the Medicines Transformation Programme Manager has been paused due to the delay in the Transformation BC progressing, due to the current Medicines Governance team not having the capacity to take on some of the bigger projects within the Medicines Transformation programme.
A first draft of a capacity review has been completed on the current medicines governance team and is being reviewed by the Executive Medical Director.

QIG 9: End of Life Care
EOLC oversight group has been established and a baseline analysis of EOLC activity has been completed, work is progressing in this area and is expected to deliver as planned.

QIG2: Serious Incidents backlog is progressing well and is on target to be delivered by the end of December.

Breached open actions has been reduced to 22 as 31/10/2022, as of 08/12 it is now 10.

QIG 3: Risk management continues to progress with a new policy being approved and implemented. Reviews of all risks are underway.

Welfare Calls/Clinical Safety in EOC:
The Trust Quality Summit held in September 2022 reviewed the whole patient journey across the 999 service, from call taking through to final outcome/clinical decision. The journey was broken down into six areas each with specific functions, risks and issues – these were explored using real patient stories by the multi-disciplinary table groups at the summit.

There are three clinical call queues within the system with clinicians working on each and a Clinical Safety Navigator (CSN) having oversight. There is also an EOC clinical on-call who can, as required, dial in to support the CSN in decision-making.

The Clinical Safety Navigators are responsible for the oversight and management of the safety and risk to our patients within our Emergency Operations Centres. A key part of the role is to maintain oversight of the Trust's waiting incidents, with the capability of managing EOC clinical resources to provide clinical safety assurance and risk mitigation to our patients.

To address some of the gaps identified, improved standardisation of the CSN role is required – those undertaking it are experienced clinicians, but feedback has been that both the CSNs and those working with them would benefit from a more consistent approach.
There is a need to explore options for greater automation and digital recognition within Cleric to allow clinicians to work smarter not harder.
A trial in development to enhance the input of local clinical hubs on Operating Units led by Paramedic Practitioners, whereby locally based Band 6 Paramedics can assist in undertaking

call-backs and reviewing/managing a local clinical queue.
A performance/business intelligence tool needs to be created to support the measurement of effectiveness and efficiency within the EOC clinical team.

It was recognised that all of the recommendations from the Quality Summit were not achievable at the same time and as a result, a joint forum was convened in November to agree a priority area of focus. The following was decided:

- Focus on Keeping patients safe in the Stack
- QI programme will be led by the Deputy Director of QI. QI group will meet on 4th January 2023 to start this work.

Action from Trust Board September

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.

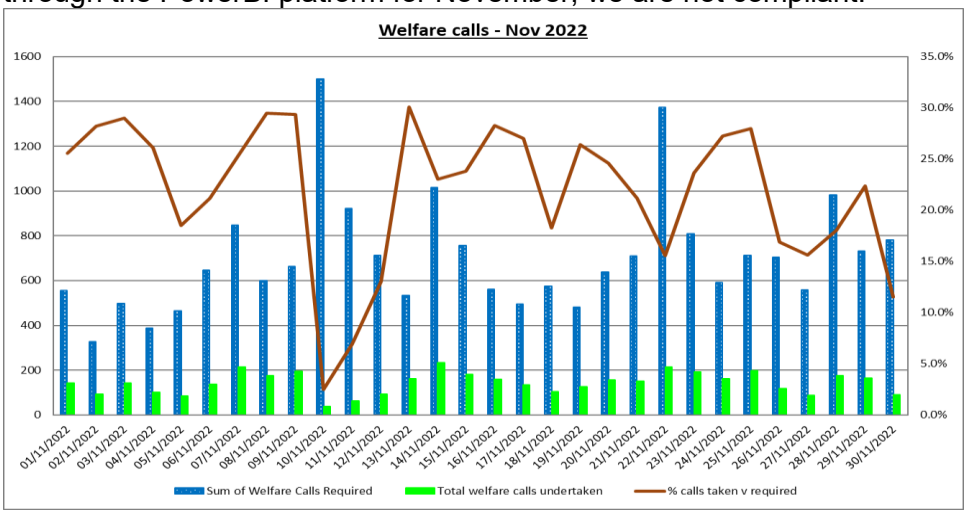
The Patient Welfare Call Procedure states that patient welfare calls will be carried out when:

- a response to scene is likely to be delayed beyond the Ambulance Response Time (ARP) set for the patient during the initial triage within 999,
- the 'breach time' is reached for clinical contact, identified within the KMS111 Clinical Tail Audit Procedure (for the IUC CAS), or
- if there is a clinical risk identified by the Clinical Safety Navigator (CSN) or Clinical CAS Navigator (CCN).

In each case, the welfare call will be undertaken by suitably trained staff with the intention that this will provide an opportunity:

- to reassess a patient's presenting complaint,
- to manage patient's expectations and enhance patient experience, and
- aim to reduce the number of call-backs to the Trust during their wait.

With regards to the standards within the procedure as can be seen for in the data as published through the PowerBI platform for November, we are not compliant.



The largest challenge with meeting these standards relates to the availability of staff to undertake these calls – at this current time with EOC staffing (particularly for EMAs) being significantly under required, there is not the consistent capacity to undertake welfare calls. It is important to note that in addition to welfare calls, welfare texts are sent to patients where appropriate however these are not included in the data for welfare calls above.

When reviewing the SECAmb welfare call process, we are somewhat of an outlier as most other ambulance Trusts do not undertake welfare calls, and rather manage duplicate calls when they are received. The SECAmb team is liaising with the North-West Ambulance Service to understand and adopt where necessary the impact of the actions they took to stop generic welfare calls and move to only undertake calls as designated by the EOC clinicians/CSN. Any findings will be shared with the EOC Clinical team and wider clinical stakeholders to agree next steps for SECAmb – this is likely to take a number of weeks.	
Recommendations, decisions or actions sought	1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area. 2. That the Board note the quality metrics and performance against this Trust Priority Area. 3. That the Board note the actions being undertaken to address the risks and improve performance within this Trust Priority Area. 4. That the Board is asked to note the improvement in the SI actions and backlog.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	70-22

Name of meeting	Trust Board
Date	15th December 2022
Name of paper	Patient story - Executive Summary to the Board
Trust Priority Area	**Delivering Quality**
Author / Lead Director	Dr Fionna Moore, Executive Medical Director Emma Williams, Executive Director of Operations
Primary Board Papers	BAF Risks N/A Integrated Quality Report (slides 40 – Cat 3 response times) Improvement Journey (Responsive care – Falls project)

The December Board story relates the experience of an elderly patient who fell at home. Although uninjured she was unable to get off the floor unaided. She was attended by Community First Responders (CFRs), who had undertaken additional training in the assessment of older fallers and in the use of a lifting device. She reflected on previous occasions when our response had taken some hours.

The project to utilise CFRs to assist older fallers was trialled in the Gatwick and Polegate areas and is now being rolled out more widely across the Trust. Currently 97 existing CFRs have expressed interest in undertaking the training – these spread across all geographical areas. All training for these volunteers will be completed by the end of January 2023 and from April, the falls training will be delivered to all new CFRs so it becomes an embedded part of their role in the future.

This plan will help reduce our response times to the group of uninjured fallers who spend time alone, uncomfortable, and unable to get up. It allows the CFRs to assess the patient, and either assist them up off the floor, or to make them comfortable and safe. They can then discuss any further needs with a Paramedic Practitioner on a local hub whilst they await the arrival of an ambulance to complete the assessment.

In addition to providing assistance to this group of patients, this initiative will reduce the risk to a number of patients waiting in the pending stack in EOC.

Recommendations, decisions or actions sought	The Board is asked to note this initiative which will improve the Trust's ability to respond to uninjured older fallers in a more timely way.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	70-22

Name of meeting	Trust Board
Date	15 December 2022
Name of paper	Learning from Deaths Q4 Report 2021-22
Strategic Goal	Delivering Quality
Responsible Executive	Dr Fionna Moore, Executive Medical Director
Author	Dr Richard Quirk, Deputy Medical Director

As per national policy this report is provided to the Board for its information. It has been reviewed by the Quality & Patient Safety Committee.

Consistent with previous quarters, the overwhelming majority of care we provide to patients at the end of life or after death is excellent. Where care has been judged as less than satisfactory, a delay to getting to the patient is the cause in the majority of cases. Again this quarter we have not identified any patients who died as a result of our poor care or died as a result of a delay in getting the patient.

There are three specific actions from this quarter's reviews. We will review the categorisation of patients who are 'already dead' (currently they are category 3). We will review the resource deployment to patients who are 'already dead' (currently a Dual Crewed Ambulance is dispatched). We will finalise the Trust's approach to 'verification of death' (currently we are frequently called to verify death when other agencies are better placed to undertake this role).

Recommendations, decisions or actions sought	The Board is asked to note the report and the actions that the Trust is taking.

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

Learning from Deaths Report – Quarter 4 – 2021/22

1. Introduction

1.1. When deaths occur, it is important that we review the care to understand if there is anything that we could have done differently before the death, during the death or following the death. This review of care should then improve future care. If carers, relatives, staff or other organisations raise concerns to SECAmb, about the care of a patient at the time of their death, they will be fully involved in any review of the death.

1.2. SECAmb Trust Board approved the Learning from Deaths Policy in November 2019. This policy sets out the national standards of randomly reviewing the care of 20 patients per month (from across the 10 Operating Units) and must include deaths during a C1/C2 delayed response, deaths during a C3/4 delayed response, deaths following hand over of the patient to another provider and deaths where the initial decision was to leave the patient at home and then they subsequently died.

1.3. There are additional statutory requirements to provide information to the Child Death Overview Panel for all children who die, a requirement to report deaths of people with Learning Disabilities to LeDeR (Learning Disabilities Mortality Reviews), a requirement to report all deaths of people with serious mental health conditions to their mental health trust and a requirement to report all obstetric incidents (which meet their criteria) must be reported to the Healthcare Safety Investigations Branch (HSIB).

2. Overview of Quarter 4 (21/22) mortality data

2.1. Table 1 shows the total number of deaths per month broken down into sex. Where the sex of the patient has not been recorded or staff have been unable to identify the sex, this is categorised as 'unknown sex'.

Table 1

	2020				**2021**				**2022**			
Month	**F**	**M**	**U**	**Total Deaths**	**F**	**M**	**U**	**Total Deaths**	**F**	**M**	**U**	**Total Deaths**
Jan	277	377	7	661	406	543	0	949	312	425	1	739
Feb	265	369	4	638	286	378	1	665	254	355	1	610
March	285	413	9	707	248	383	0	631	288	429	0	717
April	341	466	11	818	254	366	0	620				
May	265	347	5	617	207	335	1	543				
June	214	325	13	552	204	323	1	528				
July	223	367	2	592	229	403	0	632				
Aug	266	370	3	639	208	336	0	544				
Sept	204	333	3	540	238	346	0	584				
Oct	240	354	0	594	305	406	0	711				
Nov	225	380	1	606	254	426	2	682				
Dec	334	464	0	798	341	432	1	774				

2.2. Table 2 shows the breakdown of the number of people who died in each age bracket:-

Table 2

Age Range (Yrs)	No. of patients who died – January 2022	No. of patients who died – February 2022	No. of patients who died – March 2022
Under 1 year	3	3	2
1-18	1	6	4
18 – 29	15	16	16
30 – 39	21	22	24
40 – 49	29	42	40
50 – 59	78	55	72
60 – 69	111	85	98
70 – 79	176	125	169
80 – 89	183	164	192
90 – 99	99	82	85
100+	9	8	8
Age unknown	14	2	7

2.3. Table 3 shows the numbers of patients who had an Advance Care Plan (ACP)/Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, those who were 'dead on arrival' and those on whom we attempted resuscitation:-

Table 3

	No. of patients who died – January 2022	No. of patients who died – February 2022	No. of patients who died – March 2022
Dead on arrival	328	266	280
Resuscitation attempted	225	188	239
Advance Care Plan/Do not attempt resus (DNACPR)	149	123	160
Professional Decision not to Resuscitate	30	26	38
End of Life	6	7	1

3. Review process

3.1. In accordance with the Trust's Learning from Deaths policy, 20 random cases have been selected to be reviewed per month (60 reviews per quarter). The 20 cases were from across the 10 Operating Units. The Structured Judgemental Review (SJR) is the nationally approved review process and SJRs were carried out on the 60 cases.

3.2. The Executive Medical Director, Deputy Medical Director, Assistant Medical Director (Critical Care), Assistant Medical Director (Urgent Care), both Consultant Paramedics (Urgent Care) and the End of Life Care Lead undertook the reviews.

3.3. Table 4 shows the outcomes of the Structured Judgemental Reviews of the 60 randomly selected deaths in Quarter 4 21/22.

Table 4

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	30 (50%)	15 (25%)	12 (20%)	3 (5%)	0	0
On scene handling (Care)	54 (90%)	4 (7%)	2 (3%)	0	0	0
Transfer and Handover (Including discharge and worsening care advice)	23 (38%)	3 (5%)	0	0	0	34 (57%)
Other Aspects of Care (quality and legibility of records)	51 (85%)	6 (10%)	1 (2%)	2 (3%)	0	0
Overall Assessment of Care	42 (70%)	14 (23%)	3 (5%)	1 (2%)	0	0

3.4. **Trends of poor care over previous quarters**

3.4.1. Table 5 shows the number of times that care was found to be 'poor' or 'very poor' in each phase of care provided (initial, on scene, transfer, other and overall).

Table 5

	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Poor Care	16 (5%)	6 (2%)	11 (3.7%)	11 (3.7%)	7 (2.2%)	7 (2.2%)	6 (2%)
Very Poor Care	1 (0.3%)	0	2 (0.7%)	1 (0.3%)	0	1 (0.3%)	0

3.5. **Learning from each phase of care**

Most judgemental reviews undertaken identified good or excellent care. Of particular note is the level of compassionate care provided to families and carers. There is some identified learning from each phase of the care as detailed below:-

3.5.1. Initial Management

In the 15 cases where care was seen to be 'adequate' or 'poor', the reason for the majority of these ratings was a delay in reaching the scene. The majority of calls are classed as Category 1 and should receive a response within 7 minutes (on average). For most of those incidents where the Trust has taken longer than 7 minutes to arrive on scene, the reviewers have not identified any significant harm caused to those patients as they were either already dead, were receiving adequate bystander CPR/defibrillation or getting there sooner was unlikely to make a difference to the outcome.

The specific delays are as follows:-
14 minute response to a C1 call
11 minute response to a C1 call
8 minute response to a C1 call
10 minute response to a C1
10 minute response to a C1
17 minute response to a C1
9 minute response to a C1
1 hour 41 minutes response to a C2
42 minutes response to a C1 (patient had a DNACPR)
21 minute response to a C2 patient with chest pain
15 minute response to a C1
11 minute response to a C1
13 minute response to a C1
2 hour response to a C2 patient who was 91 with chest pain (see below)

One case was reviewed and found to be 'poor' care for a 91 year old with chest pain who was categorised as a C2. There was a 2 hour response time. This case has been referred to the Serious Incident Group for an assessment.

The reviewers also assessed the likelihood of success of resuscitation if the crews had arrived any earlier and felt that in the majority of cases, the outcome is unlikely to have been any different.

3.5.2. On Scene Handling

Most cases reviewed this quarter were found to have excellent or good care on scene.

One review found to be 'adequate' was related to extremely poor quality of the notes leading to a judgement that the Trust can not be confident of the on scene care as it has not been documented comprehensively. This will be followed up with the crew.

One review found to be 'adequate' was related to a patient where we have the documentation from the call log but no electronic patient record can be found. There is therefore no record of the care received on scene other than the brief notes from the Emergency Operations Centre in the call log. A local investigation is needed to find out where the medical records have been misplaced.

3.5.3. Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying.

3.5.4. Other aspects of care (including documentation)

There were three patients where the care was described as ‘adequate’ or ‘poor’.

One of these cases related to a patient where the notes do not record the decision of why resuscitation was not commenced. This will be addressed with the individual.

One case is related to no ePCR being available to view (the same case mentioned in 3.5.2 above.

One case related to a patient where there were no Air Ambulance records documented in the patient’s records. It is not clear why this is the case at this stage.

3.5.5. Overall Care

The three cases identified as overall ‘adequate’ were directly related to the cases already discussed in the sections above.

3.6. **Avoidability**

For each Structured Judgemental Review a decision is made on whether the death could have been avoidable. If the death could have been avoided, a Serious Incident is declared and then investigated.

3.6.1. Table 6 shows the outcome for the avoidability of death reviews undertaken.

Table 6

	No of reviews
Definitely Avoidable	0
Strong possibility of avoidability	1
Probably avoidable (more than 50:50)	0
Probably avoidable but not very likely (less than 50:50)	0
Slight evidence of avoidability	4
Definitely not avoidable	55

4. Referrals to the Learning from Deaths panel

4.1. During this reporting period, one case has been referred to the Serious Incident Group for assessment. This case has been shared earlier in the report and relates to the 'strong possibility of avoidability' in Table 6 above. This is a 91 year old with chest pain who was categorised as a C2 and had a 2 hour response time.

5. Deep Dive – Traumatic Cardiac Arrests

5.1. Introduction

This quarter, the panel reviewed the care of all patients in January, February and March 2022 who died as a result of a 'Traumatic cardiac arrest'. This means the heart stopping as a result of serious trauma e.g. road traffic accidents, falls from height etc. It does not include those patients who died as a result of 'hanging' which is categorised separately. The identification of cases relies on them being coded as a 'traumatic cardiac arrest' and therefore the following cases may be lower than expected due to cases being coded under different categories e.g. 'cardiac arrest' rather than 'traumatic cardiac arrest'.

5.2. Cases of Traumatic Cardiac Arrest

There were 25 Traumatic Cardiac arrests (coded) in Q4 of 2021/22.
Of these 25 cases:-

- 20 were as a result of a Road traffic Collision
- 1 fall from height
- 1 blunt trauma falling down the stairs
- 1 self inflicted abdominal wound
- 1 stabbing
- 1 gun shot

5.3. Table 7 shows the outcomes of the Structured Judgemental Reviews of the 25 traumatic cardiac arrest deaths in Quarter 4 21/22.

Table 7

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	11 (44%)	6 (24%)	5 (20%)	3 (12%)	0	0
On scene handling (Care)	23 (92%)	1 (4%)	1 (4%)	0	0	0
Transfer and Handover (Including discharge and worsening care advice)	14 (56%)	0	0	0	0	11 (44%)
Other Aspects of Care (quality and legibility of records)	21 (84%)	4 (16%)	0	0	0	0
Overall Assessment of Care	19 (76%)	4 (16%)	2 (8%)	0	0	0

5.4. Analysis of 'adequate' or 'poor' care

5.4.1. Initial Management

Five cases were judged as being 'adequate' for initial care. These were broken down as follows:-

11 minute response to a C1 call
19 minute response to a C1 call
17 minute response to a C1 call
9 minute response to a C1 call
10 minute response to a C1 call

Three cases were judged as being 'poor' care for initial care. These were broken down as follows:-

20 minute response to a C1 call
22 minute response to a C1 call
12 minute response to a C1 call

Further analysis of these cases has concluded that there was only a slight possibility that our delay in responding had an impact on the outcome of two of the above cases. For the other cases, the patient's condition made it unlikely that they would have survived from their injuries.

5.4.2. On Scene care

One case was judged to be 'adequate' due to a delay in placing an igel (a plastic tube inserted to support the patient's ventilation). This is unlikely to have affected the ultimate outcome for the patient.

5.4.3. 5.4.3 Transfer

No patients were judged to have received 'poor' or 'adequate' care during transfer.

5.4.4. 5.4.4 Other aspects of care

No patients were judged to have received 'poor' or 'adequate' care for 'other aspects of care'.

5.4.5. 5.4.5 Overall care

Two cases were judged to be 'adequate' for overall care – these two cases have already been described above.

5.5. Learning from the Deep Dive into Traumatic Cardiac Arrest deaths

5.5.1. The care provided by the Trust to patients with a Traumatic Cardiac arrest is 'good' or 'excellent' in the majority of cases.

5.5.2. We have not identified any patients where the care provided by the Trust caused harm or brought about their death.

5.5.3. Delays getting to the scene continues to be the major cause of 'adequate' or 'poor' care in the initial phase of the care provided.

6. Learning from the random review of 60 deaths

6.1. In the majority of the 60 reviews undertaken, the care of the patient good or better. In most cases, our policies were correctly followed, thorough history taking was completed, examinations were robustly recorded and the outcomes for the patient were clearly documented.

6.2. In a small number of reviews there was a delay in attending the patient. The reviewers have not found evidence that these delays significantly impacted on the outcome for these patients, with the exception of one case. This is a 91 year old patient with chest pain where we took 2 hours to get to the scene for a category 2 call. This case has been referred to the Serious Incident Review Group for assessment.

6.3. Crew members are making sensible and compassionate judgements when talking to relatives and carers about resuscitation attempts and are clearly documenting these conversations.

6.4. Support from Operational Team Leaders (OTLs) and Critical Care Paramedics (CCPs) in the management of complex arrests is clearly documented and it is evident that everything that could be done to save life is being attempted.
6.5. Consistent with other ambulance trusts, we do not have a system to identify patients who have died within 24-48 hours of admission to hospital to be able to review their pre-hospital care. NHS Improvement are looking into ways of identifying these patients.

7. Conclusion

The panel have identified many examples of very good compassionate care. Delays in getting to the patient continues to be the leading cause of concern related to care of people at the end of their life or care of relatives when the patient

8. Actions resulting from the review of deaths from Quarter 4 21/22

Action	Who?	Update/Date	
Review of the guidance on when to call Police to scene.	End of Life Steering Group	August 2022	**COMPLETE**
Remind SJR assessors that we are assessing the care provided by the Trust and not other organisations.	Learning from Deaths Group	August 2022	**COMPLETE**
Agree formal route to feedback to Nursing Homes/Care Homes when care provided pre-arrival of the crew has been substandard	Learning from Deaths Group	August 2022	**COMPLETE**
Review the categorisation of patients who are already dead	EOC Senior Leadership team	December 2022	
Review resource deployment to patients who are already dead	EOC Senior Leadership team	December 2022	
Finalise the Trust's approach to calls for 'verification of death'	EOLC Steering Group/Quality Governance Group	December 2022	

Dr Richard Quirk
Deputy Medical Director
September 2022

SECAmb Board

QPS Committee Escalation Report

Overview of issues covered at the meeting on 17.11.2022

Item	Purpose	Link to BAF Risk
Quality Improvement	To provide an update from the newly appointed Deputy Director for QI on her impression and initial plans to introduce QI across the Trust.	Risk 256 - QI

The committee heard from the new QI lead about the approach using Lean Six Sigma methodology which has been widely implemented across healthcare services with good effect. Six Sigma provides a clear and simple structure for approaching problems and is designed to fight root causes, not just symptoms. Six Sigma starts and ends with customers, is process orientated and focuses on eliminating defects. It is based on data-informed decisions and provides results. The initial work to assess state of readiness has led to a view that we are ready at SECAmb and the lead explained that it is in fact a good time given the challenges and excellent work happening already, albeit in pockets. Senior managers are ready for change as reflected in the staff survey and other feedback where they are asking for mechanisms to help them drive improvement and a process to empower them.

There will be a fuller presentation to the Board at the December meeting setting this out, asking for the Board's support. If agreed, the QI strategy will then be developed during Q4 before being brought back to Board for decision.

In the meantime, the committee supported the plan to start working on some QI projects immediately, including aspects of patient safety identified at the September Quality Summit. There will also be training in January for those staff who will be early adopters.

The committee is really encouraged by this, which aligns with our cultural change and impacts staff and patients. It will receive regular updates from the different QI projects.

Safeguarding	This was a management response requested at the previous meeting related to gaps in assurance with level 3 training, capacity to deliver, and how we work with system partners.	Risk 15 – ETD

From this management response there was good evidence that the gap in training is not having a negative impact on our safeguarding culture. The committee is assured by the plan to ensure more training, with the forecast to get to 67% by March 2023. The executive felt that we will probably exceed this as some OUs are below what is expected and they are being supported with more bespoke / targeted training. The committee welcomed this but challenged how realistic it is given we are currently 20% off this target and moving into the winter period where there will be conflicting demands. The executive responded with confidence that because some of this training can be delivered virtually and there is a plan to ensure staff are abstracted, the target will be met.

In terms of the issue of capacity in the team, a business case is going through the process, but with the necessary financial control measures, there is some work to assess affordability. In the meantime the team are manging the referrals well, with support of alternative duties staff.

The committee was encouraged to hear about the good relations with system partners, such as our Local

Authorities and local safeguarding boards. 15% of all referrals have aspects of continuing care, rather than pure safeguarding concerns and so in due course we will need to work with the safeguarding boards on how we approach this differently.

Overall, the committee is assured with the way the executive is prioritising resources and closely monitoring delivery. There is also assurance that we are not seeing any reduction in referrals and so it is unlikely there is any adverse impact from the gap in training.

IJ Deep Dive - Harm Reviews	To seek assurance that progress with this priority within the IJ is in line with the plan and that learning is having a positive impact on patient care.	Risk 14 – Operating Model

The committee received a good paper reinforcing the finding in the Warning Notice about the way harm is addressed, specifically the lack of methodology applied which would likely lead to inconsistent judgments on levels of harm. The Trust did a high number of harm reviews last year, in excess of 4,000. This year it is circa 200. In response to this gap in assurance, one of our Consultant Paramedics, Julie Ormond, who attended this meeting undertook research in tested methodologies for us to adopt. Julie confirmed the new approach which will be to use different methodologies dependent on the harm we are looking for. This is currently being written into a standing operating procedure (SOP).

The committee is assured by this progress which demonstrates good cross-directorate working, and by the consideration being given to the quality control for reviewing the reviewers.

The committee has asked for a management response to include the SOP; timescale for when it will be implemented; how it will be sustained; and an example of an outcome of one the reviews.

In meantime, the committee sought assurance from the executive that we will be doing harm reviews now and over the winter period until this new framework is in place.

Keeping Patients Safe	To seek assurance on how we are keeping patients safe in periods of high demand; what is in place an, what arrangements do we have to ensure that it is working.	Risk 14 – Operating Model

This item included a review of the outputs of the Quality Summit in September, related to the key risks within the patient journey:

1. Demand v resources for call answering
2. Triage of patient reported injury/illness/concern
3. Management of risk within clinical call queues
4. Availability of resources to dispatch to incidents requiring a response
5. Assessment of patient on scene
6. Clinical decision making regarding differential diagnosis and destination

The committee noted that the related BAF risk reflects the issue between available resources and patient demand. Overall, demand isn't necessarily high and so our issue is more related to our resources, which links to the separate BAF risks related to recruitment and retention.

Risk 3 is felt to be the highest area of risk, which is more within our control, ensuring we can keep patients safe who have ben triaged and waiting for a response. A table was presented assessing the assurance levels against each risk, as mitigated by the various actions. The majority are assessed as 'partially assured' which accounts for some of the gaps in control that management are trying to close.

The committee agreed that jumping in to action plans for each of these risk areas is probably not the right approach as we need first to ensure organisational alignment. There was a good discussion about how we use data to more deeply quantity risk to then drive improvement in patient safety / experience. This requires a more considered and sustainable solutions, as reflected in the 'operating model' BAF risk.

Although it impacts patient safety today, this a longer-term strategic risk and the committee challenged the executive to ensure clarity on how to prioritise the controls that are needed. This will continue to be a standing agenda item.

Patient Experience	To seek assurance that we are making progress against the five key actions from the strategy	n/a

We heard directly from members of the 111 Patient Experience Team about the really excellent work happening in this service to engage patients, carers and their families. The committee challenged the executive to ensure we learn from this success and use it in other parts of our service. It also asked that we engage Governors on the review of the Patient Experience Strategy.

Annual Reports	Three reports were received at this meeting in line with the cycle of business: Learning from Deaths Q4 21-22 IPC Annual Report 21-22 Quality Account Mid-Year Review	N/A

Learning from Deaths Q4 21-22

The committee noted that the outcomes are consistent with previous quarters, with the overwhelming majority of care we provide to patients at the end of life or after death is excellent. Where care has been judged as less than satisfactory, a delay to getting to the patient is the cause in the majority of cases. The review found that no patients died as a result of sub-optimal care or as a result of delay. The committee supported the actions to review the categorisation of patients who are already deceased; the resource deployment this group of patients; and to finalise the approach to 'verification of death'.

IPC Annual Report 21-22

The annual report provided a summary of the work carried out during the past year and compliance levels for all IPC practices. Learning outcomes have been added to the IPC Improvement Plan for 2022-23. The year has provided the opportunity for the IPC Team to work with both internal and external partners which has enabled us to ensure better compliance to requirements within the Health and Social Care Act. The drop in uptake for the flu vaccine was disappointing but plans are in place to move back to peer vaccination this year.

Quality Account Mid-Year Review

The committee received details of the progress against the three priorities in the Quality Account:

1. Clinical Supervision of frontline operational workforce
2. Introduction of Mental Health First Aid (MHFA) / Training for Front-Line Staff
3. Falls: Accessing Urgent and Emergency Care for Care Homes

All three priorities are progressing well. The falls measure has provided some challenge with available resource, and the CFR expansion is now overseen by the Community Resilience Team.

Specific Escalation(s) for Board Action	**Keeping Patient Safe / BAF Risk 14 (Operating Model)** There are two aspects to this; the measures we are taking to keep patients safe today, acknowledging the gap between resources and patient demand. And then the approach to find strategic solutions to this longstanding issue, which will require engagement with commissioners and system partners. The committee is escalating this to reinforce the concern, which is a standing item for the committee and also for the Board.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	71-22

Name of meeting	Trust Board
Date	15 December 2022
Name of paper	People and Culture - Executive Summary to the Board
Strategic Goal	Focus on People
Lead Director	Ali Mohammed, Executive Director of HR and OD
Primary Board Papers	BAF Risks i. Recruitment (255) ii. Retention (13) iii. Culture and Leadership ***new*** Integrated Quality Report (slides 20-32) Improvement Journey (People and Culture)

Risk Overview

In terms of key people risks, we continue to operate at a sustained level of high operational pressure leading to higher than planned staff turnover and sickness. The previous combined risk of retention, culture and leadership has been split into two risks with one now specifically focusing on retention and the other on culture and leadership.

The major new risk is that of confirmed industrial action by the GMB with strikes planned for 21 and 28 December 2022. This risk was reviewed by the Executive Director of HR & OD on 8 December 2022 and scores increased to reflect the changed situation since the risk was created on 16 September 2022.

The IQR is reflective of the current risks (except for industrial action) through the key metrics set out in the Overview (slide 21).

Recruitment

The vacancy rate and time to hire continue to show positive progress. A bottleneck has been identified in the resourcing team to process compliance checking as we are recruiting almost twice the number of call handlers as normal. This is being addressed through some temporary additional capacity and this should resolve the current situation within the next few weeks.

We will have successfully recruited the planned 75 international experienced paramedic recruits we were aiming for this year and have developed a business case to recruit a further 70 experienced paramedics and 30 NQPs.

Retention

In November, EMB and SMG have discussed and agreed a plan to improve staff retention. Key initial areas of focus include establishing good people management as standard (regular 1-1s, career development, health and well-being and ‘stay’ conversations). Additional actions include a more flexible approach to careers and supporting staff more with development.

Despite sustained operational pressure, the IQR shows we continue to make reasonable progress with appraisals and statutory/mandatory training although more focused performance management will be required to ensure that the annual rolling targets are achieved into Q1 23/24.

Culture and Leadership

A new role of Programme Director (Culture) was appointed on 5 December 2022 and is expected to be able to start within the next two months to lead the implementation of the NHSE Culture and Leadership Programme.

Whilst employee relations and FTSU cases remain at a high level, sustained focus on the most serious cases (these normally involve staff suspensions) has resulted in continuing improvements as evidenced by the falling time on suspension for staff suspended due to alleged serious misconduct. As a proportion of cases, approximately 18% of all employee relations cases currently open relate to bullying, harassment and/or sexual misconduct Training workshops for all managers in sexual safety at work continue with 370 managers now having attended a workshop and just over 100 left to attend.

The Executive Director of HR & OD has formally invited ACAS to work with the Trust to mediate with its recognised unions to improve and set out future working relations. This work has commenced in November with the ACAS specialist currently meeting with all full-time officers.

An external review of the HR and OD function has been completed in response to a request by the CQC. This was considered by the Executive Board in November 2022 and accepted in full. It also raised issues for action in respect of the quality of people management which form part of our management development plans. A full action plan has been developed in response to the review. One immediate action put in place is for a peer HRD to work with the HR team to review our most complex cases to provide fresh perspective to help resolution as well as development of a longer-term approach to managing case volumes. This initial work will be completed in December 2022.

Finally, we had an excellent response to the completion rate for the annual NHS staff survey – with c.62% of colleagues once again completing the survey making SECAmb the best responding ambulance service. Results are due in Q4 22/23.

Recommendations, decisions or actions sought	We continue to face a number of operational and workforce challenges. These are reflected with the BAF and Trust Risk Register. A new risk has been developed for Culture and Leadership to reflect the amount of work required in this area. The Board is asked to **consider** and **agree** this**.** The work set out in the Improvement Journey People and Culture workstream focuses initially on those areas within the CQC warning notices but importantly also starts to address the deeper issues in respect of culture, leadership and staff experience. It is **recommended** that the Board continue to endorse the actions taken to date and individually and collectively own and support the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	71-22

Name of meeting	Trust Board
Date	15th December 2022
Name of paper	Reading the Signals – East Kent Hospitals Maternity Review - Executive Summary to the Board
Strategic Goal	**Focus on People**
Author / Lead Director	Dr Fionna Moore, Executive Medical Director

The **purpose** of this paper is to provide a summary of the 'Reading the Signals' independent investigation in to the Maternity and Neonatal services in East Kent, and how this is relevant to SECAmb; specifically what comparisons can we draw and what arrangements do we have in place to ensure that we can learn lessons from this, and other recent reports on maternity services.

This is a harrowing report which highlights the failures in clinical care over a period of eleven years, from 2009 to 2020, despite a series of local and national reports which flagged concerns over various aspects of maternity care.

The Board is asked to note the contents of the report, to reflect on the parallels with the cultural and other issues experienced in SECAmb and in other Trusts nationally and to note the recommendations highlighted in the report.

Although SECAmb provides maternity care in the prehospital environment, and interfaces with maternity units and staff across our geography, the clinical aspects of this report are of limited relevance to our service, however the culture and governance issues raised by this report are eminently transferable.

The findings mirror those of the Ockenden report, stressing the importance of teams who work together, should train together. Other direct comparisons can be drawn from the importance of listening to patients, of providing compassionate care, of the importance of leadership, professionalism and teamwork.

It is of interest that SECAmb were not asked to participate in stakeholder feedback, which, given the importance of the relations between our clinicians and midwives in receiving maternity units is a learning point for both Trusts.

Recommendations, decisions or actions sought	In the context of this external review the Board is asked review the recommendations and comparisons with issues identified in SECAmb; to test the controls and mitigating actions set out in the Improvement Journey and the People and Culture Programme and, where it identifies gaps, agree what corrective action needs to be taken by the Executive. The Board is asked to review the recommendations in this report in the development work on Culture commencing in January 2023.

‘Reading the Signals’. Maternity and neonatal services in East Kent – the Report of the Independent Investigation

Background and context

Dr Bill Kirkup CBE published this independent report on 19th October 2022. It was not the first review of both maternity services, nor the East Kent Hospitals. Several reviews of maternity services (Morecambe Bay 2015, Shrewsbury and Telford initial findings 2020, final report March 2022, current investigation into maternity services at Nottingham University Hospitals NHS Trust, initiated September 2022 and due to report March 2024) have all highlighted failures in patient care. Findings from the earlier reports have led to significant policy initiatives in maternity services. The lack of discernible improvement over the period examined in this report suggests that a different approach is required

At the heart of this report is the belief that publishing yet another report suggesting that the failings at East Kent represented the isolated failure of a system, a freak event which ‘will never happen again’ with a series of recommendations, policy changes and action plans will not prevent further major service failures, as the previous reports indicate that this approach does not provide the expected benefits. Rather it highlights the deep seated cultural issues which have led to failures of teamworking, of compassion, of listening and the lack of professionalism of the staff working in the two units over an eleven year period.

Findings

The report examined the maternity services at Queen Elizabeth the Queen Mother (QEQM) and William Harvey Hospital (WHH) between 2009 and 2020. It found that if care had been given to nationally recognisable standards the outcome could have been different in 97, or 48% of the 202 cases assessed by the panel and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.

The report highlighted the origins of the harm identified as the following:

Failures of teamworking; gross failures in the teamworking chiefly between midwives and obstetricians, but also paediatricians and other professionals involved in the care of mothers and babies. The dysfunctional behaviour hindered the recognition of developing problems, so that escalation of care and interventions were delayed.

Failures of professionalism; staff were disrespectful to both colleagues and patients, deflecting criticism and sometimes blaming mothers for their complications and adverse outcomes.

Failures of compassion; many of the cases illustrated in the report demonstrated a gross lack of compassion and kindness.

Failures to listen; many patients reported that their concerns were not taken seriously, that they felt belittled and undermined. This made the impact of an adverse outcome even more damaging.

Failures after safety incidents; there was a failure to undertake appropriate investigations, or to take responsibility when things went wrong. There was a tendency to blame junior members of staff, or indeed mothers. There was a tendency to minimise the importance of adverse events and not to identify and implement the learning.

Failure in the Trust's response, including at Trust Board level; the problems arising between midwives and obstetricians was recognised but not addressed, neither was the bullying culture identified within a group of midwives, where the Head of Midwifery was not supported when a grievance was raised and subsequently left. The poor behaviour of some senior obstetricians, including refusing to attend when on call was also not addressed.

Maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust have also been the subject of previous external reports (East Kent CCG (2013), CQC 2014, RCOG 2016) as well as internal reports commissioned by the Executive Medical Director (2010), a bullying and harassment allegation reported to the Chief Nurse which resulted in an investigation by the then Head of Midwifery Services (2014/2015). The 'Reading the Signals' report suggested that none of these had resulted in sustained improvements in care and indeed listed them as missed opportunities. It found that the Trust Board took false reassurance in outcome measures which suggested they were not an outlier in terms of neonatal and maternal deaths, however in a specialty where giving birth is generally a normal physiological event, even unusual complications, adverse outcomes and deaths require forensic investigation.

The report found no evidence of sustained improvement in outcomes or suboptimal care over the period from 2009 to 2020.

Impact on patient care

The report provides a significant number of case histories which illustrate the impact of suboptimal and poor care on mothers and babies. In addition to illustrating the failures listed above, these provide a harrowing account of the suffering of a number of families, perhaps culminating in the case of Harry Richford who died of hypoxic ischaemic encephalopathy in 2017. This case, widely reported in the media demonstrated the conflict between the teams caring for Harry's mother, the delegation of care to a junior obstetrician, lack of input from the consultant on call, as well as the failure to communicate with the family, lack of explanations and to recognise any learning from the case.

Impact on staff

The panel who complied the report undertook an extensive engagement with staff from maternity services, as well as Board and Executive members. It reflected that EK NHS Foundation Trust was formed through the merger of three Trusts in 1999, following the local review of services 'Tomorrow's Healthcare'. Following the merger there were two main hospitals, the William Harvey Hospital at Ashford and the QEQM at Margate. Each

hospital had a maternity unit, though WHH also had a level 3 neonatal unit. There were two Midwife Led Units at Dover and Canterbury, which were subsequently merged into the two acute hospitals. The impact of the merger on morale at both units was significant and the panel heard that the units functioned very independently.

The distance between the two units is significant. Between them they serve a large and deprived geographical area where staff recruitment and retention has been problematic.

The report highlights the failure of teamwork, professionalism and leadership with a culture of bullying reported among the midwives; arrogance and poor behaviour from some of the obstetricians and poor staff morale. It also highlights the failure to acknowledge that mistakes had been made, and to learn from them. This is reflected in the blame culture cited by many staff and the reaction to external reports such as that from the CQC where rather than learning from the issues identified many staff challenged the content and findings, concentrating more on the typographical and grammatical errors in the report, rather than what they could learn from it.

Governance issues

Poor relations with the various regulators and commissioner, in particular the CQC, RCOG, local CCGs and latterly the HSIB who commenced an investigation in 2018, finding it very difficult to gain any traction despite having recurring concerns around the high number of referrals in comparison with other Trusts.

Actions

Unlike previous reports which often suggest a large number of actions leading to improvements this report differs. Previous reports have clearly not had the desired effect, as evidenced by the need for this review. Instead the report suggest 5 key action areas, the last being specific to EKUHFT, so not included in this summary. The other areas and recommendations are:

1. **Monitoring safe performance**. The report highlights the lack of true outcome measures, focusing more on process measures, such as caesarean section rates. League tables were used which served only to provide false reassurance that the Trust was not an outlier.

   Recommendation 1: The establishment of a task force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

2. **Standard of clinical behaviour – technical care is not enough.** This reflects the lack of compassion, the sometimes poor behaviour and lack of role models to influence more junior members of staff and trainees. The report reflects that the unprofessional behaviour of senior consultants seen at EKUHFT is not unique, but a national issue and the impact of a stubborn and poorly behaved consultant is not only extremely disruptive but also difficult for senior medical managers to tackle.

Recommendation 2. Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.

Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

3. **Flawed teamworking – pulling in different directions.** This recommendation is relevant to all clinical teams, but perhaps especially relevant to maternity services where close working between midwives and obstetricians is especially important. This recommendation resonates with that from the Ockenden report around teams working together training together and has particular relevance to SECAmb staff, as maternity emergencies are fortunately rare, but of great concern to our staff and of huge importance to the outcomes of mothers and babies.

Recommendation 3: Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing a common purpose, objectives and training from the outset.

Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to improve support, teamworking and development.

4. **Organisational behaviour – looking good while doing badly**. This key action highlights the defensive position taken by Trusts under scrutiny, with the understandable reaction to protect reputation with denial, deflection, concealment and aggressive responses to challenge. The report reflected a lack of scrutiny and 'check and challenge' of the information being presented. This was at board level in particular was confounded by action plans with rag ratings of green, which suggest things have been done.

   The report highlights the common response from NHSE to replace either CEO or Chair with the consequences that steps to recovery may be halted and also that the Trust will be even less likely to engage on emerging problems.

   Recommendation 4: The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

   Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

Parallels with culture and behavioural issues in SECAmb

Although SECAmb provides maternity care in the pre hospital environment, and interfaces with maternity units and staff across our geography, the clinical aspects of this report are of limited relevance to our service, however the culture and governance issues raised by this report are eminently transferable. Some of the obvious parallels are as follow:

- ✓ A multisite Trust covering a large geographical area, including areas of both significant wealth and deprivation.
- ✓ Workforce challenges with recruitment and retention. Finding time for training for staff and development for managers
- ✓ Poor staff survey with a culture of bullying and harassment.
- ✓ Board to ward disconnect.
- ✓ Leadership challenges with most of the workforce not having a voice on the Board.
- ✓ The patient's voice not heard at the Board.
- ✓ Junior staff insufficiently nurtured and developed.
- ✓ Tendency to challenge critical reports rather than look for the learning.
- ✓ The golden thread of quality governance not reflected through the maternity services

SECAmb were not recognised as a stakeholder in this review – and possibly should have been. A higher regional profile is required so that we can contribute to any subsequent reviews, and are regarded as a valued partner.

Recommendations

The Board is asked to review this report, to reflect on the elements of culture and governance which are clearly transferable and to examine how the observations and recommendations can contribute to the Board development work on culture starting in January 2023.

Fionna Moore

Executive Medical Director

28th November 2022

Southeast Coast Ambulance Service NHS Foundation Trust

WWC Escalation Report to the Board

Overview of issues covered at the meeting 23.11.2022.

Item	Purpose	Link to BAF Risk
Before the main agenda began the Director of HR&OD provided an update on the position with Industrial Action and the plans being put in to place as a system. Internally, we have set up a management response group and a joint group with unions will be established too to support the communications. There was also an update on the Crawley College Apprenticeship Programme. There is still a back log and while students are getting through it is not as efficient as we would expect. There are regular meetings to ensure they are held to account. A formal update will be brought to the next WWC.		
Improvement Journey – Culture & Leadership Programme	To seek assurance the culture and leadership programme is being implemented effectively.	Risk 257 – Improvement Journey Risk (tbc) – Culture
The committee challenged the executive on its level of confidence that we are learning from the past in the development of our plans to address culture differently and more effectively this time. The response was that the main difference to past programmes is the approach to this NHS Culture and Leadership Programme is total engagement and involvement of our workforce. This is not a programme of work 'done to', but rather 'done with' our staff. There was also executive to executive challenge on this point, exploring how we will measure that these key success factors are being followed through, as the plan currently is light on measures that will help us assess the extent to which the approach is landing well. For example, how will we measure we are listening and engaging. It was accepted that we don't have the answers yet to this, but the scoping phase will help to establish these measures. Although we are the first ambulance trust to implement the NHS Culture & Leadership Programme, the committee noted it has been adopted by several other NHS Trusts and so asked how we can learn from them, including on the challenge about measurement. As the lead director, the Director of HR & OD will explore this with the NHS England team who are supporting us with this programme. The committee has some concern about the programme plan timeline as there has been some slippage. The new timeline will be reviewed early in the New Year, along with a milestone plan which the committee will need to ensure effective challenge and holding to account.		
Employee Relations	To seek assurance that the actions agreed in September leading to the 3-month Road Map, to increase capacity to manage employee relations cases is being implemented effectively. And assessing the actions against the	Risk 257 – Improvement Journey Risk (tbc) – Culture

	relevant metrics.	

The committee received an update on the ER cases in the two months following the presentation of the Employee Relations action plan in October. Data was presented that demonstrated some improvement including significant work undertaken to develop and refine the data and metrics to support case management. September and October saw 69 new cases opened, but November has seen a reduction from prior months. The mean duration of cases has reduced to 82 working days and the mean duration of suspensions has now reduced to 181 from 323 days in November 2020.

The committee is concerned about the delay in the business case to increase capacity to enable better management of the high ER workload, which is due to be concluded in January 2023. Also that the time taken to resolve ER cases, despite improving, is still very long. Some assurance was gained from the external HR review and related support that will both inform the priority for the business case and help to resolve the more complex cases. The committee also noted the training needs analysis being undertaken to ensure upskilling of existing staff, including operational managers.

The committee has asked for greater clarity on the timeframe for improvement and will continue to monitor this throughout 2023.

EOC/111 Culture Action Plan	To seek assurance that there continues to be senior ownership in place to ensure the change in culture that was identified by the review in 2021, and that the pace of this change is appropriate.	Risk (tbc) – Workforce / Culture

The paper received summarised the work to-date and the executive acknowledged that despite best intentions, it has not progressed as had been hoped. This is in part due to capacity and capability to own the change, and also links to our approach to a more sustainable culture and leadership. That said the Director of Operations set out a plan over the coming weeks encompassing an approach for the whole directorate which include a number of workshops as illustrated below:

Operations Directorate – Teams A Workshop 1

- Setting the scene, personal/team commitment to change
- Review of all the steps/activities within the improvement journey with consideration of 'what does this mean for us'

Operations Directorate – Teams A Workshop 2

- Focus on communications within the directorate – what we have/do vs. what we need to have/do
- Consideration of the steps/activities in the improvement journey in terms of priority, complexity, support required etc
- Review of current work to consider how we create additional capacity to focus on this work

Operations Directorate – Teams F Workshop

- A one-day, 4-session a listening & engagement workshop with approx. 100 managers & leaders from across all operational teams to open out the discussions had with Team A members with a wider audience.

Change to Meeting schedules

- All operational team meetings to have agendas/approaches changed to include essential component parts relating to people, culture & leadership on a recurrent basis

Reporting route for this programme

- Engagement with the Improvement Journey team to confirm reporting route for activities and impacts of the programme to ensure alignment
- Confirmation of other reporting/update requirements (e.g., to WWC)

The committee supported this new and better broader approach, which includes but is not limited to the previous EOC 111 culture review. It also acknowledges that not everything needs to be done at scale (trust wide) and there will be a need for focus on specific teams.

Violence & Aggression	Arising from the Board in September, to receive information about the new Violence and Aggression Group established to oversee the implementation of the Violence Reduction Standards. And to seek assurance that we are applying the national standards.	N/A

Firstly, the committee is encouraged by the greater level of reporting, following some targeted campaigns, for example in Ashford who are now highest reporters. There is therefore an expectation that reporting will increase over the next 12 months. The new Working Group meets monthly and includes representation from across the organisation. One objective is to develop a new policy / strategy. While there is currently low compliance with the new national standards, this is consistent with other NHS providers, and there are robust actions in place to improve compliance in the coming year. The deadline for compliance for all Trusts is December 2023. Immediate next steps include:

- Continue to develop the Violence Reduction Working Group structure to ensure a two-way flow of information so that decision making can occur at the appropriate levels of the organisation.

- Develop a strategy and policy to embed and developing the standard, the Trust have representation within Sussex ICS and at a national level where strategies are being developed and should be available for sharing. This would allow a consistent approach to be followed. A strategy and policy will be developed by February and May, respectively.

- The trust currently has two members of staff attending Level 7 NHS sponsored courses on public health approaches to violence. This staff progression should allow for a more proactive, rather than

the current reactive approach to develop responses in the future.

The committee supports the application of national standards and the QI methodology. It will receive an update in June to check progress.

Training and Appraisals	Arising from the Board in September, to receive information showing the numbers of staff booked / attended the leadership and management training courses, and also appraisals. And to seek assurance that staff are attending training and having appraisals.	Risk 15 – Education Training & Development

Appraisals
The overall rolling appraisal compliance rate at the end of October 2022 was 49.46% against the target of 52.1%. The committee explored the actions in place, which include targeted support to specific hotspots. The Director of Operations reassured the committee that she is personally reinforcing the importance of this with her team.

Fundamentals First Line Manager Programme booking and attendance
67% of first line managers have either completed the training or are scheduled in the coming weeks. The committee sought assurance that we will enable people to be released to undertake this, which was provided. In fact, the feedback from this training has been so positive there is a push to complete it even faster.

Sexual Safety Workshop for Managers
81% of managers have attended this training and assurance was provided that there is sufficient capacity to ensure all managers attend. There is an evaluation plan too, and the outputs of this will come to the Board, likely in Q1 of 2023/24. The executive is exploring the slightly different type of training and awareness for other groups of staff, which will be determined early next year.

Statutory & Mandatory Training	To seek assurance that the issues identified by the recent 'Partial Assurance' Internal Audit have been fully considered and that the management actions are reasonable and timely.	Risk 15 – Education Training & Development

An audit on statutory and mandatory training was undertaken by the Trust's internal auditors in September 2022. The conclusion deemed that the controls in place at the Trust to manage statutory and mandatory training is deficient. Some areas of good practice were identified including Key Skills training, training delivery during/post COVID and training alignment with the NHS Core Skills Training Framework (CSTF). The report identifies several instances of a lack of key controls, inadequate control design, and ineffective

control operation; including the absence of a Statutory and Mandatory Training Policy, which is felt to have contributed to a lack of clarity over roles and responsibilities, inconsistent processes and procedures, and a lack of accountability and consequences for training non-compliance.

The executive has accepted the findings and the committee reviewed the related action plan, which includes better tracking and targeted support. The committee challenged the executive to ensure greater pace and sought assurance that there is no issue with abstracting staff. The Director of Operations confirmed that abstraction for this training was agreed at the start of the year. However, FTSU was added to the list mid-year and this was not accounted for. The committee noted this and the need for expectations to be better managed to ensure we prioritise the right training.

Retention Plan	To seek assurance that the plan is focussed on the right areas that will ensure the greatest impact.	Risk 13 – Workforce Retention

The committee received a new plan which is more focussed than the draft it received in August. This new Retention Plan is built from a mixture of available internal data (Exit Interviews, Staff Survey Results, and IPR report data), and best practice, and has been aligned to the Improvement Journey. The plan sets out three main outcomes:

1. Retention is the responsibility of all line managers
2. Every leaver/potential leaver has a face-to-face Exit Interview / Stay Conversation
3. Reduction of turnover by 30%

In reviewing the planned impacts the committee is assured that there is good alignment with the Culture and Leadership Programme and that this plan demonstrates good collaboration between the HR and Operations Directorates.

However, the plan did not include all targets (for completion) and these are being established by the related action owners. The committee agreed to review the implementation and impact of this plan bi-annually and asked the executive to see whether we could reflect a metric / SPC chart in the IQR, to help the Board track the trend.

Health & Wellbeing	To receive the H&W Plan and, as requested by the Board in September, details of the specific initiatives to support staff during the cost-of-living crisis. To seek assurance that the plan ensures we are doing all we reasonably can to ensure the health and wellbeing of our workforce.	Risk 13 – Workforce Retention

The Wellness Plan was received, and this is built from our self-assessment against the NHS Wellbeing

Framework, using the NHSE Wellbeing Diagnostics Tool. We measured our Trust provision (not the Wellbeing Hub) using the 77 lines of enquiry. We will repeat the self-assessment at 6, 12, and 18 months to measure our improvement. The Wellness Plan has been aligned to the Improvement Journey to ensure all workstreams relating to the Health and Wellbeing of our people are in one place. The plan is informed by the seven strands of the NHSE Health and Wellbeing Framework.

In terms of financial wellbeing the committee noted the directory of services to which we are signposting staff in line with the NHS England framework.

The committee is assured by the Health and Wellbeing plan, which it will regularly monitor, and asked that in the ongoing development of the IQR we include metrics to ensure greater Board visibility.

Specific Escalation(s) for Board Action	**Staff Health & Wellbeing** The committee felt that the Board has good visibility of aspects of Culture and Leadership, such as the C&L Programme, Sexual Safety etc., but has less visibility on Staff Health and Wellbeing. As mentioned, a request has been made to include metrics in the IQR in due course and, in the meantime, it is suggested that at its meeting on 2 February the Board receives a paper setting out the vision and approach to ensuring the wellbeing of our people.
	Training & Development In the context of the growing list of training needs for staff, the Board needs to be sighted on the various aspects so that it can take an informed view on how this is prioritised in the training plan(s) for 2023/24 and beyond. The committee suggests that a report is received by the Board at its meeting on 2 February, setting out the requirements with a proposed order of priority.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	72-22

Name of meeting	Trust Board
Date	15 December 2022
Trust Priority Area	**Delivering Modern Healthcare**
Author / Lead Director	Emma Williams, Executive Director of Operations
Primary Board Papers	Summary of Operational Performance & Efficiency
Update Summary	This paper builds on that provided to the previous Trust Board considering the areas of greatest risk, performance issues and the Improvement Journey actions and workstreams. This paper will consider four main areas related to the above: • The 2022-23 Winter Plan • Performance against the planned efficiency targets • The Operating Model • The Single Virtual Contact Centre model for 111
Recommendations, decisions, or actions sought	1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area. 2. That the Board note the quality metrics and performance against this Trust Priority Area. 3. That the Board note the actions being undertaken to address the risks and improve performance within this Trust Priority Area.

Update Summary

<u>2022-23 Winter plan</u>

- It is recognised that this winter is expected to be extremely challenging for SECAmb and the wider NHS for a range of known reasons plus the more recent issues relating to paediatric respiratory infections and Strep A concerns. In addition to this, the announcement of planned industrial action from Trade Unions on a national and local level will add to the complexity.
- The Trust continues to fail to meet the national ARP standards but maintains a reasonably strong position across most response times (particularly C2), however noting recent deterioration in call handling performance.
- There continues to be ongoing engagement with ICBs at all levels focusing on optimising patient flow during this winter period. This has more recently been linked to the 'Going further on our winter resilience plans' published by NHSE in October. This work focuses on several specific areas:
    - We have seen some focused work on handover times, particularly in Kent through the implementation of the System Control Centres – this has contributed to a reduction in lost hours at Medway Maritime from 883.18hrs in October to 327.58hrs in November.
    - In addition, focus on the use of community and urgent care response pathways is seeing benefits – this has been particularly noted in areas of Sussex.
    - The Trust continues to rollout the CFR falls programme across with positive feedback from patients and staff. The 97 volunteers within the programme will have completed their additional falls training programme by the end of January, and new CFRs will receive this training as standard going forward.

- The SECAmb trust winter plan was collated and shared at the end of September and within this each area/team confirms actions being taken to support service delivery and patient care over the winter period. Due to the significant challenges being experienced this year, the plan focuses on maintaining business as usual activities, as opposed to looking to develop & introduce new ideas above/beyond those listed above.

Efficiency targets in line with the plan for 2022-23

- The predicted performance trajectories across this financial year which were agreed last autumn were based on a suite of efficiency metrics being used this way for the first time. As can be seen from the table below, we did not meet the planned trajectory for any metric except the C1 90th, the others were significant longer in terms of actual v plan.

Measure	Q2 Trajectory	Q2 Actual
C1 Mean	08:30 - 09:00	09:23
C1 90th	15:30 - 17:00	16:56
C2 Mean	27:00 - 33:00	38:59
C2 90th	54:00 - 67:00	80:59

- It has been recognised that the assumptions made were not realistic in terms of delivery despite careful consideration, being set with limited engagement and practical implementation decisions. Through the past 6 months the Trust has gone on an intensive journey in the improved use of data and trends through the 'Making Data Count' and SPC work – this has provided far greater insights and understandings which will result in significant improvements in both the review of underlying efficiencies and planned trajectories for 2023-24.
- Also, though the components within the Responsive Care Group workstream of the Improvement Journey, there is far more tangible and focused attention on specific areas of work which will also directly feed into these assumptions, for example rota efficiencies.
- Finally in this section, whilst the above covers the quantitative assumptions, it must be recognised that the people and culture work that is required to not only improve the leadership and culture across the Trust but to support improvement work generally, is still in the early stages. This is important as the practicality of working with people/colleagues to deliver the efficiencies had not been considered fully when they were proposed – without engagement, communication, empowerment, and accountability such changes will not occur in a meaningful and tangible way.

Operating model

- The structure and function of the clinical delivery/operating model is main strategic risk to the Trust. It is based on key components ranging from local population health needs to workforce structures and partnership working arrangements.
- It has been recognised that the model needs a full review as it is not meeting the need of our patients, partners, or staff. Significant engagement with all stakeholders will be required to develop a new model of care taking the best of the current model, lessons learnt elsewhere and bringing additional evidence into the mix on a wide range of topics.
- It is important to note that as a system partner across 4 ICBs our strategy and any future model of care must be aligned to ICB strategies and the national Urgent & Emergency Care strategy from NHS England – of these 5 documents, all only 1 is currently available in an draft format- it is expected the others may be some time coming.

SVCC

- The funding envelope for the Kent, Medway, and Sussex (KMS) 111 IUC (Integrated Urgent Care) service has been approved and this will require a transition to a new model that has a far greater focus on call handing at the front end and a somewhat scaled back CAS (Clinical Advice Centre).
- The transition to this new model requires greater levels of fast-tracking of clinical calls to downstream providers to support the same level of clinical care and service delivery as seen at present. We are working with the KMS commissioning team to deliver this change in a safe planned way but at pace.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	73/22

Name of meeting	Trust Board
Date	15 December 2022
Name of paper	Achieving Sustainability/Working with Partners
Executive sponsor	Martin Sheldon, Interim CFO
Author name and role	Martin Sheldon, Interim CFO

BAF Risk 17 – The reforecast of the Trust financial position has been completed and identified an overall financial risk of £8.9m for the year. The detailed reviews with each Directorate are underway. Our plan is to identify cash-releasing savings in year to reduce the risk to as close to recurrent breakeven as possible.

Improvement Journey – All aspects of the S&P workstreams are on track. The recent Internal Audit Financial Sustainability action plan is being incorporated into the relevant workstream. The recently added policy & process improvement workstream is also being incorporated. All workstreams are on track to deliver this financial year

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Financial Performance - The Trust is reporting a deficit of £2.7m against a plan of £2.0m for the year to date (31 October 2022).

The forecast breakeven position assumes delivery of efficiency plans and non-recurrent measures totalling £8.9m.

The break-even position is a requirement of the SE Region, our challenge is now to identify how we are intending to deliver recurrent savings to close the gap to recurrent breakeven in year. This work is underway with each Directorate and meeting will continue each month to ensure delivery.

Recommendations, decisions or actions sought	The Trust Board review the current financial position and support the work being undertaken with Directorates to deliver cash-releasing savings to achieve as close to recurrent breakeven in 2022/23.

SECAMB Board

Finance and Investment Committee (FIC) Escalation Report

Overview of issues covered at the meeting on 07.11.2022.

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

The committee reviewed the current financial position at Month 6, and the key points include:

- We are on plan, but with much risk to the year-end position
- There are opportunities to reduce waste
- Abstraction is an issue and sickness is very high.

The focus of the meeting however was on the re-forecast.

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

The initial financial reforecast is designed to identify the most likely financial outturn for 2022/23 if the Trust doesn't improve its budget management nor deliver its recurrent savings plans.

There is a £1.4m deficit at 30 September, with £1.1m of non-recurrent provisions. This includes a £2.3m overspend in 111. The forecast year end position without mitigation is £8.9m deficit, up to half of which can be covered with non-recurrent income.

A presentation was received setting out the position, but this did not provide assurance on the mitigations or how they will be implemented. The Chief Finance Officer confirmed that this is in the process of being agreed with the Executive Management Board. See escalation below.

Commissioned Contracts	To seek assurance on the management of commissioned contracts	N/A

This report provided an update on the Trust's NHS commissioned contracts and services, highlighting some of the ongoing discussions with commissioners. It helped to provide assurance of the effective contract management and early awareness of potential issues, risks, and opportunities.

Although the plan is to sign a contract in March 2023, the committee reinforced the risk of not having a contract in the meantime for KSS Air Ambulance. It also challenged the executive to ensure we are clearer on costs so that when we review with commissioners, we ensure we are paid fully for the services we provide.

Business Case Tracker	Update for awareness	Risk 16 – Financial Sustainability
The committee noted the tracker and the review of the business case process that is being undertaken to ensure more effective prioritisation and allocation of resources.		
Sustainability IJ	To seek assurance this is progressing as planned	Risk 257 – Improvement Journey
The committee reviewed the scope of the programme, which reports at each meeting of the Board.		

Specific Escalation(s) for Board Action	**Finance Re-Forecast** There are significant risks to the year-end financial position and ongoing sustainability. Mitigating actions are being put in place and the Board will need to seek assurance on these actions, at its the next meeting in December.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	74-22

Name of meeting	Trust Board
Date	15.12.2022
Name of paper	Improvement Journey - Executive Summary to the Board
Strategic Goal	**All**
Lead Director	David Ruiz-Celada, Executive Director for Planning and Business Development
Author(s)	Matt Webb, Associate Director of Strategic Partnerships & System Engagement David Ruiz-Celada, Executive Director for Planning and Business Development
Primary Board Papers	BAF Risk 257 IQR pages 27 and 28 (Culture), and pages 11 and 12 (Incidents and Harm)

This report summarises the progress made through the Improvement Journey (IJ) portfolio during the month of November 2022. The BAF risk (ID: 257) remains scored as a 12 with a continued focus on tracking and achieving supporting evidence by the end of November, as per the Section 29A warning notices expiry. The risk is now also reflective of the need for the Improvement Journey to shift its focus to be strategically driven and designed to enable those closest to patients in delivering the improvements.

Current progress against target evidence is 99% for the warning notices and 80% for must-do requirements, up from 60% and 54% respectively, as reported at the October Board. Having observed a continued improvement in evidence being submitted by each Improvement Journey programme, the overall portfolio rating has remained at *amber*. A series of peer-review sessions, supported by internal subject matter experts and external parties, were completed through November to assure against the evidence submitted.

In addition to evidence-focused peer-review sessions, the Board development day planned undertaken on 1st December focussed on the findings of the internal and external peer reviews for warning notices one to four. The purpose of this development session was to aid the Board in highlighting areas for continued improvement to help shape the Improvement Journey plans beyond the expiry of the Section 29A warning notices.

Section 4 of the IJ report identifies gaps in assurance and provides corrective actions to be taken through the remainder of Q3, ensuring the Trust remains in a strong position to provide the CQC with tangible evidence of significant progress against 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.

It has been acknowledged by the Board that the Trust needs to concentrate on promoting a culture of continuous and sustainable learning and improvement, facilitated through agile, supportive and safe conditions. To enable this, the Trust Board and executive will need to consider its risk tolerance and appetite, ensure there is a robust compliance mechanism in place to maintain adherence to the CQC key lines of enquiry (and other regulatory requirements) and a commitment to supporting key enablers for continuous improvement. The Board will be doing a Risk Appetite facilitate workshop in January as part of it's on-going development and effectiveness plan.

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.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	74-22

Name of meeting	Trust Board
Date	15.12.2022
Name of paper	Strategic Priorities 2023/2024
Executive sponsor	David Ruiz-Celada Director Planning and Business Development
Author	David Ruiz-Celada Director Planning and Business Development

As we mature our Improvement Journey, there's a need to plan beyond the regulatory-driven nature of the Warning Notice, Must Do and Should Do, and focus on shaping a strategically driven framework for improvement that the Board use to deliver against long-term aspirations.

This paper sets out a summary of the key next steps we will take to build on the improvements made to date, and so that we can set SECAmb up for success in the long-term.

Recommendations, decisions, or actions sought	The Board is asked to approve the Strategic Priorities for 2023/24 which are summarised in section 3.2, following the outcomes of workshop sessions held in November with the senior management group and council of governors.

Strategic Priorities 2023/2024
December 2022 Update

1. Introduction:

1.1. In 2022/23 we have developed our organisational alignment framework around four key strategic priorities, which align with the strategic goals.

1.1.1. Quality Improvement
1.1.2. People and Culture
1.1.3. Responsive Care
1.1.4. Sustainability and Partnerships

1.2. Establishing the priorities on which the Improvement Journey is based has helped the Board strengthen the Board Assurance Framework; we now have a BAF that is structured around the strategic goals and priorities, with clear line of sight with the risks against this BAF, how we measure improvements as part of a re-vamped Integrated Quality Report that aligns to these 4 pillars, as well as a programme of improvement in the form of the "Improvement Journey" which fully aligns in delivering our outcomes.

2. Developing a long-term sustainable improvement model

2.1. The focus on the Improvement Journey has been to deliver against the Warning Notice issued by CQC as a result of the Well Led inspection earlier this year.

2.2. However, the focus in Q4 will begin to shift towards building on the foundations of the improvements made, in particular around our People, Culture and Quality agenda.

2.3. This will be done by progressing both the Must Do, Should Do and RSP requirements, as well as starting to embed a strategically led approach to improvement.

2.4. As part of the senior leadership engagement done over the last 6 months with colleagues at all levels, we have heard that we need to develop a clear vision and new strategy on which to build the infrastructure for improvement going forward.

2.5. This has been described to us as an identity crisis, born from the competing needs placed on staff at all levels as a result of the increased complexity and demand from patients both in the Emergency and Urgent care, as well as aspects of increasing social care pressures placed on the Ambulance service.

2.6. In delivering change through the first 6 months of the Improvement Journey, we have also identified the need to step towards de-centralisation our approach to improvements going forward. The approach will need to shift towards developing robust centralised mechanisms of support that enable local and regional improvement to happen using the right

combination of skills, whether that be analytics, QI methodologies, change management, etc.

2.7. To setup SECAmb up for success, we have identified the following key steps that we will need to take in Q4 of 2022/23:

2.7.1. **Step 1** - Set a clear Board direction of travel: Build on our Strategic Goals and Priorities to help set overall direction over the next 12 months

2.7.2. **Step 2** - Empower our local leaders and those closest to patients to drive improvements: Throughout Q4, we will be working with all our operating and business units to develop their plans for 23/24 in line with the Strategic Priorities, focussing on providing clarity, accountability, and support as part of the on-going planning process

2.7.3. **Step 3** – Develop the necessary infrastructure for sustainable improvement: Developing our newly established Quality Improvement function, along with our project management and system transformation teams, to become an enabling function for improvement across SECAmb

2.7.4. **Step 4** – Address the identity crisis: Begin the process of updating our strategy, in a way that it delivers a clear vision for the organisation for the long term

3. Step 1 – Set a clear Board direction of travel

3.1. The Executive Team has hosted 2 workshops with its most senior managers, the Board, and the Councill of Governors through November 2022, to help shape and define the Strategic Priorities for 2023/2024

3.2. The following table is a summary of the outcomes:

"To deliver safe and equitable services for our patients and our people"				
We will…	**Quality Improvement**	**People and Culture**	**Responsive Care**	**Sustainability and Partnerships**
	QI1 – Build and embed a world-class approach to Quality Improvement at all levels **QI2** – Become and organisation that Learns from our patients, staff, and partners **QI3** – Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk	**PC1** – Build a culture around our values, where everybody is respected and well supported **PC2** – Make SECAmb a great place to work, becoming the employer of choice **PC3** – Empower, involve and support our people to identify and drive improvements for the benefits of patients and staff	**RC1** – Deliver safe, effective and timely response times for our patients **RC2** – Implement smarter and safer approaches to how we respond to patients **RC3** – Provide world-class support for our people delivering patient care	**SP1** – Develop a refreshed vision and strategy for SECAmb and our operating model **SP2** – Be a great system partner, establishing SECAmb as a system leaders in the UEC arena, becoming the partner of choice **SP3** – Become a Sustainable Urgent and Emergency healthcare provider

3.3. The Executive team will be refining these in the form of more targeted impact-based outcomes relevant for each directorate, and we will be using this framework to support departments and local operating units to set their own objectives and plans for the year