South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

02 February 2023
10.00-13.00

Trust HQ
Nexus House, Crawley

Agenda

Item No.	Time	Item	Paper	Lead
Board Governance				
77/22	10.00	Welcome and Apologies for absence		Chair
78/22	10.01	Declarations of interest		Chair
79/22	10.02	Minutes of the previous meeting: 15 December 2022		Chair
80/22	10.03	Matters arising (Action log)		PL
81/22	10.05	Chair's Report		DA
		Board Well Led Self-Assessment		
82/22	10.15	Chief Executive's Report		SM
83/22	Primary Board Papers	a) **Board Assurance Framework** b) **Integrated Quality Report** c) **Improvement Journey**		
Delivering Quality				
84/22	10.35	**Keeping patients safe**	BAF Risks 14, 255, & 256 Improvement Journey IQR	RN
			Q1 Learning from Deaths Report	RO
			Quality & Patient Safety Committee Report Incl. Cardiac Arrest Annual Report	TQ
Focus on People				
85/22	11.05	**Improving Culture**	BAF Risks 348, 13 & 15 Improvement Journey IQR	AM
			Staff Health & Wellbeing	AM
	11.30	Break		
Delivering Modern Healthcare				
86/22	11.35	**Operational Performance & Efficiency**	Board Story	EW
			BAF Risks 13, 14, 17 & 255 Improvement Journey IQR	EW
			Call Answer Performance	EW

Delivering Sustainability & Partnerships				
87/22	12.10	**Achieving Sustainability / Working with Partners**	BAF Risks 14, 16 & 17 Improvement Journey IQR	MS
			Finance Report	MS
			Finance & Investment Committee Report	HG
Our Improvement Journey				
88/22	12.30	**Strategic Priorities 2023-24**	BAF Risk 257	DR
			Improvement Journey	
Board Effectiveness				
89/22	12.50	▪ Improving quality of information to the Board ▪ Improving professional curiosity and triangulation		Chair
Closing				
90/22	12.55	Any other business		Chair
After the meeting is closed questions will be invited from members of the public				

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 15 December 2022

Banstead MRC

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Siobhan Melia	(SM)	Interim Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
David 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
Martin Sheldon	(MS)	Chief Finance Officer
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Robert Nicholls	(RN)	Executive Director of Quality & Nursing
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Christopher Gonde	(CG)	Associate NED
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary

Chairman's introductions

DA welcomed members, those in attendance and those observing this meeting in person or via MS Teams.

62/22 Apologies for absence

Steve Lennox	(SL)	Improvement Director

63/22 Declarations of conflicts of interest

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

64/22 Minutes of the meeting held in public 27.10.2022

The minutes were approved as a true and accurate record.

65/22 Action Log [10.03-10.04]

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

66/22 Chair's Report [10.07–10.15]

DA used his report to set the context and to outline the evolving structure to the meeting; he encouraged Board members to use the Assurance Cycle to help ensure the right conclusions. This builds on the Board

Effectiveness Review, and DA referred to the separate report setting out the findings and recommendations which have been accepted and will help the Board to become increasingly more effective.

DA then asked PL to confirm the plan for Board development. PL spoke to the paper which also summarises the development sessions this year to-date. The proposal is to focus of the three remaining sessions to April on the Board's role in setting the organisational culture. Our Improvement Director has engaged 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, as set out in the paper. The areas of focus of Board development from April onwards will then be determined by the outputs of the well led self-assessment, in January. PL concluded by asking for the Board's support of the plan between January and March, and then to note that a paper setting out a proposed plan from April 2023 will come to the Board meeting on 6 April. The Board agreed this.

Returning to his report, DA then outlined the current issues and focus over the winter period. He expressed the need during today's meeting to ensure that we test how well we are prepared to keep patients safe and to support staff during this challenging time. This will be a main focus of today's meeting. DA also asked Board members to keep in their minds when exploring issues today, the themes coming through from staff during the leadership visits.

Lastly, and before updating on the Board succession plan, DA cross referenced the concerns expressed by the Council of Governors at its most recent meeting, which are covered by the Board's agenda today, e.g. culture, staff welfare and patient safety.

67/22 Audit & Risk Committee Report [10.15–10.30]

MW summarised the output of the last meeting, drawing to the Board's attention two issues in particular. Firstly, the EPRR Annual Assurance Assessment. This year substantial compliance was achieved, which is an improving picture. The paper is appended to the report. The committee also received a good paper on how we are responding to the implications of the Manchester Bombings. Like other Trusts there have been some gaps in testing during COVID, so more work needs to be done and therefore we do carry a residual risk.

Secondly, risk management which of course was a focus in the Warning Notice. The conclusion reached by the committee is that there is lots of excellent work and we are now in a much better place. However, there is much still to do and three specific areas for continued development as listed in the paper. Firstly, the way in which we record risk, and we need further assurance this is embedded to ensure consistent description of risk that draws out systemic issues. Secondly, as a Board we need to be more curious, and when we have a risk register need to draw out systemic issues rather then just the functional risks. Underlying systemic risk is patient safety. Thirdly, we looked at the BAF and corporate risk register and the underlying focus on patients is strong. However, when we read the risk register it could be even more explicit in how it focusses on patients; this is an area for development the committee reinforced.

DR asked about EPRR in the context of CQC findings and this self-assessment and whether the findings are consistent. EW responded that they are approached / audited in different ways. This was part of the national core standards via NSHE / ICS which is a more detailed review.

DA reflected that the attention of the executive and healthcare system is to ensure resilient plans. This needs to be kept under review and we need programme of improvement with consideration to allocation of resources / new investment.

CG followed up on the point MW made about Board curiosity and asked whether we think we are more curious. MW felt that this is about joining the dots and the session last month with NHS Providers (effective challenge) was a good start but we need to keep working at it.

HG asked for timeline until we have full assurance on EPRR and risk. MW confirmed that the committee will remain focussed and RN added that part of the issues of curiosity relates to quality of information and if we look at the risk management process, we have taken a step forward including how the corporate risk register looks and feels, e.g. included 12+ risks to ensure greater visibility at senior leadership level.

DA summarised that the Board acknowledges the focus of the committee, which will follow through to ensure further improvement in both EPRR and risk management.

68/22 Chief Executive's Report [10.30–11.03]

SM took the Board through some of the key points from her report, highlighting the following:

1. EMB – there has been significant progress in risk reporting in the last 6-8 weeks, reflecting the changing approach in the new risk policy. We have trained our people to ensure we capture risks and ensure right mitigating actions. We now receive regular reports on 12+ risk and the BAF includes all the extreme-rated risks.

2. IT outage – we had a critical incident related to an IT outage on 10 November. Colleagues did a great job in responding to this incident, ensuring we mitigated the impact on patients and staff welfare. That said, we need further assurance that we learn the lessons to prevent recurrence. We were on planned phased replaced of the hardware that failed and sadly this happened just before this was finalised; the new kit makes us more resilient but a look back review will seek assurance that this won't happen again. We are seeking independent support to review our resilience.

3. Operational Performance – we cannot not overstate the pressure our people are under. There is a relentless push to ensure patient safety. We continue to be in REAP 4 due to a significant increase in demand. It is important to acknowledge this and thank our people for their continued efforts, going above and beyond. The level of fatigue we need to acknowledge too.

   Related to the action on the action log PL referred to earlier, SM confirmed that she meets with ICB CEOs every 4-6 weeks and uses this to ensure we are clear about what we need from the system, e.g. access to primary care, handover delays and partnership with local authorities to ensure good flow of patients into social care. Workforce is the biggest rate-limiting factor, both in health and social care. So there are significant system challenges. Sussex as our future lead commissioner is coordinating better with Kent and Surrey, e.g. winter board. SM reflected a palpable difference in the level of understanding of these issues impacting our ability to respond to patients.

4. Industrial Action – negotiations have been constructive with GMB. They concluded yesterday and it felt like a partnership approach to how we manage the critical factors balancing patient safety and the legal right to strike. A joint statement was shared last night and the key messages are that we agreed derogations / local exemptions; GMB is working hard with its members to reach these levels - EOC and 111 we have agreed 75% derogation and 50% in field operations. In addition to this we have agreement that for certain type of calls if there are no ambulances available staff will dispatch from the Picket Line; this will be the most serious incidents such as C1s. There is national agreement too to draw military support and we have secured this support.

DA thanked SM for this update and opened to questions.

SS asked about the timeline for look back review related to the IT outage. SM confirmed that from the perspective of patient safety / harm, the quality governance team are checking for any increases in SIs, complaints etc. to determine any adverse impact during the outage; this is an internal exercise as part of

quality governance and QPSC will receive the output of this. The external review relates to the more technical issues linked to why it happened and whether we are resilient; the assurance requested by AUC. While we can take a view internally it is best to get an external view too for additional assurance given the significance and length of the outage. MS added that the initial IT review is complete and this will feed in to joint EPRR review. A third element will be the external review to ensure we haven't missed any learning. Our review showed the critical nature of the IT infrastructure in provision of services and so we need to maintain a very high level of IT 'up time'; at least 99.9999%. The output of the review will help us achieve this high level of resilience.

SS asked again for the timescales. EW responded that it will be by the end of January.

PB agreed that our response to this was very well handled and he reflected on how the Trust learnt from the 2021 incident, as this resulted in significant additional external funding which led to the replacement programme SM mentioned. He asked that we take a similar approach this time.

MW asked that the CEO is clear in the Annual Governance Statement (AGS) how / why this happened and the action taken.

Action
The AGS to sufficiently cover the IT Critical Incident; why it happened, the impact and the action taken.

Related to industrial action, there were some questions about the expected impact. The Board acknowledged that we will not know until the day what staff have chosen to strike; this is the inherent uncertainty of strike action. However, there was good assurance on the derogations and the agility of our incident management approach, which will ensure the most effective use of resources, including the 100 military. Planning and training for this is underway.

DA summarised by first thanking the executive for the way they are dealing with this, along with the GMB. Every effort is being made to mitigate impact but risk increases with every staff withdrawn. Plans will therefore mitigate only so far; as a Board we understand there are risks despite the planning and we stand ready for any escalation, as needed. He also thanked AM and JC for the clarity of communication.

69/22 Primary Board Papers
As reflected by DA in his Chair's Report to the Board, the primary board papers will be used as reference documents to inform the areas of focus within the agenda.

70/22 Keeping Patients Safe [11.03-11.35]
FM introduced the **Board Story** which focusses on an initiative to improve the safety of patients who fall at home and are unable to get up and the impact of delays currently experienced. The video was then played.

FM reflected that it is important to recognise the number of CRFs interested in joining this scheme. DA asked QPSC to oversee implementation of this programme.

Action
QPSC to seek assurance on the implementation and effectiveness of the Falls Programme.

HG heard during a recent leadership visit about 'Star 6', which seemed to be an excellent concept. This is an agreement with the care home that when a person falls, they phone direct to avoid an ambulance being dispatched. It appears to be a local initiative in Thanet. FM explained that we are working with ICBs as until

recently we had six different numbers to access support for this type of incident and in Sussex, we now have a single point of contact. EW added that falls training is now be offered to all CFRs. This led to a discussion about our approach to CFRs and whether this is consistent across the Trust, given the key role(s) they have. The Board noted that all new CFRs will have routine training and that work is ongoing in the areas where there are low levels of CFRs.

Moving on from the Board Story, RN set out the key issues under keeping patient safe, as set out in his cover paper. He cross referenced to the related BAF risks and reinforced the gaps in welfare calls and work to understand how to improve this, including looking at what our peers do. RN also referred to the QI project starting in January, arising from the Quality Summit, relating to how we keep patients safe while they are waiting for an ambulance. FM then updated on some of the medicine risks before the Chair opened up for questions.

LS referred to clinical call backs and gaps in resources and timeliness and asked when we expect improvement. RN responded that we are in discussion with NW ambulance service who do this well and reassured the Board that we will implement corrective actions in a short timeframe. EW added that the key thing is that we are trying to do welfare calls for everyone and this is just not achievable. We therefore need a risk-based approach; this is the learning from NW that RN referred to.

Action
At its meeting in January, QPSC to seek further assurance on the corrective action being taken to ensure clinically appropriate and timely welfare calls to patients who are delayed waiting for an ambulance.

RN then moved on to highlight three areas within the IQR. Firstly, the month on month progress with reducing the SI backlog as set out on page 11 of IQR. At 8 December, we have nine outstanding, each one has an investigator assigned and they are expected to conclude by the end of December. We currently have 43 open SIs. There is good progress too with open actions and the expectation is that we will close all by the end of December. At the end of November we had 377 open incidents outside the 45 day period. We know areas with the highest numbers are EOC 111 and so bespoke support is being provided to bring these numbers down. Importantly, all incidents reported are reviewed within 48 hours and any moderate (or above) harm is escalated to the SI Group which meets weekly. We are conducting audits of 30 cases to test how incidents are managed. On Safeguarding, there is improvement with level 3 training compliance; we are on track to meet the target by the end of March 2023. Lastly, we had a backlog of complaints overdue, half of which we have now responded to and on track to complete the remaining by the end of December.

FM then talked about cardiac survival; a common cause variation identified in the IQR. She explained that despite this the annual review shows a positive picture which will come to the Board in February. The STEMI Care Bundle is improved now we are formally allowed to count the use of analgesic, but FM reinforced that this is a relatively meaningless metric and so we are campaigning nationally to get it changed as it increases on scene time which is not good for patient outcomes.

DA opened to questions.

HG referred to the IQR and the process failure identified related to controlled drug breakages; the target of which is zero. He asked for more information on this and also the concerning trend related to audits. FM responded that the zero target is not realistic and reminded the Board that we have a small number of controlled drugs. The most common is diazepam and morphine and FM outlined the circumstances that could lead to breakages, confirming that the numbers are small. We are looking at trends by OU and by individual. FM and DR will review the zero target. On medicines audits FM outlined some of the contributory

factors including the demands on OTLs. This led to a discussion about how we are engaging OTLs to support them in finding a way of prioritising quality tasks.

DR noted that this is the first time we are seeing a clear picture on cardiac and stroke, and asked like with fallers earlier, we start to look at the whole pathway of cardiac and stroke patients to better understand their experience. In other words, find a way to start talking more about patient groups rather than categories (C1, 2 etc.).

Action
As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.

DR also noted that we are seeing for first time harm in slide 12 of the IQR links between response times and harm. This is important to demonstrate more clearly how delays impacts on patient outcomes. TQ supported this and reflected that major harm from delays relates to cardiac, heart attack and stroke, in particular. FM added that this reinforces the need to further segment C2, in order to prioritise the greatest need (and to DR's point look more at patient groups). Clinical Navigators look at the C2 stack but when there are lots of people waiting it can be difficult to identify who is more urgent than another.

SM referred to the issues with complaints management, as set out in the IQR. She will ensure EMB reviews the complaints process in light of the special cause variation related to response times.

Action
In light of the special cause variation in the IQR, related to complaints responses, EMB will review the process map for complaints management and report back to Board the reasons and corrective action.

<u>Learning from Deaths Report</u>
FM explained that there is little difference to previous reports. She summarised the items we are taking forward as set out in the report and confirmed that the care provided was found to be good. Work ins ongoing to ensure consistency of reporting where we decide care is poor / very poor with new standards being introduced for the next report.

DA clarified with FM that she is essentially reporting that there are no significant issues arising from these reviews. FM confirmed that this is right. However, there are issues with delays, but the care provided is good and we have found that the delays had no impact on the eventual outcome.

The Board explored how we might ensure some external support in these reviews and asked this to be considered to ensure some independence. FM confirmed that we are talking to some of our peers to see what they do in this regard. In the meantime, FM assured the Board that we do have internal peer review.

<u>Quality and Patient Safety Committee (QPS) Report</u>
TQ summarised his report noting under QI that we have a presentation in Part 2 later today.

There is one escalation related to Keeping Patient Safe / BAF Risk 14 (Operating Model). TQ explained that 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 finding 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.

SM added that early in the new year we need to think about whether we are set up to work effectively in partnership with our multiple stakeholders. In discussion with other ambulance CEOs some have director of partnership-type roles. There is a real eagerness from ICBs to have people round table, but we don't have capacity currently. SM will be discussing this with the executive team and will bring the outputs to a future Board development session.

Action
The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.

DA summarised that we have had a comprehensive review of how we are keeping patients safe. There is some good progress and we have agreed actions to close the assurance gaps identified.

[Break 11.58-12.05]

71/22 Improving Culture [12.05-12.56]
AM outlined from his report to the Board some of the work to improve culture, linking to the relevant parts of the BAF, IQR and Improvement Journey. He highlighted the reasons for high sickness levels and the actions being taken. The trend in the IQR is slightly improving. Between operations and HR we are exploring more of the underlying causes and are bringing a report to EMB in January. The Board noted that gaps in establishment impact staff welfare as we don't always provide meal breaks and there are too many shift overruns, all having adverse impact and, in some cases, leading to sickness. This is a complex set of issues that manifest in poor employee experience and moral as seen in the staff survey. The Board reinforced the need focus on root causes and the balance between the needs of patients and staff.

AM referred to the new risk on culture and leadership in the BAF as agreed last time. Following on from the discussion earlier re industrial action this is now one of highest risks on the corporate risk register, as reflected in the BAF report.

The Board noted the improvement on vacancy rate and time to hire. Also, the success of international recruitment. AM thanked those responsible for leading this process.

On retention, AM outlined a new plan to improve this which was agreed recently by EMB. Key aspects of this are set out in the paper. The IQR is showing reasonable progress with appraisals and statutory/mandatory training. AM confirmed that a recent Internal Audit identified significant gaps in control for statutory/mandatory training and we have agreed management actions and WWC will oversee implementation.

In relation to culture, AM confirmed that we have appointed expertise to help drive this programme. Until it Stops workshops are ongoing and there are 100 managers left. It will then be rolled out wider.

AM then updated the Board on the mediation with unions supported by ACAS. We start the next phase in January.

Lastly, AM referred to the external HR review. We have accepted all the recommendations and a full action plan has been developed. Immediate action was to get support from a HRD of another Trust, which has been completed and we are in the process of reviewing the most complex cases with plan to resolve each one.

DA thanked AM and reflected on how much is going on. It is good to see progress in some of the processes with the experience of staff continuing to be the focus. He then opened to questions.

DR fed back to the Board his experience of kicking off a recent fundamentals course. The feedback from those attending was extremely positive. He also met colleagues who have undertaken the sexual awareness training and their feedback is that this is helping to ensure a shared understanding.

DR then referred to the IQR and the chart showing we are failing against the 5% target for shift overruns. He agreed that this is a significant factor in the high sickness rates. In the context of the operating model what are we doing about this it to try and better balance patient safety and staff wellbeing. We must address root causes like this if we are to improve sickness and other indicators linked to staff experience.

Action
WWC to seek assurance that the executive is striking the right balance between patient safety and staff welfare, related to shift overruns. Noting the failing process identified in the IQR

SS noted the positive leadership training and the improvement in time to hire. She asked about recruitment numbers/target of 3946. There appeared to be some confusion about this as the actual number is 3992, indicating we are above target, which DR did not think was right. He will check the target of 3946.

Action
DR to clarify the recruitment target of 3946 (reported in the IQR) as there was some confusion about whether this is the right number.

RN led a discussion about international recruitment and specifically how we are seeking assurance that we learn from before (4-5 years ago) when many then left within he first 12 months. This need to include onboarding and induction and ensuring we encourage a buddy arrangement.

Action
WWC to seek assurance that we are ensuring robust induction, training and support to the international recruits to ensure they are welcomed and supported in the transition to the UK and to SECAmb. Ensuring learning from when we did this 4-5 years ago when a high number of recruits left within the first 12 months.

HG welcomed the positive improvement trend in the IQR related to active suspensions. He then challenged the rolling annual turnover in EOC 111 which is now over 40%. Acknowledging the plans cited in the report to address this by May 2023, HG was curious as to how we are doing this as this percentage suggests something is fundamentally wrong. EW responded that the reason for this high turnover is the relentlessness nature of the work given current challenges. Medway will create a better environment in the East but fundamental changes are need to the operating model to sustainably address staff welfare. DA reinforced the need of the Board to be focussed on the strategic solutions and asked WWC to pick up what these strategic solutions are. AM corrected an error in the IQR, which should state improvement *by* 10%.

Action
WWC to seek assurance that we are identifying strategic solutions to improve the working experience in our EOCs, to address the very high turnover rates identified in the IQR.

In the context of the fundemtnal and sexual safeyty training, MW asked how the executive ensures we achieve the impact of all training we provide. This is important assurance to ensure this investment delivers the change we need. AM responded that we evaluations but accepted this is not consistent. MS added that the cascade of objectives and appraisals will help judge impact of training.

Action
WWC to seek assurance that we have a consistent process in place that ensures we evaluate the impact of training 9using appropriate metrics) to test that it delivers what is expected, to include specifically Fundamentals and Sexual Safety.

SS reflected that however great the evaluations are, what we need is change in hard metrics e.g. appraisals, less bullying and harassment etc. as until this we will know it isn't working. So the IQR metrics should be used to determine impact. Also the impact of staff survey and other feedback mechanisms.

DA summarised that we have heard about some improvements in processes, and about the need to tackle lived experience of staff across the board, but in particular in 111 EOC given the very high turnover. Let's ensure good evaluation of training, but we have good metrics already as mentioned earlier. While the Board supports the work on culture, it acknowledges that we won't make the significant improvement required, all the while staff are in survival mode. This links to board development on culture and the role of the Board in setting culture and how we help achieve a better working experience for our people.

<u>East Kent Maternity Review</u>
FM introduced this report that was published in October. It is a harrowing report of poor care, lack of compassion and lack of leadership. There are five recommendations and the paper pulls out the cultural similarities to SECAamb, nine different areas on page 5. It is for the Board to reflect and seek assurance that these areas are adequately covered in our Improvement Journey.

FM noted that we weren't involved in this investigation. We have however done much work via our Consultant Midwife to ensure we use the learning using the mantra: those who work together should learn together.

SM is struck by the much greater focus on culture than the technical clinical aspects. Making Data Count helps us mitigate one issue related to not having visibility at Board on what is in front of it. Culture and leadership is critical to good clinical care. On organisational behaviour looking good while doing badly, SM reflected that she has seen at Board acceptance and a degree of reflection that this took a while for us to get to, but we can demonstrate now a positive change from June, with our focus around the Improvement Journey to help get to the root of issues which is what we are doing.

LS asked what happens to this review next and will we share it more widely as it is a good assessment. FM will explore how to use this to inform the fundamentals course.

Action
WWC to confirm how we intend to ensure the learning from the East Kent Maternity Review as it is applicable to SECAmb and seek assurance that there is a process in place to ensure we use the lessons from the various culture-related issues.

In summary, DA reflected on how we must not fall into the mistakes of East Kent and use this in way to ensure we learn the lessons.

WWC report

SS focussed on the areas of escalation. Firstly, related to 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. The Board supported this.

Action
WWC reported to the Board in December that the Board has good visibility of aspects of Culture and Leadership but has less visibility on Staff Health and Wellbeing. It 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.

The second escalation related to 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. The Board supported this.

Action
In the context of the growing list of training needs for staff, WWC suggested that 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 Board agreed that at its meeting on 2 February, a report is received setting out the requirements with a proposed order of priority.

72/22 Operational Performance & Efficiency [12.56-13.15]

EW provided an overview, outlining the performance challenges and where we sit against ARP and how we compare nationally. She focussed on the areas in her cover paper, reinforcing the need for a root and branch change to the operating model, which relates to the associated BAF risk.

DR expressed concern about the special cause variation in the IQR related to call answer performance, and its link to patient safety. EW is also concerned about this and is working with her senior team across operations, medical and quality, to ensure we take actions. DA noted the gap in information to inform the Board's level of assurance and asked for the following action.

Action
At the Board meeting in February a paper to be received that sets out the steps being taken to improve calls answer performance.

SM noted that 111 call activity is significantly above what we are commissioned and asked what more we can do. EW responded that we have 45% abandonment rate nationally and outlined some of the actions being taken, locally and nationally. DA asked that we watch this closely and if via SVCC we are adversely impacted we need to be clear about this. Also, we need to look at commissioning intentions and track the consequences of this on services we provide and the experience of patients.

TQ asked when we will review the SVCC transition which is between now and March.

Action
An update to Board in April on the transition to SVCC and QPSC in Q1 to seek assurance on the impact of this on patient quality/safety.

Performance Committee
HG confirmed that this committee is now stood down as recommended by the Board Effectiveness Review. He verbally updated one escalation related to Hear & Treat as we are significantly below the 135 target. EW responded that we are working on different measures to improve this and it will be tracked as part of IQR.

DA summarised that we need to keep a close eye on the transition to SVCC. The pressure on EOC is acknowledged and the related impact on both staff and patients; this has both executive and Board focus.

73/22 Achieving Sustainability / Working with Partners [13.15-13.33]
MS confirmed that we are testing the new finance report in Part 2 and it will come to Part 1 from February. In the meantime, there is focus on the BAF risk related to financial sustainability. At 31 October we have a deficit of £2.7m against the target of £2m. We know the underlying risks are about £8.9m. We have identified £5m of this and are taking steps to close gap further; £2m of this relates to receiving less income following funding being withdrawn late by commissioners.

MS reflected that we haven't paid enough attention to cash and eroded quite a bit this year. We are a capital heavy organisation and so need in future to make a surplus, making recurrent and cash releasing savings. The change next year is to move from a business case to an improvement case process using the Six Sigma approach that must improve performance of the organisation, finance and/or quality. The Board clarified the cash forecast of £30m and was content with this.

SS is concerned about our work on culture and the need to make investments in HR and other areas, so she asked for assurance that as we make savings, we don't adversely impact the key improvements we need to make, noting culture drives everything we do. MS has seen the culture change business case and in the context of the non-recurrent nature of this against the likely funding over the next two years, he is confident the investment needed is affordable.

There was a discussion about our investments in MRCs and the need to ensure we deliver the benefits. The Board has an agreed estate strategy and the overall aim is to improve the working environments for our people to enable then to deliver the best possible care to patients.

FIC report
The Board noted the report and the key issues arising have already been covered.

74/22 Regulatory Compliance / Strategic Priorities 2023-24 [13.33-13.45]
DR reinforced that the Improvement Journey has been the framework to address the issues highlighted by the staff survey and CQC to help us deliver sustainable improvements. We are moving from the sprint to a marathon. Having focussed on the Warning Notice we now need to take a more sustainable approach using QI, as per the scheduled presentation in part 2. The plan for the next three months is to develop a framework for the Must / Should Dos and RSP Exit Criteria, and the related 60 deliverables we are thematically arranging within our priorities. Building on the discussion today related to staff welfare and operating model, the Improvement Journey will evolve into our strategic delivery plan.

The paper sets out the strategic priorities arising from the recent engagement sessions, and these will be shaped during January to help ensure a bottom-up improvement journey.

The Board acknowledged that the Improvement Journey BAF risk will be reviewed post the CQC session in January.

DA felt that we are able to demonstrate significant progress, as reflected by some of the discussion today which has covered the various elements of the Warning Notice. In terms of Board disconnect, we have today focussed on the current issues staff and patients are telling us, and we are developing priorities to ensure alignment. In terms of quality of Information, the IQR and BAF has improved significantly. The next level development will be to empower local OUs to use data to drive decisions locally to improve care and staff experience. Progress has been described today in risk management, but still more to do and we continue to have a central focus on culture and will do for the foreseeable future.

The Board noted the plan to confirm the strategic priorities in Q4 ahead of the new financial year and use these to inform local objectives so there is alignment throughout the organisation. It supported the aim to evolve the Improvement Journey into strategic delivery, in the context of the work we need to do over the coming year to establish a new Trust strategy.

75/22 Review of Board Effectiveness [13.45-13.50]
The Board felt that the quality of information is helping to inform the right discussions and challenge. There was reference to the SPC charts in the IQR but a sense that this could be even more explicit using the SPC methodology.

The Board welcomed the new metrics on fleet. This is for many the main clinical workspace and so we need greater visibility of issues and impact on patient safety and staff welfare.

The Board felt the meeting was effective, but very long (4 hours). This risks impacting energy levels and so asked if we could arrange the agenda in future to 3 hours.

76/22 AOB
None

There being no further business, the Chair closed the meeting at 13.55

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 _____

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	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	C	15.12.2022: To be picked up in the CEO report to Board and under the agenda item - keeping patients safe. See Minute
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	C	15.12.2022: MS confirmed that this BC is being reviewed to ensure it is aligned with requirements in particular the recruitment pipeline. He will help to ensure resource needed in staged in a way that ensures affordability. EW added that we are also looking at skills mix and this will determine the structure needed within clinical education. SS asked about the timeframe and MS responded that it will be mid-January as the bulk of the planning will be done by then. This will help ensure we right size Clinical Education. **22.01.2023: PL has added this to the forward plan for WWC to pick up at its February meeting as part of the workforce plan paper. WWC will report back to the Board on 6 April as part of its Escalation Report.**
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	C	15.12.2022: On the agenda - keeping patients safe. See Minute
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	C	15.12.2022: Pl confirmed that this was reviewed by EMB on 09.11.2022 and is covered on the agenda, referring the Board to the cover paper for Improving Culture and link to the IQR. See Minute.
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	C	15.12.2022: Added to the agenda of QPSC from January 2023 and to the COB for 23/24. Outputs of the committee's review will be set out in the report to Board.
27.10.2022	66 22d	AUC to receive assurance that the process for recording FTSU cases is implemented	RN	15.12.2022	AUC	C	15.12.2022: PL confirmed that the report to AUC was deferred from the meeting on 7 December for the reasons set out in the committee's Board Escalation Report. However, the IQR now includes additional metrics, including the numbers of FTSU cases (which helps to demonstrate better clarity of recording cases). Action is closed and the AUC Board report will reflect its ongoing review of FTSU.
15.12.2022	68 22	The AGS to sufficiently cover the IT Critical Incident; why it happened, the impact and the action taken.	PL	Q1 2023/24	AUC	IP	Draft AGS scheduled for March meeting
15.12.2022	70 22a	QPSC to seek assurance on the implementation and effectiveness of the Falls Programme.	PL	Q1 2023/24	QPS	IP	Added to COB
15.12.2022	70 22b	At its meeting in January, QPSC to seek further assurance on the corrective action being taken to ensure clinically appropriate and timely welfare calls to patients who are delayed waiting for an ambulance	RN	24.01.2023	QPS	C	Paper received on 24.01.2023 - see QPS Board report on agenda
15.12.2022	70 22c	As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.	DR	Q1 2023/24	Board	IP	
15.12.2022	70 22d	In light of the special cause variation in the IQR, related to complaints responses, EMB will review the process map for complaints management and report back to Board the reasons and corrective action.	RN	06.04.2023	Board	IP	
15.12.2022	70 22e	The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.	SM	Q1 2023/24	Board	IP	
15.12.2022	71 22a	WWC to seek assurance that the executive is striking the right balance between patient safety and staff welfare, related to shift overruns. Noting the failing process identified in the IQR	EW	16.02.2023	WWC	IP	On agenda 16.02.2023
15.12.2022	71 22b	DR to clarify the recruitment target of 3946 (reported in the IQR) as there was some confusion about whether this is the right number.	DR	02.02.2023	Board	IP	DR to verbally update on 02.02.2023:
15.12.2022	71 22c	WWC to seek assurance that we are ensuring robust induction, training and support to the international recruits to ensure they are welcomed and supported in the transition to the UK and to SECAmb. Ensuring learning from when we did this 4-5 years ago when a high number of recruits left within the first 12 months.	AM	16.02.2023	WWC	IP	On agenda 16.02.2023
15.12.2022	71 22d	WWC to seek assurance that we are identifying strategic solutions to improve the working experience in our EOCs, to address the very high turnover rates identified in the IQR.	AM	16.02.2023	WWC	IP	On agenda 16.02.2023
15.12.2022	71 22e	WWC to seek assurance that we have a consistent process in place that ensures we evaluate the impact of training (using appropriate metrics) to test that it delivers what is expected, to include specifically Fundamentals and Sexual Safety.	AM	Q1 2023/24	WWC	IP	Added to COB
15.12.2022	71 22f	WWC to confirm how we intend to ensure the learning from the East Kent Maternity Review as it is applicable to SECAmb and seek assurance that there is a process in place to ensure we use the lessons from the various culture-related issues.	AM	16.02.2023	EWWC	IP	On agenda 16.02.2023
15.12.2022	71 22g	WWC reported to the Board in December that the Board has good visibility of aspects of Culture and Leadership but has less visibility on Staff Health and Wellbeing. It 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.	AM	02.02.2023	Board	IP	Scheduled for the Board agenda but has been deferred.
15.12.2022	71 22h	In the context of the growing list of training needs for staff, WWC suggested that 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 Board agreed that at its meeting on 2 February, a report is received setting out the requirements with a proposed order of priority.	AM	06.04.2023	Board	IP	Initially scheduled for 2 Feb, but deferred to April to give time for a review at the ETD Group. In the meantime a paper on Key Skills came to QPSC in January, giving assurance that there is sufficient links to learning from complaints and incidents in the design of the training programme.
15.12.2022	72 22a	At the Board meeting in February a paper to be received that sets out the steps being taken to improve calls answer performance	EW	02.02.2023	Board	C	On agenda
15.12.2022	72 22b	An update to Board in April on the transition to SVCC and QPSC in Q1 to seek assurance on the impact of this on patient quality/safety.	EW	06.04.2023	Board	IP	

Key

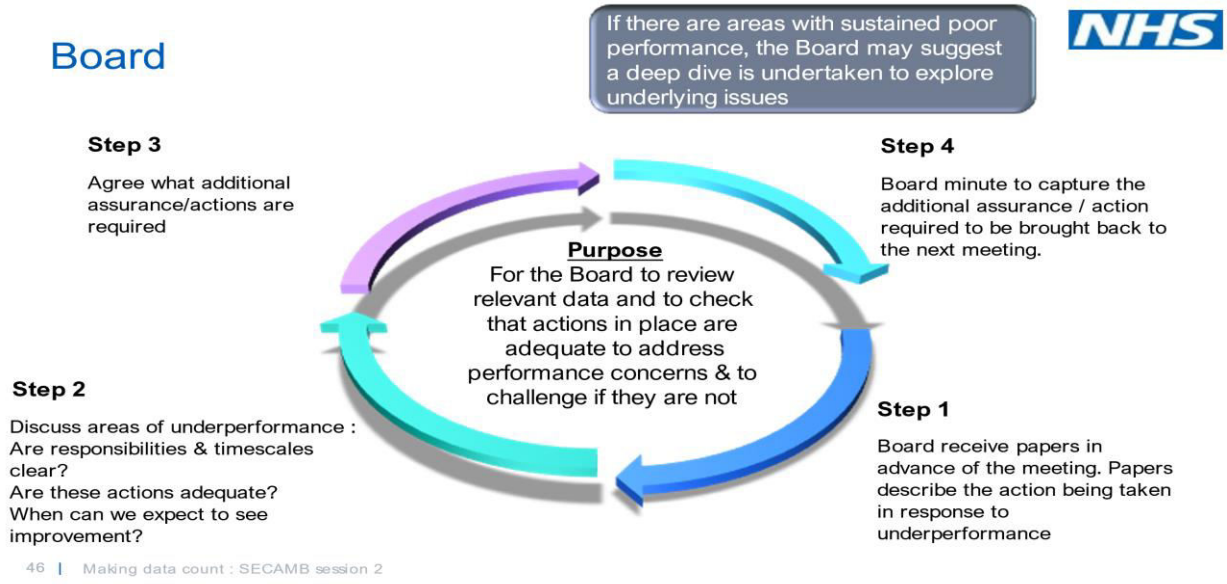
- Not yet due
- Due
- Overdue
- Closed

		Item No	81-22
Name of meeting	Trust Board		
Date	02.02.2023		
Name of paper	Chair Board Report		
Report Author	David Astley, Chairman		

Board Meeting / Effectiveness

The Board has taken positive steps in the latter half of the year, to ensure meetings are more effective. There is clearer links with our strategic goals and related risks, using the primary board papers – the Board Assurance Framework; Integrated Quality Report; and Improvement Journey.

Using the steps of the assurance cycle, this meeting will follow up on some of the additional assurance sought in December as captured in the actions, such as the concerning 999 call answer performance.



At the last meeting, I set out the outputs of the Board Effectiveness Review, undertaken by our Improvement Director. The Escalation Reports to the Board will describe how each committee is implementing the recommendations from this review. On today's agenda we will consider the outputs of the meetings of both the Quality & Patient Safety Committee and Finance & Investment Committee, with Workforce & Wellbeing and Audit & Risk next meeting in February and March, respectively.

The Effectiveness Review also made recommendations for the Board itself, and progress to date is outlined below:

Recommendation	Progress
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.	This has been historically covered by the Standing Orders (SOs). The SOs are currently being reviewed and will come to the Board early in Q1 2023/24.
To ensure the views of the council of the Council of Governors (COG) is expressed and considered at the Board	These are picked up in the Chair's Report. The Report in December covered the COG meeting the week before and aligned closely to the issues covered by the Board at that meeting. The Report to the next Board in April will cover issues from the COG on 23 February.
Individual authors, the Chair and the Secretary to ensure papers adequately address the need to assess, monitor and drive improvements.	This is ongoing, to ensure continuous improvement.
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.	As set out in the December Chair's Report, the focus of Board development throughout Q4 will be culture and the specific role of the Board.
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.	This was introduced in December 2022.
In the summary of a discussion, the Chair to make it explicitly clear how any identified assurance gaps will be addressed	Ongoing. The minutes and action log provide evidence of this.
The chair to consider if the introduction of a disciplined framework to questions and answers will further strengthen the operation of the Board.	The Board agendas are now organised against the strategic goals and the 'primary documents' are used to guide the key areas of assurance the Board needs to explore. Making Data Count and the development of the new IQR leads the Board to focus primarily on the failing processes, as identified by the SPC charts. Executive Directors are reminded to summarise briefly the key points, therefore allowing the time for questions and challenge, using the assurance cycle included in the Chair's Report.
It is recommended that personal engagement is identified in the Development Need Analysis of the Board and addressed through the development plan.	This was confirmed as one of the outputs of the Workshop on 18 January 2023, related to the Board's Well-Led Self-Assessment. It will be addressed through objective setting for

	2023/24 and overseen by the Appointments & Remuneration Committee (for Executive Directors) and the Nominations Committee (for Independent Non-Executive Directors).
It is recommended that the Board reviews its current frequency.	The Board has reviewed its frequency of meetings and has reverted to meeting formally bi-monthly; the first Thursday of each month. In the intervening months the Board will meet informally to address its identified development needs. The focus of the development meetings in January and March 20023 will be Culture and the plan for 2023-24 will be agreed at the Board meeting in April, using the outputs of the aforementioned Well-Led Self-Assessment.

In the table above I have referred to the Well-Led Self-Assessment, which we undertook as a Board during November and December. This was a really helpful exercise. The Workshop on 18 January facilitated by our Improvement Director was also helpful in working through our assessment and we have a fairly consistent view about where we are against the key lines of enquiry. The summary of this is that despite the ways in which we have improved as Board, especially in the past six months or so, there is much improvement still required. This will inform the design of the Board's development programme for the coming year, and I will be bringing details of this plan to the next meeting on 6 April 2023.

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. Board members have continued these and I visited our EOC's in Crawley and Coxheath during the last day of industrial action. I spoke with staff and Trades Union colleagues. All were working in partnership to ensure that patients received an appropriate response. Since the meeting in December some of the specific issues arising from the leadership visits include:

- Visibility of senior leadership on the "floor" and the quality of 2-way communications.
- CPD is a consistent theme with staff feeling supported or having limited options available to them.
- The flexibility of rotas
- Recognising success has been a common theme in terms of what can be done to improve moral

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

meeting.

Board Appointments

I am delighted to be able to welcome two new additions to the Board. Firstly, Rachel Oaten - Chief Medical Officer, will join on 1 February 2023 and so this will be her first Board meeting. Rachel succeeds Fionna Moore who is stepping down from her role as Medical Director as announced last year, after 50 years' NHS service. In addition to Rachel, Max Puller will be joining on 6 February, as Independent Non-Executive Director. We will welcome Max formally to the Board at our next meeting in April.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	82-22

Name of meeting	Trust Board
Date	02.02.2023
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 December 2022 and January 2023 to date. Section 4 identifies management issues I would like to specifically highlight to the Board.

A. Local Issues

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

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

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

- Reviewed the mental health/wellbeing support available to staff
- Closely considered 999 call answer performance and associated risks and mitigations
- Reviewed pressures on provision of medicines

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 **Launch of 'Your Mind Matters' internal campaign**
I am pleased that on 30 January 2023 we launched 'Your Mind Matters' – an internal campaign focusing on the need for self-honesty about our own mental health and which clearly outlines the support and help that is available for all colleagues, our volunteers and our students.

7	The campaign is running for four weeks and we are utilising all of our communication channels, including posters, podcasts and pop-up messages and close working with our partner universities, to ensure as much exposure as possible
8	In addition, to ensure that all colleagues are aware of the support that is available to them if needed, we are issuing everyone, individually, with a small card containing the relevant information.
9	The framework for the campaign is based on the Association of Ambulance Chief Executives (AACE) mental health continuum, which emphasises the importance of honest self-awareness and which utilises four levels - in crisis, struggling, striving and thriving – to help people to recognise that they may need help.
10	At a time when we know many are finding things tough, we are keen to ensure that we are doing what we can to make sure everyone knows what help and support is available.
11	**Go live of new internal social media platform** On 1 December 2022, we went live with 'Yammer', our new internal social media platform, available to all staff and volunteers via our Intranet and Teams platforms and via the Yammer app on all Trust iPADs and mobile phones.
12	Yammer is a Microsoft 365 product that includes a range of mechanisms to allow colleagues internally to communicate, share ideas and recognise each other's achievements. It is based on a framework of communities/groups, that can be created by teams or based around areas of interest; as part of the go-live, we created a 'Team SECAmb' community, with all staff and volunteers as members.
13	It will take time for the platform to develop and grow but we are encouraged that we have already seen almost 50 new communities created and much positive debate and engagement on the site. We will continue to work hard to grow use of the platform as part of our on-going work to improvement internal communications and engagement.
14	**Christmas Stars initiative** To coincide with the launch of Yammer on 1 December, we also launched our peer-to-peer recognition initiative – 'Christmas Stars'. This involves colleagues nominating a colleague, who they feel deserves particular recognition, as a 'Christmas Star'. 24 'Stars' were then picked to feature each day during December across all of our internal communication platforms.
15	The names of all 'Stars' were subsequently entered into a prize draw, with three winners picked randomly on Christmas Eve each receiving prizes generously donated by a number of our suppliers.
16	Between 1 and 16 December when nominations closed, we received 111 nominations, exceeding last year's total of 85, from every OU, EOC and 111 centre and from almost every corporate team, as well as for some of our volunteers. The initiative was very positively received, with really positive feedback from all those

17	involved. Themes from other feedback provided included: • The initiative provided a good and visible opportunity for managers to recognise team members • It provided an opportunity to recognise all areas of the Trust, including those we sometimes hear little about • It provided an opportunity to break down barriers (perceived or otherwise) between different teams and areas
18	We will continue to build on positive initiatives such as this as we developed our broader recognition approach.
	B. Regional Issues
19	**Volunteer Emergency Responder trial** I was pleased to see the trial begin at the end of January of a new volunteer Emergency Responder role within the Trust.
20	The trial, which covers areas within the Ashford and Tangmere Operating Units, will last two years and sees two Emergency Responder (ER) teams, each consisting of 12 Community First Responders (CFRs), operating out of a SECAmb base or standby point rather than responding from home.
21	The ERs have undertaken blue-light driving courses and additional clinical training and will respond in a specially marked and equipped Trust vehicle, utilising blue lights and sirens to reach patients. Their scope of practice focuses on providing a safe and effective initial response to life-threatening emergencies, where extended care may be required prior to the arrival of an ambulance clinicians.
22	As is the case with CFRs currently, we will also assign a staff response at the same time as assigning an ER.
23	This new concept is targeted at some of our hard-to-reach more rural areas and sees us testing a new approach to responding to patients, in a way which has previously only been utilised in London. By having the capability to respond in a Trust vehicle and using blue lights and sirens we are extending the geographical reach of volunteers.
24	We are incredibly proud and grateful for the commitment shown by all our volunteers and I would like to thank all those who have been willing to step forward to test this innovate role at SECAmb and to further support patients in the communities we serve.
	C. National Issues
25	**Industrial Action** Following a ballot as part of the national pay dispute, our local GMB branch undertook industrial action on 21 December 2022 and on 11 January 2023.
26	Ahead of both periods of industrial action in our region, we worked closely with the union and all staff to ensure we were able to continue to respond to our most seriously unwell or injured patients and that the impact of any industrial action on our

	patients was kept to a minimum.
27	We would like to thank our staff and volunteers for their hard work and commitment, including colleagues who, while participating in industrial action, continued to respond to patients in line with the arrangements agreed with our local GMB union branch.
28	Our thanks also go to NHS colleagues and other partners, including hospital teams, for their support in ensuring patients were able to be handed over at hospitals in as timely a manner as possible and for the public who helped us by using our services wisely during these periods.
29	We have been informed by our local GMB branch that they intend to undertake further periods of industrial action on 6 and 20 February and 6 and 20 March 2023. The RCN have also notified us of industrial action taking place on 6 and 7 February 2023. We await the outcome of ballots underway currently by our local Unison (16 February) and Unite (10 February) branches.
30	**National Ambulance Volunteer Strategy** We were pleased to see the recent launch by the Association of Ambulance Chief Executives (AACE) of the first Ambulance Volunteer Strategy.
31	The new Strategy, which has been developed utilising input from a wide range of stakeholders, recognises the significant benefits that volunteering brings for patients, staff, organisations and volunteers themselves and demonstrates the commitment to supporting and enhancing volunteering opportunities in the ambulance sector.
	D. Escalation to the Board
32	**Improvement Journey** Delivery of our Improvement Journey has continued during December and January. Whilst continuing to address the Warning Notices, issued previously by the CQC, we are also starting to shift our focus to prioritise the 'Must Dos' and embed a more sustainable approach to improvement as business as usual.
33	I have been pleased to see us begin to utilise a more focussed 'Quality Improvement' approach to the different workstreams under our Improvement Journey, using robust and relevant data from our Business Intelligence (BI) team. A good example of this was the recent work undertaken as part of the 'Responsive Care' workstream, which focuses on reducing harm to patients awaiting a clinical call back.
34	**Operational Performance** All ambulance services remain under significant pressure, although we have seen an overall reduction in recent weeks in both 999 and 111 demand.
35	We continue to work hard to ensure that we provide as responsive a service as possible to our patients although we continue to see high levels of sickness amongst our operational staff, which impacts on the level of resources available to us.
36	In Categories 2 and 3, we continue to perform well compared to our peers nationally. However, our 999 call answer time performance has deteriorated significantly during

37	Q3 and we are an outlier for this metric when compared to our colleagues nationally. This remains the key area of focus for us currently in terms of operational improvement.
38	We continue to review our REAP Level regularly but remain at level 4 currently.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	83-22

Name of meeting	Trust Board
Date	02.02.2023
Name of paper	Board Assurance Framework
Strategic Goal	All
Author	Peter Lee, Company Secretary

This BAF report seeks to align with the strategic goals and priorities within the Improvement Journey, and the relevant metrics in the IQR. It 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 ensure the right areas of focus. This is reflected in the committee reports to the Board, which reference the related BAF risk(s).

The BAF risks also inform the focus of Board meetings, as reflected on the agenda and set out in the separate cover papers.

The BAF was reviewed last by the Audit & Risk Committee at its meeting on 7 December 2022, and by Executive Management Board on 25 January 2023.

The Board is asked to use this report to inform its discussion and, in particular, cross referencing against the stated controls and mitigating actions. Then, using the assurance cycle referred to in the Chair's report, where gaps in control are identified to 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 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 following the update in December, will be covered in the Improvement Journey report to Board on 2 February 2023.

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.

2.5. 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.

3. Structure of the BAF Risk Report

3.1. 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.

3.2. 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.

3.3. 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

4. Oversight & Delivery

4.1. 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**
				
	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

5. BAF Risks

5.1. The Board Assurance Framework has ten strategic risks, as listed in the Dashboard below.

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

5.3. The Risk and Assurance Group meets monthly and reviews all risks on the risk register and this informs the Risk Report received by EMB each month.

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

5.5. Each BAF risk cross references to the relevant SPC chart from the IQR, where applicable. The Key to the SPC icons is in Appendix 2.

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

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

5.8. Risk 257 (Improvement Journey) will be reviewed following the meeting with the CQC on 31 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			Nov 21	Jan 21	Mar 22	May 22	Aug 22	Sep 22	Dec 22	Jan 23			
14	Operating Model	QPS	✓	✓	✓	✓		20	20	16	16	16	16	20	20	20	⇔	08	Mar-24
255	Workforce – Recruitment	WWC	✓	✓	✓	✓		20						16	16	16	⇔	04	Mar-23
13	Workforce – Retention	WWC	✓	✓	✓	✓		16	16	12	12	12	16	16	16	16	⇔	08	Mar-24
348	Culture & Leadership	WWC	✓	✓	✓	✓		16							16	16	⇔	08	Mar-25
17	Integration of 111 & EOC	QPS/FIC			✓	✓		16		16	16	16	16	16	16	16	⇔	08	Mar-23
256	Quality Improvement	QPS		✓				16					12	12	12	12	⇔	04	Jun-23
257	Improvement Journey	All	✓	✓	✓	✓		12					08	12	12	12	⇔	04	Jan-23
15	Education Training & Dev	WWC	✓	✓				16	12	12	12	12	09	09	09	09	⇔	06	Mar-23
16	Financial Sustainability	FIC	✓	✓	✓	✓		16	16	16	12	12	16	16	16	16	⇔	08	Mar-23
71	Cyber Attack	FIC		✓		✓		16						12	12	12	⇔	09	TBC

BAF Risks

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

Underlying Cause / Source of Risk:	**Accountable Director**	Executive Director of Operations
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.	**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	Resource need has been mapped against predicted demand however due to the need to pause to address several grievances, implementation of new rotas has been postponed. The hearings into these issues have been completed and next steps have been agreed which should lead to implementation across all operational areas during Q1 2024/24.
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	Comprehensive plan that sits in the Improvement Journey under the Responsive Care Group – now also gaining QI support to drive the pace and quality of improvement. Current focus on the C3/C4 revalidation work and considering increased performance seen on the days of industrial action.
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	Prioritisation of recommendations completed with initial focus on reviewing the standard operating procedures, resetting the Dispatch Team Leader role and developing a quality assurance framework for the dispatch function including KPIs for staff.
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	Three component parts have been identified with different approaches to each: 1) mobilisation/dispatch time which is partially addressed within the dispatch review above, 2) the Clinical Advisory Group has been tasked to look at the on-scene component, clarifying what is expected from a clinical and patient management approach, 3) handover and wrap-up times – this is a business as usual function with improved visibility through unit statistics reporting.

	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 Workforce Plan monthly monitoring of projected position
- Additional Recruitment Events
- International Recruitment
- Increasing capacity of compliance checks driving delays in EMA recruitment
- Review of Recruitment Pathway *(new)*

Integrated Quality Report Metrics for Assurance	Variation	Assurance
WF-1 "Number of Staff WTE"		
WF-3 "Time to hire"		
999-12 "999 Frontline Hours Provided %"		

Gaps in Control

The Trust is currently 140 WTE behind on its frontline workforce plan for the month of December. The projected shortfall by the end of the year is projected to be 38 WTE against the plan of 2555 WTE due to the mitigating actions taken through AAP recruitment. Our EMA establishment is currently 74 WTE behind plan, with a projected shortfall of between 58 and 77 WTE against a requirement of 277 WTE by end of the FY.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) December Integrated Plan: 140 WTE below plan (999 frontline) (-) December Integrated Plan: 74 WTE below plan (EOC EMA) (-) On road hours significantly below target (+) 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 58 to 71 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 have been additional recruitment events held to recruit external AAPs.	Director of HR	31.03.2023	Update 20.01.23 - further assessment centres have now been held with 50 ECSWs offered AAP apprenticeship places (first course starting April 2023). A further 41 have started the AAP apprenticeships in January 2023 (2022 recruits).

(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	Update 20.01.23 - 37 international recruits have now started, a further 18 will be starting in March 2023 plus 45 experienced paramedics are in the offer stage; Additionally, 30 international NQPs are in the offer stage with further assessment centres booked for 21.01.23 and 25.02.23 (19 candidates in pipeline currently). SECAmb have been invited by HEE (with YAS and SCAS) to take part in an in-person recruitment event in Brisbane, Melbourne and Sydney in late January/early February. This will also include opportunities to meet with local universities to strengthen future pipelines.
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	This is being scoped and written up to pilot.
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	31.03.23	Update 20.01.23 - additional temporary support has been sourced externally (1.0 wte), internal temporary transfer from 111 until September 2023 plus further temporary appointments and transfer of operational budget to assist. Aside from the temporary 111 transfer, all other arrangements are only until the end of March 2023 and will need permanent changes to capacity from April 2023.

(P&C-7) Recruitment Pathway examined to identify where efficiencies can be made	Director of HR	31.03.2023	Update as at 20.01.23 Review of recruitment pathway – progress update. 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. a. Stage 1 to map current processes – target completion 01/10/22 - **complete** b. Stage 2 to build effective measure of data – target 01/11/22. - **complete**. c. Stage 3 to analyse data and identify ineffective processes – target 01/12/22 - **complete.** d. Stage 4 Improve processes – target 01/01/22.This has been adapted to deal with the volume of recruitment as no processes were identified as ineffective. Extra FTE has been temporarily resourced to help with the volumes of work passing thru the recruitment team, and with the reallocation of workloads is intended to help with TTH reduction. In house processes such as staff change forms are to move to Marval which will help the end of the recruitment process and will be implemented once tested. (new provisional date end of Jan 23). Other progress – (1) ‘offer on assessment day’ now implemented – since October 2022 and (2) TTH metric added to PowerBI Recruitment Pipeline Dashboard – also October 2022. e. 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	30.08.23	Interim People Strategy to be considered by EMB in February 2023

	BAF Risk ID 348 Culture & Leadership	Target Date: March 2025

Underlying Cause / Source of Risk:		
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.	**Accountable Director**	Executive Director of HR and OD
	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 - **complete**
(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 - **complete**
(P&C-8) Development of a People Strategy and related plans	Director of HR	30.08.2023	Interim People Strategy to be considered by EMB in February 2023
(P&C-5) Implementation of the NHS Culture and Leadership Programme	Director of HR	31.12.24	Implementation has commenced with Culture Working Group established, Programme Director appointed (starts 08.03.23) and Scoping Phase (Phase 1 of 4) commenced.
Implement the Just and Restorative Culture methodology and principles	Director of HR	31.12.24	Agreed to be a workstream within the Culture and Leadership Programme

	BAF Risk ID 17 Integration of 111 & EOC	**Target Date:** **March 2023**

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. • **Implementation has been deferred further to March 21st 2023** for the SE Region – MOU & DPIA under development. Continued progression against IT, workforce and commissioner actions to meet go-live requirements.	**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
• Deputy Director of QI in post • QI methodology (Lean Six Sigma) presented to Board and agreed. Now being socialised across the organisation. • QI project on Keeping Patients Safe in the Stack commenced in January 2023. • Baseline QI survey to assess competence, confidence and motivation for QI shared. 400+ respondents thus far. This will inform work plan moving forward. • JD/PS developed for Head of QI, QI Facilitator and QI Project Support Officer. All roles being evaluated. • Communication and Stakeholder Engagement ongoing including a QI page on the intranet • First Introduction to QI training session for 36 staff members booked for 25th January 2023.	TBC		

Gaps in Control
No resource for QI team currently.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Post-holder in place (+) QI methodology in place and being socialised across the organisation.	

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 has been agreed.

(QI-8) Training plan to be established and underway	Director of Quality	April 2023	Initial 'Introduction to QI' training session booked for 25th Jan. Monthly training sessions to be booked thereafter. A full training and development plan will be agreed and implemented once QI team is in place.
(QI-8) Coordinated learning infrastructure/framework in place – see QI workstreams within the Improvement	Director of Quality	April 2023	

	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 in 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. ▪	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	(-) Programme of deep dives for Must-Do's needs to be agreed and scheduled over the next Quarter to ensure Board has visibility of progress against Must-Do's (-) No agreed continuity of programme resources beyond 31st of March or agreed executive structure for development of sustainable improvement and monitoring.

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. Updated report in February to include detail behind the Must-Do's
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. Update 22/01/23 – Well-led session conducted with ID on 18/01/23. Overall position demonstrates a self-assessment of Requires Improvement. Outputs from Well-led review to be included into
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. Update 22/01/23 – Steering group has reviewed scope of all deliverables against

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. Update 22/01/23 – Initial proposal for a continuous improvement framework reviewed with the leadership team (EMB and SMG) on 18/01/23.

	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 2023/24	Director of HR	31.03.2023	To be reviewed at EDTG prior to 31.03.23

	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	The action card has been developed and is going for sign off by IT management on Monday 23rd January.
An action card is being developed to cover Trust wide cybersecurity events.	Director of Finance	25.11.2022	Additional information was required to progress this action card. This has now been obtained and a new target date set of end of February.
Board-level Cyber Awareness Training	Director of Finance	02.02.2023	Scheduled

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
304	**SECAmb's Ability to reach the Net Zero Target sent by NHS England** *NHS England have set the aim to be the worlds first net zero national health service They have set two targets* ** For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;* ** For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.* *There is a risk that significant un-quantified investment will be required to meet de-carbonisation targets, which is not currently identified within our investment plans* *There is a risk that the implications on our operating model are not fully understood, or the time required to change our operating model to achieve environmental*	15	15	10	Director of Planning

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
	sustainability *There is a risk that we have not reviewed our clinical strategy to reflect the needs of the population we serve under the implications of climate change*				
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.* *Update as 20.01.23. Industrial action continuing with further dates announced for 6 and 20 February and March 2023.*	16	25	08	Director of HR
New 34	**Sustainability in the Medicines Governance Team** There is a risk that medicines orders will not be met at the medicines distribution centre (MDC) due to increasing demand placed on staff at the MDC and the lack of resilience stock which may lead to areas in the Trust not having adequate amount of medicines to stock vehicles and patients not receiving medication. There is also a risk that other medicines portfolio work (eg PGD reviews) will not take place as a result of ongoing vacancy in the clinical pharmacist post which may lead to poor medicines optimisation and progression of any service improvement work in medicines.	12	**16**	08	Chief Pharmacist
New 82	**HART Capacity** There is a risk that the Trust will be unable to meet its HART compliance requirement to deliver a safe system of work for HART staffing, as a result of national funding arrangements which may result in patient harm and or reputational risk.	12	**20**	06	Head of Resilience and Specialist Operations
New 36	**Trend of poor identification of STEMIs by SECAmb clinicians** There is a risk that SECAmb clinicians' skills in ECG recognition is declining over time. As a result, patients may not receive timely treatment for STEMI or potentially life-threatening arrhythmias. There has been a cluster SI of 3 cases, plus 2 more incidents reported where STEMIs were not pre-alerted to pPCI centres in the last 6 months.	12	**15**	06	Clinical Pathways Lead

Appendix 1 - Risk Scoring

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

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

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Negligible	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	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 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	Service loss of any critical area Service loss of non- critical areas	Extended loss of essential service in more than one critical area	Loss of multiple essential services in critical areas

		Financial loss £10-50K	>6 hours Financial loss £50-500K	Financial loss of £500k to £1m	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.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently **HIT OR MISS** the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – February 2023

Reporting Period: November & December 2022

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

Contents

Improving Quality of Information to Board – February 2022

- Following additional Board development sessions with NHSE, we have made 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.
  - ***(New February 2023)*** Period-on-period variation markers have been added to support the Board in identifying where the trends have changed vs the immediately prior report
  - ***(New February 2023)*** Financial reporting run charts have been added against plan for the main indicators. This is supported by the standalone Finance Report received now monthly.
- 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.
- 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.
- Our focus now is to strengthen the narrative even further, before any further changes are done, and there is a development log managed by Business Intelligence
- 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. A **Data Strategy** will be developed in Q4 to drive improvement forward.

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

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

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Quality Improvement

QUALITY IMPROVEMENT

Summary

December 2022

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

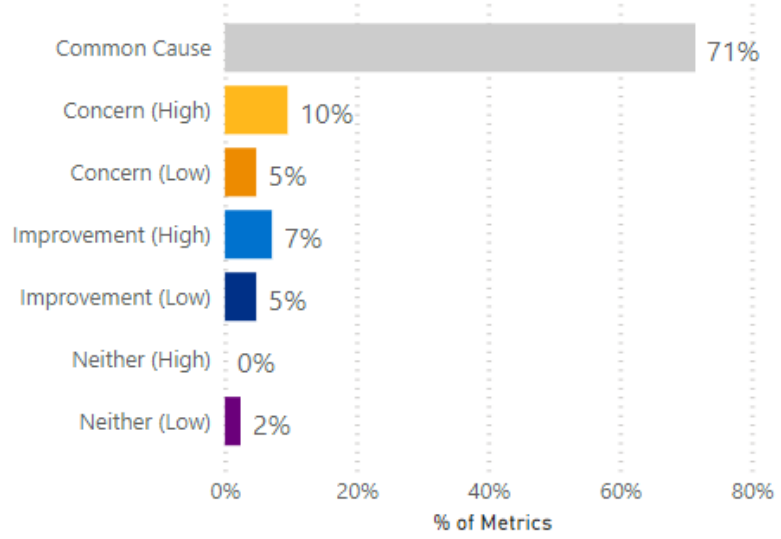
QUALITY IMPROVEMENT

Overview (1 of 3)

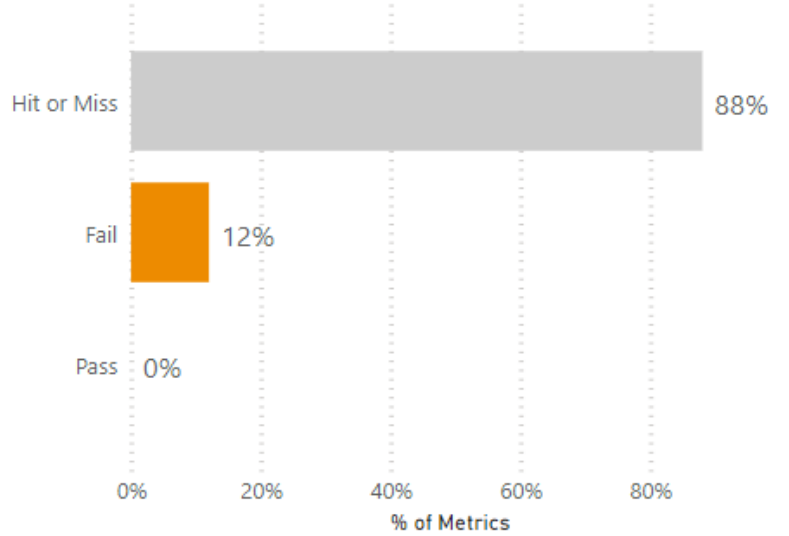
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Dec-2022	171		75.04	145.6	216.16		
Number of CD Breakages	Quality Improvement	Dec-2022	32	0	1.65	18.45	35.25		
Number of Datix Incidents	Quality Improvement	Dec-2022	1560		890.13	1391.75	1893.37		
Number of Incidents Reported as SIs	Quality Improvement	Dec-2022	7		-5.29	5.35	15.99		
Duty of Candour Compliance %	Quality Improvement	Dec-2022	80%	100%	50.43%	85.85%	121.27%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Dec-2022	106		52.75	95.45	138.15		
Number of RIDDOR Reports	Quality Improvement	Dec-2022	12		-0.38	11.8	23.98		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Oct-2022	22		50.01	78.38	106.76		
Health & Safety Incidents	Quality Improvement	Dec-2022	26		14.83	30.65	46.47		

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	3.12	26	48.88		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Aug-2022	85	0	-21.48	47.5	116.48		
Medicines Management % of Audits Completed	Quality Improvement	Dec-2022	87.9%	100%	75.73%	89.86%	103.98%		

Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Dec-2022	0%		-0.12%	0.03%	0.17%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Dec-2022	76%		8.81%	37.09%	65.37%		
Complaints Reporting Timeliness %	Quality Improvement	Dec-2022	74%	95%	35.6%	74.1%	112.6%		
Number of Complaints	Quality Improvement	Dec-2022	78		34.88	83.6	132.32		
Complaints per 1000 999 Calls Answered *Data checking*	Quality Improvement	Dec-2022	1047		-43.02	104.1	251.21		
Number of Compliments	Quality Improvement	Dec-2022	79		104.64	159.72	214.8		

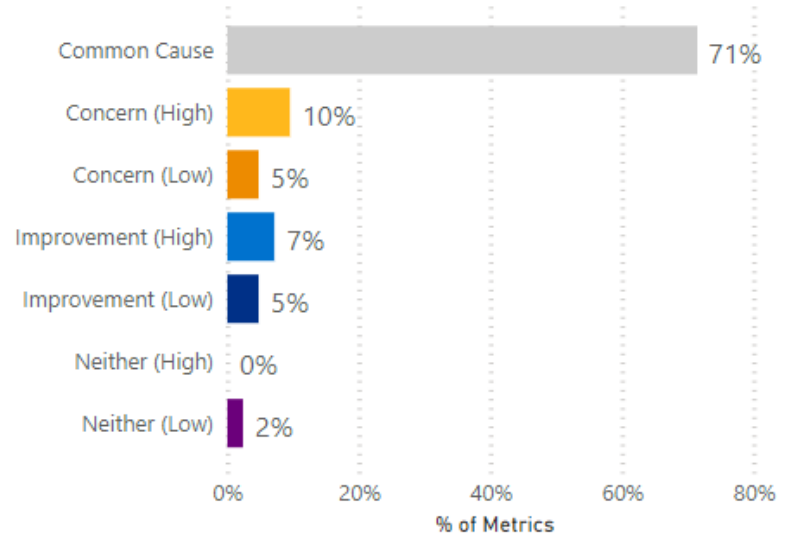
QUALITY IMPROVEMENT

Overview (2 of 3)

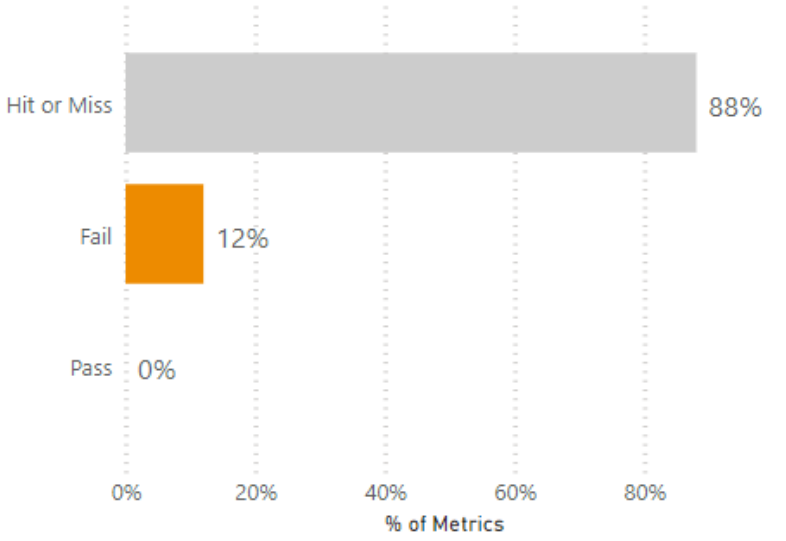
Trend improvement vs previous period

Trend degradation vs previous period

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	Oct-2022	51.6%	45.1%	27.43%	48.01%	68.58%		
**Cardiac ROSC ALL %	Quality Improvement	Oct-2022	29.7%	23.8%	15.11%	26.04%	36.98%		
**Sepsis Care Bundle %	Quality Improvement	Nov-2022	87.8%	85%	80.73%	85.56%	90.4%		
**Cardiac Survival Utstein %	Quality Improvement	Sep-2022	21.2%	25.6%	10.49%	28.31%	46.13%		
**Cardiac Survival ALL %	Quality Improvement	Sep-2022	9%	9.6%	4.33%	10.34%	16.35%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Oct-2022	80.5%	76.8%	58.21%	74.58%	90.94%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Nov-2022	78.5%	64.7%	51.65%	64.48%	77.31%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Aug-2022	02:36:00	02:22:00	02:09:34	02:31:23	02:53:11		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Aug-2022	03:33:00	03:14:00	02:45:42	03:35:00	04:24:18		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Aug-2022	01:42:00	01:29:00	01:24:57	01:40:34	01:56:10		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Aug-2022	02:31:00	02:20:00	02:03:25	02:36:56	03:10:27		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Nov-2022	95.4%	96.3%	94.56%	97%	99.44%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Oct-2022	95.2%	93.8%	83.71%	92.19%	100.67%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Oct-2022	82.6%	77.9%	67.82%	78.97%	90.13%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Dec-2022	110%		73.63%	97.85%	122.07%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Dec-2022	86%	100%	74.05%	85.25%	96.45%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Dec-2022	80%		78.71%	92.15%	105.59%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Dec-2022	101%		83.32%	98.3%	113.28%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Dec-2022	84.6%		31%	71.21%	111.41%		

Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Dec-2022	90%	90%	71.84%	86.69%	101.54%		

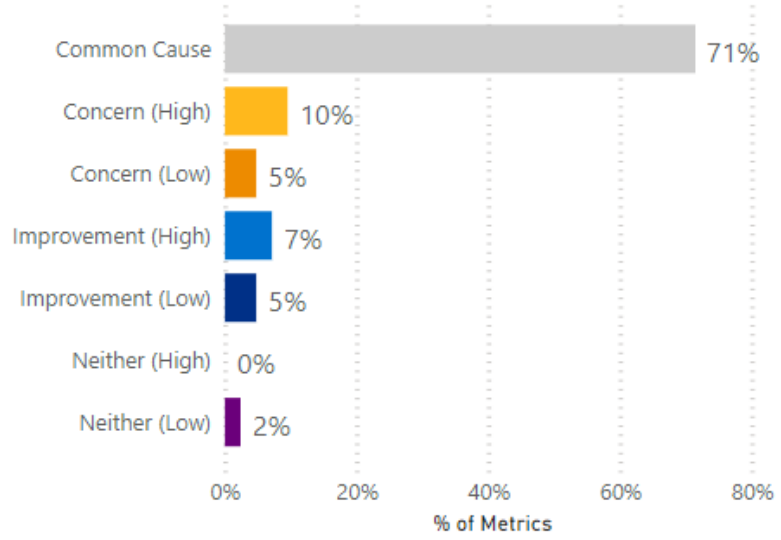
QUALITY IMPROVEMENT

Overview (3 of 3)

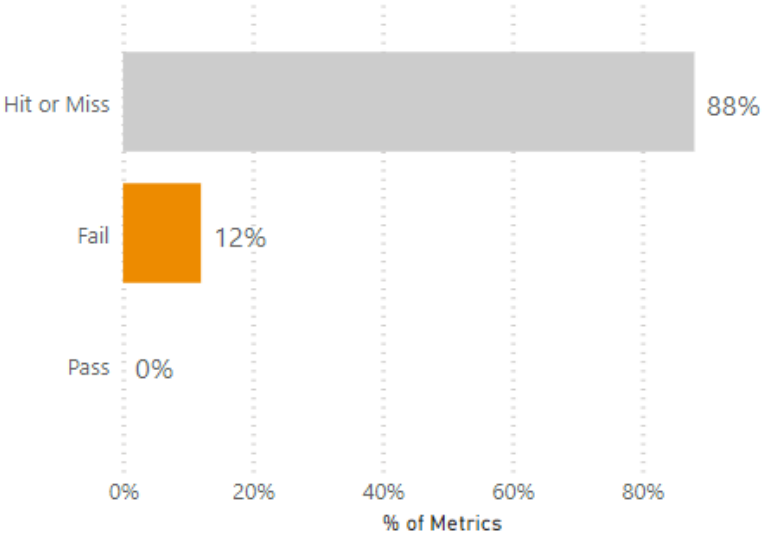
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



Health & Safety

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Dec-2022	79.5%	85%	80.83%	83.14%	85.46%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Dec-2022	77%			59.37%			
Manual Handling Incidents	Quality Improvement	Dec-2022	36		10.03	28.65	47.27		
Organisational Risks Outstanding Review % ***New metric***	Quality Improvement	Dec-2022	66.9%	30%	6.6%	48.76%	90.91%		

QUALITY IMPROVEMENT

SIs, Incidents & Violence and Aggression

QS-2

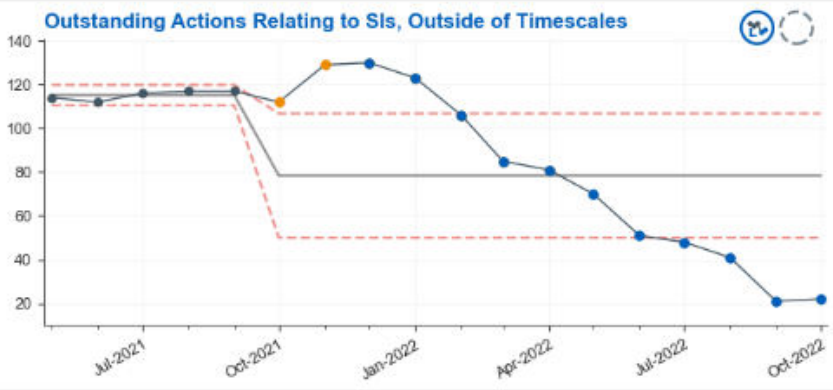
Dept: Quality & Safety
IP: Quality Improvement
Latest: 7

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: 1560

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: 106

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

Summary

(QS-1) Non-SI incidents saw a decrease of 9% for November and 9.3% for December 2022 verses that of 2021. There are several factors that impacted reporting. November 2022 saw a BCI where IT systems were down for a 7 -day period and the Trust was running on BIF1 (Back Up Incident Forms). December 2022 saw Industrial Action (IA) take place that also saw a downward trend in reporting over this period. In November/December 2021 the Trust was still reporting staff absence for COVID-19 on the Datix system, which also increased the uplift of incidents over this period. The main trends over the reporting period remain the same with pharmacy, issues with triage and delay in answering 999 calls all being in the top 3.

(QS-17) SI actions – there has been a positive decline in all outstanding SI actions, with greater governance and ownership on compliance. The oldest breached action is August 2021. This has been escalated to Director level.

(QS-2) SI numbers –We currently have 37 open SIs, of which 11 have breached 60 days at the time of writing. The longest breached SI report is July 2022. This has been escalated appropriately.

What actions are we taking?

(QS-1)

- Pharmacy - there have been meetings with the local providers so that prescription issues do not keep getting referred back to 111. This has now been escalated to the ICB.
- Delays in answering 999 calls is down to demand and capacity , the Trust also had IA take place on 21.12.22. There is currently a recruitment drive in place for EMA's (*See workforce section and Call Handling Action Plan paper*)
- Issues with Triage are calls being referred to the incorrect service. EMA/HA's are feedback to on the back of call audits.
- The Trust have set in place a 20% threshold for breached incidents and escalations will take place at this point.
- Incident life cycle raised at QUAPS monthly for 111/999 and operations.
- Monthly Datix training in place for the Trust

(QS-2 / 17) SI actions - The last remaining actions are being raised with heads of dept. and requests made to action owners to complete actions asap. All open SIs and Actions have been escalated to the appropriate Director.

(QS-13) - The Trust is working towards delivery of the NHS violence reduction standards, and this is monitored by WWC.

QUALITY IMPROVEMENT

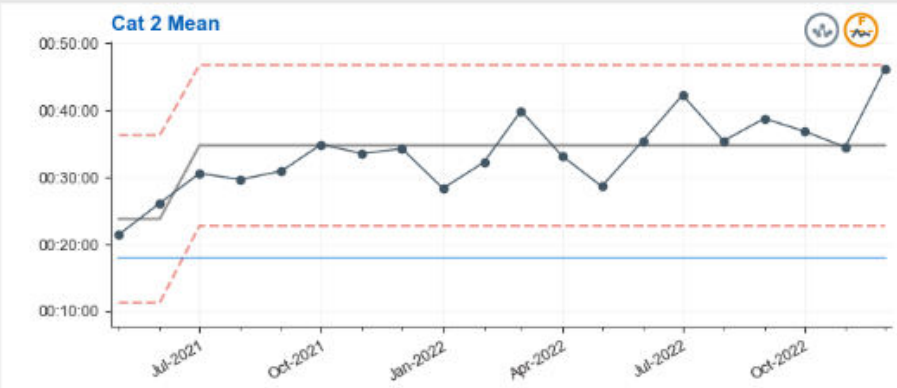
Harm (1 of 2)

QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 4.38

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

QS-29
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1.45

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



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:46:11
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

Over November & December 2022, the Trust reported 2816 incidents, the Grade of Harm (GoH) reported is as follows

- 98.6% of all reported incidents sat in the no harm/low harm
- 1.3% of incidents sat in moderate to death GoH.
- It is important to note that Datix has two levels of harm recorded within, the first is the incident reporter's assessment of harm, whereas the second is provided by the incident reviewer/manager as the post review level of harm. Those incidents that require a more thorough investigation could have their level of harm altered again once this has been completed.
- The Trust's harm levels over this period remain similar for each month, the Trust saw an BCI for 7-days over November 2022 and industrial action (IA) in December 2022, which impacted on incident reporting. We saw a drop in incident reporting so it is possible that incidents may be underreported. From the data that we have from Datix, there is no indication that IA has impacted negatively on patient harm but the impact of any IA over the coming months will be monitored.

What actions are we taking?

- The Datix team will continue to pull a report at 17.30 on every day of IA that will then be shared with the Deputy Director of Quality. They will also undertake a sift of the whole day's incidents to assess any harm related to IA.

Please see panel (2 of 2) on next slide for further actions.

QUALITY IMPROVEMENT

Harm (2 of 2)

QS-30
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1182

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

QS-31
Dept: Quality & Safety
IP: Quality Improvement
Latest: 244

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

QS-32
Dept: Quality & Safety
IP: Quality Improvement
Latest: 4

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

QS-33
Dept: Quality & Safety
IP: Quality Improvement
Latest: 3

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

Summary

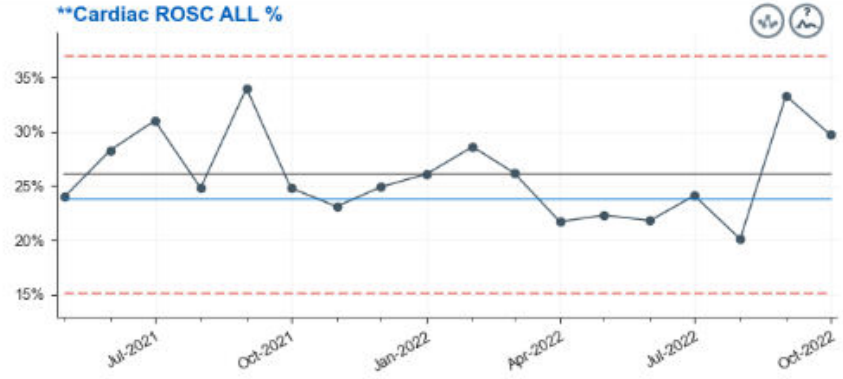
- **(QS-31)** The Trust are still seeing an uplift in incidents category of pharmacy this to do with community pharmacist Consultation Service and PHARM+ concerns, whereby the pharmacy is not following the contractual agreement if they are unable to assist the patient. System-wide discussion are underway involving ICB (Integrated Care Board) leads. The Trust is also in a BCI with medicine packing, which is also causing an uplift of reporting, all these incidents are no harm/low.
- Delay in answering 999 calls, prevalence in delays in answering 999 calls, most of these incidents resulted in no or low harm and 1 moderate harm and 1 severe that is still under investigation and therefore level of harm may change.
- Issues With Triage, these incidents are raised when a clinician or health advisor contacts a patient and believes that there was an element missed from the previous assessment. These are reviewed and any learning is fed back to the staff member involved in the initial triage. All currently no/low harm.
- There are no obvious themes identified from severe harm incidents.

What actions are we taking?

- Pharmacy issues in the community have now been escalated to the ICB
- Trust aware of BCI for medicine packing.
- Delays in answering 999 calls is down to demand and capacity , the Trust also had IA take place on 20.12.22. There is currently a recruitment drive in place for EMA's.
- EMA/HA's Issues with triage are feedback to from call audits.
- Harm reviews are undertaken during industrial action (IA) periods to ascertain the impact on patient safety.
- Incidents that have been reported moderate or above will go through the weekly serious incident shrift.
- Monthly Datix training carried out across the Trust, so all staff members have a better understanding of harm and reporting culture.
- A QI project on keeping patients safe in stack has commenced.

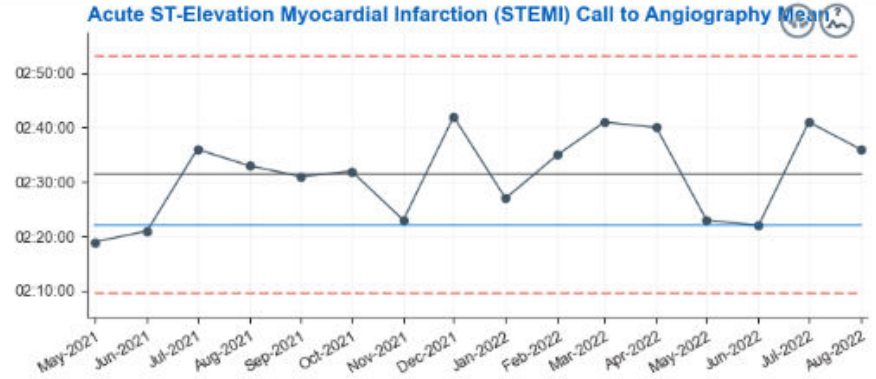
QUALITY IMPROVEMENT

Impact on Patient Care - Cardiac



M-2

Dept: Medical
IP: Quality Improvement
Latest: 29.7%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

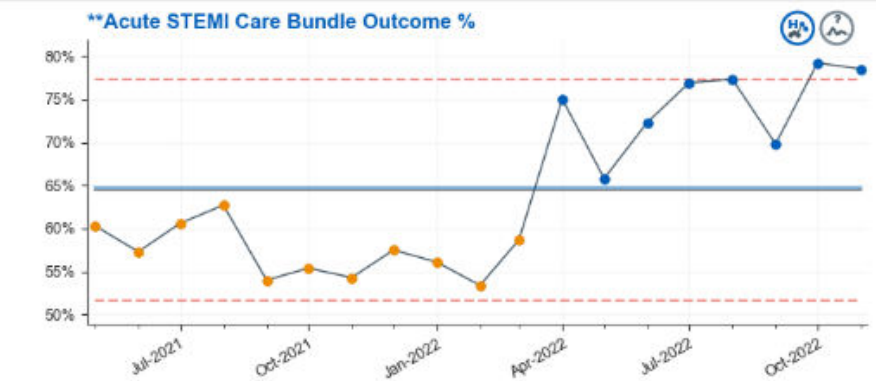


M-6

Dept: Medical
IP: Quality Improvement
Latest: 02:36:00
Target: 02:22:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

M-1

Dept: Medical
IP: Quality Improvement
Latest: 51.6%
Target: 45.1%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-5

Dept: Medical
IP: Quality Improvement
Latest: 78.5%
Target: 64.7%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

Summary

Cardiac Arrest Survival: – continues to demonstrate common cause variation. The annual Cardiac Arrest Report is being presented to the Trust Board during Q4. The report will provide the Board with greater insight of Trust performance, and benchmarking against other Ambulance Trusts.

STEMI Call to Angiography – continues to demonstrate common cause variation. Partly due to delays to arrival on scene.

Acute STEMI Care Bundle Outcome: Continued improvement in compliance since June 2022 which reflects 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 key skills materials emphasise 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.

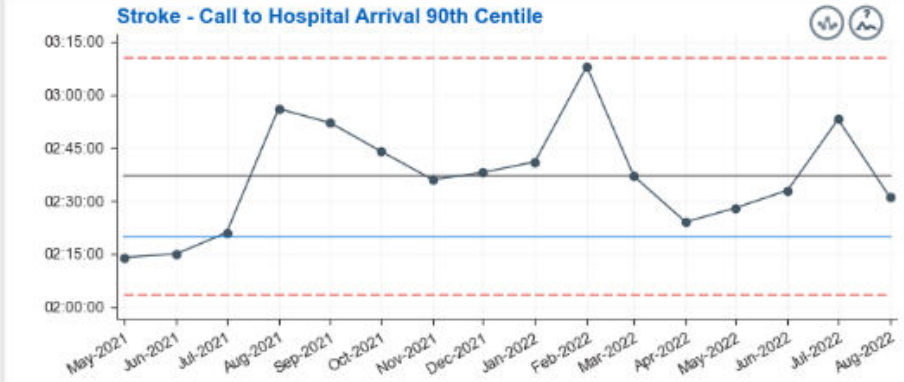
Acute STEMI Care Bundle Outcome: The South East Cardiac network has raised concerns that the current STEMI care bundle increases on scene time, and has recommended alternative measures which are under discussion at NASMeD.

QUALITY IMPROVEMENT

Impact on Patient Care – Stroke

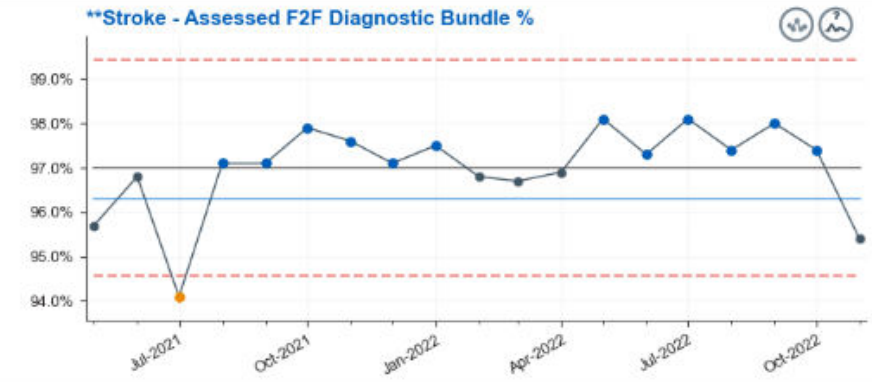
M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:42:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:31:00
Target: 02:20:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-10

Dept: Medical
IP: Quality Improvement
Latest: 95.4%
Target: 96.3%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Stroke – Common cause variation continues. 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, compliance against the Diagnostic Bundle has largely 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 two 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 is to be added to the 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 the Trusts C2 performance.

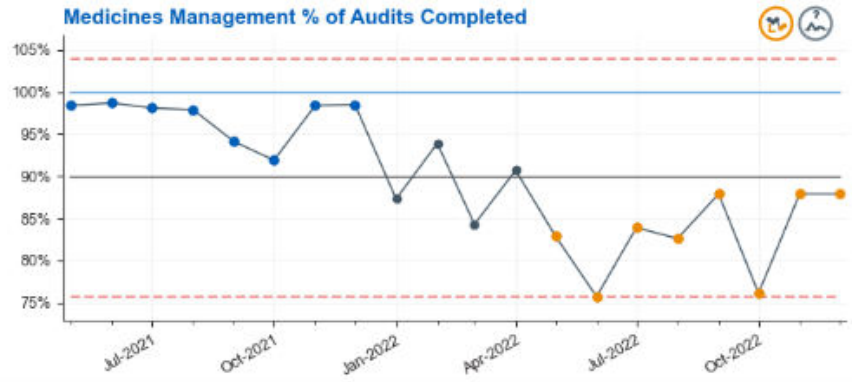
QUALITY IMPROVEMENT

Medicines Management

MM-1

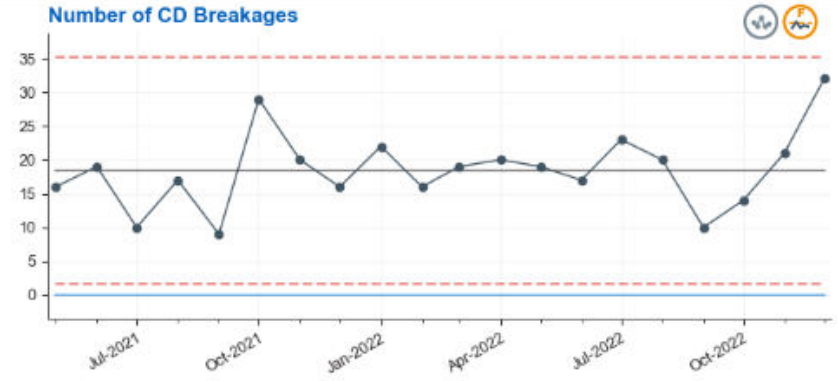
Dept: Medicines Management
IP: Quality Improvement
Latest: 171

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



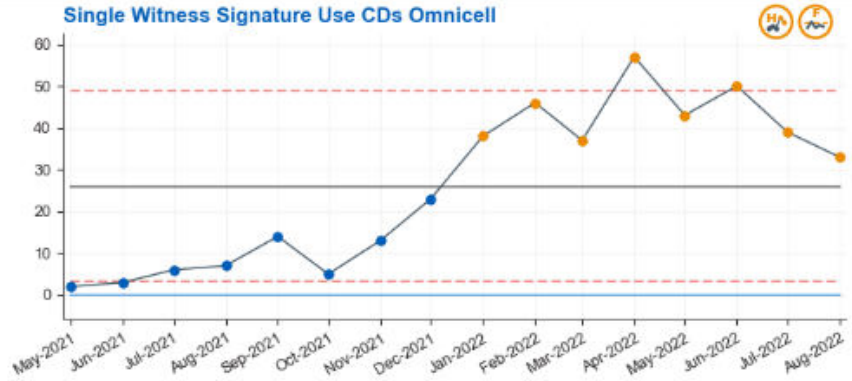
MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 87.9%
Target: 100%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 32
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



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.

Summary

Note: Work is required around reporting for medicines service. There are other areas of medicines activity that will need reporting on e.g. compliance to Patient Group Directions (PGDs) and medicines training for IQR data.

Non compliance to medicines audits is being picked up through Medicines Governance Group and Senior Operations representatives. There is also work ongoing to change this over onto a new reporting platform. This is currently in test phase.

Single Witness signature for CDs work continues to address this area of activity and the reporting of it is going to go onto the weekly operational team leaders (OTL) checks.

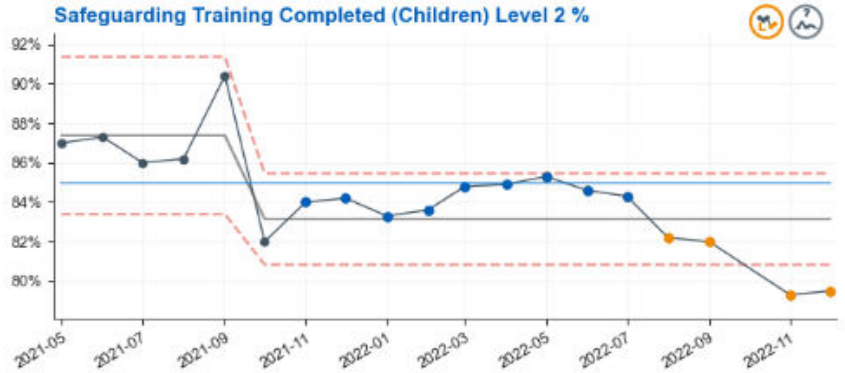
What actions are we taking?

Medicines team to meet with Power BI team and software developers to move forward with medicines data and presentation on central platforms.

Single Witness Signature: OTL reporting is moving to central platform and CD single signatures will be picked up as part of this.

QUALITY IMPROVEMENT

Safeguarding



QS-8
Dept: Quality & Safety
IP: Quality Improvement
Latest: 79.5%
Target: 85%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

QS-8
Dept: Quality & Safety
IP: Quality Improvement
Latest: 77%

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

- No update or change to report in the narrative on L2 Safeguarding Children since previous IQR report. L2 training is not part of this year's training requirement (only rolled out every 3 years).
- From the 22nd of September to the 1st of December 22 the Safeguarding Team have trained 392 staff in Level 3 Safeguarding Adults and Children over 8 sessions, at an average of 49 staff attending each session.
- Level 3 Safeguarding training as of 01 December 2022 is at 77% compliance across the trust. Total L3 compliance level at the beginning of September 2022 was at 55%. Commissioning requirements for Safeguarding expect a minimum 85% compliance across provider services.

What actions are we taking?

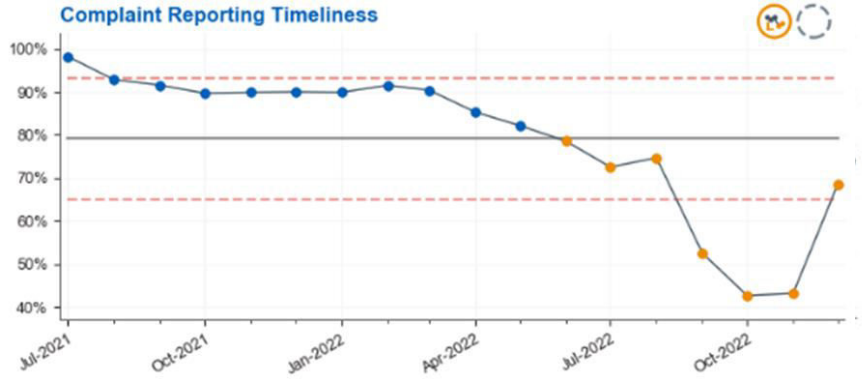
- From April 2023, Level 1&2 Safeguarding training will be rolled out in line with the requirements within the intercollegiate document.
- There are areas which have been identified as having low levels of Level 3 Safeguarding training. These areas have been targeted and compliance is being reviewed within QGG.
- **Safeguarding is working closely with senior operational leaders to identify and address areas of low uptake. The training position, in particular the lower performing units were discussed at January's Quality Governance Group with an action for respective areas to present a plan to the February meeting on how the training trajectory will be met over the coming months**

QUALITY IMPROVEMENT

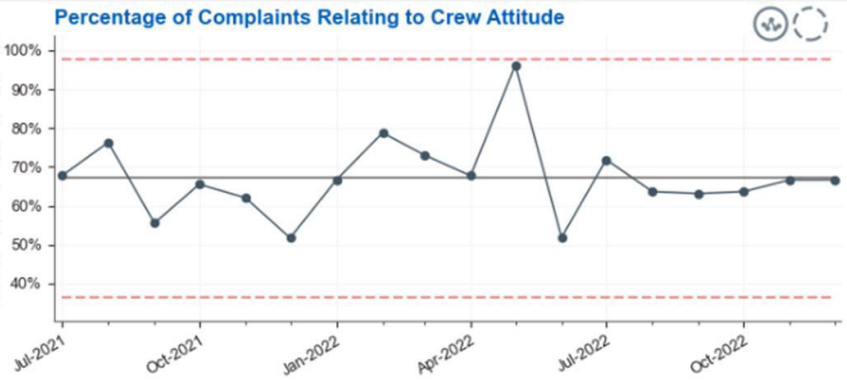
Patient Experience

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

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: 74%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-10
Dept: Quality & Safety
IP: Quality Improvement
Latest: 76%

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

QS-3
Dept: Quality & Safety
IP: Quality Improvement
Latest: 80%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

- The number of complaints received by the organisation is consistent.
- Staff attitude complaints have remained constant at between 63% – 66% for the past five months and an average of 65% for the past 18 months.
- Since May 2022, timeliness of complaints has seen a downward trajectory. This was initially due to recruitment and staff sickness.
- Since August 2022, the team have worked hard to focus on the back log but this has impacted on timeliness of response to new complaints coming into the service. Capacity challenges were also identified in managing complaints as well as trying to deliver the patient experience and engagement strategy.
- Since November 2022, the responsibility for Patient Experience and Engagement has moved to another team. The number of outstanding EOC complaints was escalated again at the beginning of January 2023. Since then, in collaboration with senior management, the team have developed a clear action plan which is being monitored daily. This has demonstrated good progress. There are now 41 open EOC complaints and 9 of these have breached.
- DoC - decline on compliance throughout October – December due to a number of facets, namely, delay in allocation, new staff joining the team and learning the expectations on them, and staff missing deadlines due to festive leave. The breach represents 1 out 5 patients who we did not manage compliance with.

What actions are we taking?

- Close monitoring of the breached complaints with senior management within the directorate being updated weekly on the progress. The aim is to have these clear by the end of February 2023.
- It has been recognised that the team need to review working practices to ensure efficiency and effectiveness and build resilience within the team to ensure that a potential backlog is identified at the earliest opportunity and appropriate mitigation taken.
- To support this, the team are holding a process mapping day on 27 February 2023 to review the current processes and identify any opportunities improvements. This will enable clear processes and effective, timely management of these.
- The target to return to 95% of complaints being responded to in time is planned to be achieved by May 2023.
- (**QS-3**) DoC - A new allocation process for investigations has been introduced, staff are now embedded and understand the needs of their role, and SIM's are aware of the decline and are proactively monitoring the compliance to step in where necessary and prevent the compliance from breaching.

QUALITY IMPROVEMENT

Safety in the Workplace

QS-20

Dept: Quality & Safety
IP: Quality Improvement
Latest: 26

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

QS-7

Dept: Quality & Safety
IP: Quality Improvement
Latest: 90%
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: 36

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: 76%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

- During November 2022 (31) Health and Safety incidents were reported.
- The 3 occupations which reported the greatest number of Health & Safety incidents for November are listed below:
  - Paramedics (8)
  - ECSW (5)
  - Ambulance Technicians (5)
- During December 2022 (26) Health and Safety incidents were reported.
- The 3 occupations which reported the greatest number of Health & Safety incidents for December are listed below:
  - Paramedics (9)
  - ECSW (7)
  - Ambulance Technicians (4)
- The regional and Trust Health & Safety group will continue monitoring incident trends.
- 10 RIDDOR were reported in November and 12 in December, which is in line with the last 15 months trend.

Hand Hygiene Compliance – Note: Nov 22 the Trust BCI which caused IT issues effected the IPC Audit reports so the figures are not accurate.

In Dec22 we saw the results for hand hygiene compliance reach the compliance level of 90% for the first time in four months. This is due to some additional communications between the IPC Team and Operations.

What actions are we taking?

The Health and Safety Committee TOR have been reviewed and now include at least 2 members of the EMB group. A new report has been developed which will report periodically to EMB on all aspects to Health and Safety compliance across estates, fleet, operations, etc.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

December 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 Time to Hire (Days)
Common Cause	DBS Compliance %		Annual Rolling Turnover Rate 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 Number of Wellbeing Hub Referrals
Special Cause Concern		Vacancy Rate %		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.

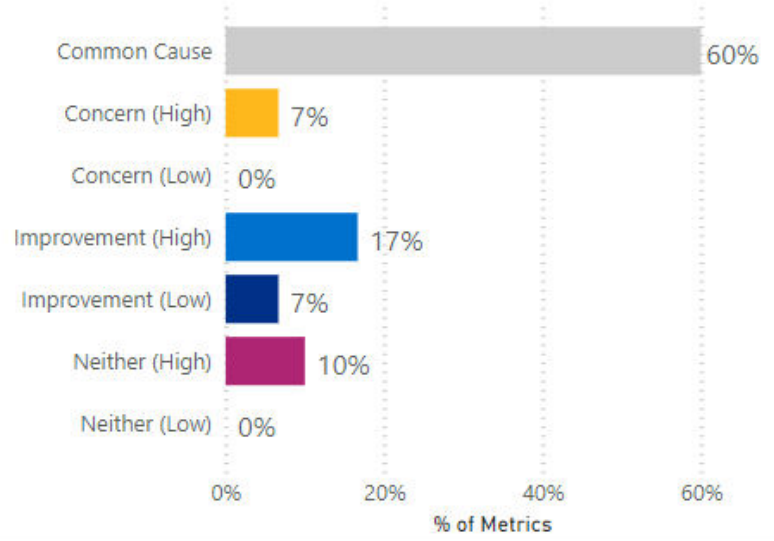
PEOPLE & CULTURE

Overview (1 of 2)

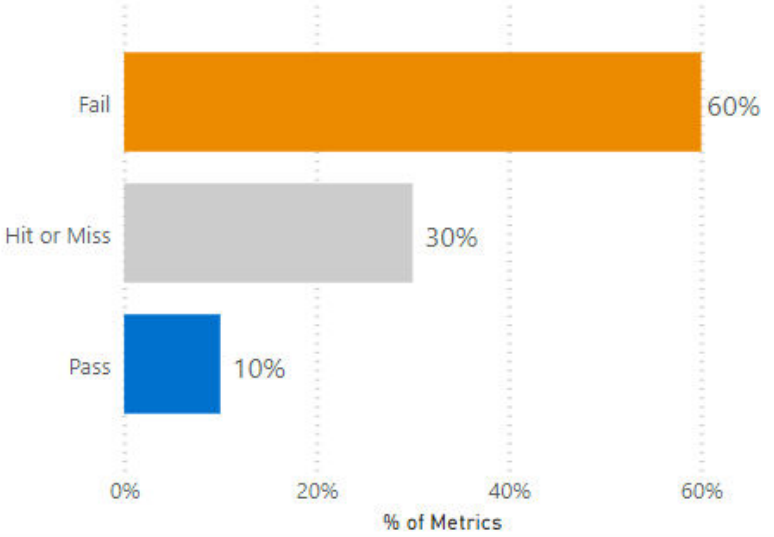
Trend improvement vs previous period

Trend degradation vs previous period

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	Dec-2022	4017.3	3946.96	3884.31	3945	4005.68		
Number of Staff Headcount (Exc bank and agency)	People & Culture	Dec-2022	4436		4281.74	4348.1	4414.46		
Vacancy Rate %	People & Culture	Dec-2022	4.5%	5%	-0.02%	3.09%	6.2%		
Turnover Rate %	People & Culture	Dec-2022	1.4%		0.83%	1.42%	2.01%		
Annual Rolling Turnover Rate	People & Culture	Dec-2022	17.7%	15%	16.42%	17.56%	18.69%		
Sickness Absence %	People & Culture	Dec-2022	10%	7%	7.57%	9.42%	11.26%		
DBS Compliance %	People & Culture	Dec-2022	100%	100%	100%	100%	100%		
Current licence details held for Operational Staff %	People & Culture	Dec-2022	96.1%	100%	88.03%	93.53%	99.03%		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Dec-2022	75.6%	95%	59.22%	68.11%	77%		
Appraisals Rolling Year %	People & Culture	Dec-2022	49.2%	85%	32.55%	38.82%	45.09%		

Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Dec-2022	55.1%	5%	46.59%	52.2%	57.81%		
Average Late Finish/Over-Run Time	People & Culture	Dec-2022	00:43:00		00:35:42	00:41:56	00:48:10		
% of Meal Breaks Taken	People & Culture	Dec-2022	97.3%		96.36%	97.95%	99.53%		
% of Meal Breaks Outside of Window	People & Culture	Dec-2022	73.5%		35.11%	57.83%	80.55%		

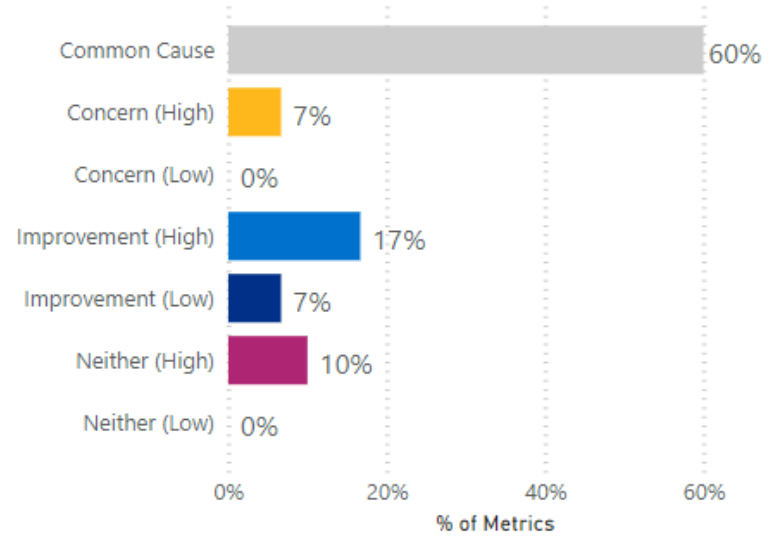
PEOPLE & CULTURE

Overview (2 of 2)

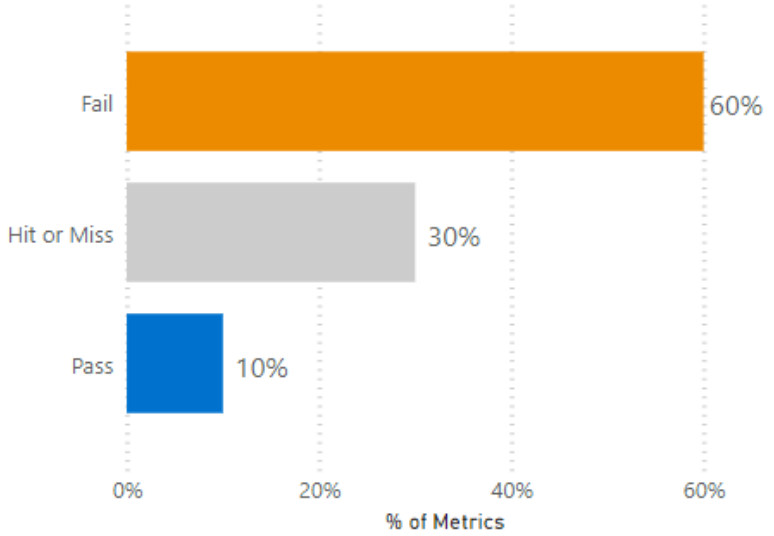
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



Culture

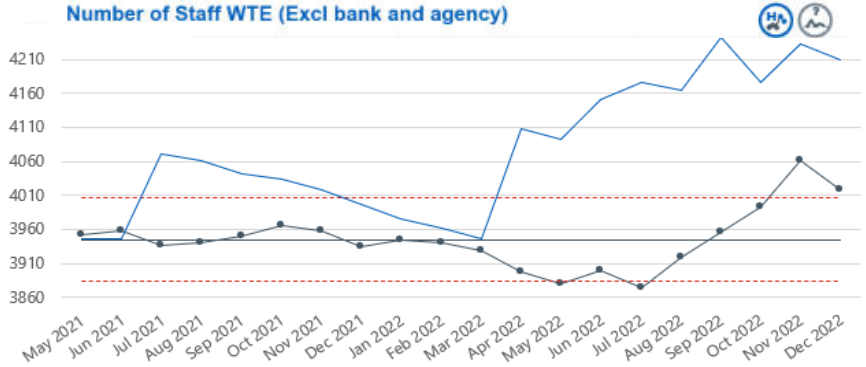
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Dec-2022	10		-0.47	10.45	21.37		
Collective Grievances Open	People & Culture	Dec-2022	2		-1.44	1.5	4.44		
Count of Grievances Closed	People & Culture	Dec-2022	13		-1.59	9.75	21.09		
Grievances Mean Case Length (Days)	People & Culture	Dec-2022	158.12		0.95	85.26	169.56		
Bullying & Harrassment Internal	People & Culture	Dec-2022	2	0	-4.12	2.6	9.32		
Whistleblowing	People & Culture	Dec-2022	0		-0.69	0.15	0.99		
Disciplinary Cases	People & Culture	Dec-2022	5		-2.41	4.45	11.31		
Freedom to Speak Up: Total Open Cases	People & Culture	Oct-2022	23		6.91	26	45.09		
Freedom to Speak up: Cases Opened in Month	People & Culture	Dec-2022	9		-2.82	8.1	19.02		
Freedom to Speak up: Cases Closed in Month	People & Culture	Dec-2022	5		-5.28	5.5	16.28		
Policies & Procedures Outstanding Review %	People & Culture	Dec-2022	35%	0%		38.65%			
Count of Until it Stops Cases	People & Culture	Dec-2022	3		-4.57	4	12.57		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Oct-2022	111		26.76	104.25	181.74		

PEOPLE & CULTURE

Workforce (1 of 3)

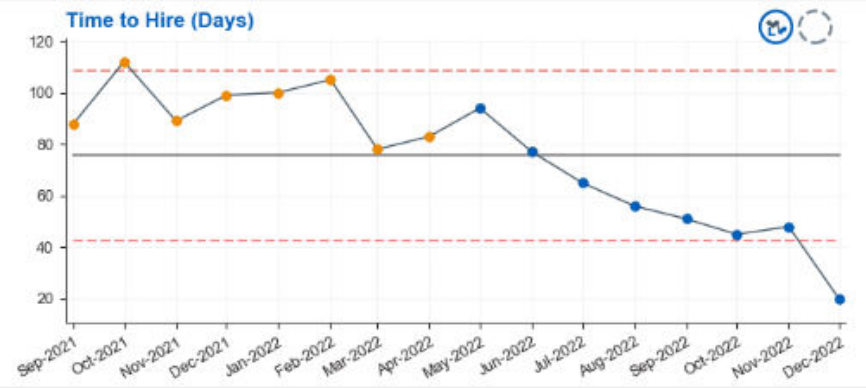


WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 4017.3
Target: 4208.81
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: 4.5%
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: 20

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

Summary

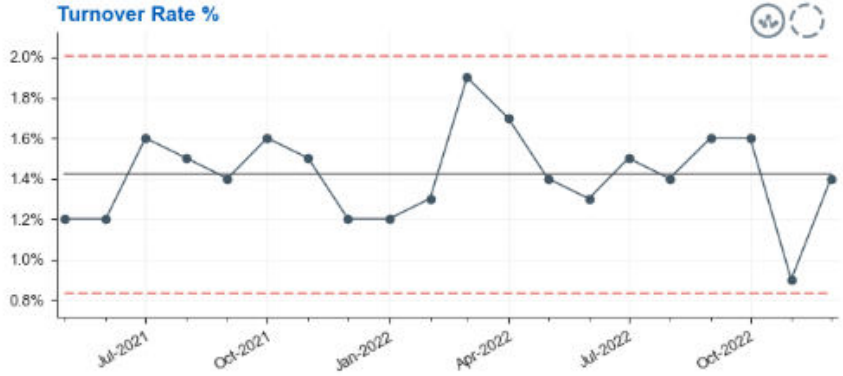
- Increased recruitment for operational roles is helping to achieve level of WTE despite leavers in the directorate continuing.
- Time to hire has reduced significantly due to the reduction in new starters for the month of December – 19 compared to previous month of 119.

What actions are we taking?

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

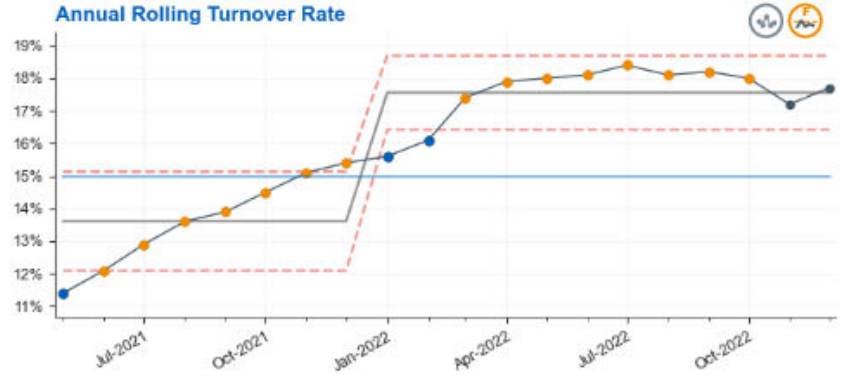
PEOPLE & CULTURE

Workforce (2 of 3)



WF-48
Dept: Workforce HR
IP: People & Culture
Latest: 1.4%

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: 17.7%
Target: 15%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Our December and Mid- January Exit Interview themes include (in order of frequency):

- Better/Fairer Career Development Opportunities
- More Pay
- Work/Life Balance
- Culture Change

This is a slight variation of order when compared to other months, however given the economic downturn; cost of living crises; and industrial action, we expected to see pay feature more prominently.

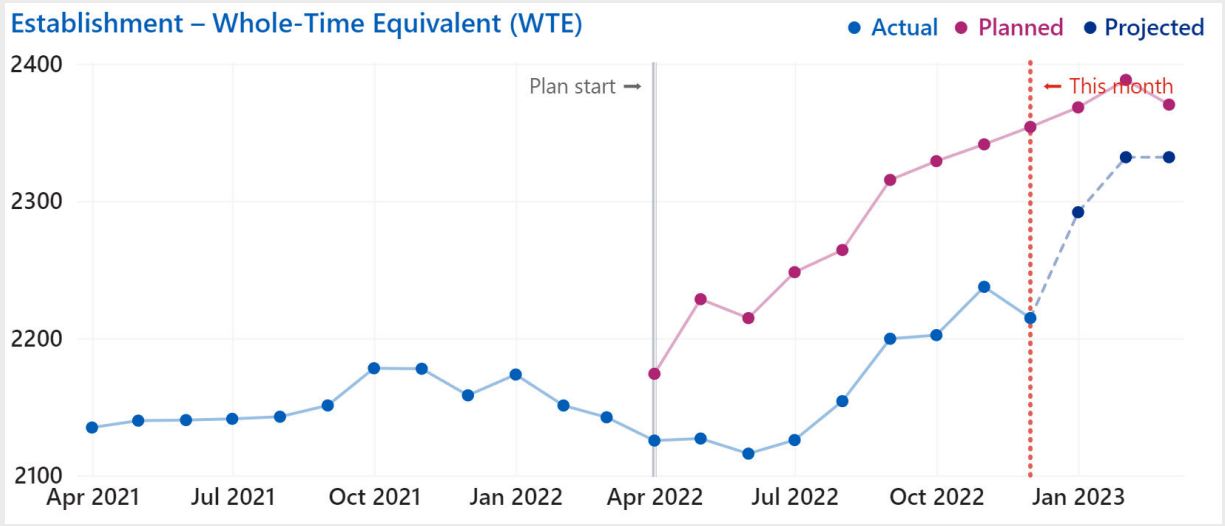
What actions are we taking?

We are holding a series of engagement sessions with managers on the Retention Plan, ensuring mangers understand the agreed priority areas of focus, and their responsibilities towards the delivery of the actions.
We have also developed a retention plan engagement tool using PageTiger for those managers who can't attend the engagement sessions, and for our colleagues. This engagement tools aims to ensure that everyone understands our commitment to the agreed priority areas.
We are writing a series of papers for Board, via WWC, for assurance purposes on our progress against the EOC/111 Retention Plan that aims to bring about a 10% improvement in turnover by May 23.
We are also actively participation in the Sussex ICS Retention Community of Practice Group, sharing best practice on improving retention.

PEOPLE & CULTURE

Workforce (3 of 3)

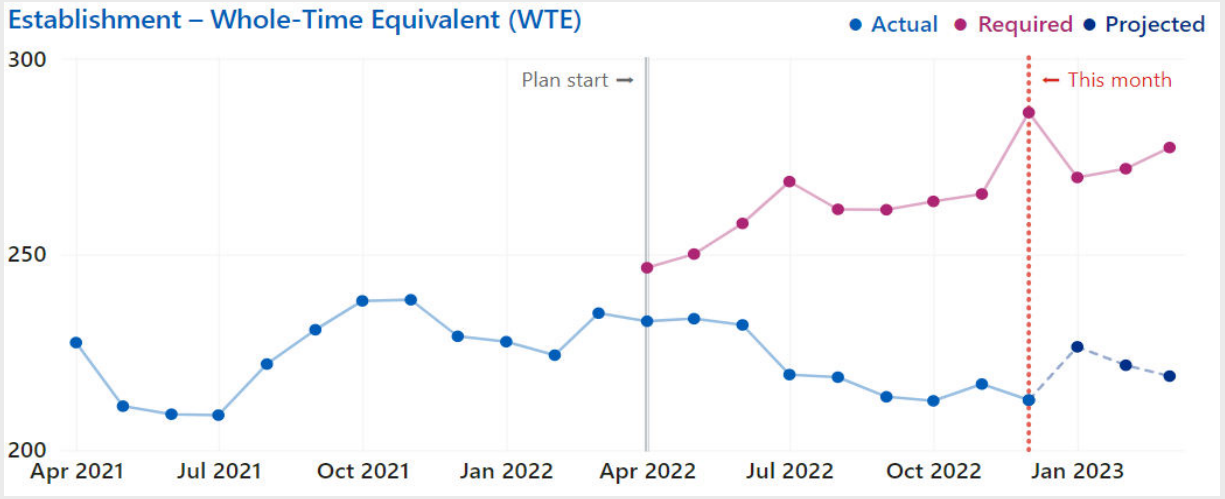
(999 Frontline)



Summary – 999 Frontline (Updated for January Board)
The Trust is currently 140 WTE behind on its frontline workforce plan which is 12 WTE position worsening within the period despite a net increase of 13 WTE since October. This is due to attrition in December being twice the projection across ECSW, NQP and AAP/Techs.
This gap will reduce to 38 WTE by the end of the year, however if the current trends continue for attrition, we could end at c. 60 WTE deficit against plan which will need to be recovered as part of the workforce plan for 23/24.

Mitigating actions – 999 Frontline (Updated for January Board)
Workforce planning for 23/24 has already started as part of the planning process. International recruitment has bypassed its target of 75 and continues to support the ongoing challenges with a further 41 in compliance or offer stages. This number is likely to increase further. Further to this plans to recruit student paramedics from partnership universities and utilised as ECSWs are to be finalised shortly and expected to be operational by summer 2023.
The retention related actions have been described in the previous slide.

(EOC EMA)



Summary – EOC EMA (Updated for January Board)
EMA establishment is currently 73 WTE below the planned levels this month. Of the 73 WTE gap, 54 WTE is attributed to attrition in excess of the plan for this year.

The current projection puts the Trust at between 58 and 77 WTE below the required levels of 277 WTE by the end of the financial year, or between 21 – 28% under plan.

EMA attrition has been 61% higher than planned Year-to-Date with 124 leavers vs 77 WTE by December 2022.

Mitigating actions – EOC EMA (Updated for January Board)
Extra resource has been sourced to help with compliance as the hike in recruitment for EMA's has placed a strain on the recruitment team. This will help to ensure that candidates are 'kept warm' and engaged. This will help close the WTE gap to target. Further work is to be undertaken to review the selection process which will support the right candidates to apply and retain their role within EOC. The retention plan will also play a key role in reducing attrition.

Please see the Call Handling Action Plan paper prepared for the Board on 2 February 2023.

PEOPLE & CULTURE

Culture (1 of 2)

QS-27

WF-10

Dept: Workforce HR
IP: People & Culture
Latest: 10

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

WF-41

Dept: Workforce HR
IP: People & Culture
Latest: 3

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

WF-42

Dept: Workforce HR
IP: People & Culture
Latest: 13

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

Summary

Until it Stops workstream – We continue to educate managers on understanding bullying and sexual harassment, to know their responsibilities as leaders in eliminating sexual harassment and knowing the action that they should take as a manager and bystander through the delivery of the sexual safety workshops. In total 394 managers have attended a Sexual Safety Workshop with a further 46 booked to attend upcoming dates. 140 managers have either not attended or booked to attend. 93 managers did not attend on one or more occasion.

Individual Grievances /Count of Grievances– we have seen an upwards trajectory of Grievances since July 2022, however, the trajectory for cases closing remains stable throughout the year. We are working closely with our unions to support our colleagues to raise concerns informally in the first instance.

What actions are we taking?

Until it Stops workstream- The Until it Stops campaign is to be included as a workstream of the wider culture & leadership programme governed by the Culture Working Group. Training for newly recruited and promoted managers is to be planned for the financial year 2023/2024. The cost of DNA to the sexual safety workshops needs to be better understood by line managers (£4107 pp) and attendance needs to be re-emphasised through line management.

Individual Grievances/ Count of Grievances – We will be working closely with L&OD to scope out training for our managers to deal with grievances or concerns informally. This will be scoped out by 10th February where training materials will be produced for the Trust management teams.

PEOPLE & CULTURE

Culture (2 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

Summary

Grievances In August through to December 2022 we saw the average number of new formal grievances increase from fewer than 5 to over ten a month, for a total of 70 cases opened in this period with the majority citing poor/unfair treatment. This incrementally began to overwhelm management and HR capacity to investigate and manage and consequently delaying existing case closure.

Until it Stops: Case length over the whole reporting period has a downward trajectory. There is a risk that increases in the number of grievance cases in August to December 2022, may cause this trajectory to stall.

What actions are we taking?

Grievances From December onwards, HR has been more assertive in requiring that employees resolve grievances informally, pushing back attempts to escalate to formal pathways. This push back is line with ACAS Code of Practice and consistent with the external independent HR review. This will have two effects; employees should see grievances handled more quickly as they will be locally informally managed. The Trust can bring resolution to formal grievances sooner too.

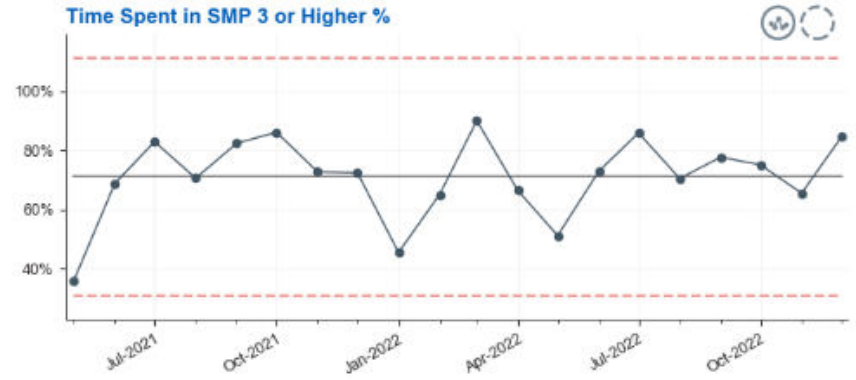
Until it Stops: Continued emphasis on reducing the incidence of cases through training for newly recruited and promoted managers and sexual safety workshops.

PEOPLE & CULTURE

Employee Experience

999-15

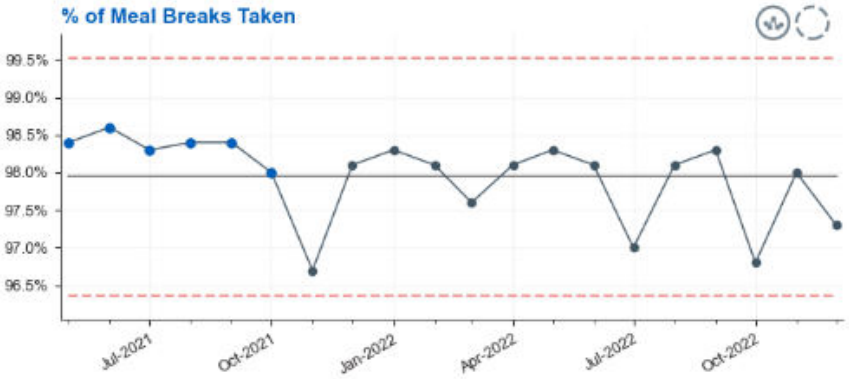
Dept: Operations 999
IP: People & Culture
Latest: 55.1%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-14

Dept: Operations 999
IP: Quality Improvement
Latest: 84.6%

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



999-27

Dept: Operations 999
IP: People & Culture
Latest: 97.3%

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

Summary

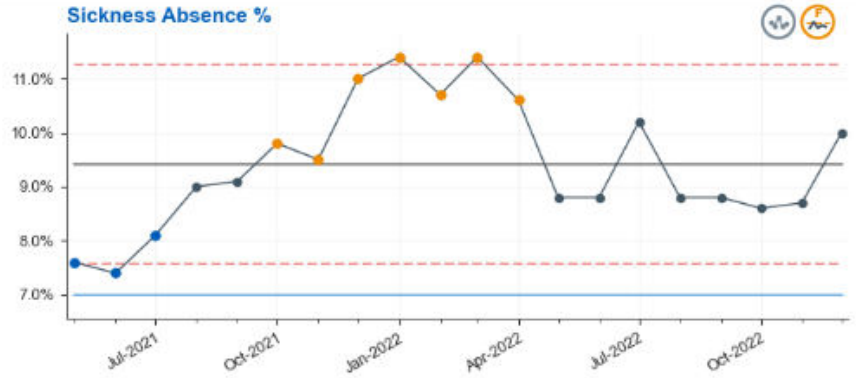
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- This is biased towards frontline road staff, and we will be developing further Employee experience dashboards to cover call-centres and corporate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

What actions are we taking?

- 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: 10%
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

Work continues in supporting managers to address sickness absence. Analysis identified that sickness is caused by different individuals becoming sick across the past twelve months, and in particular, seven OUs have persistently high levels.

A paper was taken to the Leadership meeting on Wednesday January 18th, that showed that there was no correlation between annual leave requests, school holidays, and sickness absence, nor was there a correlation between operational welfare issues (e.g. late finishes/overruns, missed or delayed meal breaks) For noting, according to a NACC report compiling sickness for all ambulance Trusts, SECAmb is not an outlier; however, it did show that WMAS had a very low sickness record.

Wellbeing referrals continue at or around the same level, and the service provides regular Trust wide updates and information. A future risk of the cessation of funding from April for resilience hubs has been raised.

What actions are we taking?

Targeted actions plans are now developed for the seven OUs with the highest persistent levels of sickness absence rates, with a dual emphasis on those who have breached sickness absence triggers and those who are close to breach sickness absence triggers. There is an opportunity to learn from WMAS in managing sickness absence, and this will be explored with Ops colleagues.

An element of national COVID funding was for system level resilience hubs that provided mental health assessment and streaming. This funding will not be in place from April and there is no indication this will be taken up by ICBs. Wellbeing and our Mental Health team will present a paper to SMG on impacts and options.

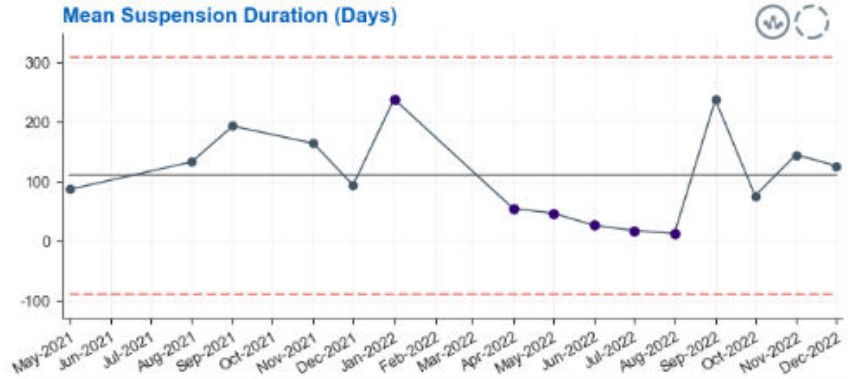
PEOPLE & CULTURE

Employee Suspensions

WF-46

Dept: Workforce HR
IP: People & Culture
Latest: 15

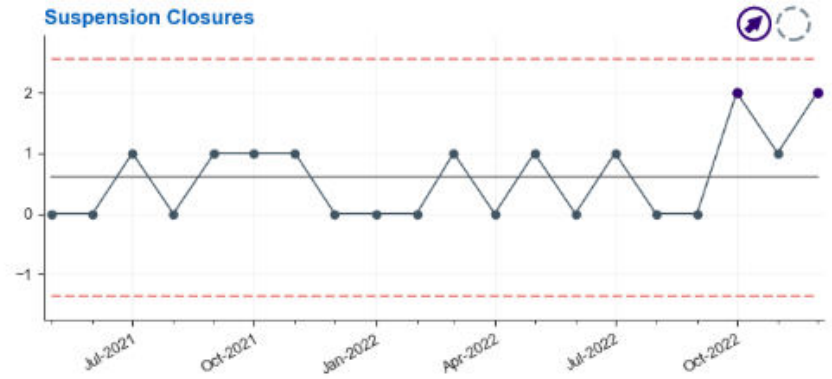
Special cause variation where UP is neither improvement or concern



WF-47

Dept: Workforce HR
IP: People & Culture
Latest: 126.36

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



WF-45

Dept: Workforce HR
IP: People & Culture
Latest: 2

Special cause variation where UP is neither improvement or concern

Summary

Suspensions: In October as many new suspensions started as were closed. The mean duration of suspensions is kept high by three of the 15 suspension cases; these cases are expected to be resolved in February, and should take the mean duration to 65 days.

Two of these cases are related to Racial Harassment, three are suspended due to Sexual Harassment, all three of these cases have police involvement. Our two highest reasons for suspension remain Bullying and Harassment and Sexual Misconduct.

What actions are we taking?

Suspensions: cases continue to be reviewed on a weekly basis by the HRBP Team with the Executive Directors.

Six of these cases are being managed along with Safeguarding and the Police, subject of criminal proceedings. We have three potential gross misconduct cases due to be considered under disciplinary proceedings by the end of January 2023.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 75.6%
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: 49.2%
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

Statutory & Mandatory Training

The emphasis on improving compliance to achieve the Statutory and Mandatory training target continues. There has been a slight improvement in compliance during the reporting period.

Appraisals

- No improvement in appraisal completions during the reporting period.
- Phase 3/4 ESR Appraisal roll out: 98 of 240 or (40.8%) OU line managers have attended ESR Appraisal Familiarisation sessions. The Operations Directorate will transfer fully to ESR Appraisal on 1 April 2023.

What actions are we taking?

Statutory & Mandatory Training

- The Statutory and Mandatory Training (SaM) Improvement Action Plan will be presented to the Education, Training and Development Group on 3 February 2023.
- A new Statutory and Mandatory Training Policy with clear roles and responsibilities has been drafted and circulated to key stakeholders for feedback; to be discussed At ETDG on 3 February 2023.
- (SaM) Subject Matter Experts met on 18 January 2023 to discuss the 2023/2024 training plan, they are reviewing the current training content to ensure consistency with the learning objectives set out in the NHS Core Skills Training Framework; to identify and highlight changes in relevant legislation, regulation, industry or professional requirements that will impact course content for 2023/2024

Appraisals

- ESR Appraisal roll out is to be evaluated to identify lessons learned and future improvements
- OU Administrators to be trained to become ESR Appraisal Super Users to provide local system support.
- Ongoing communication and promotion of the supportive resources on the Appraisal Hub on the Zone
- Following the completion of the ESR Appraisal familiarisation sessions the L&D team is planning to design a new suite of training to support appraisers and appraisees prepare for appraisal conversations; review performance; give and receive feedback; support employee development in Q1.

The Deputy Director of HR & OD is running bi-monthly clinics with directorate deputy directors focussing on rolling targets, areas for improvement and targets for both statutory and mandatory training and appraisals.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

December 2022

	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %		See & Treat %	999 Referrals A&E Dispositions Clinical Contact % Ambulance Validation %
Common Cause		A&E Dispositions %	999 Frontline Hours Provided % Hear & Treat % See & Convey % Average Wrap Up Time 111 Calls Answered in 60 Seconds % Cat 2 Mean Cat 2 90th Centile Cat 3 90th Centile Cat 4 90th Centile	JCT Allocation to Clear at Scene Mean ECAL Mean Response Time Incidents Cat 2 Proportion (Cat 1-4) Duplicate Calls % 999 Calls Answered
Special Cause Concern	Cat 1T 90th Centile Cat 1T Mean	999 Call Answer 90th Centile 999 Call Answer Mean Responses Per Incident 999 Operational Abstraction Rate %	Cat 1 90th Centile Cat 1 Mean 111 Calls Abandoned - (Offered) %	Vehicles Off Road (VOR) % FFR Attendances Number of Hours Lost at Hospital Handover Hours Lost at Handover as a Proportion of Provided Hours... JCT Allocation to Clear at Hospital Mean

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.

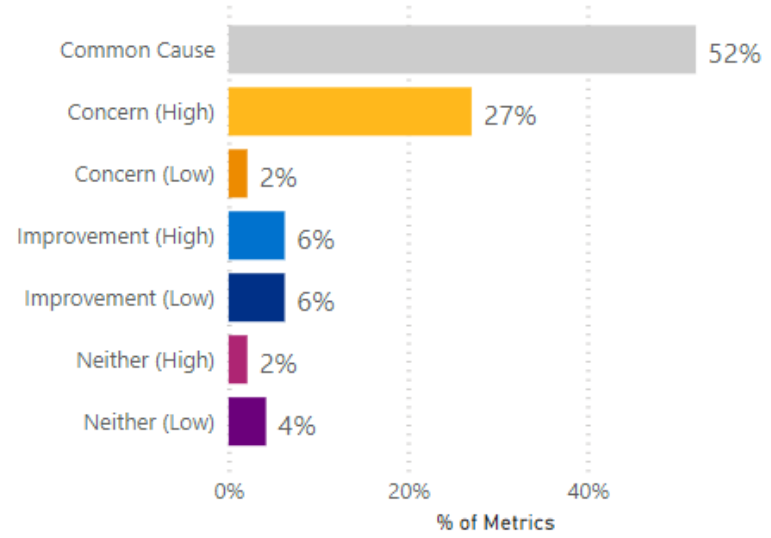
RESPONSIVE CARE

Overview (1 of 3)

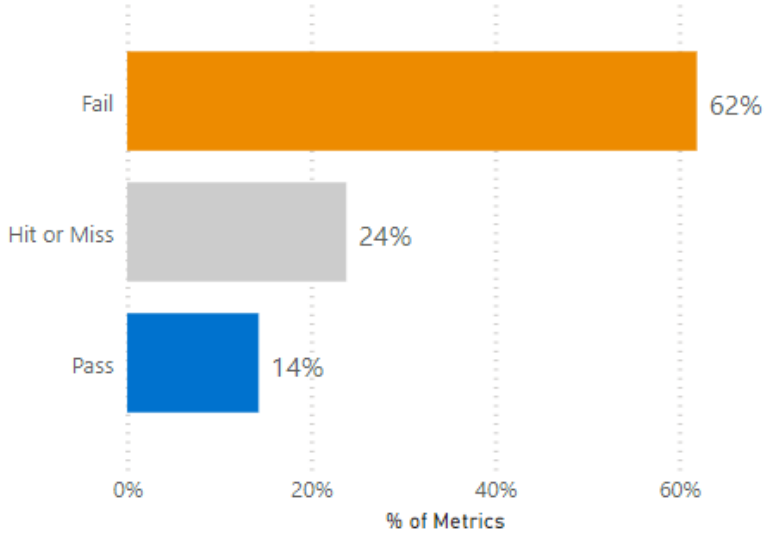
Trend improvement vs previous period

Trend degradation vs previous period

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	Dec-2022							
Section 136 Mean Response Time	Responsive Care	Dec-2022	00:32:22		00:12:52	00:27:09	00:41:27		
Cat 1 Mean	Responsive Care	Dec-2022	00:11:00	00:07:00	00:08:11	00:09:11	00:10:12		
Cat 1 90th Centile	Responsive Care	Dec-2022	00:19:28	00:15:00	00:15:16	00:16:38	00:18:00		
Cat 1T Mean	Responsive Care	Dec-2022	00:12:43	00:19:00	00:09:58	00:11:09	00:12:19		
Cat 1T 90th Centile	Responsive Care	Dec-2022	00:22:48	00:30:00	00:18:28	00:20:25	00:22:22		
Cat 2 Mean	Responsive Care	Dec-2022	00:46:11	00:18:00	00:22:47	00:34:47	00:46:48		
Cat 2 90th Centile	Responsive Care	Dec-2022	01:36:47	00:40:00	00:44:01	01:11:05	01:38:10		
Cat 3 90th Centile	Responsive Care	Dec-2022	09:55:54	02:00:00	02:37:11	06:45:53	10:54:36		
Cat 4 90th Centile	Responsive Care	Dec-2022	12:35:16	03:00:00	03:40:22	08:35:33	13:30:43		
HCP 3 Mean	Responsive Care	Dec-2022	04:03:54		01:31:49	03:17:40	05:03:31		
HCP 3 90th Centile	Responsive Care	Dec-2022	10:52:43		02:28:23	07:34:47	12:41:11		
HCP 4 Mean	Responsive Care	Dec-2022	04:59:00		02:17:27	04:11:24	06:05:21		
HCP 4 90th Centile	Responsive Care	Dec-2022	12:23:29		04:02:55	09:28:15	14:53:36		

Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Dec-2022	24.5%		21.51%	25.53%	29.55%		
999 Calls Answered	Responsive Care	Dec-2022	82494		55758.36	77533.28	99308.19		
999 Call Answer Mean	Responsive Care	Dec-2022	00:02:59	00:00:05	00:00:14	00:00:35	00:01:25		
999 Call Answer 90th Centile	Responsive Care	Dec-2022	00:07:11	00:00:10	00:00:35	00:01:48	00:04:12		

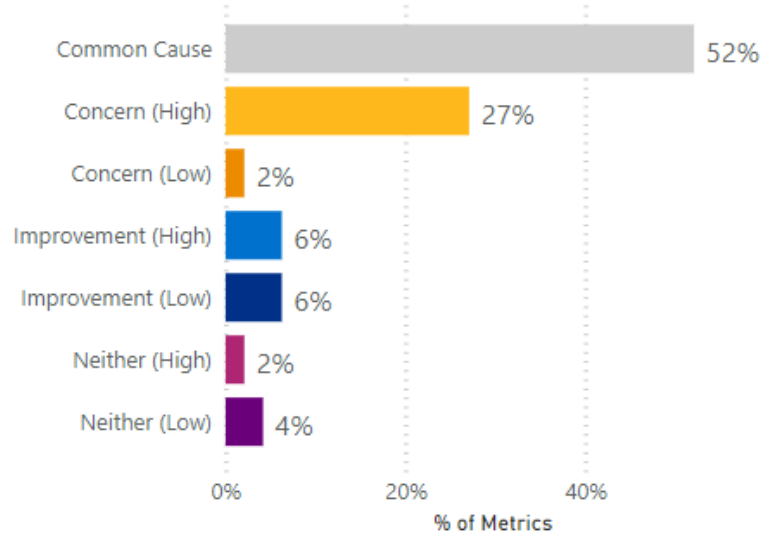
RESPONSIVE CARE

Overview (2 of 3)

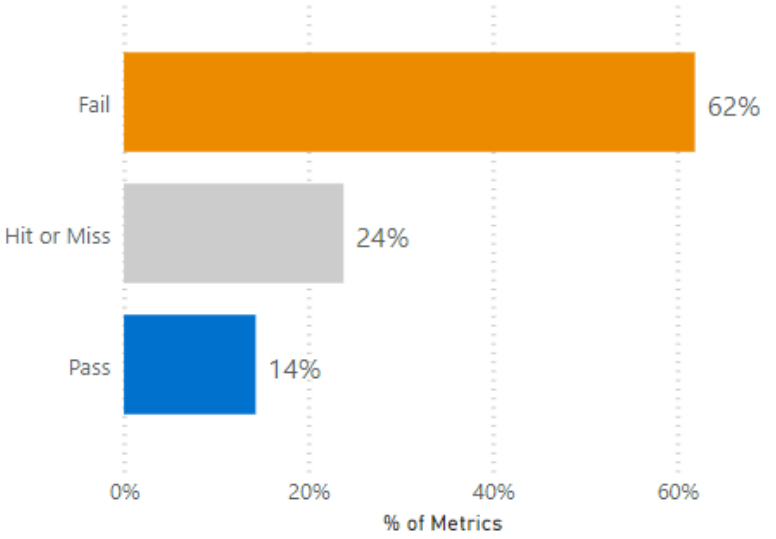
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



Utilisation

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Dec-2022	90.6%	100%	83.37%	89.58%	95.8%		
Provided Bank Hours %	Responsive Care	Dec-2022	0.7%		0.08%	0.74%	1.4%		
Provided Overtime Hours %	Responsive Care	Dec-2022	7.7%		7.23%	10.41%	13.58%		
Provided PAP Hours %	Responsive Care	Dec-2022	5.9%		4.52%	5.63%	6.74%		
999 Operational Abstraction Rate %	Responsive Care	Dec-2022	34.5%	28%	26.86%	33.54%	40.23%		
999 Remaining Annual Leave FY	Responsive Care	Dec-2022	17.4%			39.69%			
Vehicles Off Road (VOR) %	Responsive Care	Dec-2022	12.7%		8.11%	11.21%	14.31%		
% of DCA vehicles off road (VOR)	Responsive Care	Dec-2022	13.6%			12.49%			
% of SRV vehicles off road (VOR)	Responsive Care	Dec-2022	6.6%			6.99%			
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Dec-2022	182		94.62	209.7	324.78		
Number of RTCs per 10k miles travelled	Responsive Care	Dec-2022	0.64			0.67			
% of planned vehicle services completed	Responsive Care	Nov-2022	87%			76.62%			
% 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	Dec-2022	64.1%		58.14%	62.96%	67.78%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Dec-2022	5%	13%	7%	8.05%	9.1%		
Incidents	Responsive Care	Dec-2022	61458		54928.34	61854.7	68781.06		

111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Dec-2022	166547		81298.6	119541.7	157784.8		
111 Calls Answered in 60 Seconds %	Responsive Care	Dec-2022	6.3%	95%	2.25%	28.77%	55.28%		
111 Calls Abandoned - (Offered) %	Responsive Care	Dec-2022	47.9%	5%	5.08%	21.06%	37.03%		
999 Referrals	Responsive Care	Dec-2022	4039		5756.82	6773.5	7790.18		

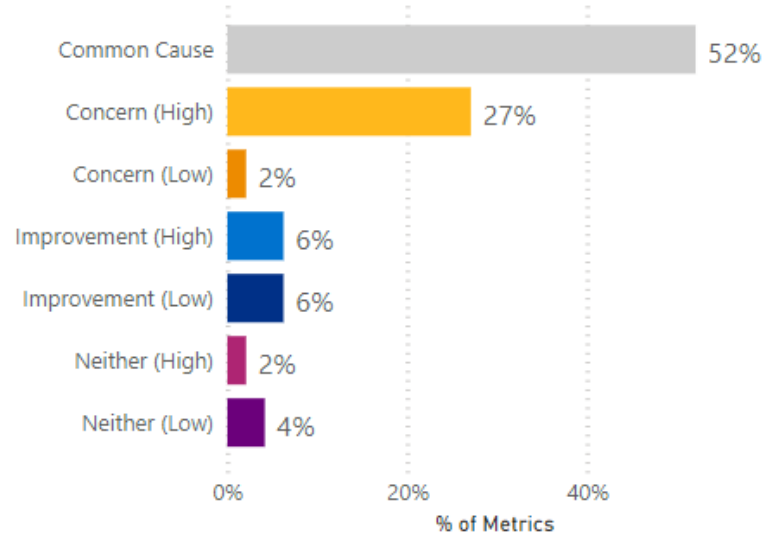
RESPONSIVE CARE

Overview (3 of 3)

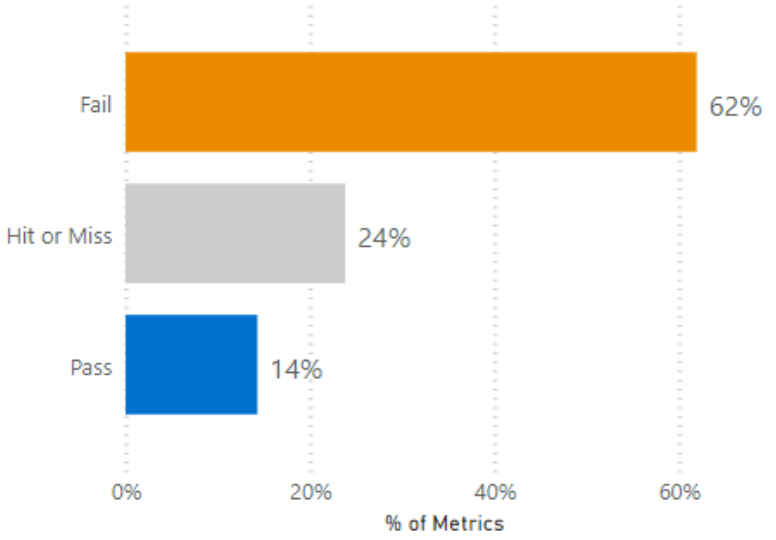
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



999 Frontline

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Dec-2022	01:18:55		01:16:08	01:17:49	01:19:31		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Dec-2022	02:03:15		01:52:59	01:56:14	01:59:29		
Responses Per Incident	Responsive Care	Dec-2022	1.11	1.09	1.08	1.09	1.11		
CFR Attendances	Responsive Care	Dec-2022	1468		958.9	1389.4	1819.9		
FFR Attendances	Responsive Care	Dec-2022	189		137.76	283.5	429.24		
ECAL Mean Response Time	Responsive Care	Dec-2022	00:23:33		00:21:38	00:23:24	00:25:09		
Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	Responsive Care	Jan-2022	30.2%			30.67%			
Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	Responsive Care	Jan-2022	17.9%			47.31%			
Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	Responsive Care	Jan-2022	51.8%			22.01%			

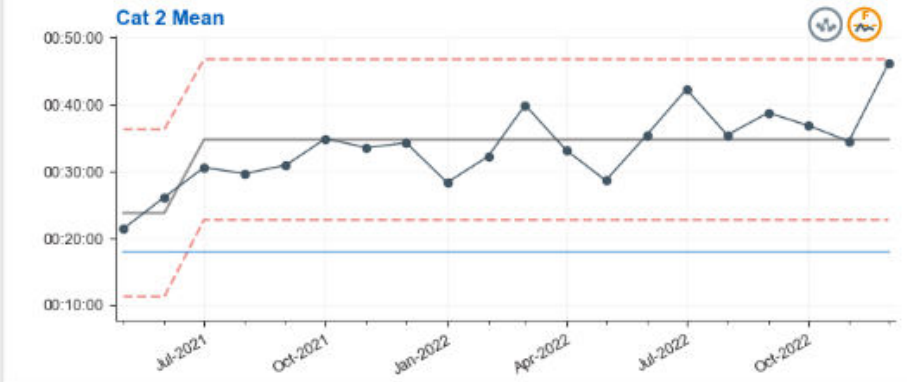
111/999 System Impacts

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Dec-2022	9.4%	13%	7.64%	9.58%	11.52%		
See & Treat %	Responsive Care	Dec-2022	33.9%	35%	30.18%	31.77%	33.35%		
See & Convey %	Responsive Care	Dec-2022	56.6%	55%	55.93%	58.65%	61.37%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Dec-2022	2.3%		0.99%	1.57%	2.14%		
Number of Hours Lost at Hospital Handover	Responsive Care	Dec-2022	6331.85		2672.85	4291.21	5909.57		
Average Wrap Up Time	Responsive Care	Dec-2022	00:17:07	00:15:00	00:16:57	00:17:31	00:18:06		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Dec-2022	45.9%		45.14%	48.91%	52.67%		
A&E Dispositions %	Responsive Care	Dec-2022	7.4%	9%	7.28%	8.64%	10.01%		
A&E Dispositions	Responsive Care	Dec-2022	6016		6208.06	7856	9503.94		
Clinical Contact %	Responsive Care	Dec-2022	56.1%		45.98%	49.27%	52.56%		
Ambulance Validation %	Responsive Care	Dec-2022	96.5%		92.04%	95.65%	99.26%		

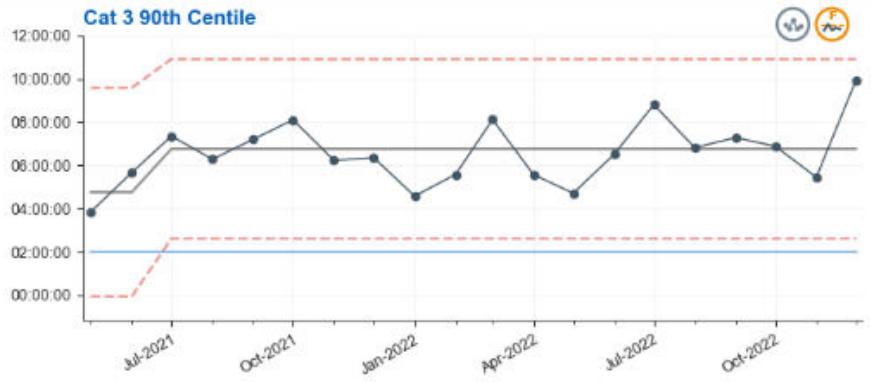
RESPONSIVE CARE

Response Times

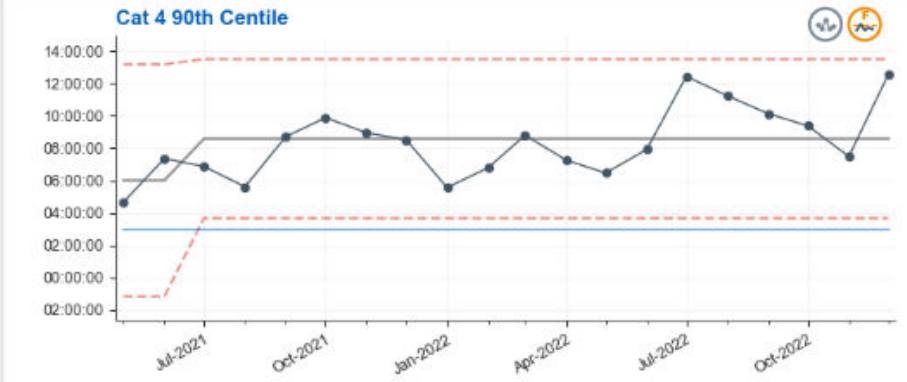
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:11:00
Target: 00:07:00
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:46:11
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: 09:55:54
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: 12:35:16
Target: 03:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

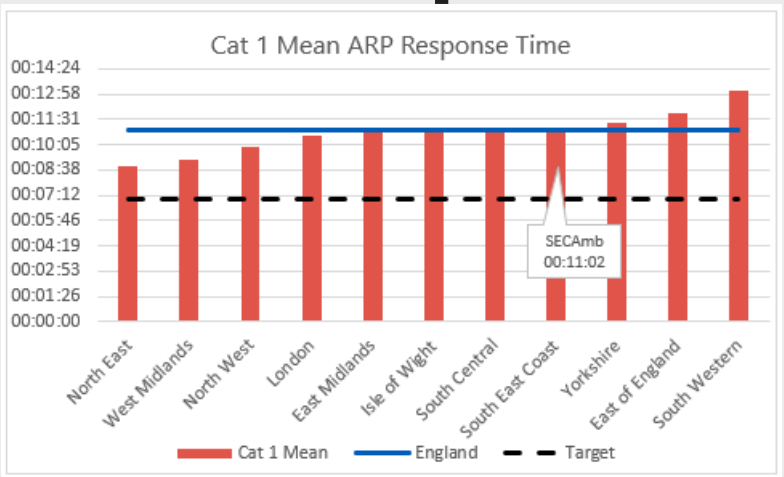
Summary

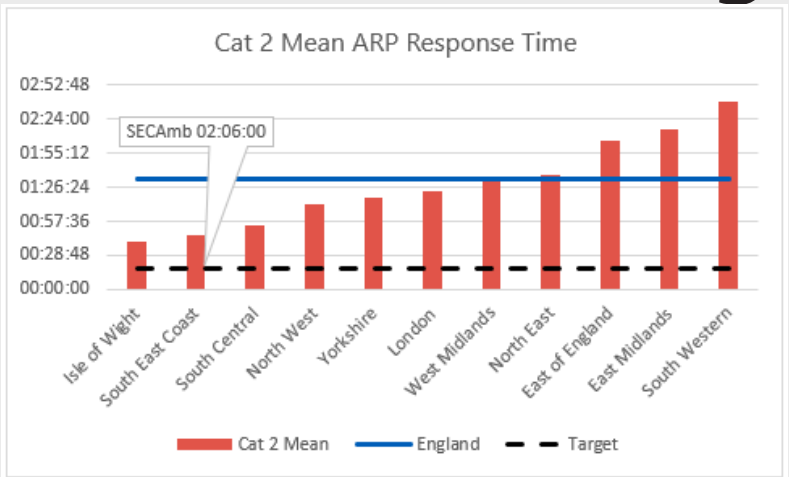
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- This performance has been strongly impacted by the fluctuating demand and resource availability – 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.

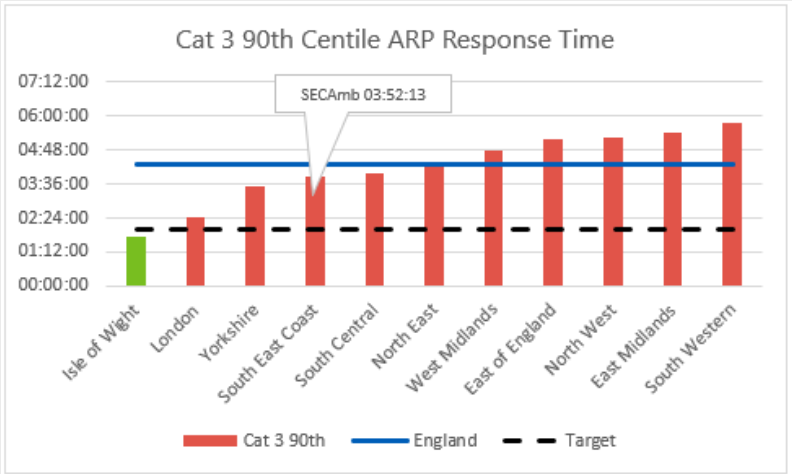
What actions are we taking?

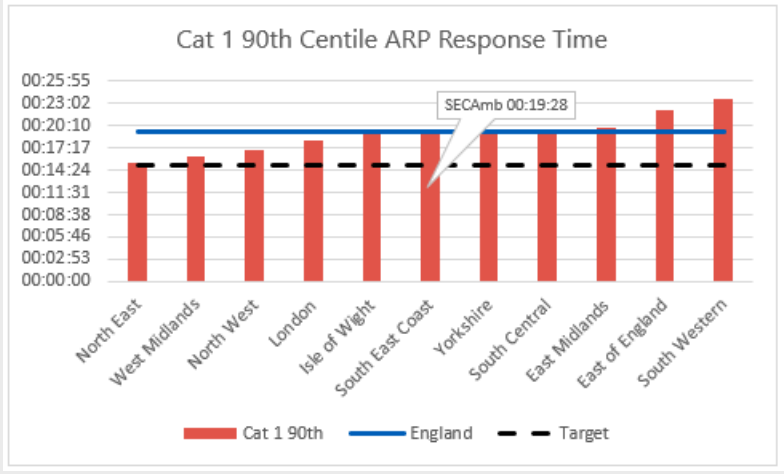
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (96.51% for Dec).
- A specific programme of improvement initiated with focus on optimising Hear and Treat 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 in field operations (7.81% Oct – a decrease from Nov of 9.48%m but influenced by the reduction in annual leave levels over the Christmas 2 week period).) and abstraction management ((remaining consistent at 34%+ across EOC & field ops).
- Continued engagement on a local and strategic level regarding hospital handover process to minimise lost hours where possible (8403.11hrs for Dec – an increase on 7062.32hrs in November).
- 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.

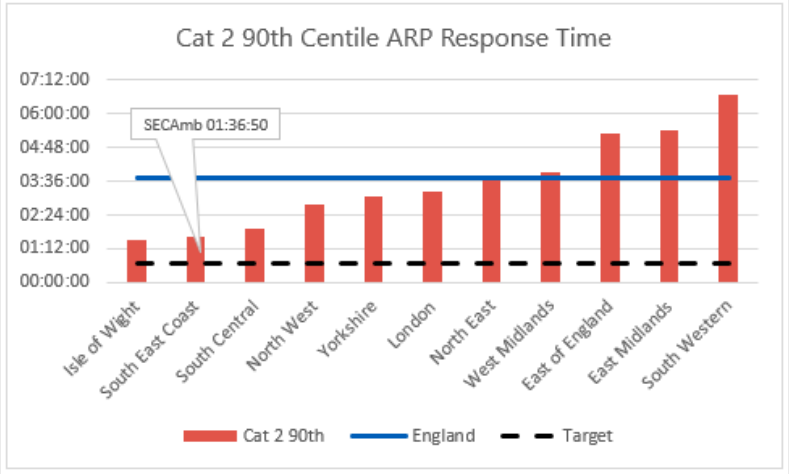
ARP Response Time Benchmarking (December 2022 Data)

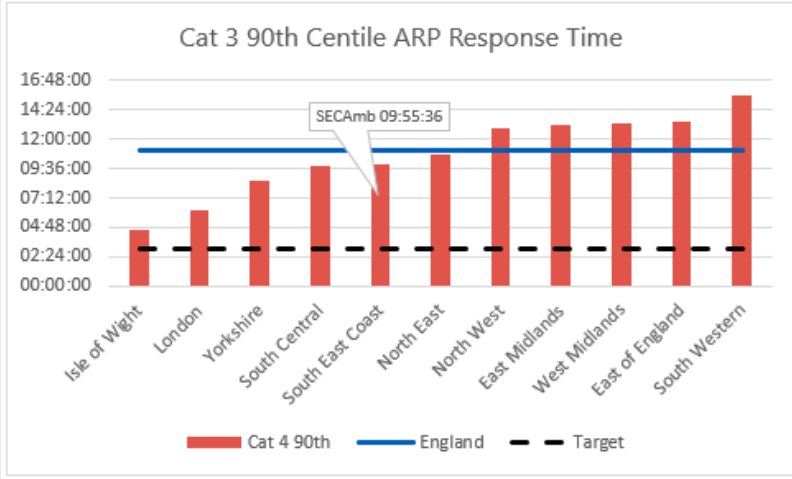












Summary

- **Our ARP Standards performance benchmarking at a national level continues in line with previously reported**
- **Performance in December has declined across the country, we remain 2nd for Cat 2 Mean which represents >60% of the most critically unwell patients that call us.**
- **The highest decline in performance has been seen in 999 Call answer performance**

RESPONSIVE CARE

EOC Emergency Medical Advisors

999-10

Dept: Operations 999
IP: Responsive Care
Latest: 82494

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

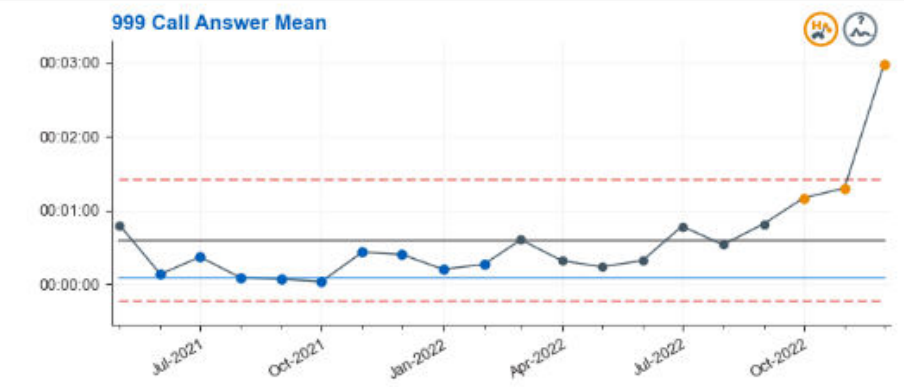
999-33

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: 9.4%
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: 00:02:59
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

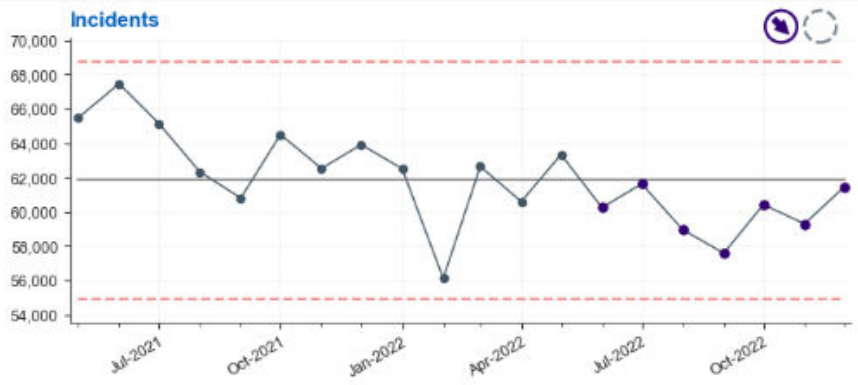
- This narrative relates to the overall efficiency and effectiveness of the call-taking functions within EOC.
- Call answer mean time has shown a steeper increase in the past two months leading to the special cause variation being noted – this is strongly aligned to the EMA resourcing levels over the 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 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 9-10%, rather than an improving trend.

What actions are we taking?

- EMA establishment is currently 51 WTE below the planned levels for Dec. Of the 51 WTE gap, approximately 75% of this can be attributed to attrition being higher than the plan for this year. EMA attrition has been 63% higher than planned this year. The end of year target is 264 WTE and dependent on attrition v recruitment rate, the Trust could fall short of this by circa 40 WTE.
- Year to date the Trust has recruited 91.1 EMAs, with a further 70.7 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 today and the need to adopt a more robust QI methodology to improvement following a review with the new Deputy Director of QI.

RESPONSIVE CARE

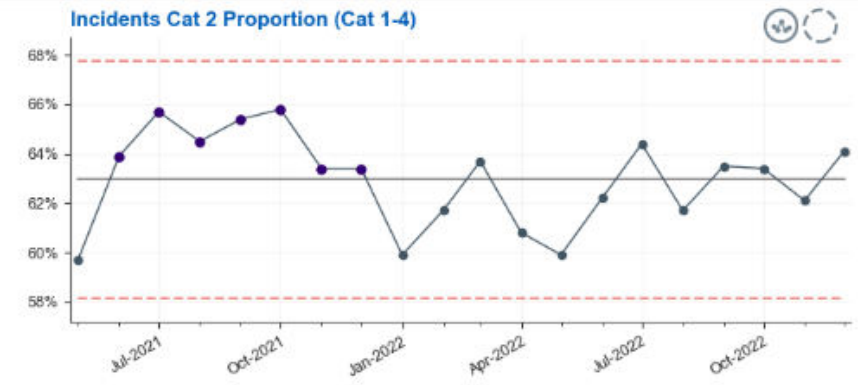
Utilisation



999-10
Dept: Operations 999
IP: Responsive Care
Latest: 61458

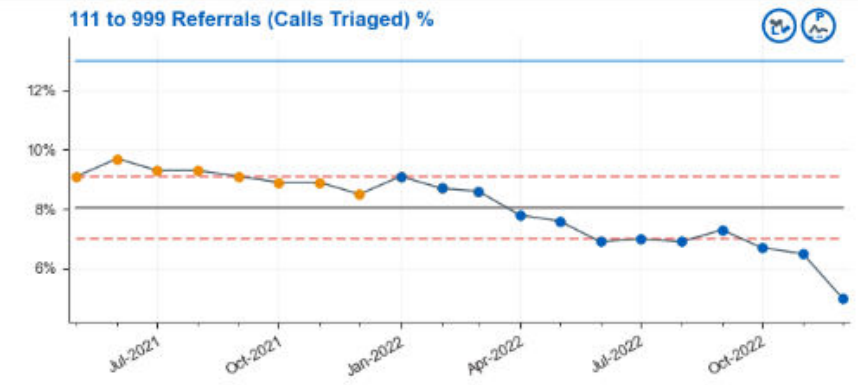
Special cause variation where DOWN is neither improvement or concern

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 90.6%
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: 64.1%

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: 5%
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 - (96.51% for Dec)
- 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

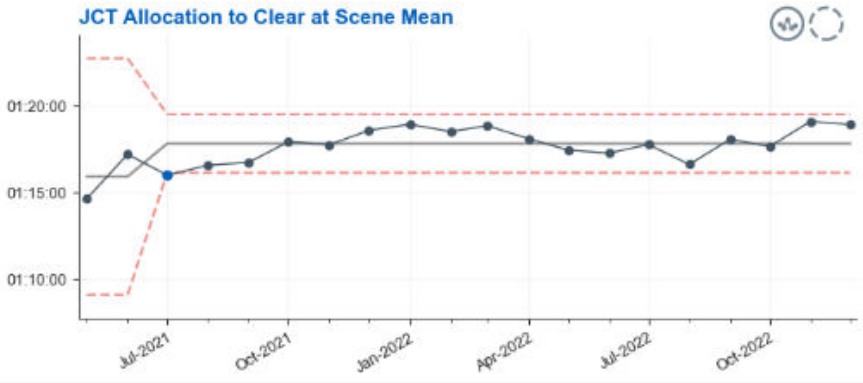
999-17

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: 00:23:33

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: 01:18:55

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: 02:03:15

Special cause of a concerning nature where the measure is significantly HIGHER. 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: 7.4%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

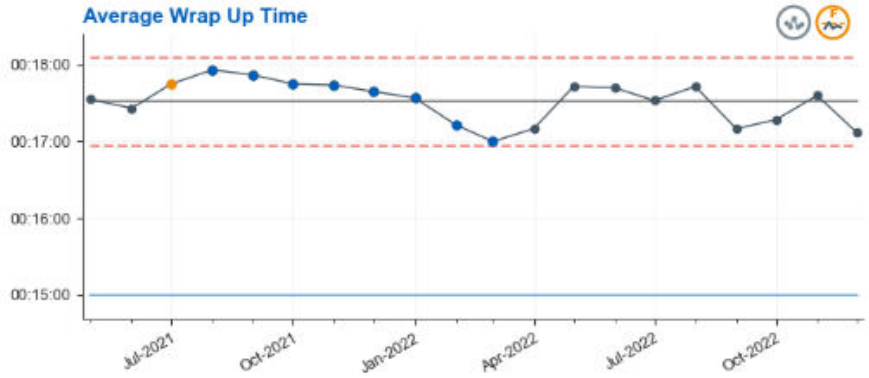
999-9

Dept: Operations 999
IP: Responsive Care
Latest: 33.9%
Target: 35%
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.

999-24

Dept: Operations 999
IP: Responsive Care
Latest: 6331.85

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: 00:17:07
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

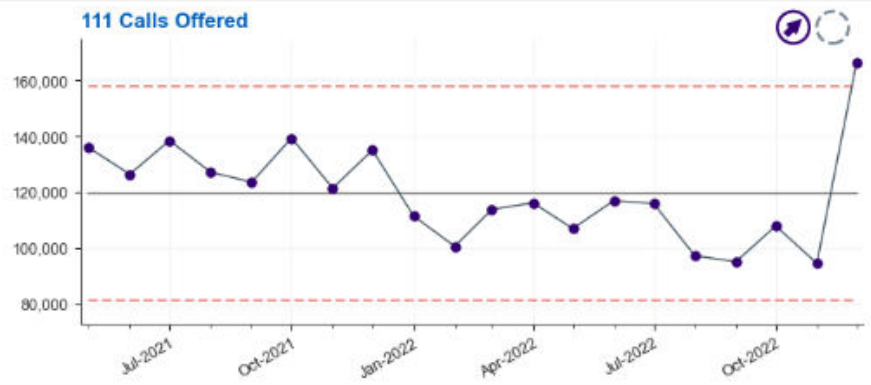
- SECAmb services (999 and 111) are key components of the emergency and urgent care health system in the SE region – this narrative provides an overview of the metrics which describe this component
- The ***111 to ED dispositions*** have been maintained at a low level since the introduction of ED disposition 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. To note: as a Trust, SECAmb has significant lower handover times across all hospitals and the whole geography than many other English ambulance services.
- Significant improvement in handover times was seen on the date of industrial action (21/12/22) following clear instruction from NHS England to all acute trusts - a level of improvement has continued into January.

RESPONSIVE CARE

111



111-1

Dept: Operations 111
IP: Responsive Care
Latest: 166547

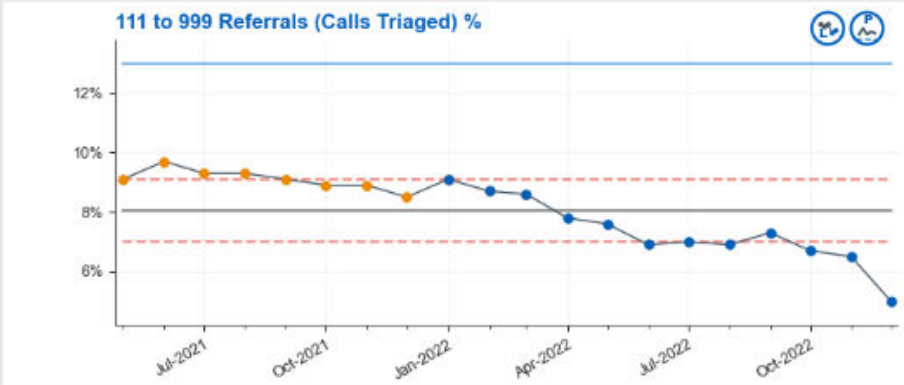
Special cause variation where UP is neither improvement or concern

111-3

Dept: Operations 111
IP: Responsive Care
Latest: 47.9%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

111-2

Dept: Operations 111
IP: Responsive Care
Latest: 6.3%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



111-4

Dept: Operations 111
IP: Responsive Care
Latest: 5%
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

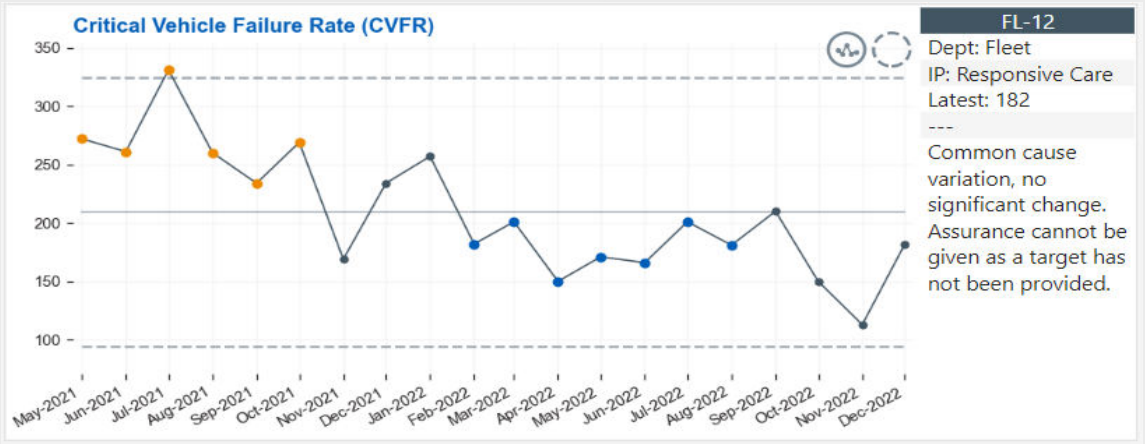
- The call activity and demand in 111 is significantly above that which SECAmb is contractually commissioned and remunerated for however this is impacted by the % of abandoned calls and therefore potential duplicates.
- The service's responsiveness remains poor, as reflected in the sustained low level 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 Access Booking (DAB).
- The Trust has been working with NHS E and secured 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
- 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

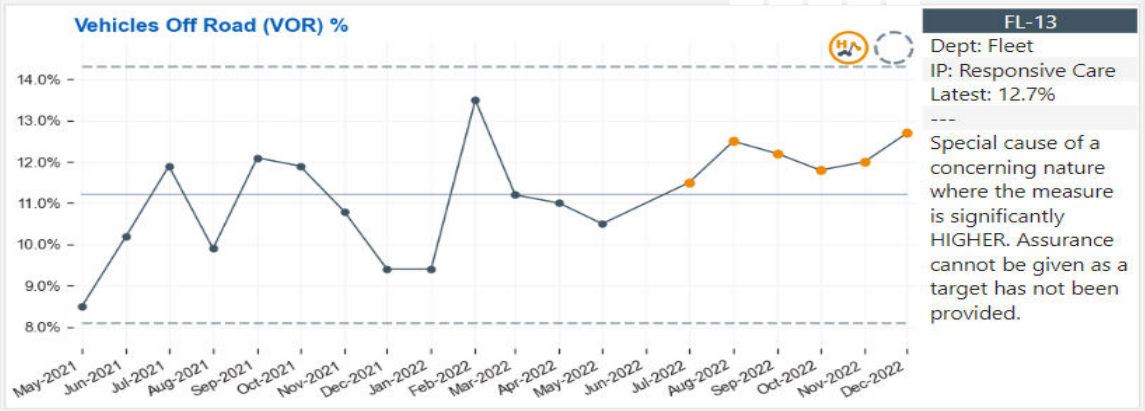
RESPONSIVE CARE

Support Services
Fleet and Private Ambulance Providers



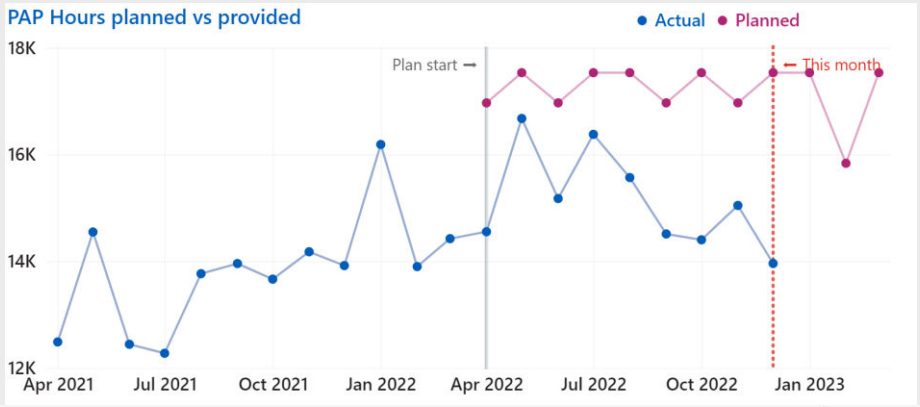
FL-12
Dept: Fleet
IP: Responsive Care
Latest: 182

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



FL-13
Dept: Fleet
IP: Responsive Care
Latest: 12.7%

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



FL-3
Dept: Fleet
IP: Responsive Care
Latest: 87%

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 and Action Plans

Critical Vehicle Failure Rate remains on a downward trend vs historic levels due to the reduction in mean vehicle age. The Fleet team have started to monitor the Average Miles between failures, which as been of 48,227miles since the 1st of April 2022, and has remained within common cause variation throughout. This will be included within the SPC IQR charts as part of the on-going development. Currently 28% of our fleet is above recommended design life (5 years for Fiat, 7 years for Mercedes), against 38% on the 1st of April.

Planned Vehicle Services completed has recovered against the position earlier in the year following the filling of vacancies. There remains a query on accuracy of the data which is being reviewed for November and December and the data seems to indicate that it could be around 75% rather than 85%. This will be confirmed for the following IQR.

VOR special cause variation is associated to an increase in mean repair time for the new FIAT Ducato DCA, due to challenges within the supply chain and limited specialist workshops on our patch.

What actions are we taking?

As presented to the FIC, the Fleet team are conducting a full life cost review of the National Ambulance choice against the incumbent Mercedes Sprinter. This will be considered alongside the accessibility challenges as reported by our staff which we have been completing personalised risk assessments for.

A decision on future fleet will be made in accordance with the data in Q4 2022/23.

Our **PAP** hour provision has been impacted by our largest supplier of hours not filling their contract. As reported in December, a contract notification has been issued and there's an improvement plan that is being monitored by the PAP team to ensure the contracted hours targets are met by the end of this FY.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

£000s	December 2022			Year to December 2022			Forecast to March 2023		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income	24,689	25,069	380	222,928	226,834	3,906	297,415	305,414	7,999
Operating Expenditure	23,175	25,009	(1,834)	223,895	228,613	(4,718)	297,417	304,794	(7,377)
Trust Suplus/ (Deficit)	***1,514***	***60***	***(1,454)***	***(967)***	***(1,779)***	***(812)***	***(2)***	***620***	***622***
System 'Control' Adjustments	*0*	*0*	*0*	*1*	*(621)*	*(622)*	*2*	*(620)*	*(622)*
Reported Suplus/(Deficit)	**1,514**	**60**	**(1,454)**	**(966)**	**(2,400)**	**(1,434)**	**0**	**0**	**0**
Cash	36,991	34,161	(2,830)	36,991	34,161	(2,830)	40,886	33,362	(7,524)
Capital Expenditure	737	1,039	(302)	27,494	21,059	6,435	36,116	31,832	4,284
Effciency Target	627	0	(627)	3,417	896	(2,521)	5,598	3,298	(2,300)

Summary

The Trust's financial performance for the 9 months to 31 December 2022 was £1.4m lower than plan due to the impact of lower 999 income and planned savings. 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 savings.
3. the Trust meets the requirement to deliver 111 Single Virtual Contact Centre (SVCC) requirement.

At month 9, 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 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, currently being severely impacted by long handover delays causing longer waiting times to deliver safe and effective patient care.
4. Ability within 111 to change the service offering quickly enough to meet the new service specification agreed by the Operations Director.

.

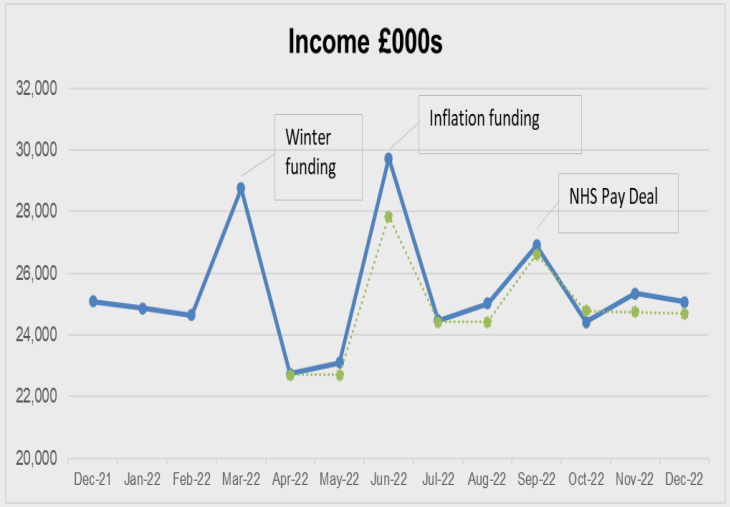
What actions are we taking?

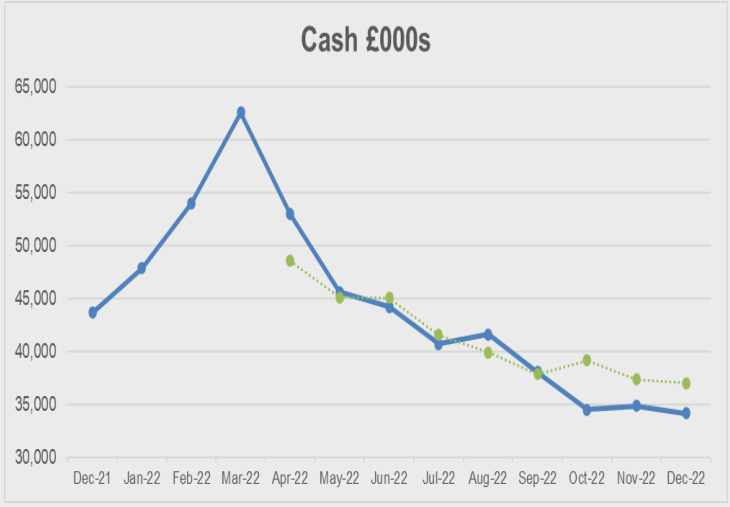
1. The Trust identified a £8.9m savings target in October 2022 to achieve a break-even position, the Trust is engaged in a financial recovery plan to achieve these savings, as at December 2022 £6.2m of savings have been identified, leaving £2.7m; The Trust is looking at a further £0.9m of savings, with a potential out-turn position of £1.8m deficit.
2. The financial recovery plan, and ongoing cost control includes:
    a) Further Executive Director challenge review meetings scheduled from 23-30 January 2023 focused on:
        I. Delivery of 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.
        VI. Planning for 2023/24
    b) Review and analysis of balance sheet provisions
3. 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.
4. Engagement with system partners on the 2023/24 plan; draft due to be submitted on 23 February 2023

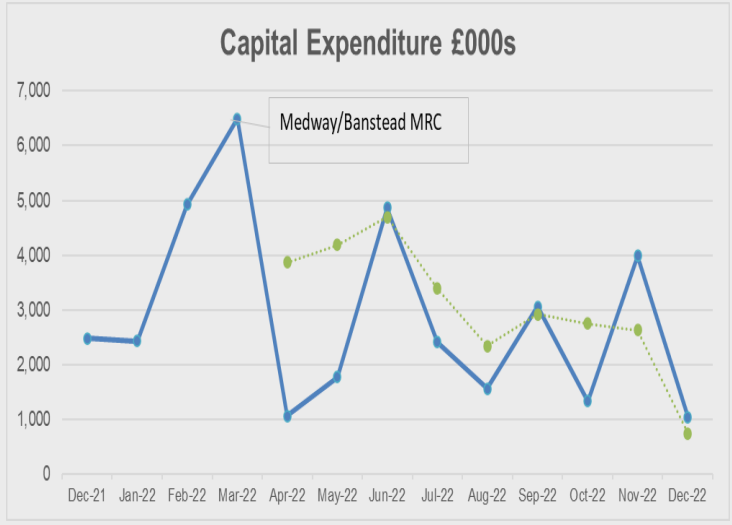
SUSTAINABILITY & PARTNERSHIPS

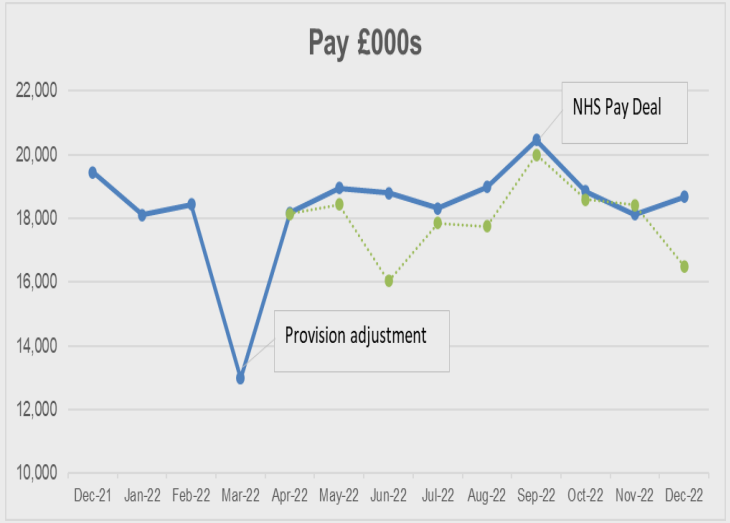
Delivered Against Plan

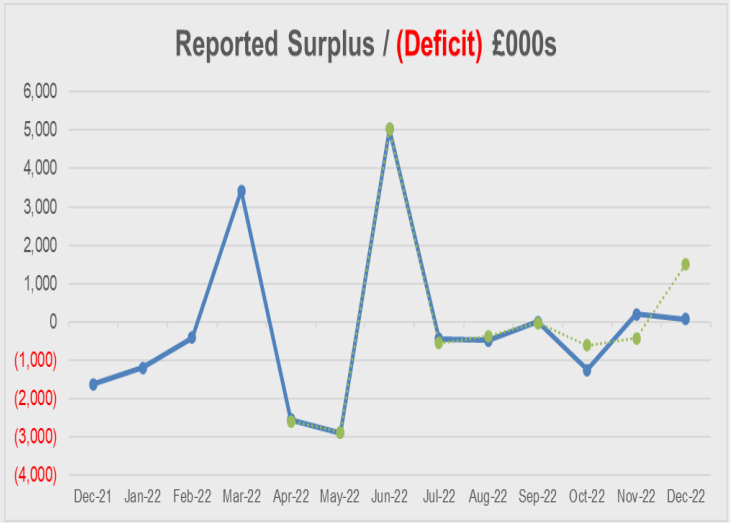
Actual Plan











Summary

The Trust's financial performance (surplus/deficit) for the 9 months to 31 December 2022 was £1.5m lower than plan due to the timing of savings and lower 999 income as a result of the block contract values being less than expected.

- Cash is below plan by £2.8 from the delay of receipts from commissioners as part of their contract commitments.
- Capital is below plan by £6.4m from the delays in the Medway MRC build and delays in new ambulances due to supply chain issues.

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 – February (2023) Board Report

Portfolio overview

Portfolio name: Improvement Journey	**Overall portfolio status:**	
	Forecast status with actions completed by the next reporting period:	
Accountable executive: Executive Director of Planning & Business Development	**Oversight:** Trust Board	
Start date: 30th June 2022 (Approval at Board)	**Projected completion date:** N/A	
Update date: 2nd February 2023	**Next update due:** 6th April 2023	
Author/s: David Ruiz-Celada, Executive Director for Planning & Business Development Matt Webb, Associate Director of Strategic Partnerships		

1. Background and portfolio aim and objectives

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

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*

1.3. 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 outlined within the inspection reports in June and October 2022 (Appendix 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).

1.5. 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).

1.6. As our Trust-wide approach to continuous improvement is developed, any Trust improvement initiative, whether it be directly or indirectly impacting patients, will continue to be facilitated through this framework.

1.7. 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.

1.8. 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.

1.9. 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.

2. Summary since the last report (Board Report – December 2022 (reporting on 22.01.23))

2.1. People & Culture

2.1.1. The Culture Working Group has been established by the Executive Management Board to oversee and provide assurance on the implementation of the NHS England Culture & Leadership Programme and associated workstreams covered by the umbrella programme.

2.1.2. The purpose of the Culture & Leadership Programme is to develop and implement strategies for collective leadership which result in a culture that delivers high quality, continuously improving, compassionate care, improving the health and wellbeing of staff and leading to better health outcomes for patients.

2.1.3. The working group is completing the scoping phase, determining project resources, funding, communications and associated plans. The Culture Working Group will next be moving into the discovery phase, diagnosing, identifying, and establishing existing organisational culture using six culture tools. These include patient experience assessments, leadership behaviour surveys, culture focus groups, Board interviews and leadership workforce analyses.

2.1.4. As a result of the external HR review, a Programme Director (Culture & Leadership) has been recruited to lead this programme, commencing on the 8th of March 2023, whilst a business case for additional support is pending approval (expected by the end of January 2023).

2.1.4.1. The Programme Director (Culture & Leadership) will also be supported by an external associate commissioned by the NHS England Transformation Team, who will assist with programme implementation and help the Board to define its vision.

2.1.4.2. The People & Culture programme temporary project lead post, introduced to ensure progress against warning notice four, was discontinued in December 2022.

2.1.5. Over 394 managers have now completed the Sexual Safety workshops and there have been 4 cohorts of 12-14 people each on the first-line managers' Fundamentals leadership development programme, a total of 59 managers have attended this programme.

2.1.6. In terms of key risks, the Trust continues to operate at a sustained level of high operational pressure leading to challenged recruitment with increased staff turnover and sickness, further impacted by ongoing industrial action. (Risk ID 348 – Culture & Leadership and Risk ID 14 – Operating Model).

2.2. Sustainability & Partnerships

2.2.1. Following the Executive Management Team facilitating workshops with the Board, Council of Governors and wider leadership team to develop the strategic priorities for

2023/24, the Planning team will be meeting with each executive director and their teams during the next 3 weeks to help define the objectives and key results for 2023/24 based on the strategic objectives set by the Board and Councill of Governors in November and December of 2022.

2.2.2. These will form the bases of our interim delivery and improvement plan for the course of 2023/24 and the Board will sign them off as part of the Planning and Budgeting at the Board in April 2023.

2.2.3. A review of each executive director's portfolio and their respective accountability is ongoing, as part of our review against the RSP-L2 requirement *"Clear lines of responsibility and accountability for individual executives"*, with any amendments to be agreed on by Tuesday 28th February. This aligns with the ongoing effectiveness and governance reviews of corporate functions which follow those undertaken across the Trust's clinical governance groups.

2.2.4. Reporting arrangements have been revised to ensure regular monthly finance Board reporting, including current financial position, mitigating actions and forecasts, together with regular reporting to the wider system via the Trust's lead commissioner and System Assurance Meeting (SAM).

2.2.5. Development of a new Sustainability & Partnerships section within the IQR is in progress and is due to be completed by 31st January 2023.

2.2.6. The Board conducted its first review of the internal Well-Led self-assessment led by the Improvement Director. Our position remains as "Requires Improvement", and the gaps identified will be used to shape the Board Development programme going forward.

2.3. Quality Improvement

2.3.1. The Quality Improvement Group (QIG) has not met since early December 2022, however, reconvened bi-weekly as of 24th January 2023. The delivery lead for this programme has changed to the recently appointed Head of Quality & CQC Compliance, with a handover having taken place from the prior delivery lead (Associate Director of Quality & Compliance – Medical).

2.3.1.1. The Quality Improvement programme temporary project lead post, introduced to ensure progress against warning notices two and three, was discontinued in December 2022.

2.3.2. As part of the transition of the Improvement Journey delivery into existing governance, day-to-day oversight of the majority of the QIG workstreams has now transferred to the Quality Governance Group (QGG). Strategic oversight of overall progress remains with the Improvement Journey Steering Group which meets weekly and is co-chaired by the Director of Quality and Nursing.

2.3.3. Delivery and workstream leads have identified key metrics aligned with the CQC must-do requirements. These are currently being added to the existing Quality Dashboard to support timely triangulation and escalation of issues.

2.3.4. Significant BI development is ongoing to develop robust patient-to-board quality, performance, and workforce integrated reporting, following the implementation of "Make Data Count". All reporting is now being migrated to SPC charts, not only the Board's Integrated Quality Report.

2.3.5. The Trust's first Quality Improvement (QI) training session for Trust staff is scheduled for 25th January 2023, with the first QI project concerning keeping patients safe in the 999-stack having commenced with process flow mapping started on the 4th of January. Both activities are currently being led by the recently appointed Deputy Director of Quality Improvement and actively publicised through our communications channels to increase the visibility of the QI agenda.

2.3.6. The Learning from SI Forum has been established and is coordinating the identification and cascade of learning from incidents and SIs. This forum will inform the next Trust Quality Summit, which is scheduled for March 2023.

2.3.7. Formal planning for the introduction of the Patient Safety Incident Response

Framework (PSIRF) is underway to ensure readiness for implementation in September 2023, with the PSIRF Implementation Lead position currently out to advert.

2.3.8. In terms of key risks, the programme has highlighted that the timely review of risks in accordance with Trust policy may become challenged once the high-level director input stops post-CQC improvement. Additionally, concerns continue regarding the capacity within the End-of-Life Care (EOLC) team to effectively reduce the needs for unanticipated EOLC (Risk ID 282 – Risk review within policy arrangements and Risk ID 75 – End of Life Care).

2.4. Responsive Care

2.4.1. In light of current operational pressures, a prioritisation exercise has been undertaken by the Executive Lead and as a result, several changes have been made to the Response Care programme and have been subsequently approved by the Responsive Care Group (RCG) and the Improvement Journey Steering Group.

2.4.2. The following RCG workstreams are currently being prioritised:

- Field Operations Rota Implementation
  - The workstream Task & Finish Group is working through outstanding concerns regarding the imbalance of operational hours through the 24-hour period. Following, the resolution of rota grievances submitted in autumn 2022, the RCG will look to implement the new rotas across the remaining dispatch desks, at which point Trust performance will be reported on for all areas.
- Emergency Operations Centre Rota Implementation
  - Metrics have been identified to monitor attrition and sickness levels. Once this data has been baselined, the workstream Task & Finish Group will use this to help track and monitor performance, with an anticipated increase in overall compliance against hours.
- Hear & Treat Optimisation
  - Overall Hear & Treat performance has demonstrated a downward trend; however, the monitoring of taxi utilisation has presented an increase with the BI team currently developing metrics which provide a utilisation percentage against the total number of applicable incidents.
- Review of Dispatch Processes
  - The workstream project team has developed an action plan to articulate how the Association of Ambulance Chief Executives (AACE) recommendations will be achieved. The project team is due to visit the South West Ambulance Service Foundation Trust (SWASFT) and North West Ambulance Service NHS Trust (NWAS) during Q4 (2022/23) to review best practice approaches to tactical command and complex incident management. In addition, the project team is also trialling the auditing and quality assurance of resource dispatchers and is finalising a Standard Operating Procedure outlining the key principles of resource deployment and staff welfare.

2.4.3. The scope of the following workstreams has been revised to ensure prioritisation of the CQC must-do requirements:

- Operational Support - primary focus altered to asset tracking and equipment management (Must-Do 12 and Must-Do 13).
- Job Cycle Time - the innovation work with the Clinical Advisory Group to improve ‘time on-scene’ will be paused until 1 April 2023.
- Operational Workforce Delivery - this workstream will be de-scoped from the Responsive Care programme as it will now form part of the People & Culture programme and Annual Planning Group.

2.5. Communications and Engagement

2.5.1. The Trust is continuing to work with Hood & Woolf, a communications and engagement consultancy. 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 which is due at the end of Q4 (2022/23).

2.5.2. The aim of this work is to support the Trust's leadership at every level to deliver enhanced and improved internal communications and engagement so that everyone across the organisation feels their voice and views have been heard. This is integral to the wider programmes of work on cultural change, leadership visibility and offering an enhanced staff experience to make SECAmb a great place to work.

2.5.3. Representatives from Hood & Woolf attended the Leadership Team (EMB and SMG) meeting on the 18th of January 2023, where they presented their findings to date and initial recommendations. Acknowledging the effective communications mechanisms which already exist within the Trust, Hood & Woolf will concentrate on enhancing the Trust's approach to engagement, working with colleagues within the HR & Organisational Development directorate, and those leading the Culture & Leadership programme.

2.5.4. The Trust has continued to receive positive feedback from staff following the go-live of the Yammer platform in December 2022. The Communications team are continuing to monitor uptake, utilisation, and activity, which will inform a review at 60-(February) and 90-days (March) post-implementation.

2.5.5. An interim OD & Employee Engagement Coordinator has been introduced to coordinate the listening and engagement activities of the Leadership Team throughout the Improvement Journey. Facilitating greater leadership visibility and listening activities as part of business as usual across the Trust, this role will undertake thematic analyses of feedback obtained and report on trends, findings, and recommendations.

Overall progress against outcomes

3. Progress against Warning Notices

3.1. The Section 29A warning notices issued to the Trust by the CQC expired on 18th November 2022. CQC colleagues will conduct a review of our progress on the 31st of January 2023 in the form of a management presentation.

3.2. Overall progress against meeting the WN target evidence achieved **100**% by the end of December 2022, with all supporting evidence being quality assured.

3.3. Appendix 4 provides a summary of the actions taken together with the expected impact and links to relevant evidence. This will support a presentation by the Executive Management Team to the CQC at the end of January 2023.

	Sep-22	Oct-22	Nov-22	Dec-22
Overall Progress against WN	42%	60%	99%	100%

Warning notice - S29A					
Warning notice - S29A	***Forecast by Nov 2022***	**Completion % Sep 2022**	**Completion % Oct 2022**	**Completion % Nov 2022**	**Completion % Dec 2022**
WN1	*75%*	40%	48%	100%	100%
WN2	*60%*	30%	66%	100%	100%
WN3	*70%*	40%	48%	95%	100%
WN4	*40%*	57%	78%	100%	100%

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

3.1. Note that 100% completion relates to our target evidence as scoped and approved at Board in July 2022. There remain clear next steps across all warning notices to deliver the full scope of the improvements we require, and those are tracked through within the Must-Do, Should-Do and RSP exit criteria, as well as our Strategic Priorities for 2023/24.

4. Progress against Warning Notices and Must-Dos

4.1. Following the expiry of the Section 29A warning notices, and subject to the CQC's follow-up visit at the end of January 2023, the Improvement Journey's focus has shifted to the associated must-do requirements.

4.2. As part of the transition to CQC must-do actions, the Improvement Journey delivery leads have been empowered to develop and determine metrics to support the monitoring of each programme's respective actions, providing evidence that the assurance target fulfils the regulatory requirements.

4.3. Appendix 1 provides a summary of the 15 must-do requirements, together with the key CQC report findings, governance and assurance mechanisms, associated metrics and additional evidence requisites. This will form the basis of assurance for the Board on an ongoing basis.

4.4. Holiday periods, together with continuing winter pressures and industrial action, have reduced the availability and capacity of the Improvement Journey executives and delivery leads during recent weeks, key metrics are being finalised for each of the must-do requirements, with a planned completion date of 31st January 2023. The Executive Team will be scheduling a deep dive into the scoped deliverables in early February.

4.5. Moving forward, subsequent Board updates will report more granular percentages of completion against the maturing must-do framework for all 15 must-do requirements.

4.6. A high-level summary of must-do requirement allocation to each of the four-existing Improvement Journey programmes is provided below.

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

5.1. The Improvement Journey Portfolio Team will be reviewing all outstanding RSP exit criteria during Q1 2023/24, determining how these will be progressed by the September 2023 deadline, with assurance continuing to be provided through the Improvement Journey Steering Group to the Trust Executive Management Team and Board.

5.2. Whilst the current Improvement Journey priority is the achievement of and demonstrating

significant process against the CQC must-do requirements, considerable progress has been noted in relation to the leadership and governance, and communications and engagement RSP Exit criteria.

5.3. Of the 19 RSP Exit criteria, eleven actions are on-track, seven are delayed with outstanding milestones considered achievable prior to the deadline, and one requirement is delayed with mitigations currently being determined by the responsible persons.

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

6.1. Overall progress against achieving the RSM considerations is 85%, up from 82% as reported in December's Board report.

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

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	Implementation of an adapted engagement approach and digital community platform. Work is also being undertaken on primary focus areas identified from the Hood & Woolf initial findings report. The communication mechanisms within the Trust are effective but the challenge remains around engagement, acknowledging 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).	24/02/2023	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-Celada	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. The additional capacity created is currently planned to end on 31/03/2023.	24/02/2023	4	3	12
R10	Finance	Funding	There is uncertainty regarding the continuation of external (NHSE) funding to support the Improvement Journey beyond March 2023.	David Ruiz-Celada	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.	24/02/2023	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-Celada	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 the development of a continuous improvement framework. Improvement Journey delivery leads, Deputy Director of QI and Associate Director of Strategic Partnerships are progressing plans to ensure the continuity of the Improvement Journey. Delivery leads are supporting portfolio progress.	24/02/2023	4	3	12
R2	Schedule Quality	Demand	Due to operational demand or unforeseen service pressures, including the continuing industrial action, 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.	24/02/2023	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 must-dos. There are identified delivery leads for each programme currently in place.	24/02/2023	4	2	8

Assurance and Actions for the reporting period ahead

7. CQC Must-Do Requirements

Progress (additive to December report)	Gaps	Actions (continued from December report, p indicates previous action)
(+) New must-do regulatory registry provides visibility of target metrics and evidence for all must-do requirements detailed within the June and October 2022 reports (Appendix 1). (+) Full review of all must- and should-do requirements from the June and October 2022 reports undertaken by the Improvement Journey Steering Group during December and January 2023, with mapping of additional requirements into Improvement Journey programmes. (+) Recruitment to internal Head of Quality & CQC Compliance completed with postholder now leading on the Quality Improvement programme and development of the Trust's ongoing compliance surveillance mechanisms against CQC domains and KLOEs. (+) Improvement Journey delivery leads, Deputy Director of QI, Associate Director of Performance & Planning and Associate Director of Strategic Partnerships are progressing plans to ensure continuity of the Improvement Journey beyond the initial compliance-driven phase – initial proposal reviewed at Leadership team meeting on 18th of January 2023. (+) External communications consultancy initial review completed, finding that the Trust's communications mechanisms are appropriate and not the root cause of the challenges faced. (+) Survey to scope QI capability and capacity across the Trust introduced with a review of responses planned for the end of January 2023. (+) Responsible executives (CFO and Director of Planning) overseeing the planning process for 2023/24, incorporating plans for delivery of improvement as well as budget, workforce, performance, etc.	(-) Board and wider leadership team effectiveness and stability may be impacted by upcoming changes in the executive team, UEC recovery actions (2023/24) and continuing industrial action. (-) Plans are outstanding to ensure the continuity of the Improvement Journey beyond the sprint phase. (-) Further development of the regulatory registry with executive and delivery leads is required to confirm governance arrangements, key metrics and prioritisation for each must-do requirement. (-) Approval of the Culture & Leadership Programme business case is outstanding.	**Action 25:** Executive team to conduct a joint review of the defined scope and delivery plans including milestones for each Must-Do in early February 2023 following completion of the CQC Warning Notice Management presentation. **Action 26:** H&W is supporting the Culture Working Group in developing a simple narrative to explain the CLP programme, approval is expected at the end of January 2023.

8. RSP Exit Criteria and System Assurance

Progress (additive to December report)	Gaps	Actions (continued from December report, p indicates previous action)
(+) National entry meeting with NHSE completed on 14th October 2022. (+) Mapping to the former warning notices and must-do actions demonstrates strong alignment between deliverables. (+) Full RSP progress tracking will commence from Q1 (2023/24), with an Improvement Journey Steering Group review having been undertaken in early-	(-) Clinical Education Strategy approved however business case has not yet been approved.	**Action 27:** WWC agenda in February will review the emerging workforce plan for 2023/24 and triangulate how the Clinical Education department is sized to deliver against the plan.

January 2023. (+) RSP exit criteria tracker which identifies responsible persons, key metrics and reporting routes has been developed and populated and is monitored by the Improvement Journey Portfolio Team.		

9. RSM Recommendations

Progress (additive to December report)	Gaps	Actions (continued from December 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 the commencement of the planning round, coordinated by the recently appointed interim Associate Director of Performance & Planning.	(-) Uncertainty regarding the continuation of external (NHSE) funding to support the Improvement Journey beyond March 2023.	**Action 15(p)**: Sustainability & Partnerships programme to lead the 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.

10. Programme, Risks and Engagement

Progress (additive to December report)	Gaps	Actions (continued from December report, p indicates previous action)
(+) 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. (+) Hood and Woolf's strategic communication delivery plan shared with next steps outlined, including a co-designed internal communication and engagement strategy – with staff, for staff. (+) Continued promotion of the digital community Yammer platform.	(-) The overarching Improvement Journey BAF risk (20) remains scored as 12 with a target risk score of 4. (-) Funding does not currently cover resourcing beyond the 31st of March, causing continuity and recruitment challenges for project resources. (-) Due to the different levels of maturity in the workstreams and different must-do actions, 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 28:** Continuous Improvement Framework is under development and job descriptions are being developed to ensure continuity of the team beyond 1st of April 2023.

Appendices (updated 23.01.2023)

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	84-22

Name of meeting	Trust Board
Date	02 February 2023
Name of paper	Keeping Patients Safe - Executive Summary to the Board
Trust Priority Area	**Delivering Quality**
Author / Lead Director	Dr Rachel Outen, Chief Medical Officer Robert Nicholls, Executive Director of Quality & Nursing Jane Spencer, Business Support Manager Quality & Nursing
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:

The second iteration of the Trust's risk register report was presented to the Executive Management Board on 10th January 2023. The report continues to be of a good standard that enables the Board to have meaningful discussions and agree actions. There are 67 risks on the corporate risk register that represents all risks rated high (12+) and extreme (15+). The extreme risks (Section E of BAF) are listed as follows:

Risk 28 - Drug Seeking Behaviour via 111 Electronic Prescribing Service (EPS)
Risk 29 - EPRR response time
Risk 34 - Sustainability in the Medicines Governance Team
Risk 36 -Trend of poor identification of STEMIs by SECAmb clinicians
Risk 82 - Hazardous Area Response Team (HART) capacity
Risk 136 - Process of tagging medicines pouches is not working effectively
Risk 273 - Industrial Action
Risk 304 - Climate Change

The Corporate Risk Register is monitored by the Trust's Risk and Assurance Group (RAG) that is 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. RAG also looks at emerging risks and include this in the monthly updates to EMB and quarterly updates to the Trust Board committees specific to purview.

Within Medical there are four extreme risks (28, 34, 36 and 136). Three of the four sit within the medicine's 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.

EMB reviewed the current position and agreed that the business cases should be presented separately with an initial mitigation action to relocate the staff to the ground floor of the building. The relocation of the distribution centre will consist of a phased approach over 2023/24. The business cases are expected to be presented to the Business Case Group at the end of January 2023. At the beginning of January 2023, the Director of Finance has authorised the Chief Pharmacist to begin the recruitment for initial staffing needs. Medicine risks was discussed at the 24th January 2023 QPSC and the Director for Quality and Nursing in collaboration with the Chief Medical Officer and Deputy Medical Director will conduct a review of medicine's risks in February 2023. The review will include all internal key stakeholders and the Regional Chief Pharmacist.

The outcome of the review will be presented at the next QPSC meeting.

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.

BAF Risk 256: Quality Improvement

Keeping Patients Safe in the Stack QI Project
At the beginning of January, we commenced a QI project utilising the DMAIC framework which is the chosen framework for our continuous improvement approach. The QI project will focus on reducing harm to patients awaiting a clinical call back. Working with colleagues in EOC, the QI project is about keeping patients safe in the stack. We know that we are not consistently reaching patients within targeted time frames and at the Quality Summit held in September, this was highlighted as one of our biggest risks. We also have some incident data on harm from the BI Team to support this.

There is a lot of work happening regarding clinical call queue oversight and how to manage calls effectively, including a workstream reviewing Hear and Treat. This project will not duplicate existing work but deliver in partnership an opportunity for us to step back, consider all root cause contributary factors and how we might manage these more effectively, utilising a QI framework to maximise our opportunity for success. This project will include review of the pending (dispatch) queue and clinical queue. It will include all patient dispositions and both East and West EOC. As such, it will also include a review of welfare calling, where SECAmb have been identified as an outlier regarding its process compared to other ambulance providers.

Work is well under way in the collation of information for the ‘Define’ and ‘Measure’ stages of the project. The project team includes a data scientist from the BI team who is collating and analysing relevant data, the EOC team have been undertaking process mapping to highlight opportunities for improvement and stakeholder analysis is being undertaken. Wider communication is taking place with all staff through the weekly bulletin, Yammer and other social media.

Risks to the project include operational colleagues having capacity and time to support the project, interdependencies with the Hear and Treat project already underway, and a risk to delivery time frames on operational improvements within CAD due to infrastructure issues. All risks are regularly monitored and reviewed and have effective mitigations in place.

The Out of Hospital Cardiac Arrest Annual Report was published at the Quality and Patient Safety Committee on 24th January 2023. The report celebrated significant improvements in early CPR, early defibrillation, use of public access defibrillators, and post-arrest care. The QPSC heard that the report covered the period to March 2022 but since March a number of these indicators had taken an adverse direction and were concerned to hear from the Consultant Paramedic in Critical Care, that cardiac arrest actions were not as high a priority on the Trust’s agenda as they could or should be. The QPSC asked that we re-commit to the actions needed to be taken to maintain successful cardiac arrest outcome data.

The IQR for Quality & Nursing highlights the following areas:

In June 2022, the CQC requested to receive the root-cause analysis of 36 incidents including 3 that were declared as Serious Incidents. A further CQC request was made in November 2022 of 64 serious incidents reported on STEIS. CQC advised that it was part of their due diligent process, however they were concerned around the robustness of investigations and how the level of harm was applied. We have not received any formal notification of the outcome from QCQ's investigation.

The Trust took a proactive approach to these concerns and conducted a series of reviews on 3 SI cases from the initial CQC request and 27 cases from the subsequent request. The review of the first 3 cases was conducted with support from NHSE, ICB partners and the current Deputy Director of QI who at the time work at IC24. The 27 cases were reviewed by 6 panels comprising of 2 staff members in each of the panels. Staff members were a combination of clinical staff and senior staff in the Quality and Nursing Directorate. There were 6 assessment criteria from the factual accuracy of the report to the final recommendations and actions.

The results of the internal review were as follows:

Initial 3 SI cases

- reports are written well, they are coherent, logical and easy to understand
- reports demonstrate that the investigator had good understanding of the incident and of the organisational supporting processes/procedures.
- however; there could have been more robust analysis of contributary factors that may have led to better analysis of the root cause. This led to recommendation and action plans not being clear.

Subsequent 27 SI cases

- 83% of the reports being assessed as comprehensive, factual, and resulting in recommendations and actions based on sound rationale from the findings.
- only 1 case was identified as failing to identify the root cause of the incident due to taking a limited view on the incident, therefore the recommendations became irrelevant.
- 47% were assessed as having actions that were inadequate as they did not always link to the recommendations or findings, and often were not directly relevant. Some actions were not always SMART or likely to be effective.

We conducted a review of how Serious Incidents Managers (SIM) apply level of harm and in doing so make decisions on which cases were referred to the weekly Serious Incident Group (SIG). The Medical Directorate established a panel that randomly selected 30 cases that were not referred to SIG over a three-month period. The panel supported the SIM's assessment and decision not to refer the cases to SIG.

Further, a tabletop exercise looking at the Trust's SI process was conducted by the NHSE Improvement Director, and the outcome presented to EMB on 25th January 2023. The findings were measured against the relevant section of the incident pathway. The conclusion was that overall, oversight and compliance was good. There were opportunities for improvement regarding the organisation's ability to demonstrate a consistent approach to the grading of harm.

Our review and intervention to strengthen the SI process over 9 months has improved the quality of reports, recommendations and actions, however the executives recognise that further work is needed in the areas identified from the internal review. The Director of Quality and Nursing will review the recommendations and agree some key actions that will be presented to EMB in February and QPSC in April 2023.

The management of Serious Incidents (SI) and breached SI actions has been a focus for the Trust from April 2022. The current number of breached incidents (as of 30 December 2022) is 8, with clear plans in place for completion of all bar one that has been escalated to the ADO (Assistant Director of Operations) for intense support. There are now clear, defined structures and processes in place to support investigators though the challenge still is the competing operational pressures on their time for carrying out such investigations. It is important to note however, that the oldest investigation is <6 months old and SI team are working with the Associate Director of Operations to address the issues.

Since 1st May 2022 when a trajectory was set to reduce this backlog (by at least 50% by the end of July and to zero by the end of the year), there has been a significant improvement in the number of overdue actions due to intensive support and focus by leaders across the organisation and the SI Team.

Over the same reporting period, there were 53 open actions with 43 of these within their target date for completion/ implementation, 10 having breached their completion dates.

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. Over November and December 2022, staff reported 107 and 106 respectively, violent and aggression related incidents. The three most prominent themes are verbal abuse (95); anti-social behaviour (67) and assaults (45). Monthly monitoring and action planning occurs at the Violence Reduction working group and Health & Safety group.

Incidents on Datix should be investigated, actions put in place and the incidents closed within six weeks of reporting (45 working day life cycle). At this point, this information is automatically sent to the reporter via Datix. At any one time circa 900 incidents are going through the incident management life cycle.

As of 11th January 2023, there were a total of 324 breached non-SI incidents, and 81 incidents that were identified for SI investigation. Currently we are over our 20% target on overdue non-SI incident completion with 28% breaching. There are 33 Datix incidents in quarter 1 of 2022 that are the longest breaches over the 45 days period. The Director of Quality and Nursing has received the list of all the Datix incidents and will be contacting all risk owners to ensure that these risks are addressed and closed by the end of February 2023. Backlog arising in quarter 2 and 3 of 2022 will be managed in a similar way.

The Patient Experience Team continues to work on the overdue complaints however, response to complaints within the Trust's 35 working days response time has not met the 95% target. An initial review of the complaint process was conducted by the Deputy Director of Quality Improvement and intermediary measures such as readjusting the work schedule and priorities within the complaint team have been put in place to resolve the backlog by the end of February 2023. A process mapping day will take place on 27 February 2023 to review the current processes and

identify any opportunities for improvements. This will enable clear processes and effective, timely management of these. It is envisaged that full compliance of 95% will be achieved by May 2023.

Delivering Duty of Candour (DoC) has been an issue due to capacity issues within the SI team. The breach in December 2022 represents 1 out of 5 cases not responded to within the timeframe.

Safeguarding Level 3 training is in place to April 2023; As of 1st December 2022, a total of 1,654 clinicians out of a total of approximately 2,220 (77%) are in date with their L3 Safeguarding training. 130 (5.2%) have booked onto 13 further sessions planned until the end of March 2023. A priority area of the Safeguarding team remains focused on working in partnership with operational colleagues to see a continued increase in bookings and uptake of L3 training places over the coming three months. Low safeguarding numbers are reported in operating units such as HART and Brighton and as such, the Quality Governance Group will receive reports from these units on their plans to make improvement against agreed trajectories.

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. This was undertaken in Autumn 2022 for all groups.

QIG 5: The CQC medicines Must Do is relating to staff administering medicines under a patient group directive have the required training and competency. This will be included in the Medicines Risks review in February 2023.

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 have not shown an increase in backlog over quarter 2 and 3 2022. A review of the way in which investigations have been conducted and OUM's are now taking responsibility for appointing an investigation manager. We have also implemented a "buddy system" where investigators are aligned to a subject matter expert. This will improve the quality and timeliness of the investigation reports.

QIG 3: Risk management continues to progress. A new risk report to the Audit Committee is in development and will be presented to the committee in March 2023. Over quarter 4 we will be promoting risk management across the Trust using several communication streams such as Yammer, The Zone and 2 min videos.

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 that the Trust has initiated its first QI programme on 'Keeping Patients Safe in the Stack'. 4. That the Board note the actions being undertaken to address the risks and improve performance within this Trust Priority Area. 5. That the Board is asked to note the improvement in the SI actions and backlog. In addition, the CQC concerns, and internal SI review of cases requested by CQC in 2022

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	84-22

Name of meeting	Trust Board
Date	02.02.2023
Name of paper	Learning from Deaths Q1 Report 2022-23
Responsible Executive	Dr Fionna Moore, Executive Medical Director
Author	Dr Richard Quirk, Deputy Medical Director
Synopsis	The independent random reviews of the care of patients who have died in our care has continued to demonstrate compassionate care in the majority of cases. The main reason for the panel to judge care as adequate or poor is related to delays in getting to the patient.
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 1 – 2022/23

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 1 (22/23) 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	275	389	1	665
May	265	347	5	617	207	335	1	543	244	389	0	633
June	214	325	13	552	204	323	1	528	240	357	1	598
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 – April 2022	No. of patients who died – May 2022	No. of patients who died – June 2022
Under 1 year	3	8	5
1-18	2	4	2
18 – 29	20	14	11
30 – 39	22	26	19
40 – 49	33	36	30
50 – 59	82	76	68
60 – 69	95	102	73
70 – 79	153	126	147
80 – 89	166	152	153
90 – 99	84	83	81
100+	2	6	5
Age unknown	3	0	4

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 – April 2022	No. of patients who died – May 2022	No. of patients who died – June 2022
Dead on arrival	279	267	263
Resuscitation attempted	221	201	197
Advance Care Plan/Do not attempt resus (DNACPR)	140	139	120
Professional Decision not to Resuscitate	22	17	15
End of Life	3	9	3

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), 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 1 22/23.

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%)	12 (20%)	14 (23%)	4 (7%)	0	0
On scene handling (Care)	55 (92%)	4 (7%)	1 (2%)	0	0	0
Transfer and Handover (Including discharge and worsening care advice)	17 (28%)	7 (12%)	0	0	0	36 (60%)
Other Aspects of Care (quality and legibility of records)	47 (78%)	12 (20%)	0	1 (2%)	0	0
Overall Assessment of Care	41 (68%)	17 (28%)	2 (3%)	0	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	Q1 2022/23
Poor Care	16 (5%)	6 (2%)	11 (3.7%)	11 (3.7%)	7 (2.2%)	7 (2.2%)	6 (2%)	5 (1.6%)
Very Poor Care	1 (0.3%)	0	2 (0.7%)	1 (0.3%)	0	1 (0.3%)	0	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 18 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:-
18 minutes response to a C1
34 minute response to a C2
156 minute response to a C1
4 hour response to a C3 patient who was already dead
42 minute response to a C2
19 minute response to a C1
12 minute response to a C1
35 minute response to a C2
17 minute response to a C1
14 minute response to a C1
76 minute response to a C2
14 minute response to a C1
10 minute response to a C1
15 minute response to a C1
10 minute response to a C1
9 minute response to a C1
16 minute response to a C1 (Baby)
20 minute response to a C1

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 a question about why the patient had not been moved to a more suitable area to allow greater access for the crew to perform resuscitation.

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 was one patient where the care was described as ‘poor’.

This was where the crew ‘recognised life extinct’ (ROLE) but did not complete a ROLE form.

3.5.5. Overall Care

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

One of these was related to a 76 minute response time to a C2 call which resulted from a closure of the M25 whilst a crew was travelling from Dartford to Surrey. The crew drove on a road diversion which took considerably longer to get to the patient.

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 76 minute response to a C2 call following an M25 road diversion.

5. Learning from the random review of 60 deaths

5.1. 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.

5.2. 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.

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

5.4. 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.

5.5. 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.

5.6. One of the panel raised concerns about the use of photographs uploaded onto the electronic Patient Care Record (ePCR). 3 photos were attached to a ePCR relating to the Traumatic Cardiac Arrest of an elderly motorcyclist who collided with a car. The photos were not relevant to the clinical management of the patient, although 2 of the photos did demonstrate the probable mechanism of injury. From the Coroner’s point of view, the police would have captured this information. This issue is picked up in the End of Life policy (ie no photos unless clinically relevant to the patient’s ongoing care).

6. 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

7. Actions resulting from the review of deaths from Quarter 1 22/23

Action	Who?	Update/Date	
Review the categorisation of patients who are already dead	EOC Senior Leadership team	December 2022	**Nearly complete – due Jan 23**
Review resource deployment to patients who are already dead	EOC Senior Leadership team	December 2022	**Nearly complete – due Jan 23**
Finalise the Trust's approach to calls for 'verification of death'	EOLC Steering Group/Quality Governance Group	December 2022	**Nearly complete – due Jan 23**
Complete self assessment of Learning from Deaths process to assess impact	Learning from Death's Group	December 2022	**COMPLETE**

Dr Richard Quirk
Deputy Medical Director
December 2022

SECAmb Board

QPS Committee Escalation Report

Overview of issues covered at the meeting on 24.01.2022

At the start of the meeting the Deputy Medical Director updated the committee on the recent BCI at the Medicines Distribution Centre related to staff capacity following a COVID outbreak. There was a really positive response from staff and volunteers, and the BCI is now stood down following the return of staff.

There is learning from this which the executive is following up and the related business case to ensure some of the known risks are mitigated is due to be considered in the coming days. The committee asked that the Board is updated verbally on this at the meeting on 2 February.

Item	Purpose	Link to BAF Risk
Safeguarding Training	This was a management response requested last time to provide a progress update on completion of Level 3 Safeguarding training	Risk 15 – Education Training & Development
In November the forecast was to ensure 67% completion by March 2023 and, as reported to the Board last time, the committee challenged how realistic this was given we were 20% adrift and moving into the winter period and the related conflicting demands. It is therefore really pleased to confirm the assurance received at this meeting that the Trust now has a trajectory to achieve 85% compliance for L3 Safeguarding training by the end of March 2023. At the 1 December this was up to 77%.		
Quality Account Priority – Mental Health First Aid Training	A management response to confirm the numbers of staff that have completed Mental Health First Aid Training and to provide assurance on the workforce capacity to deliver this priority	Risk 15 – Education Training & Development
The commitments within the Quality Account are being met, as set out below: ▪ 3 additional instructors to be in place by end 2022. ▪ A minimum of 1 course with up to 16 places to be facilitated per month throughout 2022. This can be flexed subject to additional instructors being available. ▪ Quarterly monitoring of effectiveness with Clinical Education Team monthly. ▪ An improved booking system to be in place by end April 2022 to maximize course take up and reduce drop-out rate However, the committee noted that take up of this training is not very high, perhaps due to it being part of CPD rather than Key Skills (see separate item on Key Skills).		
Welfare Calls	To seek assurance on the management of welfare calls arising from the gaps that were identified at Trust Board in December.	N/A
The executive has reviewed this explaining that we are outlier compared with our peers, as several ambulance trusts have ceased routinely undertaking welfare calls, instead taking a more targeted approach under the direction of a Clinical Navigator. The committee acknowledged this and the impact on the capacity of clinicians to improve our Hear and Treat, for example. It therefore asked the executive to		

provide a greater understanding on the learning from elsewhere that informed their decision to take a different approach. This is an area of focus in the Keeping Patients Safe in the Stack QI project (arising from the Quality Summit in Q4); welfare calling has been identified in the process mapping as an area requiring improvement and will help inform the review of the policy.

While this is being worked through the committee noted that we do have an agreed welfare policy which requires welfare calls and so expects adherence with this.

Medicines Management	Following on from the paper received in July, the committee asked for an update on the risks and issues within the department and for the medicines action plan to be presented with dates for completion so that the committee can hold to account for the delivery.	N/A

The Chief Pharmacist attended for this item and set out the medicine risks, some of which have materialised. The committee acknowledges that some of the issues are quite complex, and it is clear that on some there are slightly differing views. Through the Medical Director and Director of Operations, the committee challenged the executive to ensure better cross-directorate working so that a clear plan is provided in response to these concerns, confirming the resources allocated and the timeframe for the actions being taken. The committee expressed concern that some of these issues are still to be addressed.

RN outlined a plan to hold a cross-directorate medicines summit to review the existing action plan and work through with haste the blockages.

In the context of the discussion at the start of this meeting related to the BCI, the committee explored the status of the business case(s) and asked the executive to confirm to the Board the precise timing of this. This is an area of escalation to the Board – see below.

Integrated Patient Safety Report	To provide integrated information on complaints, incidents, Serious Incidents, Claims, inquests etc.	N/A

This is the second iteration of the integrated patient safety report. In terms of structure, feedback was provided on how it could be strengthened further. For example, by including at the start how we are learning across the various functions and providing more OU-level information.

In terms of content, the report helped to set out the good progress with the SI backlog; the longest overdue is 6 months and as of 30 November 2022, there were 42 open SI investigations (of which 8 are breached). The open actions are also reducing and this trajectory is being maintained – 53 open / 10 breaches.

There are still a high number of incidents taking longer than expected to close; the oldest incident dates back to March 2022. The Director of Nursing & Quality is urgently reviewing this and the committee has asked for a management response for the next meeting.

There is also concern about the complaint's response backlog and overall timeliness. Corrective action is being taken to clear the backlog by the end of February, however, the process is not effective and there is a lack of resilience in the patient experience team. A session is planned for 27 February using our new QI methodology, to process map how we manage complaints. The committee will consider the outputs of this.

This report is also starting to help triangulation, although there is more work still do to. For example, the committee has asked the report to explore how the complaints about staff attitude correlate with issues with culture and try to draw conclusions from other data so that we can establish how different areas might require targeted support.

Maternity Services	To seek assurance that we are taking actions in response to the initial Ockenden report and subsequent Kirkup report.	N/A

A helpful paper was received setting out the work ongoing to ensure compliance in line with the recommendations. The committee noted that we are mostly compliant or progressing to become complaint. There are two areas of non-compliance related to risk assessments for birthing and training, both are which are being addressed.

The committee explored the level of confidence in delivering all the actions given we have just one Consultant Midwife. It noted that the executive is looking to increase resources in this area.

Overall the committee is assured progress is being made supported by evidence, but it is too soon to assess impact. Some of the actions require clearer timeframes and the committee will review this again early in 2023/24 when it will ask to see metrics that support an assessment of impact.

Key Skills	To see assurance that the proposed programme for key skills 2023/24, aligns to the learning from incidents, serious incidents etc.	

An update was provided in the proposed programme for key skills 2023/24. The committee used this to explore how this aligns with learning from complaints, incidents and serious incidents. It is supportive of the approach to triangulating with learning and reinforced how critical this is to both quality and staff development.

This proposal will now go through the usual management governance process before it is finalised. The committee asked that the executive use this to see how we might take a longer-term approach rather than just seeing this training over a one-year cycle. For example, considering a 3-year plan, with some training needed annually and others less frequently.

Clinical Outcomes - impact of Telemedicine on patients showing signs of a stroke	Seek assurance on the learning from the Kent pilot, and that we have robust plans to introduce this across the region to improve clinical outcomes for this patient group.	

Stroke telemedicine is now fully established in Kent, with robust data collection and embedded safety assurance. This model is being extended into Surrey and Sussex. There is good evidence from Kent that stroke telemedicine is safe, easy to use, and improves patient care, outcomes and system efficiency. It is fully backed by NHS England and is being piloted across nine NHS Ambulance Trusts based on experience in Kent and London.

The committee explored the evidence available from patient feedback, given this good technology is clearly providing improved patient care. The executive confirmed that in East Kent mortality is improved and the national audit of stroke ratings have improved from a 'D' to an 'A'. There has also been some engagement with stroke survivors and the feedback has all been positive.

In terms of roll out to Sussex and Surrey the committee noted that despite the will, some hospitals will not be able to implement quickly due to staffing. However, this does figure in their planning.

This provided substantial assurance to the committee and the impact will be monitored via the metrics on the IQR. Currently this is trust wide and the executive is aiming to introduce more OU-level reporting during 2023/24.

Cardiac Arrest Annual Report	Purpose: To provide details of the work in-year and how this has contributed to the experience of our people and patients. Assurance Question(s): Are we delivering effective training to our staff and care to our patients; what evidence is available that demonstrates positive impact on staff and patients; is there any learning and are the lessons being implemented?	N/A

This really positive report (Appendix 1) helps to demonstrate how we are making a positive impact on population health. Not only is it positive that our survival rates have improved (which has not been the case in other parts of the country) out of hospital cardiac arrest (OHCA) performance is a marker of a high performing ambulance service.

As the report sets out, the Trust is undertaking a significant programme to seek improvement in cardiac arrest outcomes. Resuscitation practices relating to out of hospital cardiac arrest (OHCA) have been subject to some focus, featuring on the Quality Account for three consecutive years prior to the commencement of the improvement programme. The COVID pandemic presented challenges to effective resuscitation and this promoted a particular focus on the approach to managing OHCA in order to mitigate these challenges. Through the development of new and bespoke guidance, the reintroduction of training for the clinical workforce and the provision of clinical leadership from the Critical Care Paramedic team, 2021/22 was a success story, seeing an increase in both ROSC and survival.

The committee noted the challenge from the Consultant Paramedic who presented this report to ensure there is ongoing senior leadership support to this area of clinical practice. The committee asked that this be linked by the new clinical strategy that the Clinical Advisory Group is helping to develop and by the priorities within the Improvement Journey.

In late 2021 the committee sought assurance about the mitigating actions related to the Public Access Defibrillator (PAD) site risk. Action was taken to improve oversight and management of 156 PAD sites that were owned by the Trust, and ensure they are 'rescue ready'. The circa 2,700 PAD sites owned by others were overseen by the British Heart Foundation 'Circuit'. At this meeting the committee was informed of an emerging issue related to the availability of information on some of the PAD sites on the Circuit. Further detail will come to the next meeting.

Specific Escalation(s) for Board Action	The Medicines Distribution Centre BCI and related concerns expressed by the committee arising from the items on medicines risks, highlights an urgent need for a clear plan that sets out how and when the executive intends to ensure a sustainable medicines distribution service. The business case has been in development for several months and the Board is asked to ensure clarity on the timeline and assurance there is effective cross

	directorate working.
	In Q3 the Trust's Improvement Director undertook a Board Effectiveness Review, which included a review of this committee. The findings and recommendations continue to be considered in the planning and delivery of the committee meetings. Below is a summary of progress to-date.

Recommendation	**Progress to-date**
Review committee membership to ensure robust linkage across corporate functions	The membership of this committee was reviewed in Q2 and approved by the Board. A further review will be undertaken in early 2023/24
Chair to introduce Committee Planning Meetings involving other committee members, to agree the agenda, timings, papers and Key Lines of Enquiry	These planning meetings were put in place immediately. Referring to the cycle of business, these meetings consider the BAF, IQR and Improvement Journey to ensure the committee constantly focusses on the right issues. They have to-date been between the Chair, Executive Lead and Company Secretary and going forward the Chair will also seek the input of other members. Agendas now include a summary of the purpose of each agenda item and the assurance question(s) the committee is seeking to explore. This helps management in the preparation of assurance papers and keeps the meetings focussed.
Introduce a rolling cycle of Committee Business to ensure the committee addresses all topics.	The cycle of business was already in place. It informs the planning of each meeting but is used as a guide in light of the approach outlined above.
To ensure the structure of the agenda is aligned to the Organisational risks – use the relevant BAF risks to shape the Agenda	In addition to the agendas now setting out the purpose and assurance questions, they also cross reference to the relevant BAF risk. From September, the same is also confirmed in the committee's escalation report to Board.
Ensure all actions are clear, with a Lead and timescale for delivery stipulated	The action log currently sets out each action (as agreed as per the relevant minute) and has action owners assigned with a specific timescale.
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.	Work is ongoing to improve the cover sheets, in particular with regards the level of assurance being provided.
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	Ongoing
Use standardised SPC methodology and analysis when presenting data.	Ongoing
Training to be given to senior managers preparing and presenting papers to Trust Board Committees. Writing for assurance rather than reassurance.	Ongoing - we are exploring how and when to provide training on effective report writing for senior managers.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Out of Hospital Cardiac Arrest Annual Report

April 2021 – March 2022

NHS
South East Coast Ambulance Service
NHS Foundation Trust

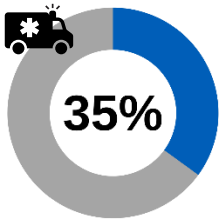
Contents

Key figures at a glance:

All cardiac arrests

8005
cardiac arrests attended

2788
resuscitation attempts made



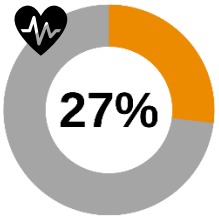
of all arrests received a **resuscitation attempt**

Our patients

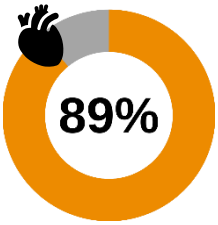
66% male
Median age: 68

34% female
Median age: 70

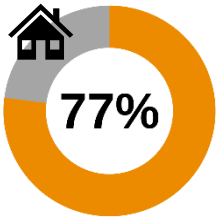
Profile of resuscitation attempts



presented in a **shockable rhythm** (VF/VT)

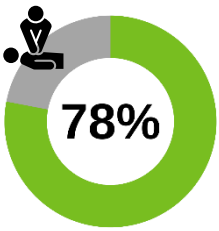


had a presumed **cardiac or medical cause**



occurred at **home or at a private address**

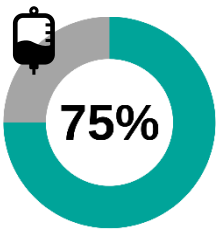
Bystander response



received **CPR from a bystander***

194
public access AEDs used

EMS response

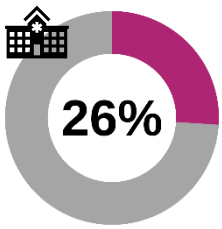


compliance with the **post ROSC care bundle**

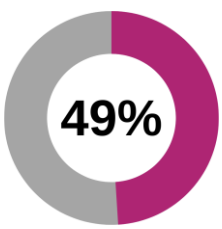
10m
mean response time*

ROSC at hospital

Overall



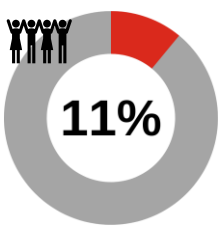
Utstein



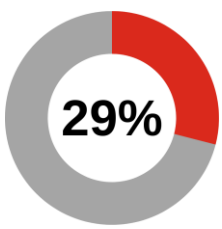
900 **patients transported to hospital**

Survival to 30 days

Overall



Utstein



299 lives saved

**non EMS witnessed resuscitation attempts*

Introduction

Out of hospital cardiac arrest (OHCA), where the heart stops beating and blood stops circulating around the body, is the most time-critical type of incident for ambulance services; without intervention, it takes only ten minutes from initial collapse to irreversible death.

Globally, survival rates from OHCA vary hugely, from less than 5% to over 60%, and depend on a multitude of factors. Many of these factors, such as patient age or cause of arrest, ambulance services have little control over. However, improvements in responding to OHCA, from treatment to timeliness, can and absolutely do save lives.

These controllable characteristics, known as 'system and therapy factors', are summarised in the four links of the Chain of Survival. This report is structured to examine the strength of each link within South East Coast Ambulance Service (SECAmb) to both identify aspects with room for improvement and to highlight areas where we can be proud of our performance.

The data for this report comes from our Cardiac Arrest Registry – a database of all cardiac arrests attended by SECAmb. Information is taken from a wide range of sources, including ambulance patient care records (both paper and electronic), the Trust's computer aided dispatch (CAD) program, defibrillator downloads, and from other supporting organisations, including hospital survival data, helicopter emergency medical services (HEMS), and volunteer and private providers.

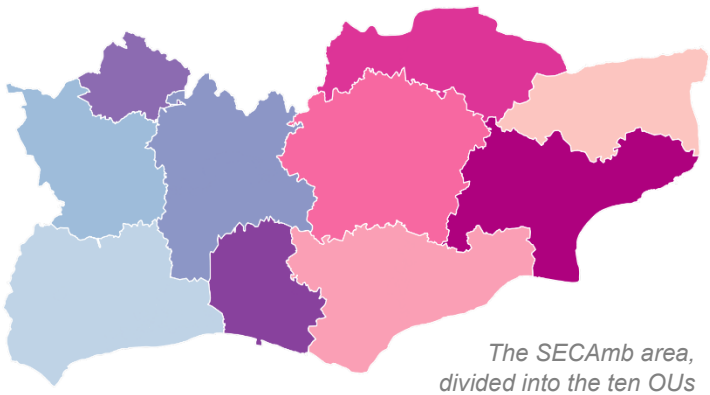
The registry is based around the Utstein style of reporting, which allows significant figures to be benchmarked against other services and against targets from the Global Resuscitation Alliance, by collecting and categorising data in agreed upon ways.

Who are SECAmb?

SECAmb has over 4000 staff working at over 100 sites, operating in an area of around 3,600 square miles, including Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire. We provide emergency healthcare to a population of roughly 5.1m, with our ten Operational Units (OUs) covering densely populated urban areas, sparsely populated rural areas, 440 miles of coastline, and some of the busiest stretches of motorway in the country.

Around 90% of our workforce are operational staff. This includes both those working in the pre-dispatch phase, caring for patients remotely at our operations centres where we receive 999 and 111 calls, and staff providing face-to-face care. The ambulance service care for a wide variety of conditions, ranging from the critically ill and injured in need of specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.

We work alongside other emergency services, including the police, fire, and other ambulance services, as well as specialist emergency organisations such as helicopter emergency services (HEMS), private and volunteer ambulance providers, and individual volunteers.



The SECAmb area, divided into the ten OUs

Mike Ferguson with Emergency Care Support Worker Susan Gray, Emergency Medical Advisor Harry Morgan, Trainee Associate Ambulance Practitioner Clare Sykes, Paramedic Gaylene Doherty, and Paramedic Shaun Seely

Mike's Story

Mike Ferguson, 54, from Barham, near Canterbury, had been suffering from chest pains for about four weeks, until he came home from work on the 6th October 2020.

"I had been experiencing some discomfort for a few weeks but it suddenly got a lot worse and felt as though someone was tightening a belt around my chest. I arrived home not feeling great at all and said to [my partner] Helena, that I thought I should call 111 – but things suddenly got a lot worse and I said 'I think you're going to have to call 999'."

A crew attended to carry out checks on Mike's heart, and when they decided that he required further hospital treatment, he was taken to the awaiting ambulance. However, as the crew continued their assessment in the vehicle, Mike went into cardiac arrest.

Mike required seven shocks from a defibrillator to restart his heart, before being rushed to William Harvey Hospital where he underwent emergency treatment to have a blockage in a main artery cleared and a stent fitted.

"I'm just so grateful for everything everyone in the ambulance and hospital teams did for me. Quite simply, without them, I wouldn't be here.

"My subsequent treatment and rehab has gone really well and I feel like a new man but I would strongly urge people not to ignore the signs of a problem and to get themselves checked out if they have any discomfort or concerns like me."

Robert's Story

Robert Ingram was returning from a football match by train in September last year when he collapsed not far from Sevenoaks Railway Station.

Luckily for Robert, he hadn't quite reached the station car park and so his collapse was witnessed by others at the station.

Robert has no memory of what happened, however Tristan Woods-Scawen recalls:

"I saw this man collapsed on the road and as it was quite late, I thought maybe he had had one too many drinks but when I went up to him, I could see that he wasn't breathing."

James McSharry had just arrived at the station to collect his wife, when he saw a small crowd of people standing around Robert. James, who is a physiotherapist, quickly manoeuvred his car so that he could put some light on the events unfolding and jumped out of the car to offer his help.

"There was a group of about ten people standing there and I went over and someone asked if anyone could do CPR and as a physio, I had some training, albeit I felt a bit rusty! So, I started chest compressions and then about halfway through he let out this breath and I knew it was agonal breathing. Someone then went off to get the defibrillator from the railway station and I carried on doing chest compressions with the support of the call taker who was fantastic. Tristan then took over the CPR because I was getting tired."

Robert received three shocks from a public access defibrillator before the crews and other emergency services arrived, and by the time the crews left the scene to take Robert to hospital, he was able to give them his name. Robert was then rushed to the cardiac unit at William Harvey Hospital for specialist treatment.

Operational Team Leader Natalie Bone said: "It is without doubt that these quick actions of the public, and easy access to a community defibrillator, saved this patient's life. It is definitely also great evidence for why community AEDs are so important."

Robert has since gone on to make a full recovery.

James McSharry, Paramedic Bronwyn Davidson, Robert Ingram, Robert's partner Vicki, and Tristan Woods-Scawen at the SECAmb Awards 2022

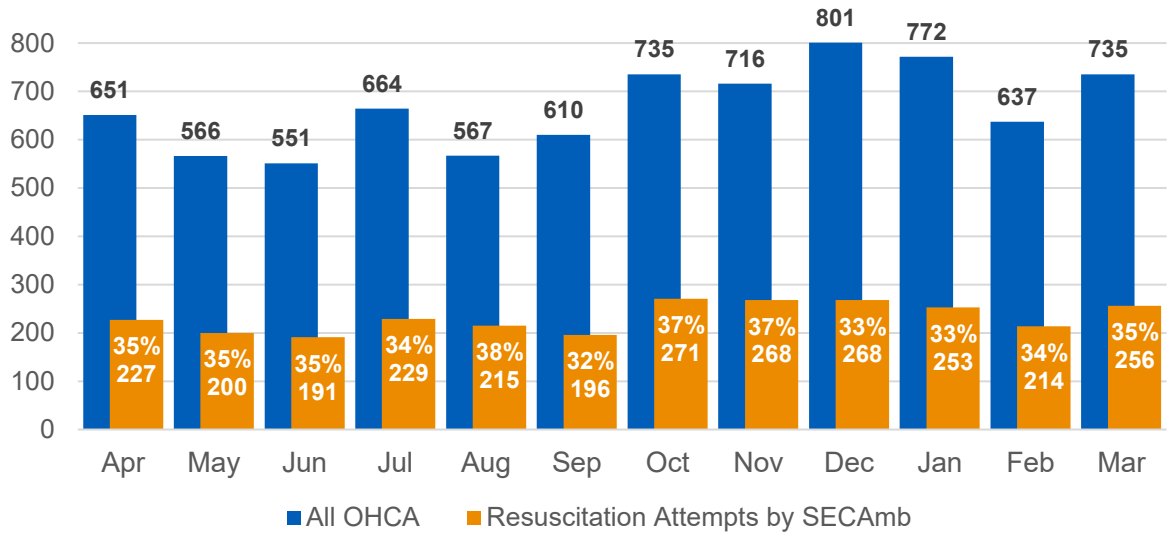
Cardiac arrests in SECAmb

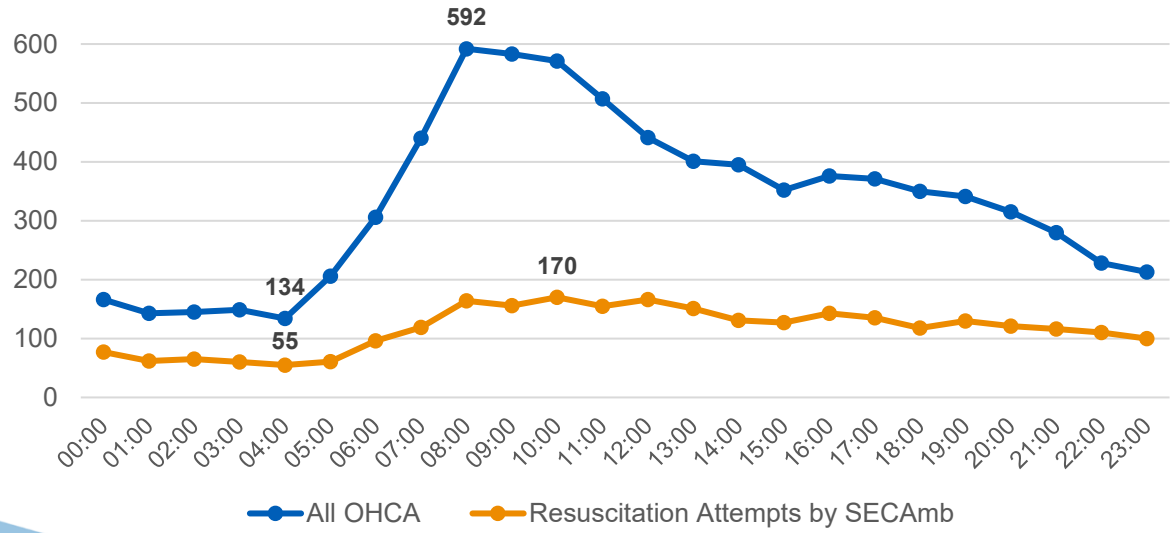
From the 1st April 2021 to 31st March 2022 SECAmb attended **8005 out of hospital cardiac arrests** (OHCA). Of these, **2788 patients (35%) received a resuscitation attempt** from our crews.

In line with previous years, cardiac arrests tend to increase in the winter months, with our busiest month being December.

Our peak time of day for cardiac arrest calls is between 8am and 11am, with 22% (1746) of cardiac arrest calls and 18% (490) of resuscitation attempts.

On average, we receive around 670 calls for cardiac arrest a month, or nearly one every hour.



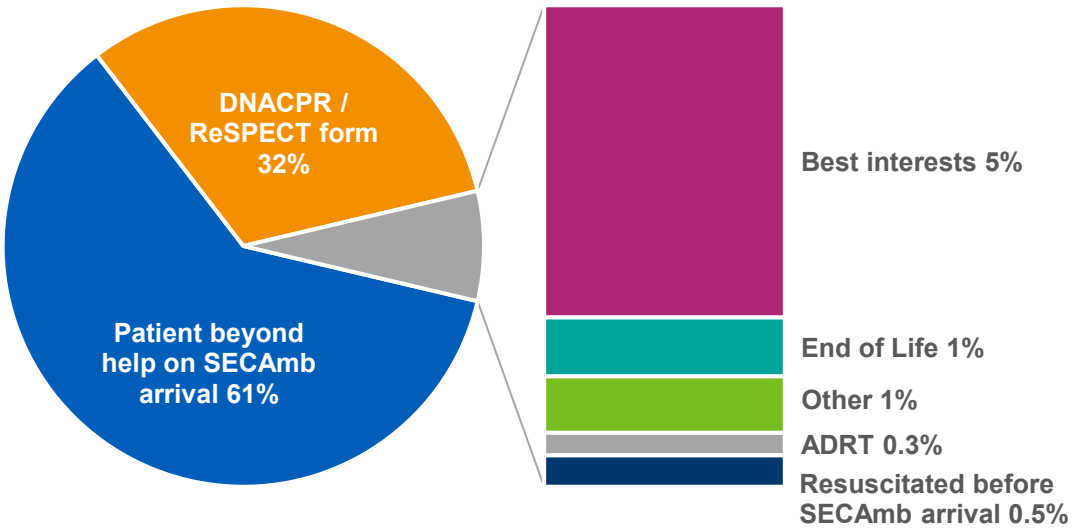


Resuscitations not attempted

The most common reason for SECAmb not attempting resuscitation was that the patient was beyond medical help by the time of SECAmb attendance (3173 patients). This is followed by patients with documentation refusing resuscitation, such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, or Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms (1654 patients).

Those with other types of advanced decisions to refuse treatment (ADRTs) made up less than 1% of patients not receiving a resuscitation attempt.

Clinicians may sometimes deem it to not be in a patient's best interest to attempt a full resuscitation; for example where no formal care decisions are in place, but wishes regarding care have been expressed, or where severe comorbidities would make a full resuscitation attempt highly unlikely to be successful but there has not been a prior written or spoken agreement that the patient is nearing a natural end to their life (known as 'End of Life'). These 'best interests' patients make up approximately 5% of cases where resuscitation was not attempted.

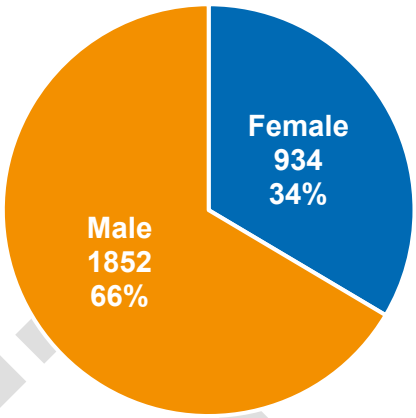


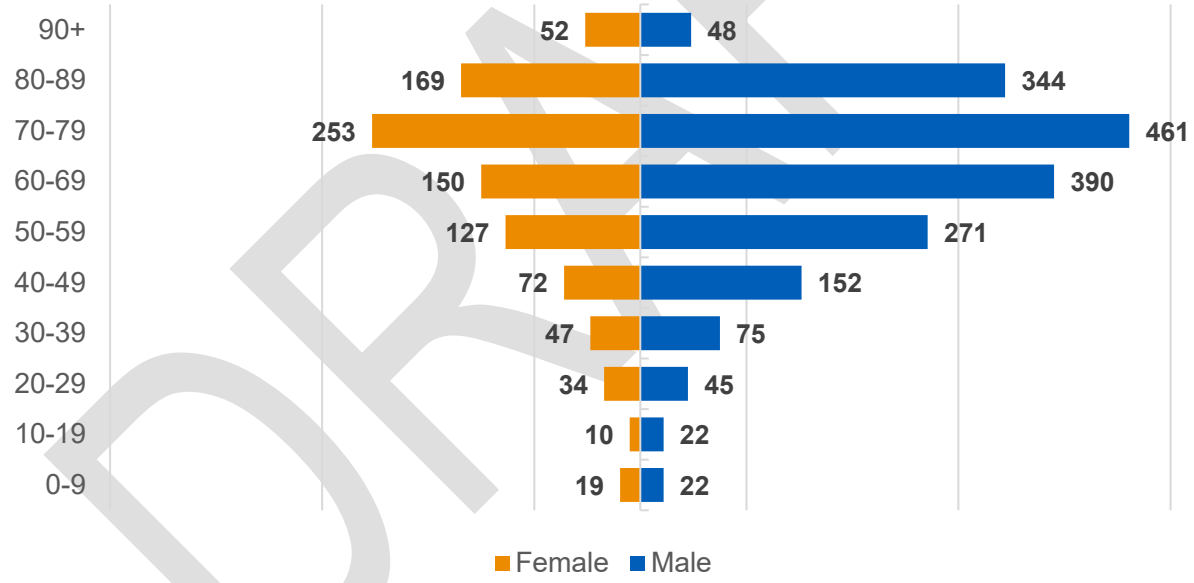
Included in the total number of OHCA were patients who were successfully resuscitated before SECAmb arrival. For 2021-22 this was 25 patients, or 0.5% of cases where resuscitation was not attempted.

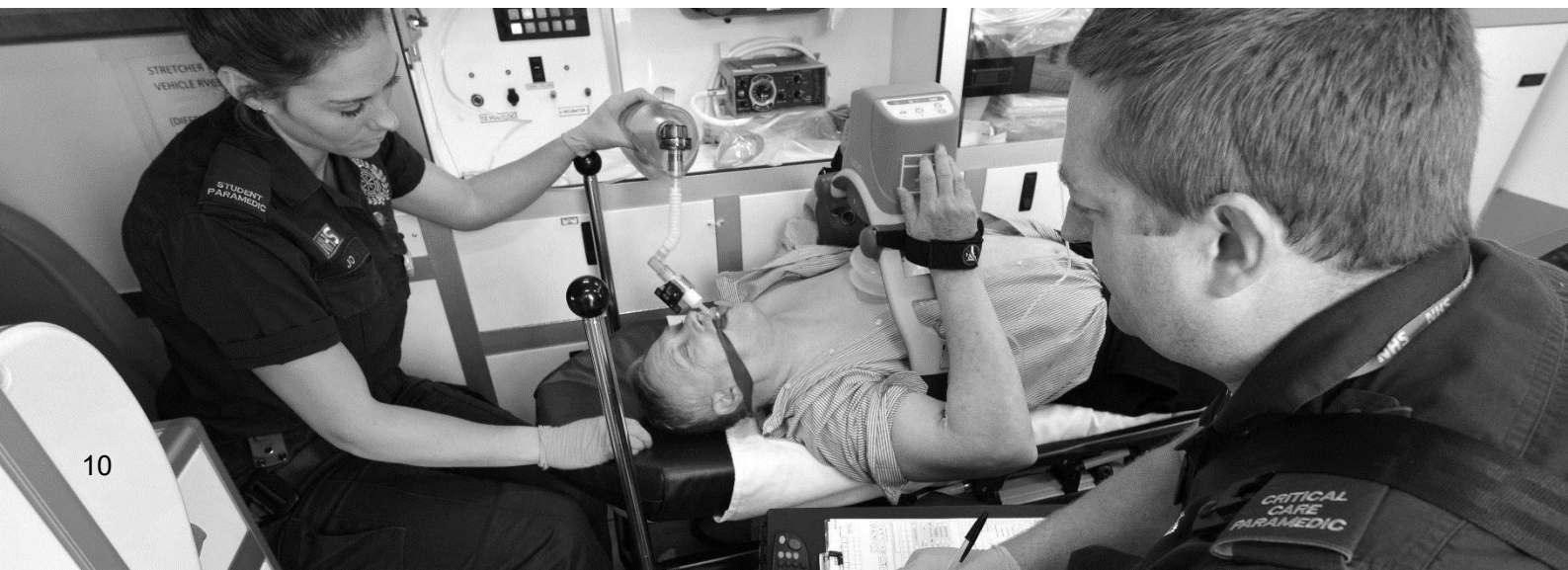
Our patients

Consistently there is a strong gender bias in patients receiving a resuscitation attempt, **with men outnumbering women two to one**. Men receiving a resuscitation attempt also have a slightly lower average age, with a median average of 68 years, compared to 70 for women.

These average ages reflect the distribution of overall ages of our OHCA patients: **over half are over 70**, and **only one in ten are under 40**.

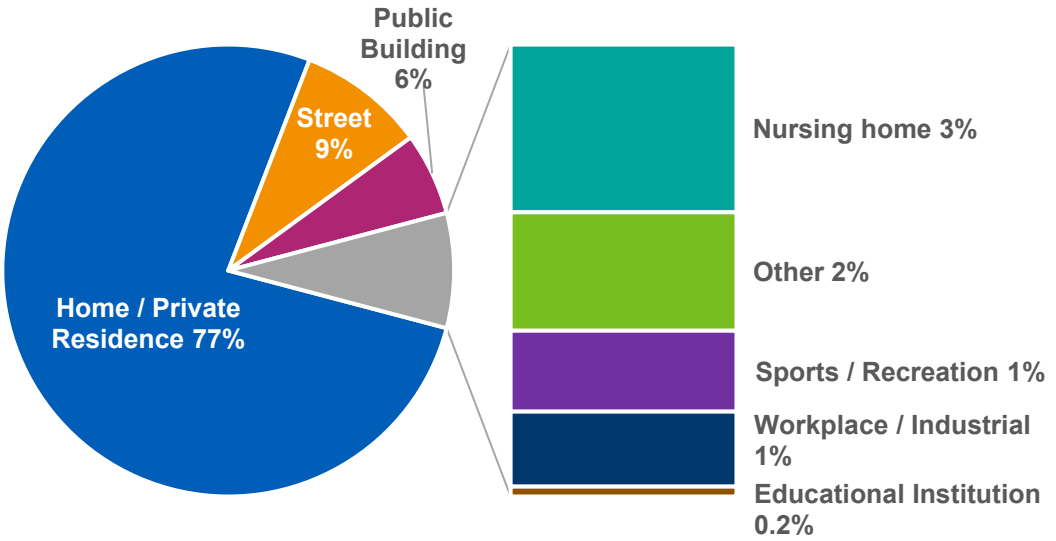




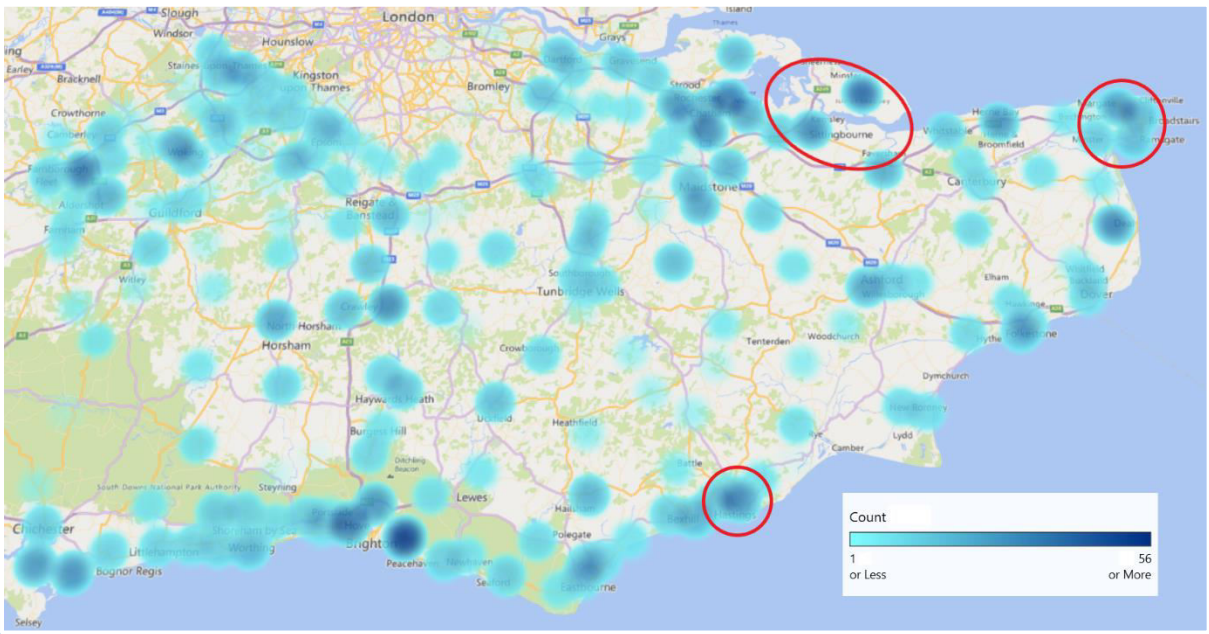


Arrest locations

Arrests at private residences, such as home addresses and care homes, made up nearly 80% of all resuscitation attempts in SECAmb for 2021-22.



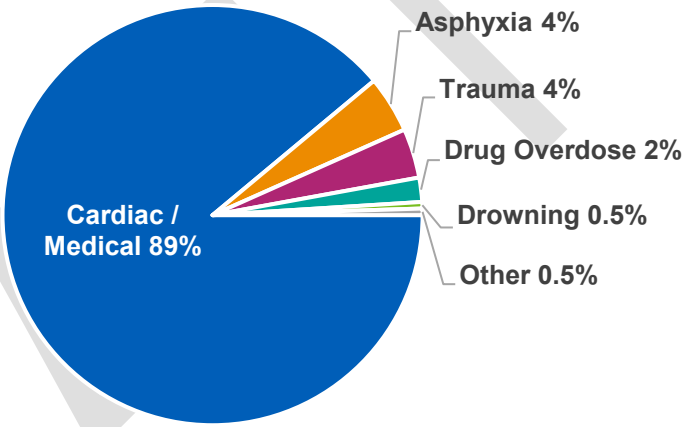
Whilst our patients are spread all over the SECAmb area, when examining the home addresses of patients there are some notable areas of particularly high incidence, several of which correlate with the highest deprived areas as reported by the most recently available English Indices of Deprivation report (2019). The map shows the home postcodes of our patients (excluding those who live outside the SECAmb area), with areas of high deprivation highlighted in red.



Causes of arrest

Information on cardiac arrest aetiology is taken from ambulance patient care records. It is therefore a presumed cause, based upon details available to clinicians at the time of the incident.

Nearly nine out of ten OHCA treated by SECAmb are presumed medical or cardiac in origin.



The definitions for aetiology used here are from the OHCAO Project at the University of Warwick, and may differ slightly from more general definitions:

- *Cardiac / medical includes clearly cardiac-related cases and other medical causes (e.g., anaphylaxis, asthma, gastro-intestinal bleeds, metabolic, and respiratory causes) and where there is no other obvious cause of the arrest.*
- *Asphyxia includes all external causes of asphyxia, such as foreign-body airway obstruction, hanging, or strangulation, excluding drowning.*
- *Trauma is specified as an arrest directly caused by blunt, penetrating, or burn injury.*

Chain of Survival

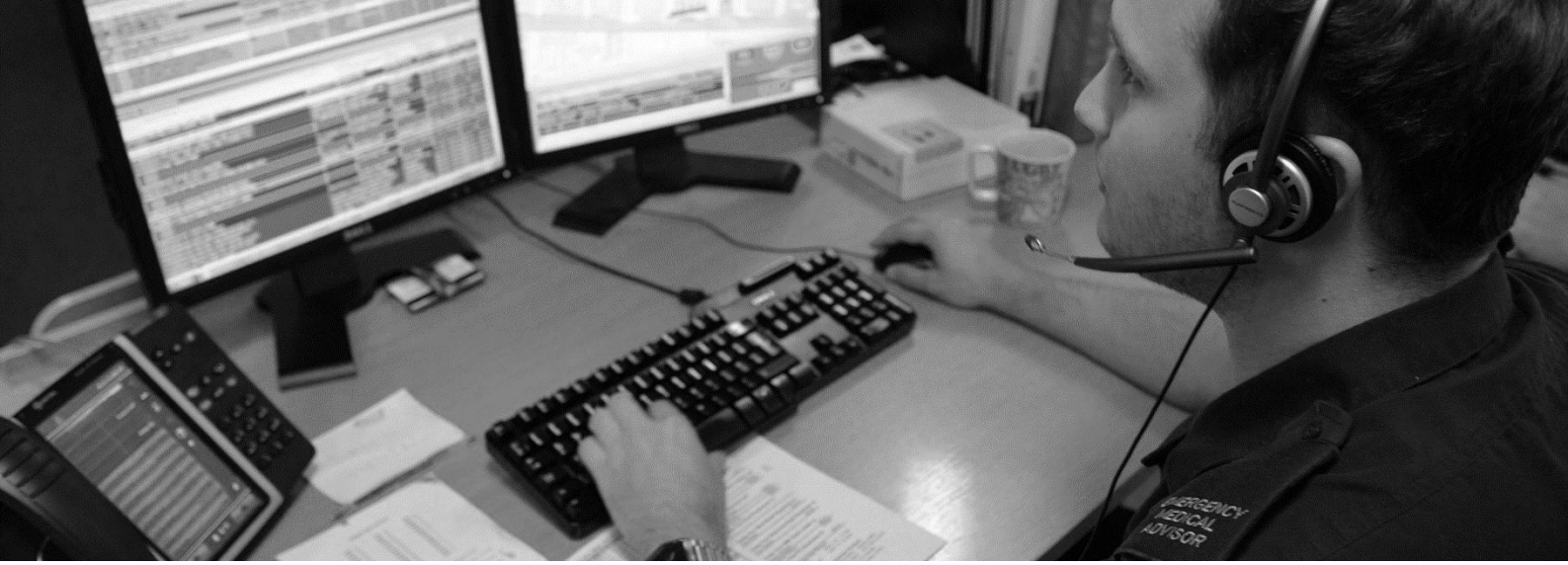
The Chain of Survival describes the key elements of addressing OHCA. It covers action from the moment of arrest through to arrival and handover at hospital, and relies on bystanders, emergency medical advisers (EMAs), and different grades of clinical staff all working together to administer high quality treatment as fast as possible, to give patients the best chance of survival.

Early recognition of cardiac arrest and call for help

Early CPR

Early defibrilliation

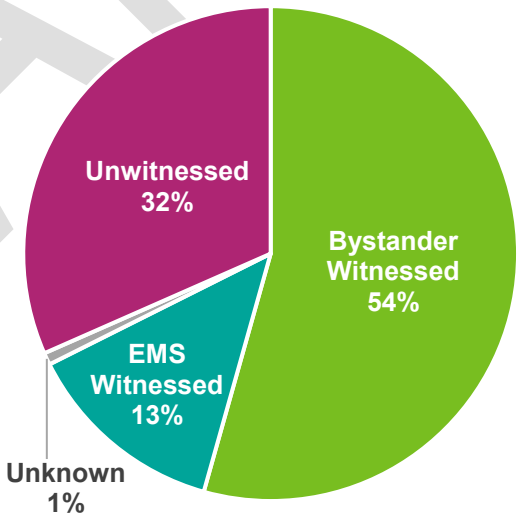
Post resuscitation care



Early recognition & call for help

87% of SECAmb resuscitation attempts are either unwitnessed or witnessed by someone other than a member of EMS. When examining response times and bystander interventions, it is these 'non EMS witnessed' arrests which are examined.

Early recognition and access does not just depend on bystanders, but also extends into emergency medical services (EMS) and telephone triage. Highly trained emergency medical advisers (EMAs) using an effective clinical decision support system (CDSS) ensure that cardiac arrests, or symptoms of imminent cardiac arrest, are recognised as quickly as possible.



The first question asked at the start of each 999 call is whether the patient is breathing, so that help can be immediately dispatched to patients who are clearly in cardiac arrest.

The time-critical nature of cardiac arrests means that these calls are assigned the highest priority available to ambulance services; a 'Category 1'. **94% of non EMS witnessed resuscitation attempts were categorised as a Category 1** (n=2262). For these incidents, our mean response time was 9 minutes, with 90% attended within 15 minutes 50 seconds.

Category 1 calls have a nationally mandated mean response time of 7 minutes, and a requirement that 90% of these calls are attended within 15 minutes.

SECAmb also measures the sensitivity of detection of cardiac arrest during 999 calls. The final diagnosis code assigned to the call by the EMA is used to account for patients who may have deteriorated into cardiac arrest during the call. **93% of non EMS witnessed resuscitation attempts were identified as cardiac arrests by EMAs** (n=1102), which significantly surpasses the Global Resuscitation Alliance target of 75%.

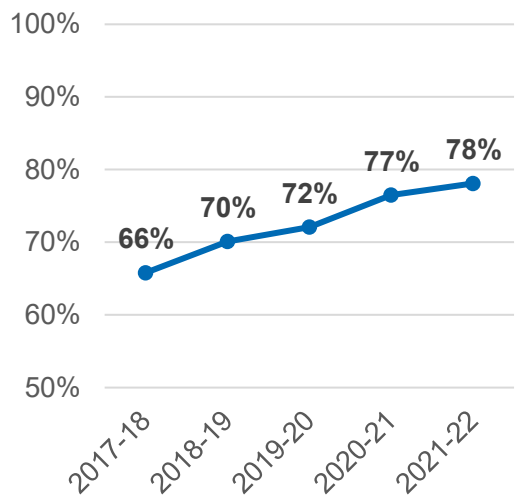
It is vital that as many cardiac arrests as possible are identified during the 999 call and the correct incident priority is assigned. Without rapid recognition, response times can be delayed significantly, leading to knock on delays in further care. For 2021-22, the mean response time for patients whose cardiac arrest was recognised during the call and were therefore assigned a Category 1 was over a minute faster than the overall mean for all patients who were in cardiac arrest on SECAmb arrival (10 minutes 2 seconds).

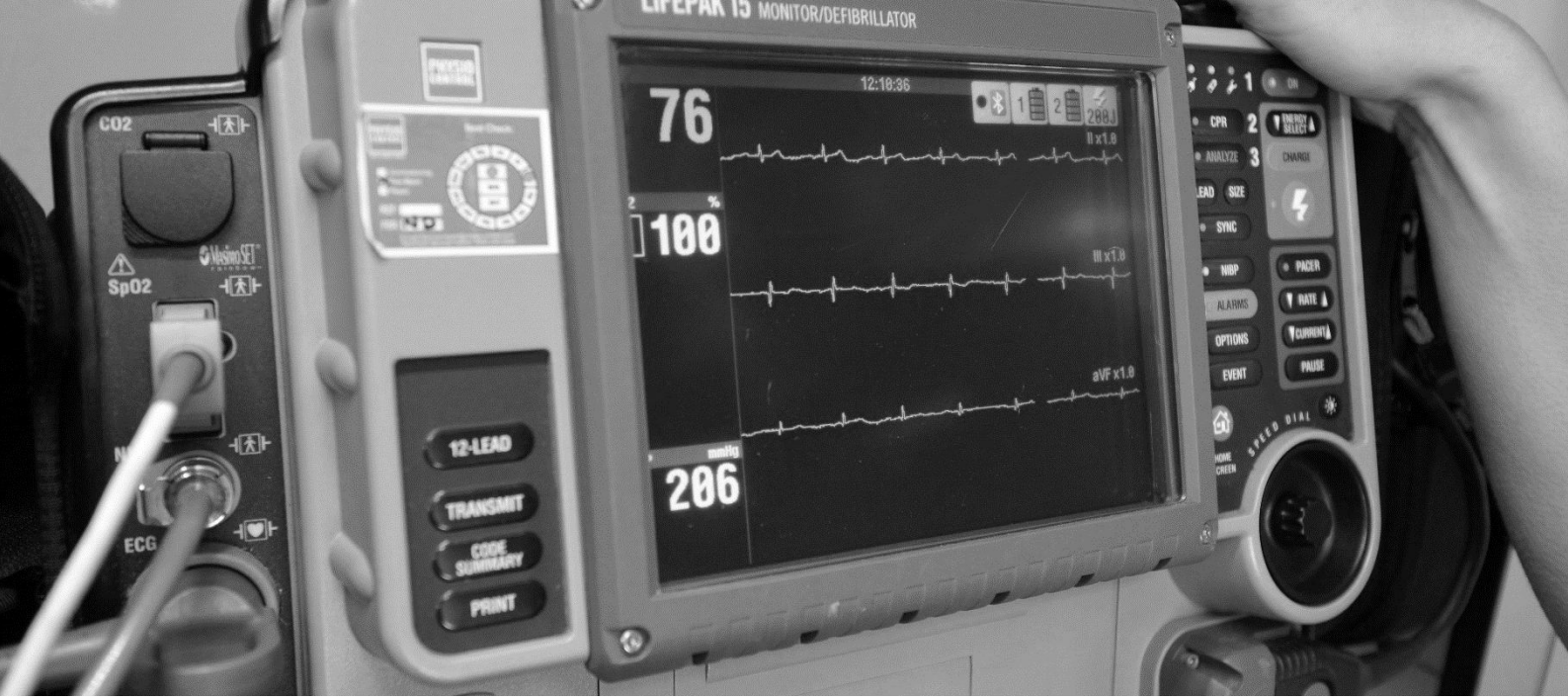
Early CPR

One of the most important ways to improve outcomes from OHCA is the involvement of bystanders before EMS arrival, as the patient's chances of survival are reduced by 10% for every minute that CPR is delayed. Early CPR keeps oxygenated blood flowing to vital organs and buys time before the arrival of EMS.

It is a key skill of EMAs to rapidly coach callers to commence and continue CPR. SECAmb EMAs use the 'no, no, go' tool to detect cardiac arrest: if the patient is not breathing and not conscious, they should 'go' ahead and commence CPR instructions.

The proportion of SECAmb's non EMS witnessed resuscitation attempts receiving **bystander CPR has been on an upward trend** for every year that this metric has been recorded. In 2021-22, this figure was **78%,** or 1889 patients, which well exceeds the target of 50% set by the Global Resuscitation Alliance.

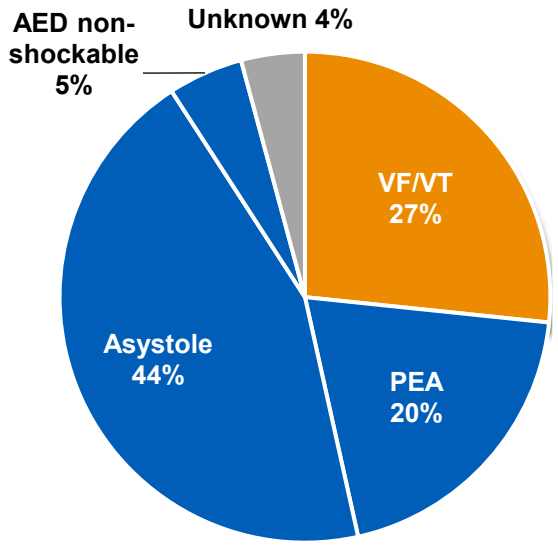




Early defibrillation

Delivering a shock from a defibrillator 'stuns' the heart to help it restart in a normal, life-sustaining rhythm. Only two heart rhythms can be shocked: ventricular fibrillation (VF) and pulseless ventricular tachycardia (VT). Shocks are more effective the earlier they are delivered: defibrillation within 3-5 minutes of collapse can produce survival rates as high as 50-70%.

Approximately **one in four SECAmb resuscitation attempts present initially in a shockable rhythm**, whilst more than one in three require defibrillation at some point during their arrest.



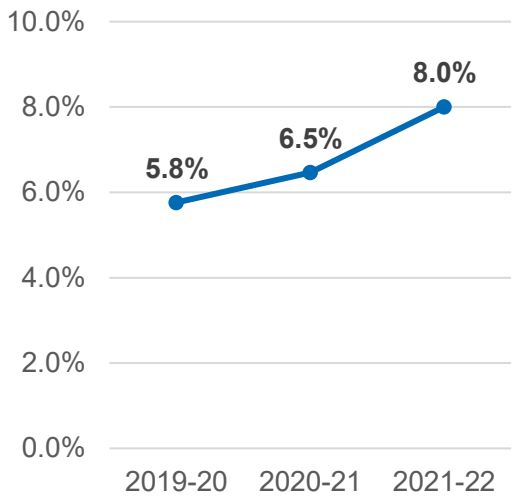
Cases presenting in non-shockable rhythms include those in asystole, pulseless electrical activity (PEA), and unspecified rhythms which have been identified by an automated external defibrillator (AED) as being non-shockable without the need for manual analysis of the rhythm (known as 'AED non-shockable').

SECAmb has a **database of around 3500 public access defibrillators** (PADs), which is linked to our computer aided dispatch system (CAD). This allows EMAs to inform callers of their closest PAD, so it can be brought to the patient as soon as possible.

For non EMS witnessed resuscitation attempts which presented in a shockable rhythm, the **median time to first shock was 11 minutes**, with 90% of these cases being shocked within 21 minutes. For cases **where a PAD was used this time drops by three minutes to a median of 8 minutes** and a 90th centile of 18 minutes.

Use of PADs is also increasing – in 2021-22 **a PAD was used on 194 patients**, or 8.0% of non EMS witnessed resuscitation attempts, compared to 6.5% (151) last year, and only 5.8% (133) the year before.

Patients successfully resuscitated before EMS arrival are not included in overall statistics, however of 17 of these 25 patients achieved a return of spontaneous circulation (ROSC) thanks to shocks from a PAD.



GoodSAM Instant.Help

SECAmb uses the GoodSAM smartphone app, which allows EMAs to alert trained, local individuals who have signed up as volunteers to perform CPR and/or bring a public access defibrillator (PAD) to the scene of the arrest. This minimises the time spent without high quality bystander CPR and reduces any delays in defibrillation, helping to increase chances of survival. The app is used worldwide by over 200 organisations and has over 1.5 million users globally.

Post arrest care

Successfully achieving a return of spontaneous circulation (ROSC) is the first step towards the goal of complete recovery from OHCA. However, the consequences of cardiac arrest on the body are complex, and the ROSC period presents a unique clinical management challenge. As well as the potential harm caused by the period of cardiac arrest, in many incidents the underlying cause (for example, a heart attack) is still likely to be present and in need of emergency treatment.

All UK ambulance services measure performance against a nationally agreed EMS post ROSC care bundle. This is a small collection of interventions which aim to ensure the best chance of survival after cardiac arrest. It applies to patients where ROSC was achieved on scene by EMS, the patient was 18 years old or over, and the cause of the arrest was non traumatic, and it consists of six elements:

Administer intravenous fluids
- if required

Measure end-tidal carbon dioxide ($EtCO_2$)
- if advanced airway used

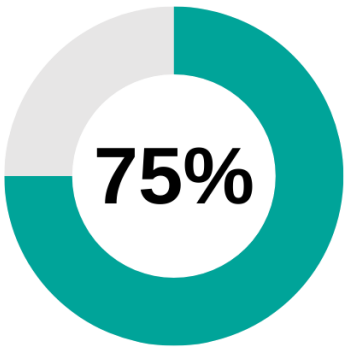
Administer high flow oxygen (O_2)
- if required

Measure blood pressure (BP)
- or note radial pulse

Obtain a 12 lead electrocardiogram (ECG)

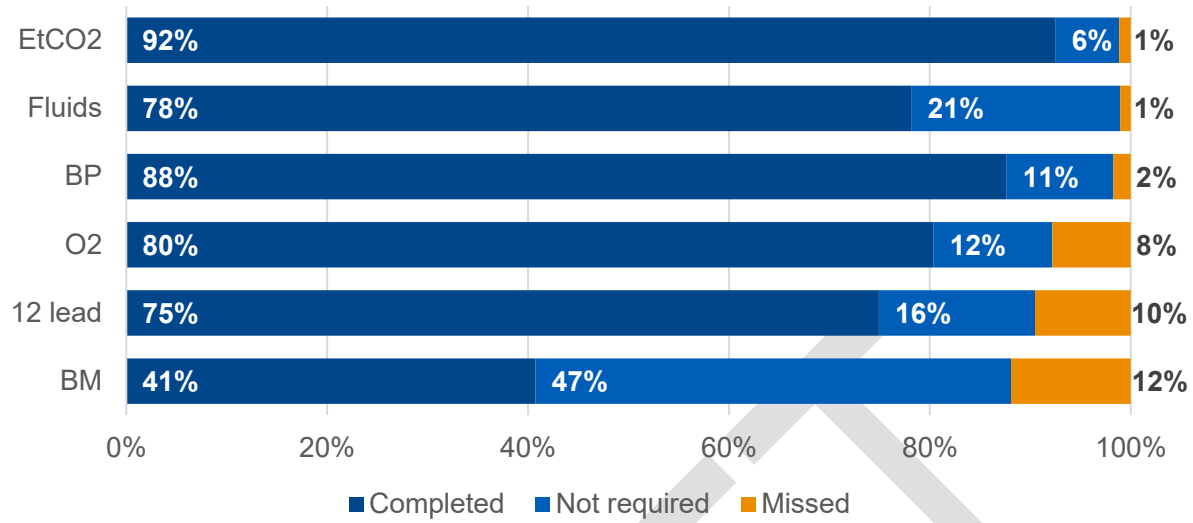
Measure blood glucose (BM)
- unless normal pre ROSC

Overall, SECAmb **compliancy with the post ROSC care bundle sits at 75%** for 2021-22, or 789 of the 1048 patients where the care bundle was required.



If a ROSC is lost within 10 minutes then any missed elements are counted as not required, as it is expected to take at least 10 minutes to stabilise a patient before they can be moved.

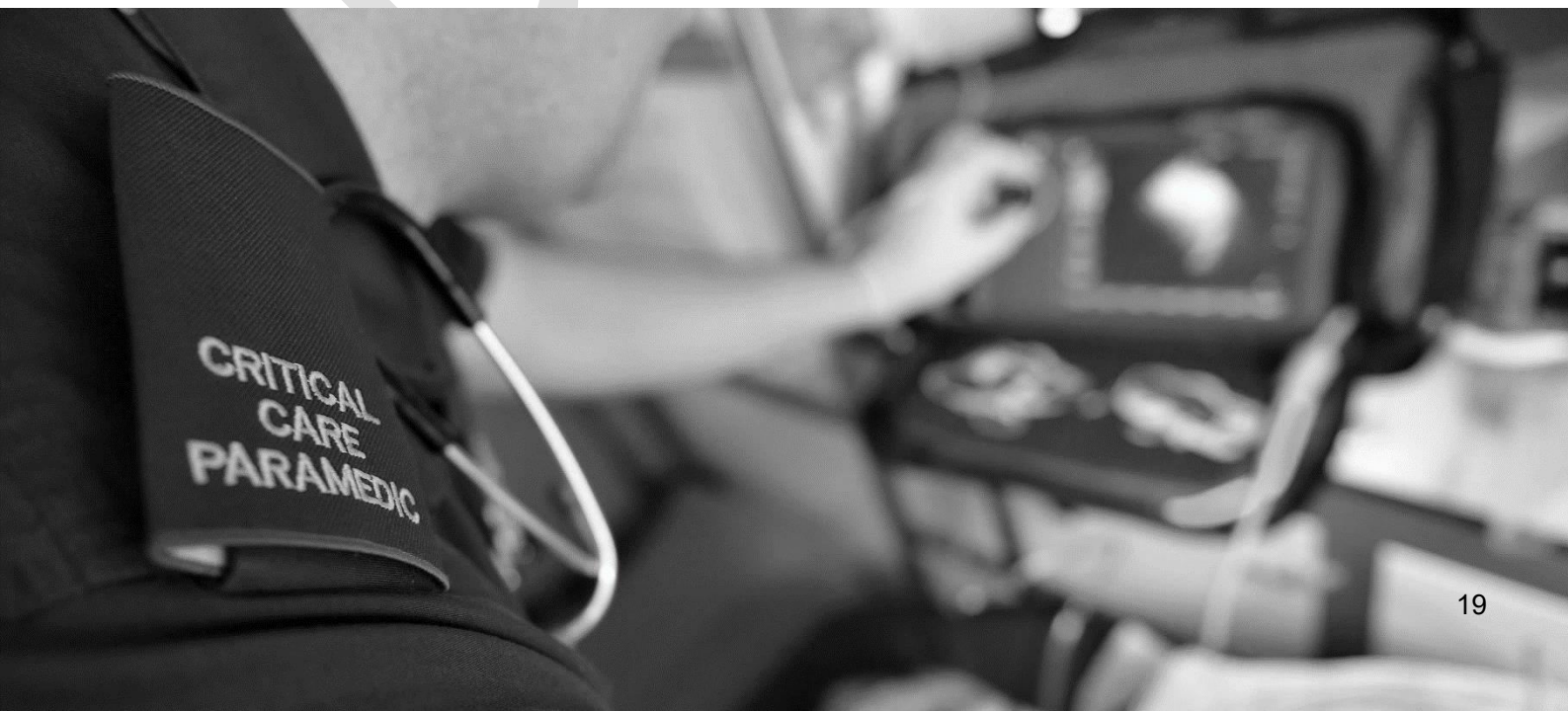
The graph below shows compliance within SECAmb for each element of the care bundle.



In addition, SECAmb's Critical Care Paramedics (CCPs) provide an extended care bundle aimed at addressing more detailed and advanced elements of care. This includes:

- Supporting and providing advanced airway management techniques
- Administering certain anaesthetic drugs to sedate and/or paralyse the patient, so that breathing can be supported with a ventilator and patient comfort can be improved
- Targeting derangement in physiology, such as blood pressure, to ensure optimal blood supply to the brain
- Treatment of abnormal heart rhythms to restore normal blood flow

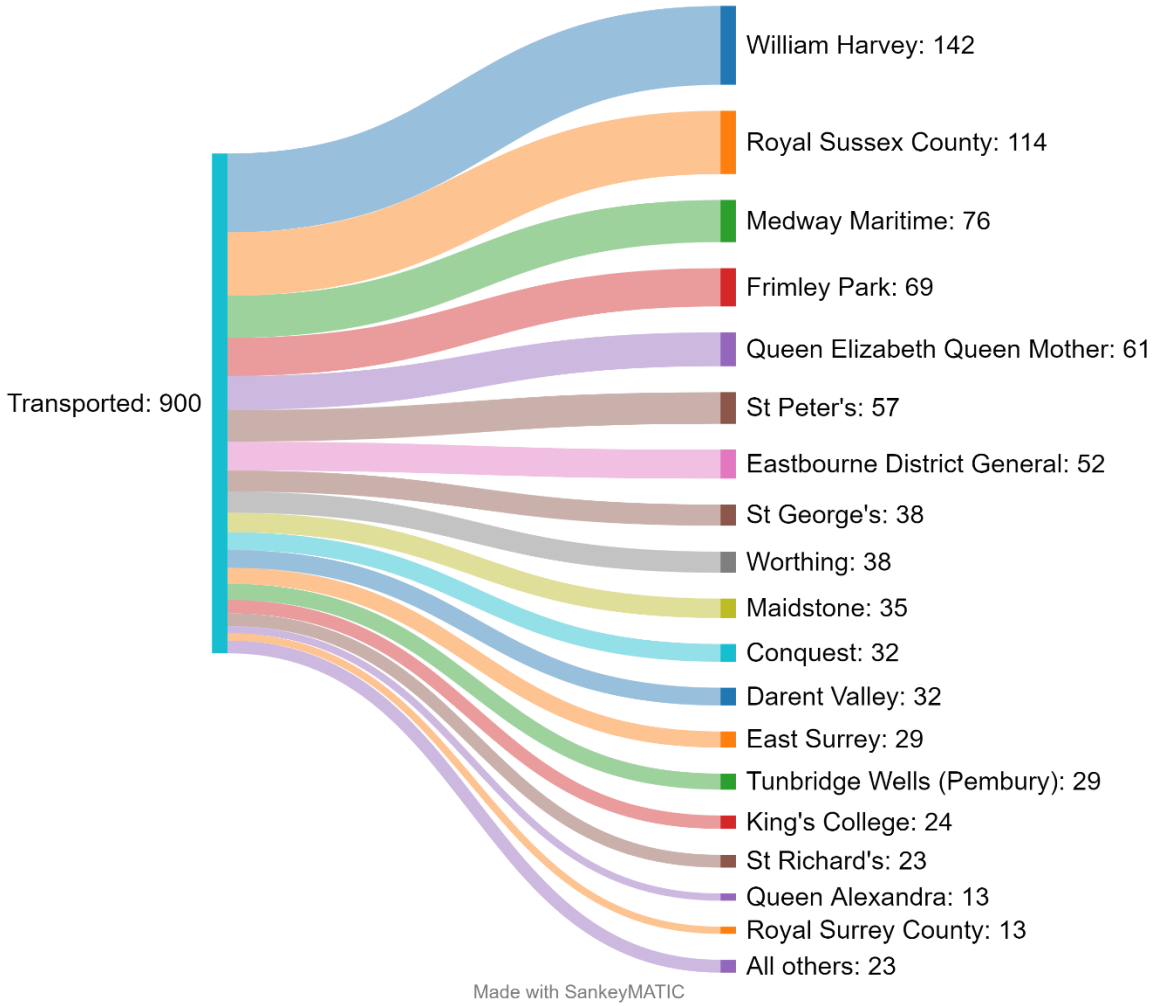
Critical Care Paramedics are specialist paramedics in SECAmb with postgraduate training. They are specifically assigned to critically unwell patients, as they can provide an enhanced range of interventions and support complex decision making.



Transported to hospital

For patients that remain in cardiac arrest despite treatment, SECAmb clinicians will normally continue resuscitation on scene until a definitive outcome is reached, rather than transport the patient to hospital in arrest. Exceptions to this apply when there are clear reversible causes that cannot be addressed out of hospital, such as a major loss of blood, or when there are other special circumstances, such as in paediatric arrests or drownings.

Overall, **SECAmb transported 900 patients to hospital, or 33% of all resuscitation attempts.** Approximately 10% (96) of transported patients were taken to a pPCI (Primary Percutaneous Coronary Intervention) centre for specialist intervention for a heart attack, with 90 of these patients handed over at hospital still in ROSC.



CPR metrics

High quality CPR is crucial to keep blood flowing to vital organs, buying time for further interventions to treat the underlying cause of the cardiac arrest. 'High Performance' CPR, as defined by the Global Resuscitation Alliance, is centred around evidence-based metrics linked with improved patient outcomes and increased survival.

Compression ratio of over 80%

In a ten minute period, no more than two minutes in total should be spent not doing chest compressions (known as time 'off the chest')

Pauses no longer than 10 seconds

Any breaks in CPR (e.g., to insert airways or check the heart rhythm) should be kept to less than ten seconds

Compression rate between 100-120 compressions per minute

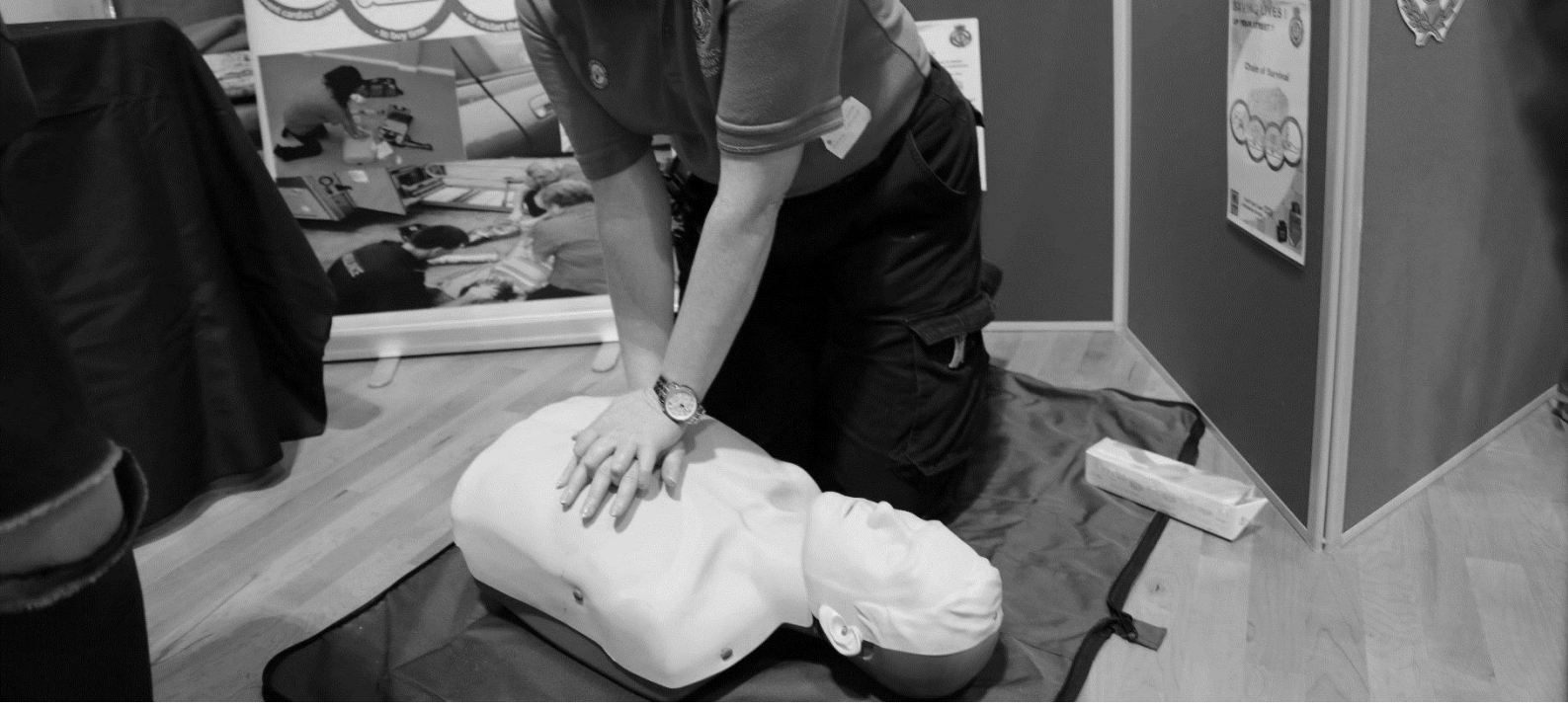
Both slower and faster rates are linked with a reduced likelihood of ROSC and survival

Compression depth of 5-6cm

To achieve the maximum output of blood from the heart

Full chest recoil

To allow the heart to properly refill



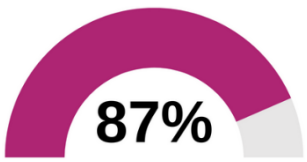
CPR in SECAmb

SECAmb is currently able to analyse the performance of our clinicians' CPR against three of these metrics, using data downloaded from the Trust's defibrillators. The first ten minutes of the download are examined (or, if EMS witnessed, the first ten minutes of the arrest), as this is deemed to be the most critical period of the resuscitation.

Data can be produced and fed back to clinicians on the CPR ratio, rate, length of pre and post shock pauses, length of longest pause, and total number of pauses over ten seconds.

A snapshot of data from the first two weeks of December 2021 showed:

of cases had the recommended CPR rate. Use of the metronome built into defibrillators is key to this excellent performance.

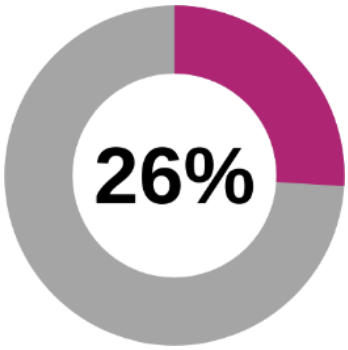


of cases had no more than two minutes off the chest during the ten minutes examined. Whilst this is good performance, there is room for improvement.

of cases had no pauses greater than 10 seconds. Improvement is needed in this area, as long pauses are linked with worse outcomes.

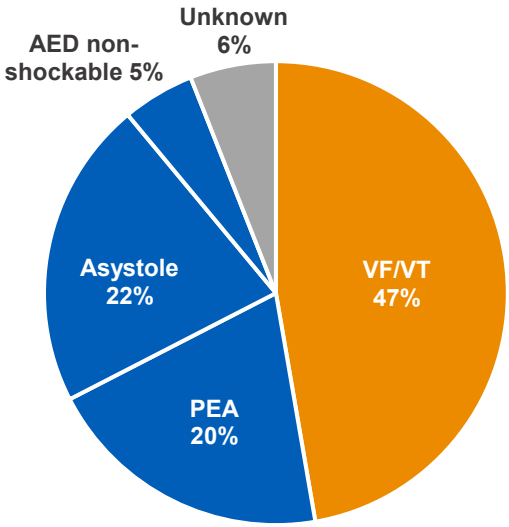
ROSC at hospital

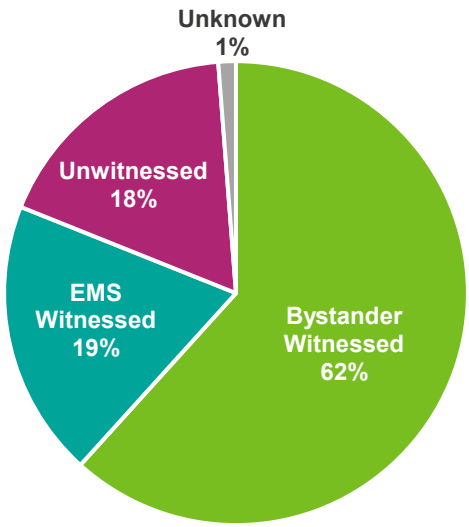
UK ambulance services measure outcomes from OHCA with two main metrics. The first of these is whether the patient achieved a return of spontaneous circulation (ROSC) which was then maintained to hospital.



For 2021-22, **26% of patients treated for OHCA by SECAmb were still in ROSC at hospital handover (734 patients)**, an improvement on last year's figures of 22% (589 patients).

There are significant correlations between the features of cardiac arrests and likelihood to maintain ROSC to hospital, in particular initial rhythm and whether the arrest was witnessed. The graphs below show these characteristics as a percentage of all patients with ROSC at hospital.

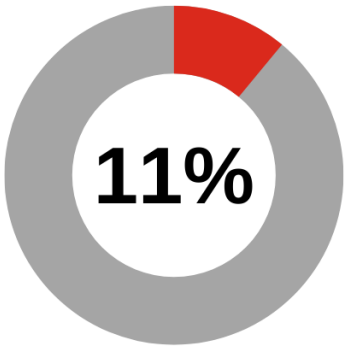




- Nearly half of all patients maintaining ROSC to hospital presented in a shockable rhythm, despite representing only just over a quarter of all resuscitation attempts.
- Initially asystolic arrests make up less than a quarter of patients maintaining ROSC to hospital, even though they represent nearly half of all resuscitation attempts.
- Less than a fifth of patients maintaining ROSC to hospital were unwitnessed arrests, despite these patients making up nearly a third of all resuscitation attempts.

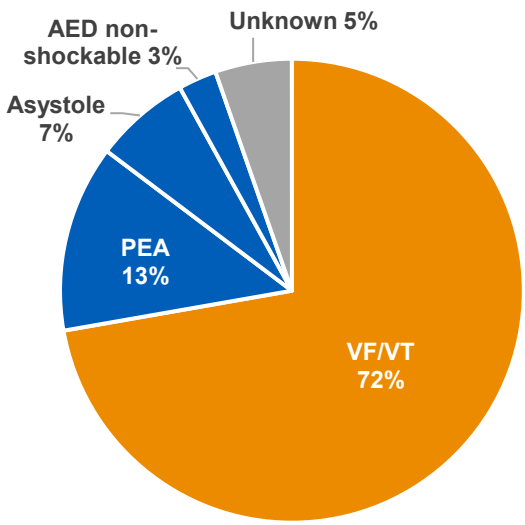
Survival to 30 days

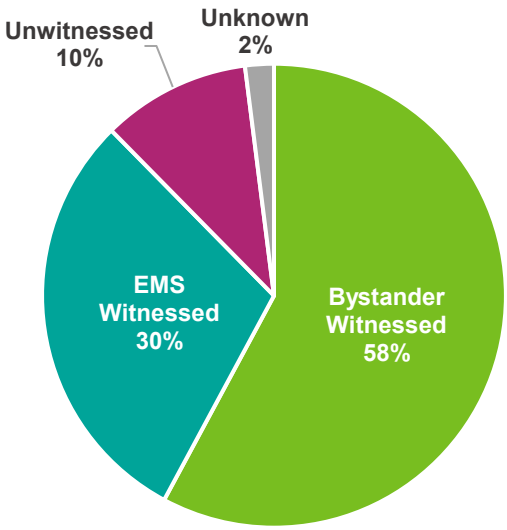
Whilst achieving and maintaining ROSC is important, the absolute measure of patient outcomes from OHCA is survival, or more simply; how many lives were saved. This is the second metric for measuring patient outcomes used by UK ambulance services, reported as survival at 30 days after the initial cardiac arrest.



In total, **11%, or more than one in ten patients receiving a resuscitation attempt from SECAmb survived to 30 days** (n=2750*), which is above the national average of 9%, and more importantly, is **299 individuals whose lives were saved**.

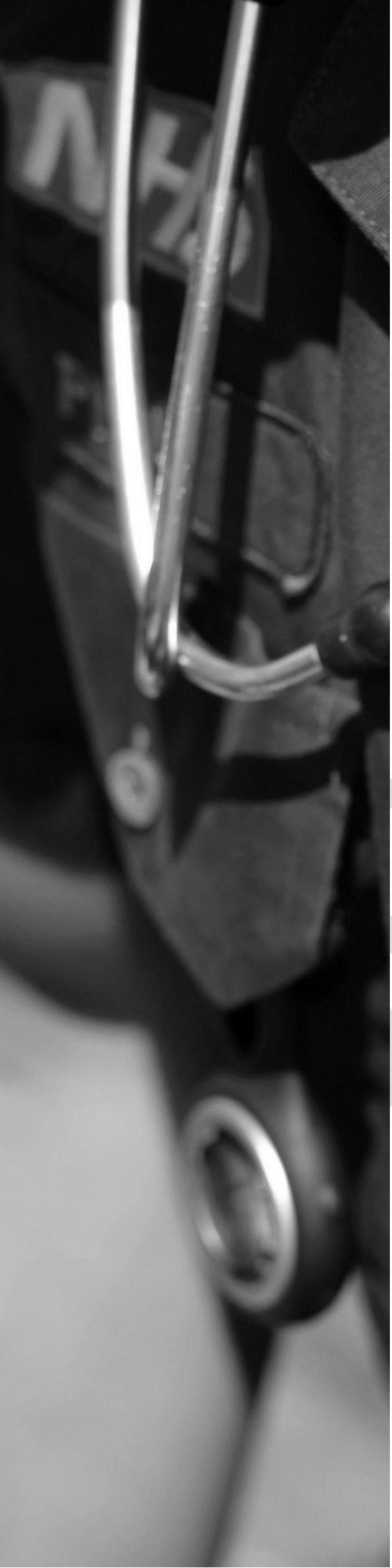
As with ROSC at hospital, both initial rhythm and whether the arrest was witnessed are correlated with patient survival, with initial rhythm being linked much more strongly. The graphs below show these characteristics as a percentage of all patients who survived to 30 days.





- Patients in a shockable initial rhythm make up nearly three quarters of survivors, despite making up only just over a quarter of all resuscitations.
- Less than a tenth of survivors were initially asystolic, but were nearly half of all resuscitation attempts.
- Unwitnessed arrests represent less than a tenth of survivors, despite making up nearly a third of all resuscitation attempts.
- EMS witnessed arrests make up nearly a third of survivors, despite being just over a tenth of all resuscitation attempts.

**patients with unknown outcomes are not included in survival calculations*



Before 2021, UK ambulance services measured survival to hospital discharge, without a timeframe. Whilst data for both metrics compared by SECAmb showed that they produced broadly similar figures, it is not possible to directly compare current survival figures against those from previous years.

Looking at the characteristics of survivors in more detail also presents further insights:

- Three quarters of survivors are male, compared to two thirds of total resuscitation attempts.
- The median age of survivors is 63, compared to 69 for resuscitation attempts overall.
- While patients over 70 make up nearly half of resuscitation attempts, they represent only just over a third of survivors.

Patients who were successfully resuscitated by shocks from a PAD before the arrival of EMS are not included in overall statistics. However, a remarkable 94% of this group survived (n=15).

The profile of survivors who presented initially in an asystolic rhythm is also considerably different from the overall population of resuscitation attempts:

- 40% of these cases were non-medical aetiologies such as drowning, electrocution, and drug overdose, compared to 11% of total resuscitation attempts.
- 35% were EMS witnessed, compared to 13% of total resuscitation attempts.
- 10% were paediatric cases, compared to 2% of total resuscitation attempts.
- All of these patients maintained a ROSC to hospital.

The Utstein Cohort

Measurements for patient outcomes are split into two groups: firstly, all patients who were treated for OHCA, and secondly, a subset known as the 'Utstein' cohort. This second group has internationally agreed fixed criteria, allowing a more equal comparison between ambulance services.

The Utstein cohort is defined as resuscitation attempts where:

The cause is presumed cardiac or medical

The arrest is bystander witnessed

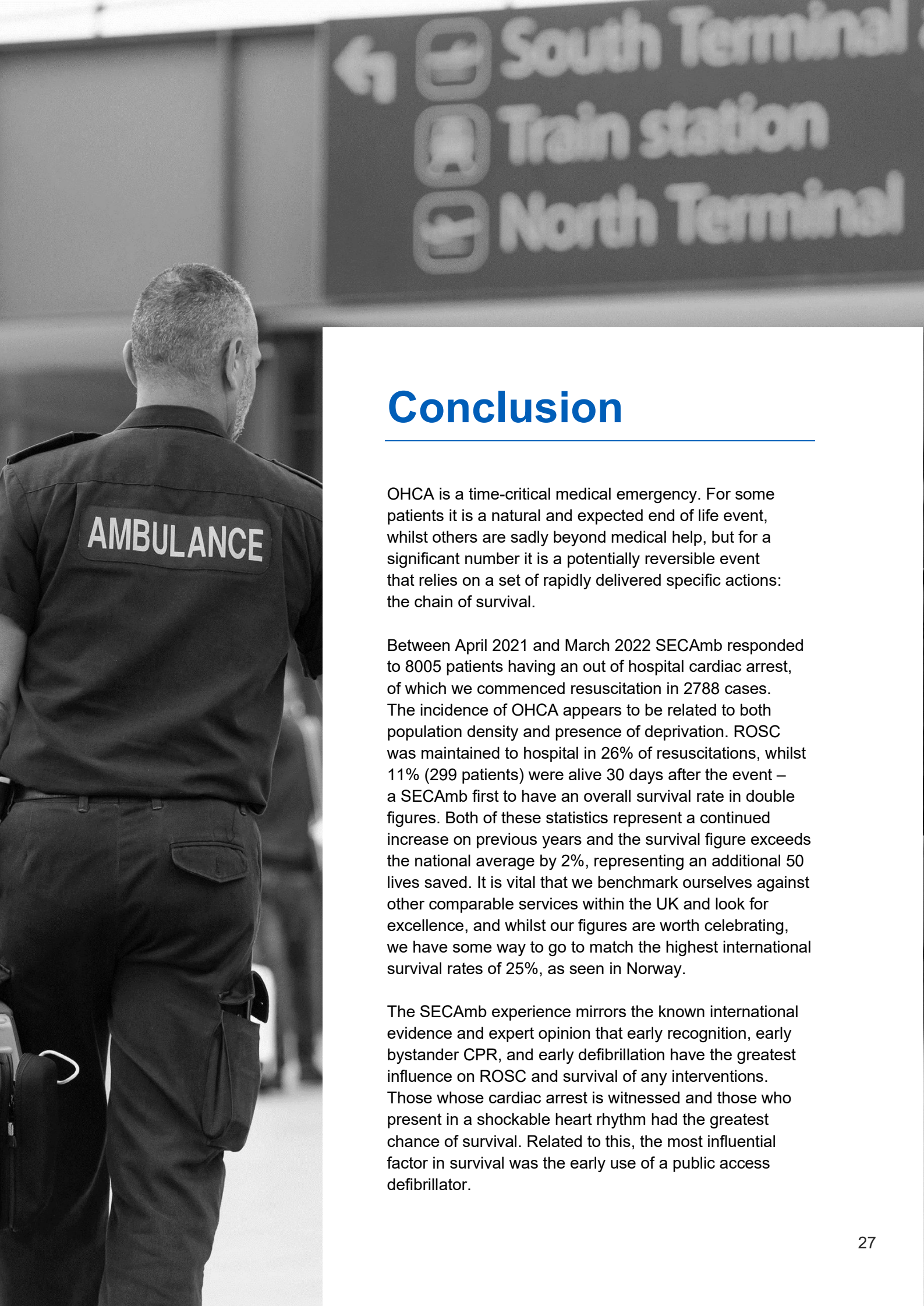
The initial rhythm is shockable

For 2021-22, **SECAmb's Utstein cohort was 504 patients**, or 18% of all resuscitation attempts.

ROSC at hospital for the Utstein cohort was 49%, or 245 patients. As with the overall figure, this is also an increase on last year's 44% (202).

Survival to 30 days for the Utstein cohort was 29%, or 141 patients (n=490*). As with the overall figures, this is also above the national average of 25%.

**patients with unknown outcomes are not included in survival calculations*



Conclusion

OHCA is a time-critical medical emergency. For some patients it is a natural and expected end of life event, whilst others are sadly beyond medical help, but for a significant number it is a potentially reversible event that relies on a set of rapidly delivered specific actions: the chain of survival.

Between April 2021 and March 2022 SECAmb responded to 8005 patients having an out of hospital cardiac arrest, of which we commenced resuscitation in 2788 cases. The incidence of OHCA appears to be related to both population density and presence of deprivation. ROSC was maintained to hospital in 26% of resuscitations, whilst 11% (299 patients) were alive 30 days after the event – a SECAmb first to have an overall survival rate in double figures. Both of these statistics represent a continued increase on previous years and the survival figure exceeds the national average by 2%, representing an additional 50 lives saved. It is vital that we benchmark ourselves against other comparable services within the UK and look for excellence, and whilst our figures are worth celebrating, we have some way to go to match the highest international survival rates of 25%, as seen in Norway.

The SECAmb experience mirrors the known international evidence and expert opinion that early recognition, early bystander CPR, and early defibrillation have the greatest influence on ROSC and survival of any interventions. Those whose cardiac arrest is witnessed and those who present in a shockable heart rhythm had the greatest chance of survival. Related to this, the most influential factor in survival was the early use of a public access defibrillator.

Throughout the period of this report there have been some areas of significant challenge regarding ambulance service response to OHCA. The most notable of these was the COVID pandemic, which resulted in numerous changes to resuscitation practices. Some of these created delays in care, such as the requirement to wear greater protective equipment, however these were routine and regularly practiced by 2021 and were slowly adapted and scaled back throughout the year, and so the impact is not as marked as in 2020. Rising demand on ambulance services has made timely response to cardiac arrest incidents increasingly challenging, and this has negatively influenced time to defibrillation where a public access defibrillator is not used, the average time sitting at 11 minutes against an aim of defibrillating within 5 minutes of cardiac arrest.

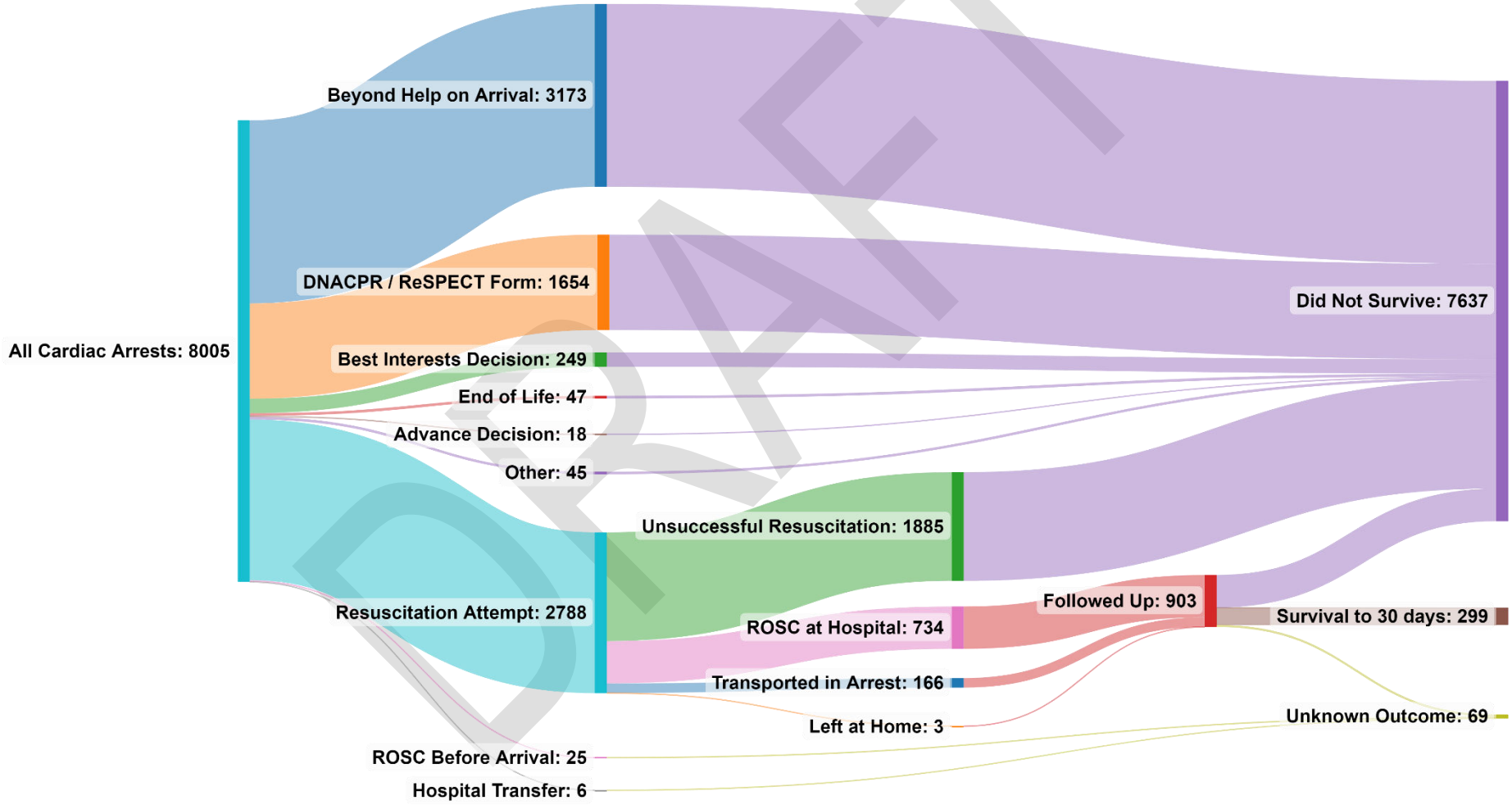
If ROSC and survival rates are to continue to increase and rival the best international experience then a programme of continuous improvement is needed, with significant focus in several specific areas:

- Increasing involvement of communities through teaching CPR, increasing the use of GoodSAM, and increasing availability of Community First Responders (CFRs).
- Improving identification of cardiac arrest at point of contact, and improving the provision of telephone CPR and signposting to PAD sites.
- Increasing the number of SECAmb resources with a defibrillator, e.g., managers, non-operational vehicles, and blue light partners.
- Increasing the number and use of public access defibrillators.
- Continuing to improve the provision of professionally delivered resuscitation by using CPR feedback both during resuscitation and as part of debriefing.
- Continuing to improve post resuscitation care through increasing compliance with the standard care bundle and by developing care pathways for patients with ROSC.
- Sharing data with Integrated Care System public health experts, to explore, for example, whether focussing quality improvement measures in areas of greater deprivation may be beneficial.

Improvement work within SECAmb is underway to address many of these areas, including expanding the Community First Responder programme, restarting routine feedback from defibrillator downloads, and beginning a programme of feedback for compliance against the standard UK post ROSC care bundle.

Overall, despite some unique challenges there continues to be an improvement in survival from OHCA within SECAmb. However, continuing to seek a culture of excellence is essential to build on these positives and to address the areas in need of improvement, to ensure that every cardiac arrest patient attended by our clinicians stands the best possible chance of survival.

Flowchart of all cardiac arrests



Definitions

ADRT	Advanced Decision to Refuse Treatment	A patient treatment plan or other documentation separate from a ReSPECT form or DNACPR, which defines the patient's wishes regarding treatment options and circumstances under which they should be applied.
AED	Automated External Defibrillator	A portable electronic device that recognises shockable heart rhythms without manual analysis and can treat them through defibrillation.
AED non-shockable		A cardiac rhythm determined by an AED to be non-shockable. Due to the nature of AEDs, no further details about the type of rhythm are available.
AED used		An AED has been applied to the patient and turned on. It may or may not administer a shock, depending on the initial rhythm of the patient.
Asystole		A 'flatline' heart rhythm. This cannot be corrected by a shock from a defibrillator.
Bystander CPR		CPR performed by anyone who is not part of an organised EMS response. This is unrelated to skill level, and could be a layperson, a member of the police, or an off duty trained clinician who happens to be nearby.
CCP	Critical Care Paramedic	Specialist paramedics within SECAmb with postgraduate training, assigned usually to high-acuity patients.
CDSS	Clinical Decision Support System	A tool used to remotely triage patients and provide initial care advice.
CFR	Community First Responder	Volunteers trained to respond to emergency calls in conjunction with SECAmb. They respond in their local areas, so often can attend before the emergency services arrive, and are therefore a vital part of OHCA response.
Codestat		The database containing all data transmitted from SECAmb's "Lifepak" defibrillators. This includes ECGs, CPR reports, observations, and other arrest details.
CPR	Cardiopulmonary Resuscitation	A treatment to maintain circulation for patients in cardiac arrest, in particular chest compressions.
Defibrillator		A machine used to administer an electric shock to the heart and 'stun' it out of an irregular rhythm.
ECG	Electrocardiogram	A reading of the electrical signals in the heart that allows clinicians to diagnose certain conditions.

EMA	Emergency Medical Adviser	An individual trained to answer 999 calls, assess the patient, and provide initial care until an EMA arrival.
EMS	Emergency Medical Services	Ambulance services, including HEMS, volunteer and private providers, and Community First Responders.
EOC	Emergency Operations Centre/Control	Where 999 calls are answered and a response is organised.
HEMS	Helicopter EMS	For SECAmb, this refers mainly to Air Ambulance Kent, Surrey, and Sussex.
Initial rhythm		The first recorded rhythm for the cardiac arrest. This may be from a PAD or from a Trust defibrillator.
OHCAO	Out of Hospital Cardiac Arrest Outcomes registry	Database of national OHCAs run by Warwick University. Data is uploaded from all English ambulance trusts and sent to NHS England for national reporting.
PAD	Public Access Defibrillator	An AED placed in a public location to be used by a bystander on a patient in cardiac arrest.
PEA	Pulseless Electrical Activity	A heart rhythm demonstrating some activity but which is too weak to produce a pulse. This cannot be corrected by a shock from a defibrillator.
pPCI	Primary Percutaneous Coronary Intervention	An emergency procedure to unblock the vessels of the heart after a patient has suffered a myocardial infarction (heart attack).
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment	A patient treatment plan, separate from a DNACPR, which defines the patient's wishes regarding treatment options and circumstances under which they should be applied.
Resuscitation attempted		Approximately 20 minutes of CPR has been performed on a patient without a DNACPR, ADRT, or ReSPECT form, during which time no signs incompatible with life have been identified.
ROSC	Return of Spontaneous Circulation	Return of a pulse after cardiac arrest.
VF / VT	Ventricular Fibrillation / Tachycardia	The two heart rhythms which can be shocked by a defibrillator.
Witnessed arrest		An arrest which has been seen or heard.

South East Coast Ambulance Service
NHS Foundation Trust

Nexus House, Gatwick Road, Crawley, RH10 9BG
clinical.audit@secamb.nhs.uk

Photographs in this report do not depict actual patients.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	85-22

Name of meeting	Trust Board
Date	2 February 2023
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 (348) Integrated Quality Report (slides 20-32) Improvement Journey (People and Culture)
Executive Summary	**Risk Overview** In terms of key people risks, we continue to operate at a sustained level of 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 now confirmed as Culture and Leadership (risk 348). The highest rated risk remains of confirmed industrial action. The GMB took strike action on 21 December 2022. Action planned for 28 December 2022 was postponed and took place on 11 January 2023. Further dates for industrial strike action have been confirmed by the GMB for 6 and 20 February and also 6 and 20 March 2023. In addition, the RCN, whilst not initially taking strike action within our Trust despite securing a mandate for action through balloting its members, has now confirmed that it will be taking strike action on 6 February 2023. This risk was reviewed by the Executive Director of HR & OD in December 2022 and scores increased to a maximum of 25 to reflect the changed situation since the risk was initially created on 16 September 2022. There is no reason to currently reduce the risk score whilst industrial action continues. 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 further improvement. The bottleneck previously identified in the resourcing team to process compliance checking continues to be addressed through temporary additional capacity until the end of March 2023. Additional permanent capacity will be required from April 2023 to avoid the situation reoccurring particularly as turnover remains significant within the control centres and it is therefore reasonable to assume a higher level of replacement recruitment than usual. Cohort 3 of the 75 international experienced paramedic recruits has commenced. The business case for a further 70 experienced paramedics and 30 NQPs is under consideration.

Retention

In November 2022, EMB and SMG have discussed and agreed a plan to improve staff retention. Positive work in this area now includes management engagement sessions to ensure proper implementation of the plan – particularly emphasising managerial accountabilities. The key areas of the retention plan have also been built into a new *PageTiger* capability to allow easy access and comprehension of the plan. This additional support has been developed to continue building on improving communication with all managers about strategic Trust wide initiatives.

The IQR highlights the continuing issue of staff retention within several parts of the Trust. The forecast end of year deficit of between 38-60 wte will place an additional demand on 23/24 plans.

Additional focused action was agreed by EMB and SMG to improve sickness absence levels as set out on slide 30 in the IQR. We will additionally be partnering with WMAS to understand and learn from how they have reduced their sickness levels to the best in the ambulance sector.

With sustained focus, we are now expecting to achieve the statutory and mandatory training target of 85% by the end of March 2023. However, more focused performance management will be required to ensure that the annual rolling appraisal targets are achieved into Q1 23/24 as the Trust moves fully to the new ESR-based appraisal system.

Culture and Leadership

The new role Programme Director (Culture) will commence in role on 8 March 2023 and will lead the implementation of the NHSE Culture and Leadership Programme. The business case for investment in this area remains under consideration.

Sexual Safety Training workshops for all managers continue with over 400 managers now having attended a workshop. Adoption of the 3Cs model for categorising severity of sexual misconduct (Clumsy, Creepy and Criminal) has resulted in improved focus for disciplinary sanctions. The impact of the Until It Stops Campaign has resulted in four proven cases of gross misconduct (three summary dismissals and one final warning) and two cases of serious misconduct.

As set out in the last Board update, the Executive Director of HR & OD formally invited ACAS to work with the Trust to mediate with its recognised unions to improve future working relations. This work commenced in November 2022 with the ACAS specialist initially meeting with all full-time officers of recognised unions. He has now also met with a range of senior and executive leaders and will be briefing the Executive Director of HR & OD in terms of next steps.

Initial raw data for the annual NHS staff survey has been received – with c.62% of colleagues once again completing the survey making SECAmb the best responding ambulance service. Full comparative results with other Trusts are due later in Q4 22/23. It is not anticipated that the results will be significantly different from last year yet.

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 and by the scale of the work set out in the Improvement Journey. 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	86-22

Name of meeting	Trust Board
Date	2 February 2023
Trust Priority Area	**Delivering Modern Healthcare**
Author / Lead Director	Emma Williams, Executive Director of Operations
Primary Board Papers	Summary of Operational Performance & Efficiency

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:

- Performance against Ambulance Response Programme (ARP) standards
- Industrial action – Service delivery and lessons learned to date
- Performance against the planned efficiency targets
- 111 Service line delivery and the Single Virtual Contact Centre model for 111

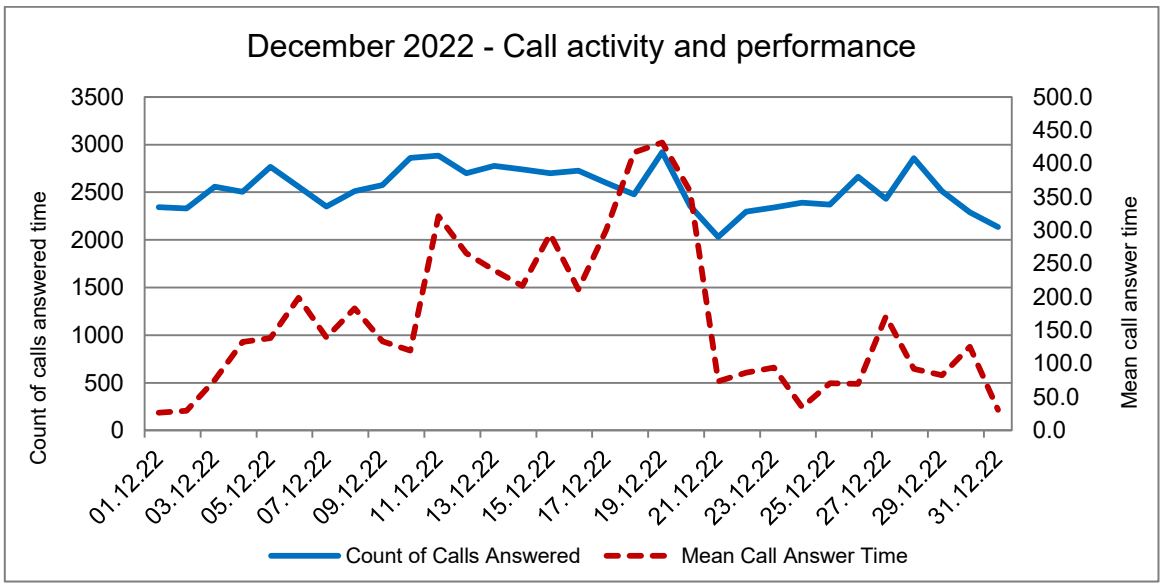
Recommendations, decisions, or actions sought	1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area. 2. That the Board note the quality metrics and performance against this Trust Priority Area. 3. That the Board note the actions being undertaken to address the risks and improve performance within this Trust Priority Area.

Update Summary

<u>Performance against Ambulance Response Programme (ARP) standards</u>

- As described in BAF risk 14 – '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.'
- 999 Call handling is particularly challenged and has been on a deteriorating trend since September which is strongly correlated with increased turnover, abstraction, and challenges relating to recruitment and training of new staff – more of this is covered in the paper presenting the plan for the improvement of call handling and EMA staffing.
- Overall ARP performance for field operations remains consistent for the monthly mean, with the national and SECAmb metrics being significantly higher than the required ARP standards, however noting that C2 and C3 performance is in 2nd and 4/5th in the English league tables. C1 performance shows a worsening trend – this was particularly seen during the first 3 weeks of December.
- Performance in December was very much divided into two periods – the 1st to 21st and then 21st onwards, with the 21st being the delineation due to it being the first day of the industrial action undertaken by GMB union members. Prior to this day of action, ARP performance and hospital handover compliance had been on an worsening trend from the start of December. The

overall reduction in activity seen on the 21st Dec (by circa 27%) appears to have had a continuing impact as can be seen in the graph below, noting the 2 spikes in later December align to Boxing day and the 28th which for many was the first day back to work after Christmas).



- The total resource hours delivered across all operational service lines continues to be challenged, with higher than planned levels of sickness, although this was mitigated somewhat over the Christmas 2-week period when a reduced level of annual leave is permitted. In addition, having reviewed the planned hours over this period, a decision was made that additional incentives for shifts over key days would not be implemented in December 2022 as it was not required – the outcome of this was positive with strong hours provided across the latter weeks of the month.
- The only part of the resource provision that was lower than required related to a Private Ambulance Provider who did not deliver the hours contracted – this is being managed through formal contract meetings with appropriate notifications made.

<u>Industrial Action (21/12/22)</u>

- Through positive negotiations with the GMB union, a strong set of derogations was agreed which, in conjunction with the Military Aid to the Civil Authorities (MACA) support, and significantly improved hospital handover times, resulted in positive performance and service delivery on this date, whilst allowing appropriate staff to use their legal right to take action.
- Lessons were learned on the day which were then included in the planning for the industrial action in early January 2023, noting that the planning for these days of action require considerable efforts from managers and staff across most directorates.
- The scheduling team completed the review of hours lost from service delivery through industrial action – these are shown below.

Area	***Total hrs lost to IA***	***Total no of staff who took IA***
Emergency Operations Centres (999)	178.50	32
111	85.48	16
Field operations	2848.00	378
Total	3112.00	426

- Within field operations, the required hours for the day were 9,592hrs and once the hours taken for industrial action have been removed, the result was that core staffing was at 6,999hrs, 27% under the target level. Also, to note that there was good CFR cover on the day with over 70 CFRs booked on attending 186 incidents in total.

Performance against the planned efficiency targets

- Hear & Treat: This programme has been reviewed with several key actions beginning to bed in and demonstrating benefits. In addition, learning from the days of industrial action where the maximum level of clinicians have been focused in the Emergency Operations Centre (EOC) – this is the longer term intention, and on those days the hear & treat rate was noticeably higher (14.5% on 21/12/22).
- Use of referral pathways: As part of the ongoing work around see & treat, and in collaboration with the SECAmb partnership team mapping and engagement with system partners to enhance the use of community & urgent pathways. Over the winter additional local promotions have encouraged operational staff (both in EOC & field operations) to refer appropriate patients to care through routes other than via an Emergency Department. Enhanced reporting is creating greater granularity demonstrating where suitable pathways are being used.
- Job cycle time: Activities related to job cycle improvement and management are components o the Responsive Care Group workstream in the Improvement Journey Programme – this is has three key components:
    1. Mobilisation. Senior ops managers mapping variation, contributing factors and actions for improvement.
    2. On-scene time. The Clinical Advisory Group (CAG) has been asked to undertake a review of the activities that should be undertaken both on a generalised and specific basis according to the patient's clinical presentation.
    3. Hospital handover. This continues to be monitored in live time both within SECAmb, regional commissioners and at a national level, recognising the recent improvements and that the hospitals in the Southeast have some of the lowest handover times on a national level.
- CQUIN - The Trust continues to rollout the CFR falls programme across with positive feedback from patients and staff. The 97 volunteers within the programme are on track to have completed their additional falls training programme by the end of January, and new CFRs will receive this training as standard going forward.

SVCC

- Work between the operations, planning and finance teams continue to 'right-size' the 111 service in line with the further agreement of the finding envelope for the Kent, Medway, and Sussex (KMS) 111 IUC (Integrated Urgent Care). With the transition in model to be far more focused on call handling, and validation within SECAmb and 'downstream' providers picking up more of the CAS (Clinical Advice Service) activity, a plan for delivering this change is being implemented.
- Monitoring of this change and its impacts will be essential for both SECAmb and commissioners to ensure quality service delivery with good impacts/outcomes is delivered.
- The Single Virtual Contact Centre remains a work-in-progress with SECAmb now being given a 'go-live' date that has been deferred further to March 21st 2023 for the South East Region. Ahead of this, the Memorandum of Understanding (MOU) and Data Protection Impact Assessment (DPIA) are under development. Continued progression against the workforce and commissioner actions is required to meet go-live requirements.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	86-22

Name of meeting	Trust Board
Date	2 February 2023
Name of paper	Patient story
Trust Priority Area	Delivering Modern Healthcare / Operational Performance
Author / Lead Director	Emma Williams, Executive Director of Operations
Primary Board Papers	BAF Risks 14 Integrated Quality Report (slides 34-45) Improvement Journey (Responsive care)

This Board Story highlights the work undertaken in partnership with the system to improve delays when handing patients over at emergency departments (EDs). The time lost at handover has and continues to be a challenge across the country. In the Southeast there has been much focus on building better relationships to help address this issue together with our colleagues at EDs.

The Board will hear from an OUM describing their work with the hospital in Brighton, and how this good partnership engagement has led to positive improvement.

Recommendations, decisions or actions sought	The Board is asked to use this Board Story as context for its review of operational performance.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	86-22

Name of meeting	Trust Board
Date	2nd February 2023
Name of paper	EOC 999 Call Handling Improvement Plan
Responsible Executive	Emma Williams, Executive Director of Operations
Author	Penny Green – Operating Unit Manager (OUM) 999 Call Handling Sean Daisy – Business Support Manager for Integrated Care (999 & 111)
Synopsis	Since the introduction of the national NHS Ambulance Response Programme (ARP) standards in 2017, the Trust has planned care in a way that meets the needs of local people and the communities it serves. However, since the rise in demand and the inevitable strain on 999 call response times, the service is not able to consistently achieve its ARP targets. The EOC 999 Call Handling Improvement Plan sets out a framework for improvement, using the Six Sigma methodology of DMAIC (Define, Measure, Analyse, Improve and Control).
Recommendations, decisions, or actions sought	The board is asked to consider and discuss the contents of this paper and support the recommendations, or to recommend any further requirements.

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

Table of Contents

1. Executive Summary

Since the national NHS Ambulance Response Programme (ARP) standards were introduced in 2017, the Trust has planned care in a way to meet the needs of local people and the communities served. In addition to achieving the national ARP targets.

The Trust's 999 service has been under sustained pressure and as a result, experienced significant activity, and capacity challenges, with a diminished ability to manage the elevated levels of demand associated with COVID-19, and the subsequent recovery phase thereafter.

The pandemic has had an impact on emergency care nationally, and 2022/23 has seen an unprecedented scale of pressure in the ambulance sector, with all ambulance services at some stage declaring the highest level of alert (REAP 4) and remaining at this level for sustained periods.

Whereas for H1 of 22/23, SECAmb was consistently in the top half of national performance for 999 call answering, when benchmarked against the other English ambulance trusts, performance tailed off markedly in Q3, culminating in the Trust being the worst for 999 call answering in England for December 2022. The cause for this deterioration is multi-factorial however, the principal reason for poor 999 call handling is linked to a significant deficit between the required Emergency Medical Advisors (EMAs) to meet escalating call demand, against available EMA call handlers. The inability of the Trust to bridge this gap has been exacerbated by high staff turnover (leaving the Trust and via internal progression), recruitment challenges including the quality and quantity of candidates, lower than usual NHS Pathways training pass rates and elevated levels of sickness, arising from the Emergency Operations Centres being an extremely challenging and pressurised working environment, with the Trust in extended periods of Surge Management Plan (SMP) escalation level 4.

The EOC 999 Call Handling Improvement Plan sets out a framework for improvement to address these challenges, using the Six Sigma methodology of DMAIC (Define, Measure, Analyse, Improve, Control). This paper includes the plan, the supporting data and analysis, in addition the summary GANTT plan for achieving the ARP target for 999 call answering.

The plan itself articulates why 999 call answering is currently so challenged, what the Trust is doing to address this deficient performance and identifies when 999 call answering is likely to improve with indicative trajectories.

With the number of actions and work streams currently in place, in addition to the proposed initiatives in Q4 of 22/23 and continued collaboration between Integrated Care (EOC and 111) and Operations (Urgent Emergency Care) and other directorates, the goal is to achieve the requisite number of EMAs to answer forecast 999 call demand by the end of Q1 of 23/24.

2. Define

2.1. Within this phase, we describe the problem we are trying to solve and the value to the organisation if we do.

2.2. The aim of the EOC 999 Call Handling Improvement Plan is to meet the ARP performance targets for mean 999 call answering rate (target 5 secs) and the 90th centile call answer rate (target 10 secs)

2.3. Timely call answering can be critical to our most acutely unwell patients in order to provide life-saving advice and ensure safe and effective health outcomes. It is also important to maintain patient confidence in emergency care service delivery.

2.4. The current problem is our performance targets are not being met consistently, putting the safety of patients and confidence in our service at risk.

3. Measure

3.1. Within this phase, we understand the process which we are trying to measure and use available data to understand how big or small the problem is.

3.2. Mean Call Answer Time – December 2022

3.3. Appendix A provides a graph of mean 999 call answering time for December 2022 for each ambulance service.

3.4. The data shows that South East Coast had the longest mean 999 call answer time for December 2022 (175s) followed by London (150s).

3.5. Mean and 90th Centile Call Answer Rate (16th Oct 2022 – 16th Jan 2023)

3.6. Appendix B provides a graph of mean and 90th centile call answer rate per day from 16th October 2022 to 16th January 2023 inclusive:

3.7. This data shows that apart from 11th January to 14th January 2023, mean answer call rate and 90th Centile answer call rate was in excess of the 5 second and 10 second respective targets. This graph shows that performance was particularly challenged in mid-December but has recently improved, although is still longer than the ARP target answer times.

3.8. Mean and 90th Centile Call Answer Rate (16th Oct 2022 – 16th Jan 2023)

3.9. Appendix C provides a graph of the inbound call volume from 16th October 2022 to 16th January 2023.

3.10. The data shows that around 2,500 to 3,500 calls per day are being received up until 4th January onwards, where volumes fell below 2,500 daily. Mid to late December 2022 was when the greatest peaks of demand were experienced. This is consistent with what would be expected from “winter pressures” in the healthcare system but the recent drops in call volume is unseasonal and is one of the reasons for recent improvement in call answering performance.

3.11. Duplicate Calls (16th Oct 2022 – 16th Jan 2023)

3.12. Appendix D provides a graph of the percentage of duplicate calls (calls which are defined as a telephone number that has already been received by the 999 service) received per day from 16th October 2022 to 16th January 2023 inclusive.

3.13. This data shows that an additional volume of calls, ranging from 14% to 30% per day, had been received into the 999 service relating to existing incidents. This percentage has recently reduced in line with recent unseasonal reduction in activity.

3.14. EMA Sickness % (w.c. 17th Oct 2022 – w.c. 9th Jan 2023)

3.15. Appendix E provides a graph showing EMA sickness % compared to the target for the week commencing (w.c.) 17th October 2022 to the week commencing 9th January 2023 inclusive.

3.16. This data shows that sickness has always been in excess of target in H2 of 22/23, ranging from 14% up to 24%, with the worst affected period being mid to late December.

3.17. EMAs In Post WTE (Jan 2022 – Dec 2022)

3.18. Appendix F provides a graph of the number of Emergency Medical Advisors (EMAs) in post WTE (Whole Time Equivalent) from January 2022 to December 2022 inclusive.

3.19. This data shows that the number of call handlers in post has been consistently below target, and over the year has deteriorated rather than improved.

3.20. EMAs Starters and Turnover Comparison (WTE, Jan 2022 – Dec 2022)

3.21. Appendix G provides a graph of starters (staff entering training) against leavers WTE from January 2022 to December 2022 inclusive.

3.22. This data shows that in 9 out of the last 12 months, more EMAs left the service rather than joined.

3.23. EMA Turnover % (Jan 2022 – Dec 2022)

3.24. Appendix H provides a graph of percentage turnover for January 2022 to December 2022 inclusive:

3.25. The data shows a large loss of staff in January 22, with many staff returning to the aviation injury, having joined the Trust during the first wave of the COVID-19 pandemic and Furlough. Contract terminations from failing NHS Pathways training were a large contributor of staff losses in August to October, which was stabilised in November.

3.26. EMA Reason for Turnover (2022)

3.27. Appendix I provides a graph showing the reasons for turnover for 2022.

3.28. The graph shows that around half of all staff losses is from resignation, with around a quarter seeking new roles within SECAmb, demonstrating that a considerable proportion of EMA turnover is positive for colleagues and the wider Trust.

3.29. EMA Resignations (2022)

3.30. Appendix J shows the proportion of resignations based on length of service within the year 2022.

3.31. The graph below shows 41% of resignations are within the first 6 months of service, and 67% are within the first 12 months of service.

3.32. Additional Measures within Quality and Governance

3.33. Additional measures that evaluate the impacts of performance are also of consideration when evaluating the impact of performance and performance improvement. These include the number of incidents received and the outcome of incident investigations, the number of Serious Incidents received, and the outcome of serious incident investigations and the number of formal complaints received and the outcome of formal complaints investigations.

4. Analyse

4.1. Within this phase, we analysed the root cause of the problem and what has the most significance in terms of impact on our improvement trajectory. This was conducted using a “5 Whys” method as seen in Appendix K.

5. Improve and Control

5.1. This phase is about **improving**, testing the best solutions to resolve the root cause of the problems identified and confirming through small scale testing that these solutions will meet the objectives, followed by **controlling**, fully implementing solutions, and establishing ongoing mechanisms to embed improvements and share learnings.

5.2. The EOC Call Handling Improvement Plan will be represented against the following tasks and the Gannt Chart in Appendix L:

Task Name	Task Description
Recruitment	
Review and reduce time to hire turnaround	The overall time to hire from Application received to starting is an average of 53 days year to date from the September - October 2022 review (just under 2 months). Review is required on the processes from application receipt to starting training and establish efficiencies to improve course fill, including compliance turnaround efficiencies.
Review training course efficiency and maximise rate of return	Review training course processes looking at the pass rate and the actions on trainees that fail the Pathways course and establish efficiencies to maximise rate of return either during or before training
Night staff recruitment	Arrange night staff recruitment to address night rota shortfalls
Retention	
Meet with Human Resources and EOC Management	Meet with Human Resources and EOC Management to review the turnover and establish what needs to be true to meet the need to reduce turnover, including any actions already identified.
Psychometric Testing	Introduce Psychometric testing into the shortlisting process to ensure candidates could perform well, and therefore remain, in their role.
EOC Call Handling Retention Premia	Offer a retention bonus to EOC Call Handling staff
SEMA uplift pilot	A pilot is proposed to review the turnover and sickness levels of Senior Emergency Medical Advisors (SEMAs). If these cohorts have lower sickness and turnover, then these will be candidates for further investment in this cohort.
Process / Efficiencies	
Pathways Triage Cut Off Tool	Evaluate and deploy the triage cut off tool to improve triage efficiency. The Pathways Triage cut off call sets a threshold acuity response and ends the triage if further questions would be required. (e.g. the 2 hour response cut off means triage ends when the potential dispositions reached by the EMA are longer than 2 hours in urgency)
Inter-Facility Transfer (IFT) Desk	An IFT desk to take calls from healthcare professionals has been set up, with training commenced in December and 6 Health Advisors have been stationed, with another course set for mid-February.

Other Considerations	
Schwartz Rounds	With Nursing and Quality, set out and deploy Schwartz Rounds to help improve patient outcomes concerning patient safety and clinical effectiveness and will be monitored for the benefits to reducing EMA sickness and staff turnover.

5.3. **Risks -** Preliminary evaluation of the plan establishes the following risks to meeting the objectives of the plan:

5.4. **Medway East EOC Transition** – As a result of the transition of East EOC from Coxheath to Medway Multipurpose Centre, there is a risk that increases in turnover may occur, which may impact on the EMA workforce and therefore the performance objectives.

5.5. Training – There is a risk that the training team may not be able to meet the demand and increase the number of training cohorts should the decision be made to recruit at pace. If we cannot meet our training needs, this will impact on meeting recruitment and therefore workforce and performance requirements.

5.6. Leadership Team capacity to support plan - There is a risk to the delivery of activities and milestones within the improvement plan as a result of insufficient capacity and competing priorities within the leadership team which may lead to slippage of improving objectives and indicators, impacting on the efficacy of the programme, and therefore not realising improvements in performance.

5.7. Assumptions

5.8. Preliminary evaluation of the plan establishes the following assumptions to meeting the objectives of the plan:

5.9. **Call Volume and Presentation Predictability** – Performance is reliant on the number of 999 calls and when they present being able to be predicted accurately. If there is an unpredictable surge in call volume, then the benefits will not sufficiently address demand to improve performance.

5.10. **EOCs** – Performance is reliant on known estate to deliver the service and the plans to recruit and retain and support staff being at set locations, notwithstanding the Medway East EOC transition risk as articulated.

5.11. **Team structure** – The plan and scope of the plan is dependent on the EOC team structure as it currently exists.

5.12. **Effectiveness of targets** – The plan and scope of the plan is dependent on the targets set out, such as for recruitment and sickness, as both SMART and beneficial to meeting the performance delivery objective.

5.13. Issues

5.14. Preliminary evaluation of the plan establishes the following key issues to meeting the objectives of the plan:

5.15. **There are not enough recruits coming through training.**

5.16. **Time to Hire** is currently almost 2 months long.

5.17. **Demand management** is an issue. We have Health Care Professionals (HCPs) unable to get through to SECAmb via the designated HCP line and are contacting 999 directly.

5.18. **Productivity issues:** Patient presentations have included lower acuity symptoms and more complex calls, requiring longer assessments.

5.19. **Staff resilience**: There are issues with employing staff with the requisite resilience for the role.

5.20. There are issues with **sickness levels** in EOC in excess of target. Key causes are related to burnout and COVID-19 symptom related absences.

5.21. <u>Dependencies</u>

5.22. Preliminary evaluation of the plan establishes the following key dependencies toward meeting the objectives of the plan:

5.23. **Human Resources** – The plan is dependent on the Human Resources Team supporting the required activities to meet sickness and consequently performance improvement objectives.

5.24. **Employee Resourcing** – The plan is dependent on the Employee Resourcing Team supporting the required advertising, compliance, interview, and onboarding activities to meet recruitment and consequently performance improvement objectives.

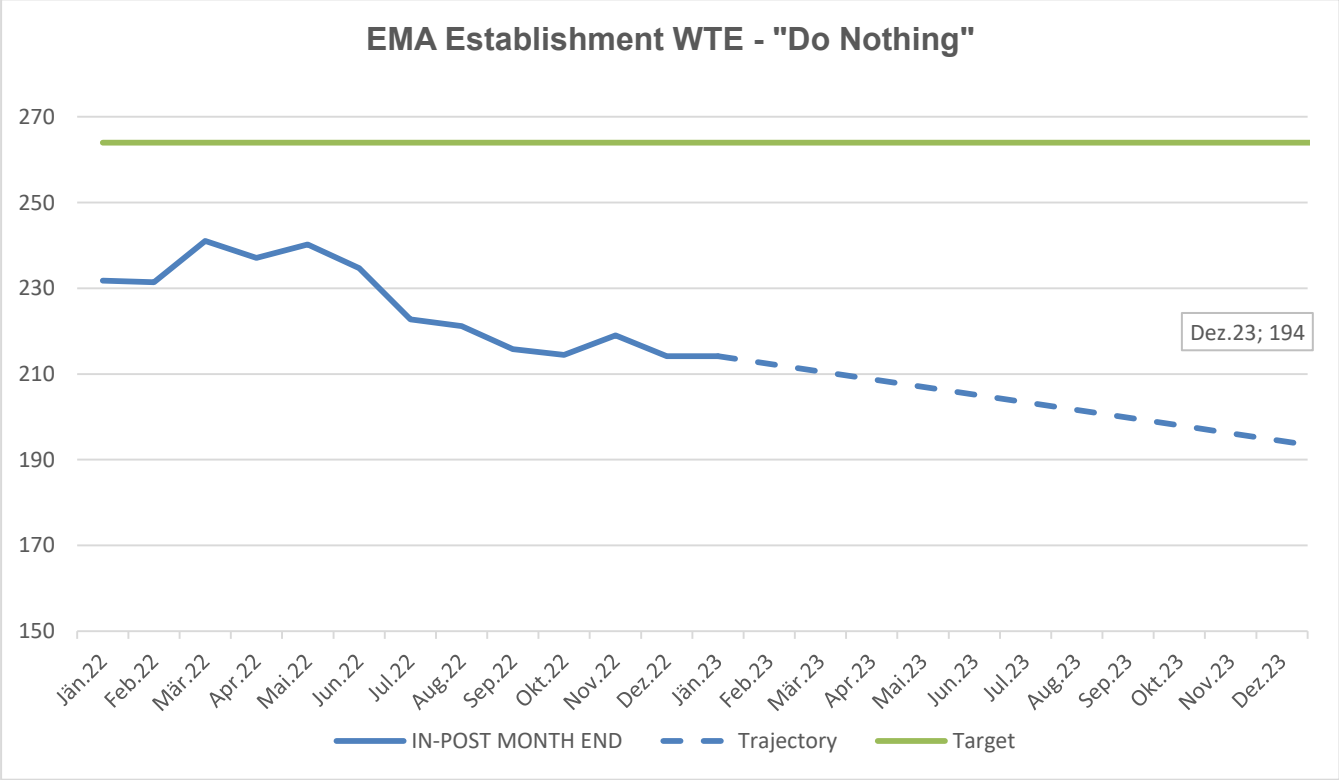
5.25. **Nursing and Quality** – the Nursing and Quality team are supporting the activities such as Schwartz rounds to support sickness and turnover.

5.26. **Finance and Corporate Services** – the Finance and Corporate Services team are supporting the activities such as EOC Call Handling Retention Premia.

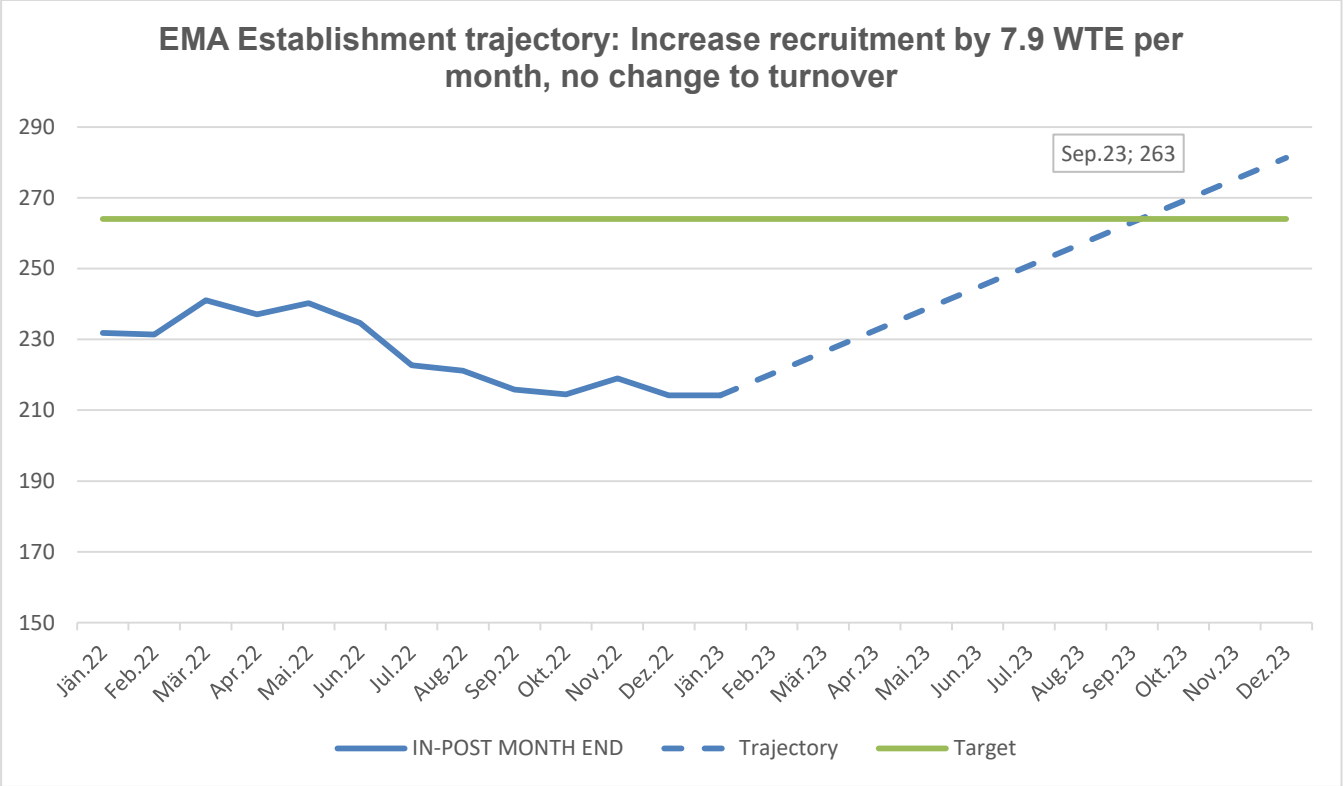
5.27. <u>Evaluation</u>

5.28. Evaluation of pilots are based on testing improvements in key metrics. An example given here is modelling current recruitment and turnover against meeting establishment target, if establishment does not significantly change by the end of January, and improvements can be embedded from February onwards. The rationale of this focus is that meeting staffing level requirements is key to ensuring other service improvements such as productivity and sickness improvement are met.

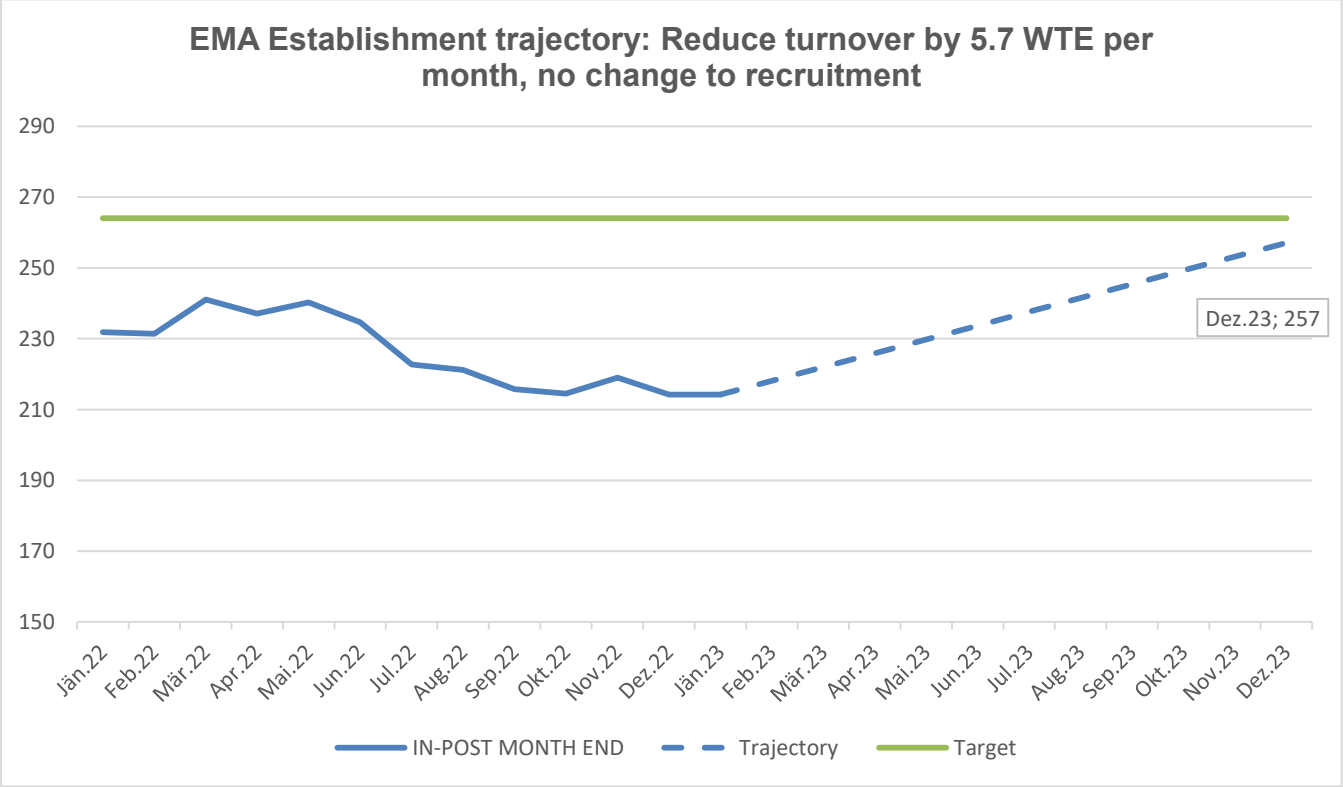
5.29. Looking at the control scenario, where recruitment and turnover remains on the same trajectory as it was throughout 2022 (“do nothing”), and no improvement is made, the graph below shows that an average of 1.8 WTE EMAs are lost a month and models that EMA establishment will decline to 194 by current year end:



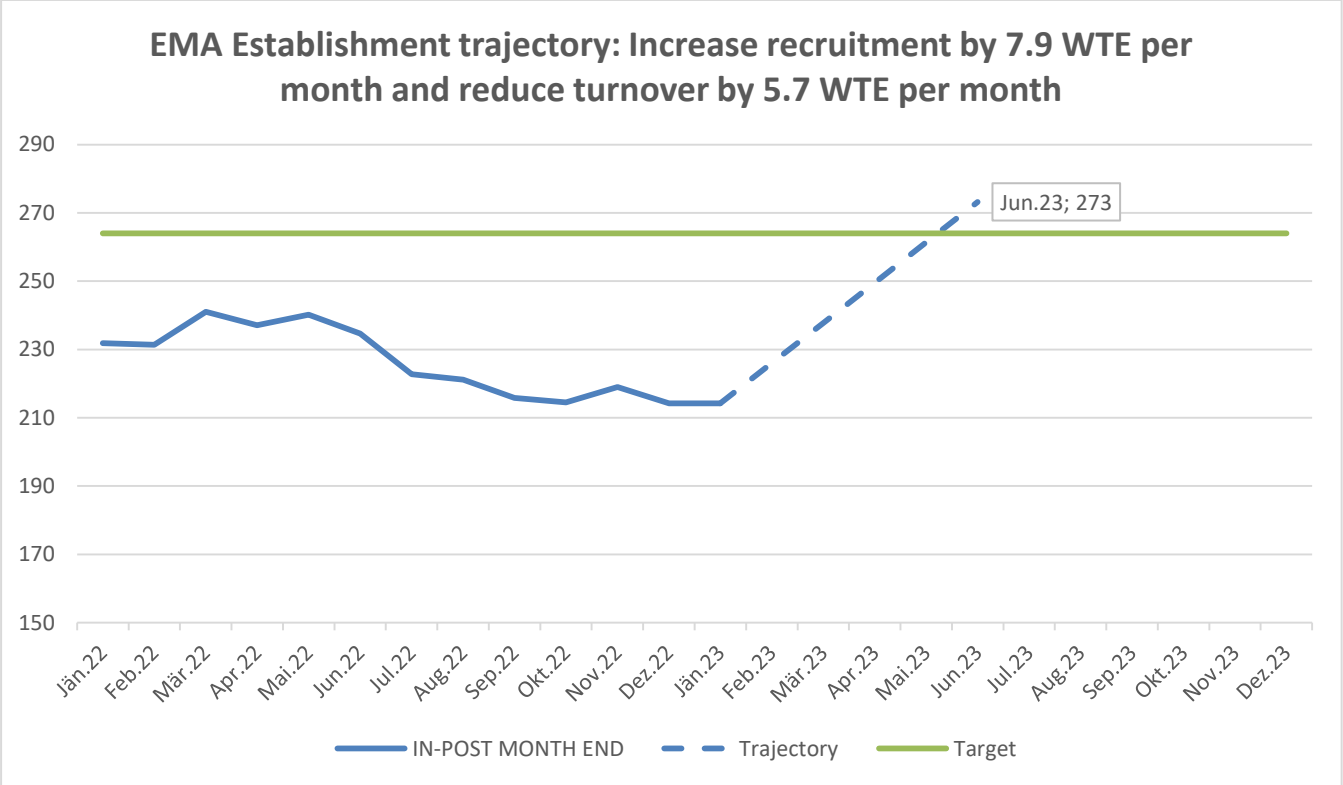
5.30. Looking at the recruitment uplift only scenario, where recruitment is increased by 7.9 WTE per month (recruiting from 15.9 WTE per month to 23.8 WTE per month) through recruitment uplift projects and there is no change to turnover, the graph below models that EMA establishment will meet target by September 2023:



5.31. Looking at the retention reduction only scenario, where turnover is reduced by 5.7 WTE per month through turnover reduction projects and there is no change to turnover, the graph below models that EMA establishment will not meet target in 2023, but will meet target by February 2024:

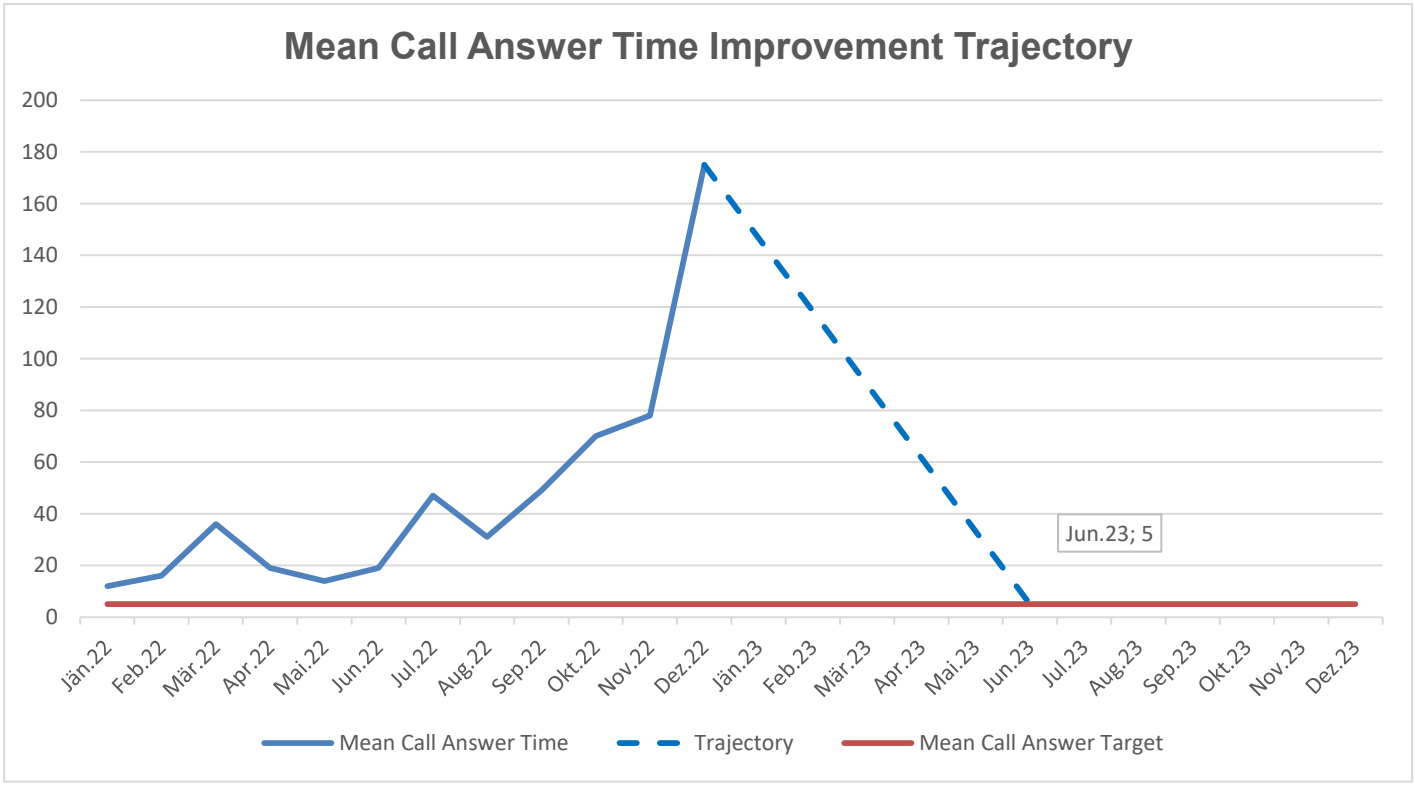


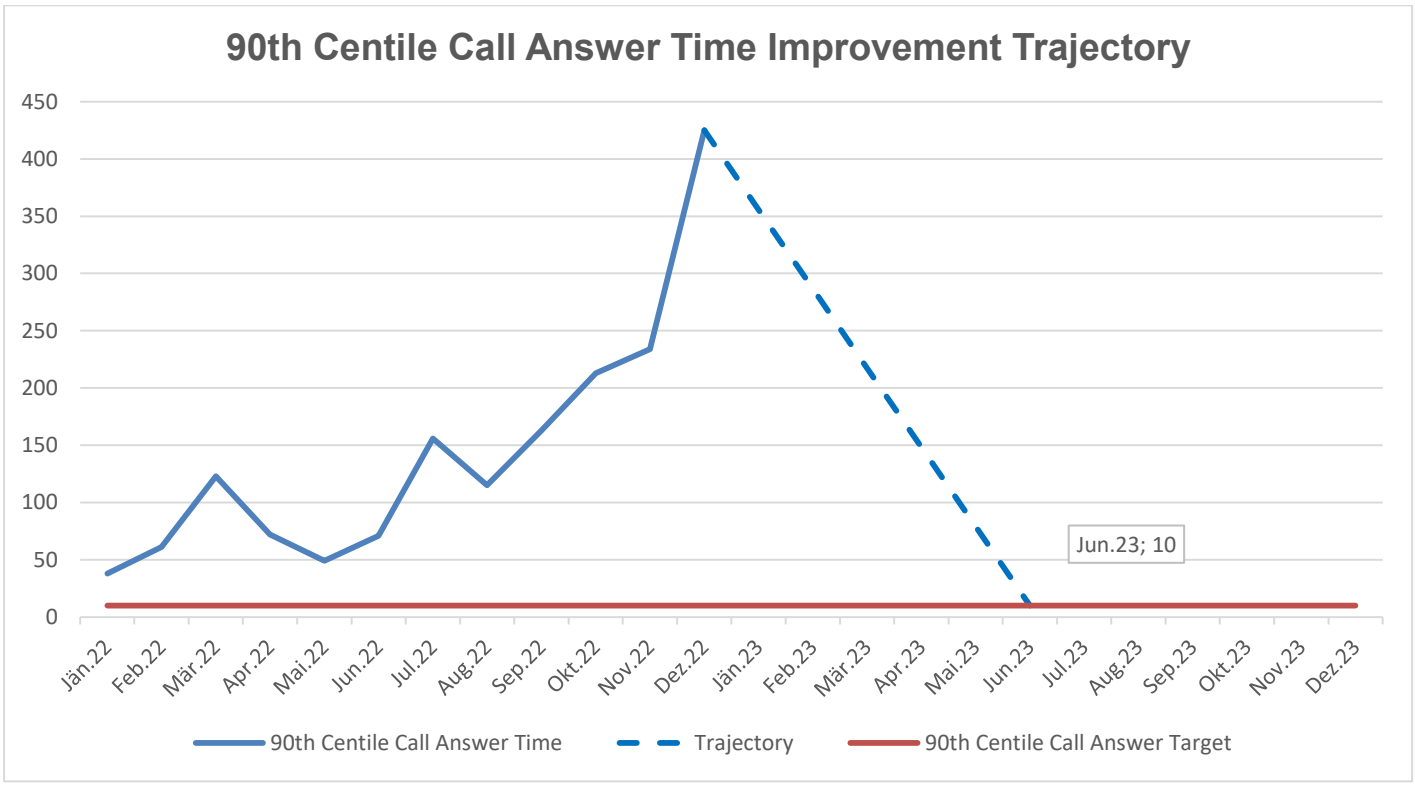
5.32. Looking at the recruitment increase and retention reduction scenario, where recruitment is increased by 7.9 WTE per month through recruitment uplift projects and retention is reduced by 5.7 WTE per month through turnover reduction projects, the graph below models that EMA establishment will meet target by June 2023:



5.33. When looking at the scenarios above as well as the fact that the EOC Call Handling Improvement Plan, the intent is to see performance improve to meet targets by the end of June 2023.

5.34. To track progress to target, the following trajectory is mapped to mean and 90th Centile call answer performance:

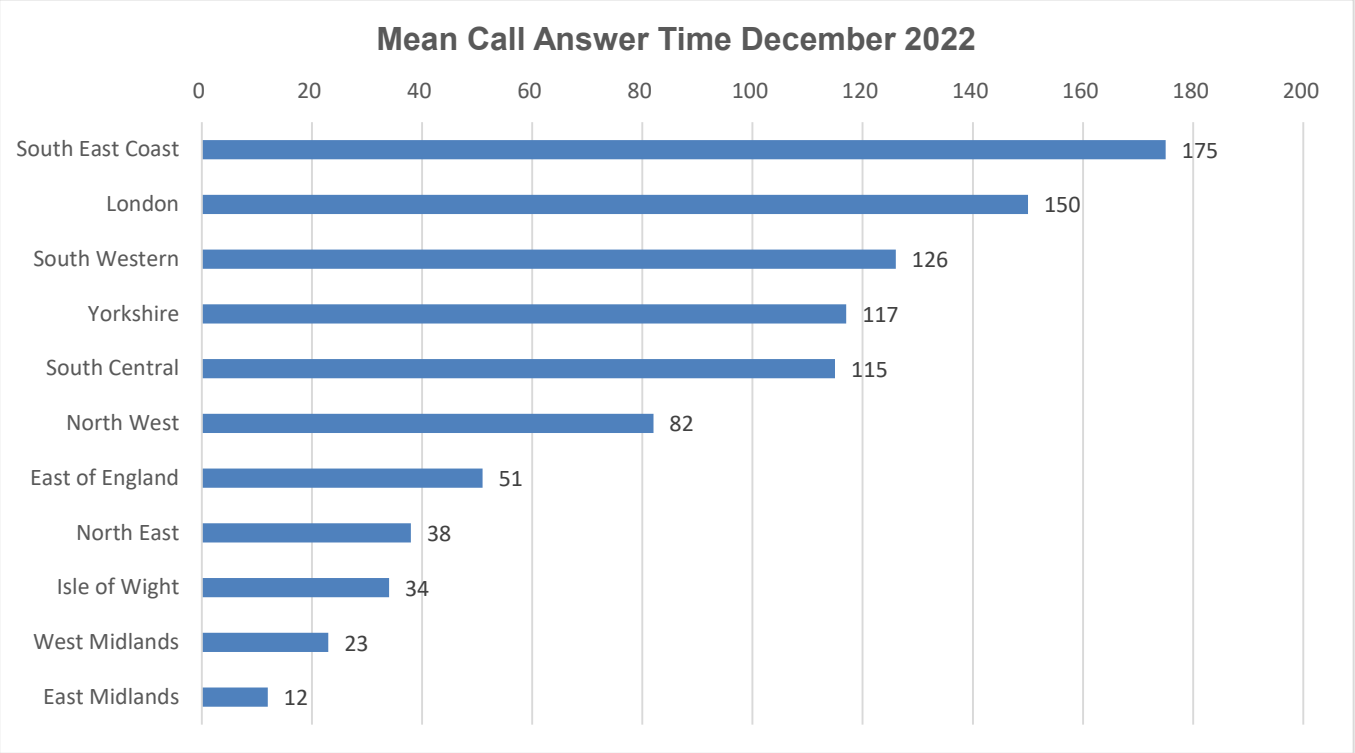




1. Conclusion

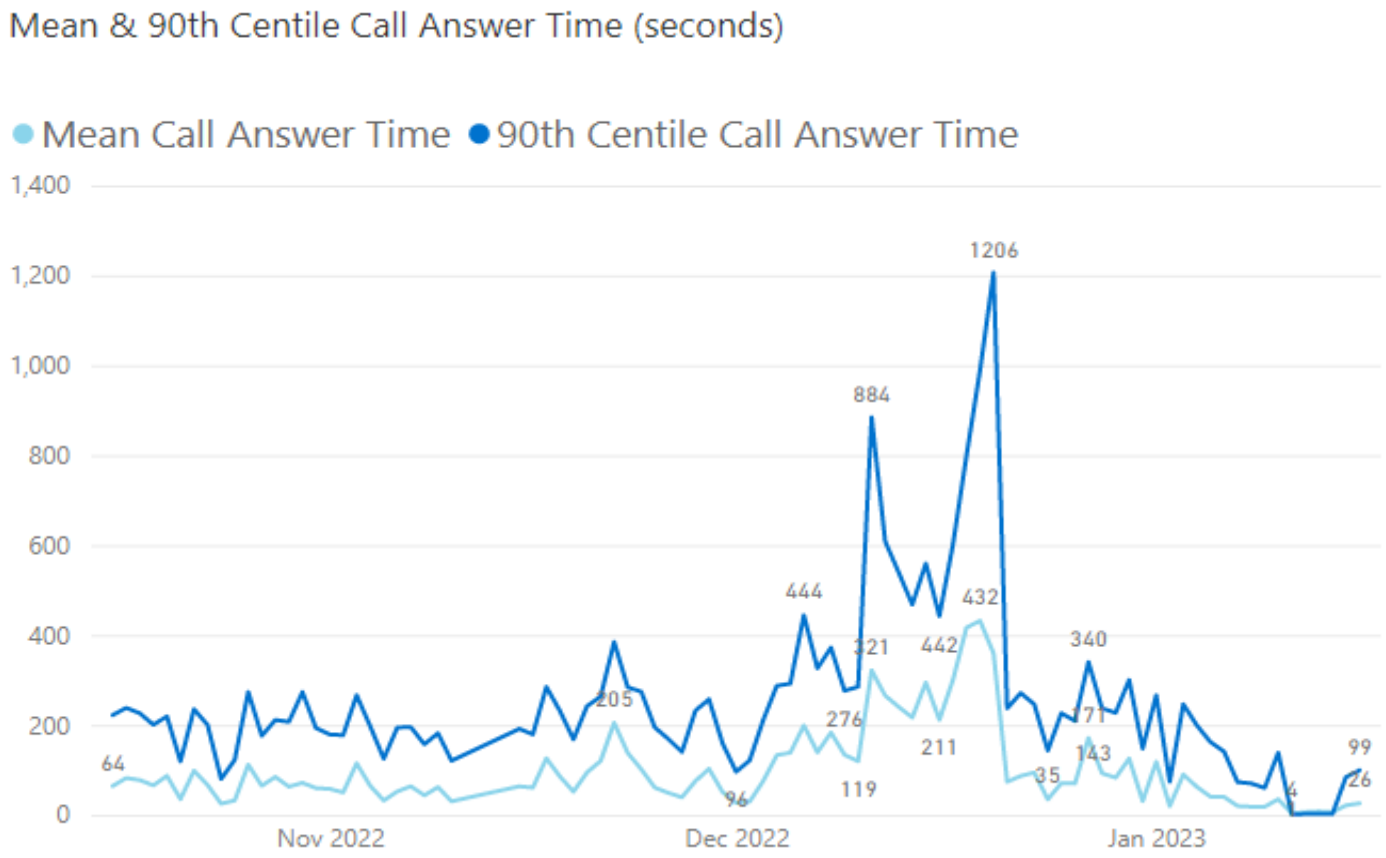
1.1. The board is asked to consider and discuss the contents of this paper and support the recommendations, or to recommend any further requirements, to ensure multi-directorate support, so that the service can consistently meet its 999 call answering ARP targets by the end of Q1 23/24.

2. Appendix A – Mean Call Answer Time December 2022



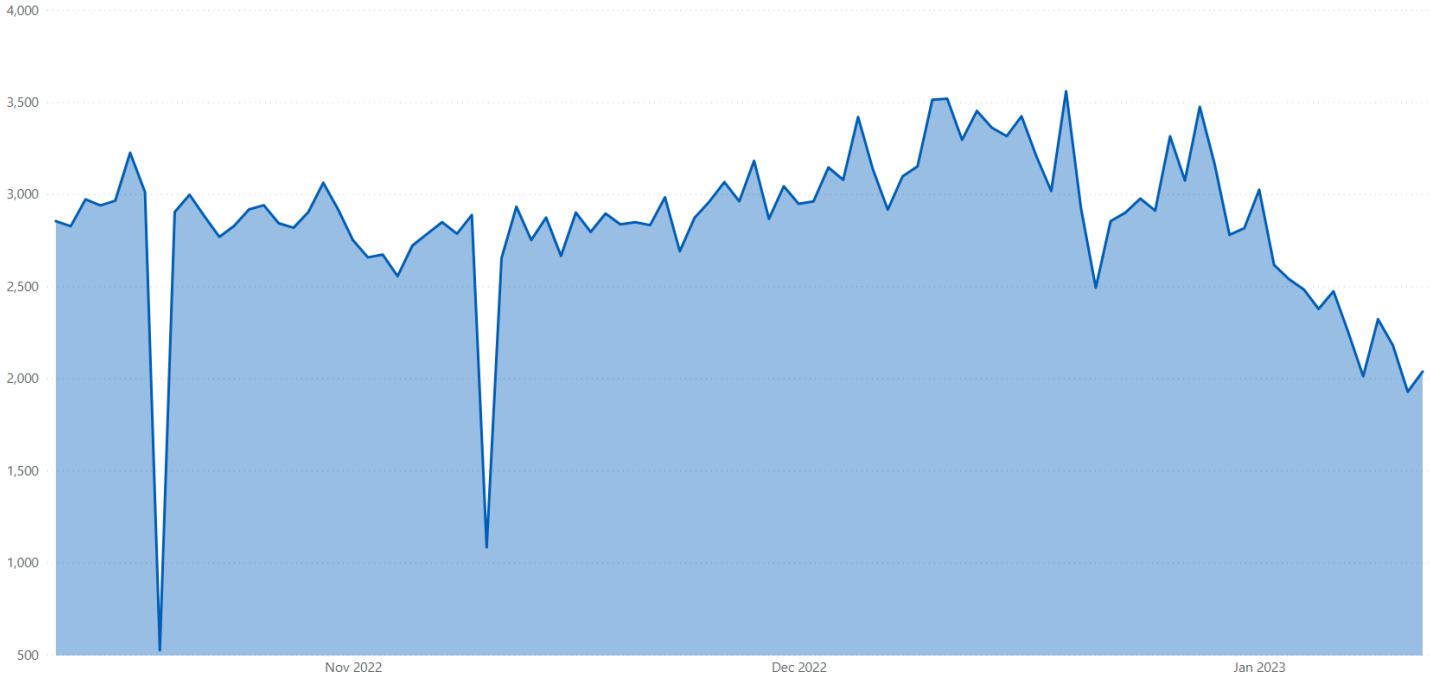
(link to return to reference)

3. Appendix B - Mean and 90th Centile Call Answer Rate per Day from 16th October 2022 to 16th January 2023 inclusive



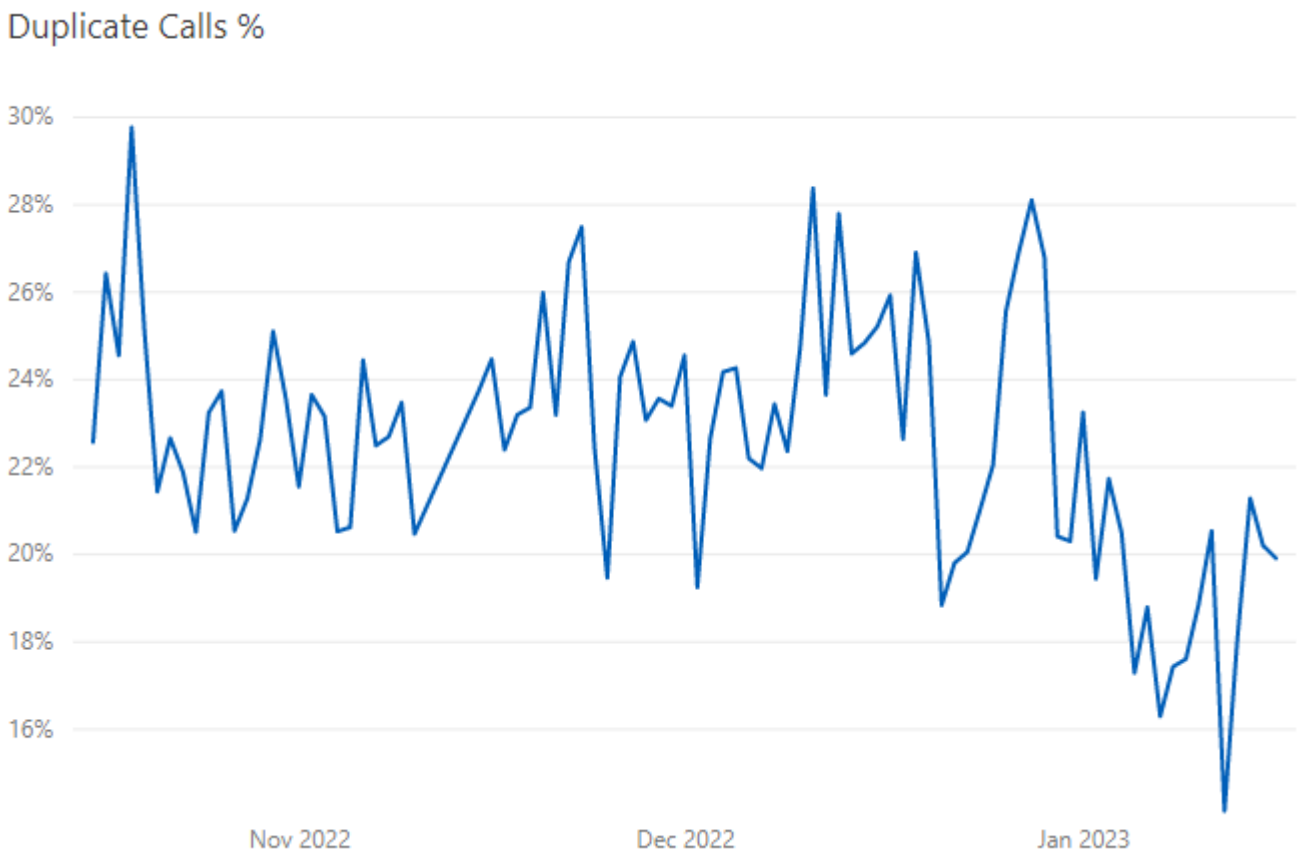
(link to return to reference)

4. Appendix C – Inbound Call Volume (16th Oct 2022 - 16th Jan 2023)



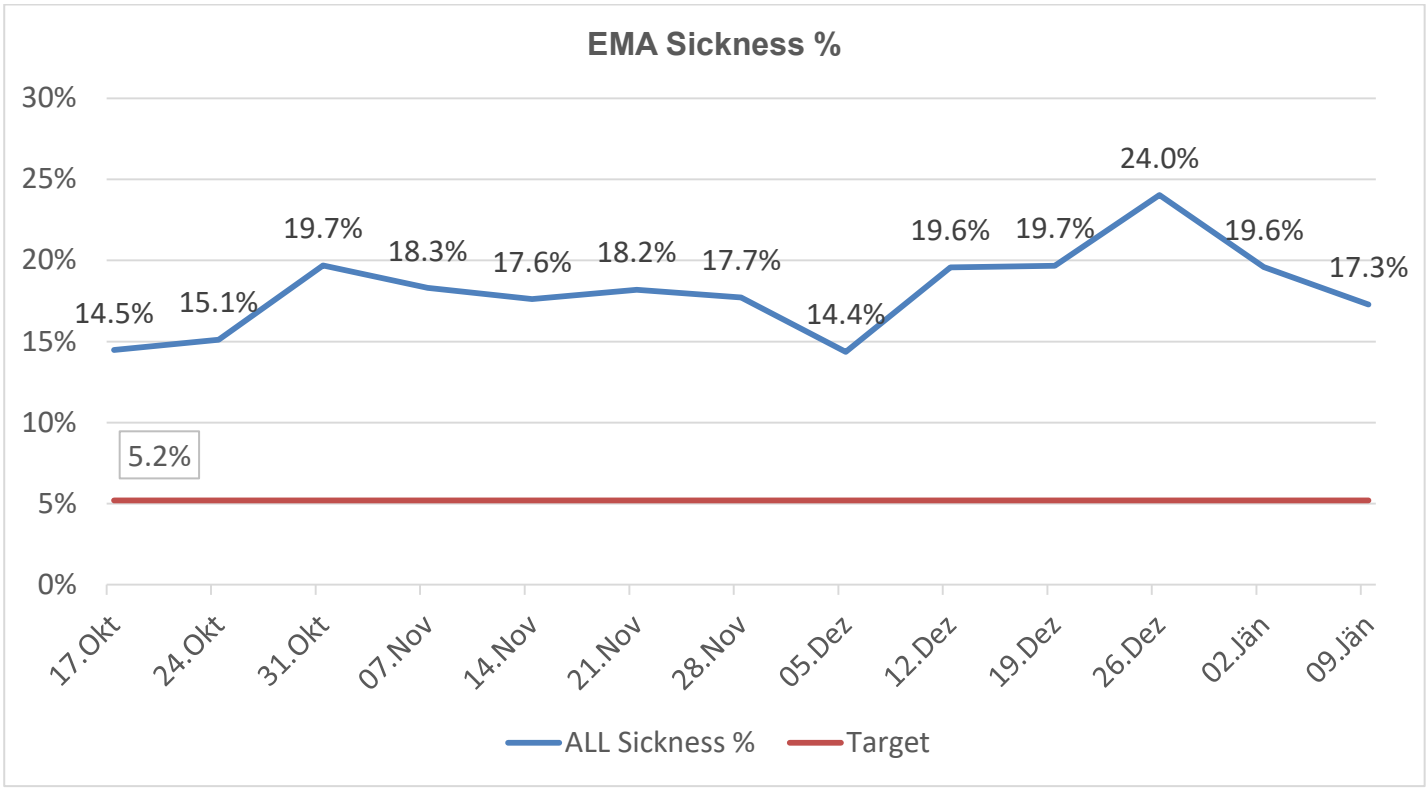
(link to return to reference)

5. Appendix D – Inbound Call Volume (16th Oct 2022 - 16th Jan 2023)



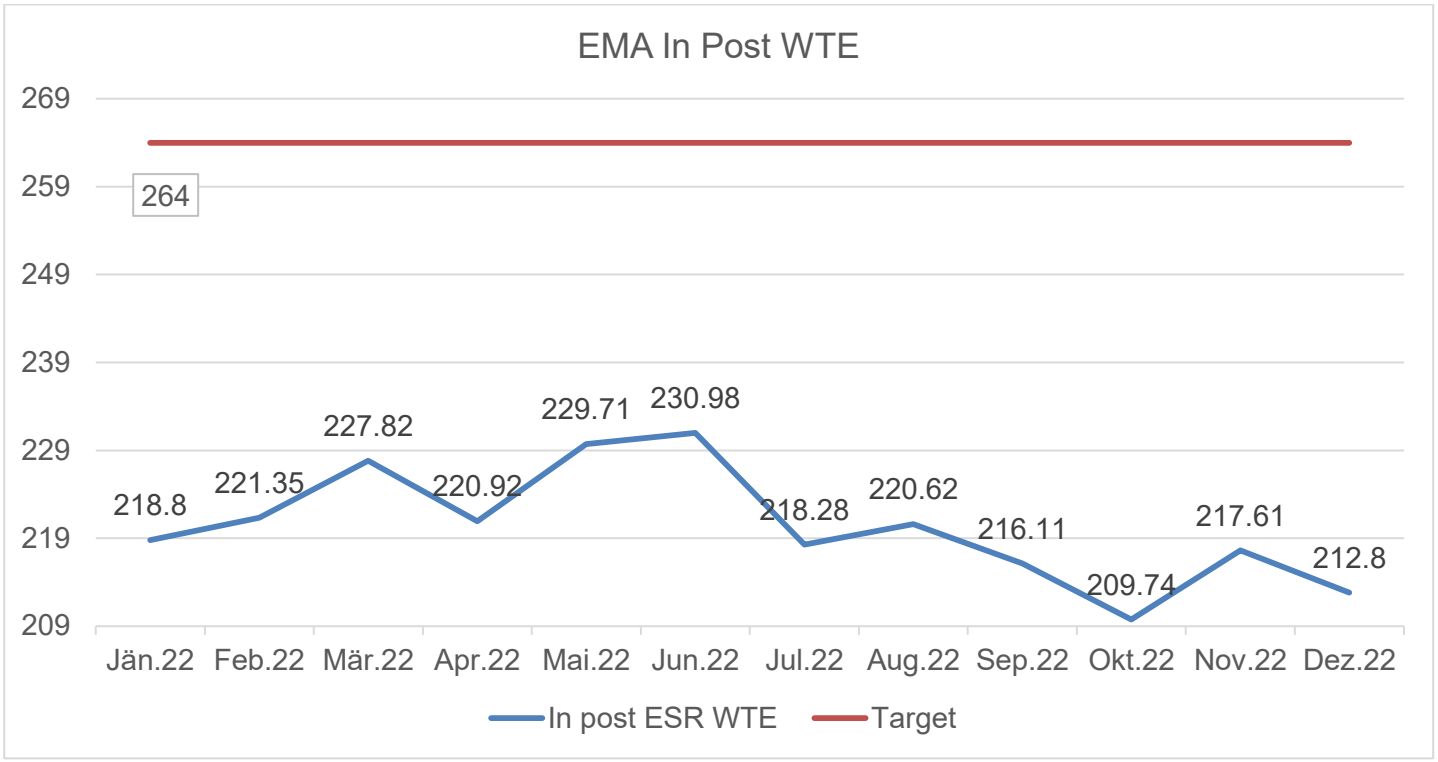
(link to return to reference)

6. Appendix E – EMA Sickness % (w.c. 17th Oct 2022 - w.c. 9th Jan 2023)



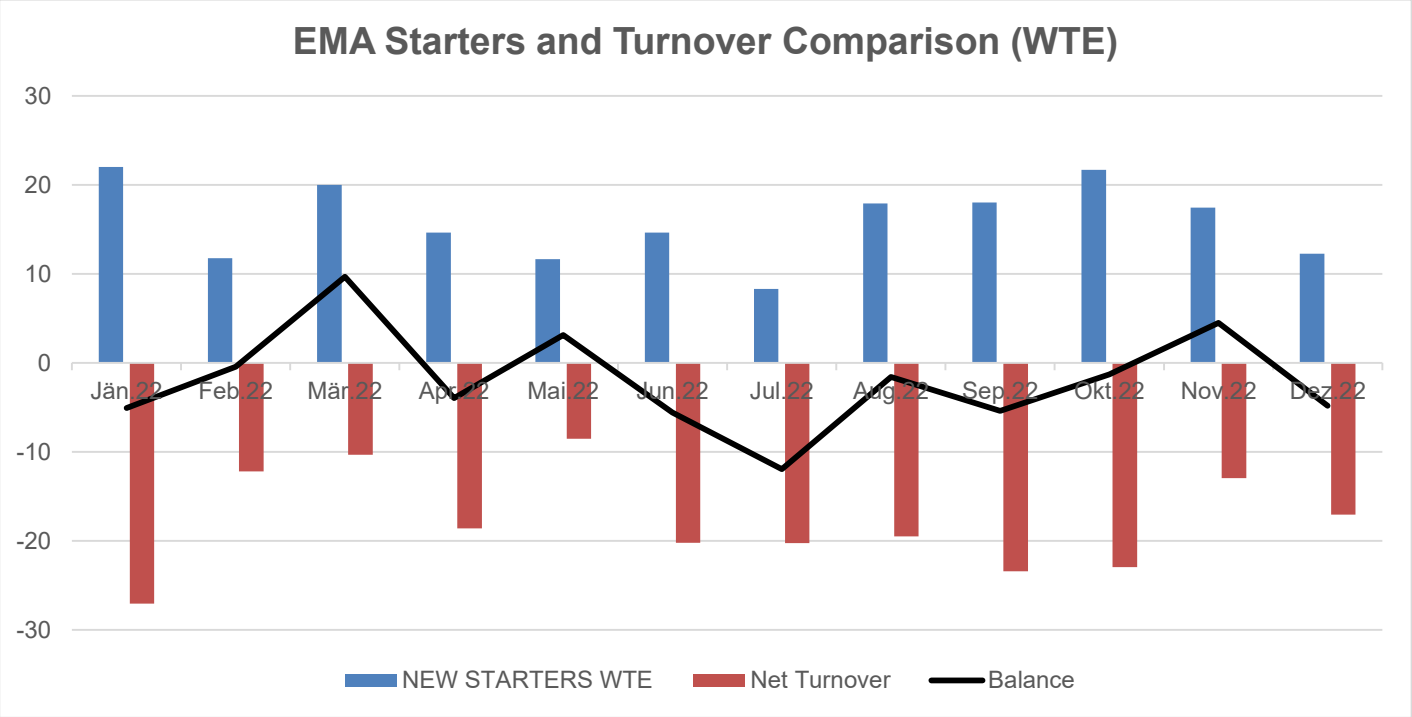
(link to return to reference)

7. Appendix F – EMAs In Post WTE (Jan 2022 – Dec 2022)



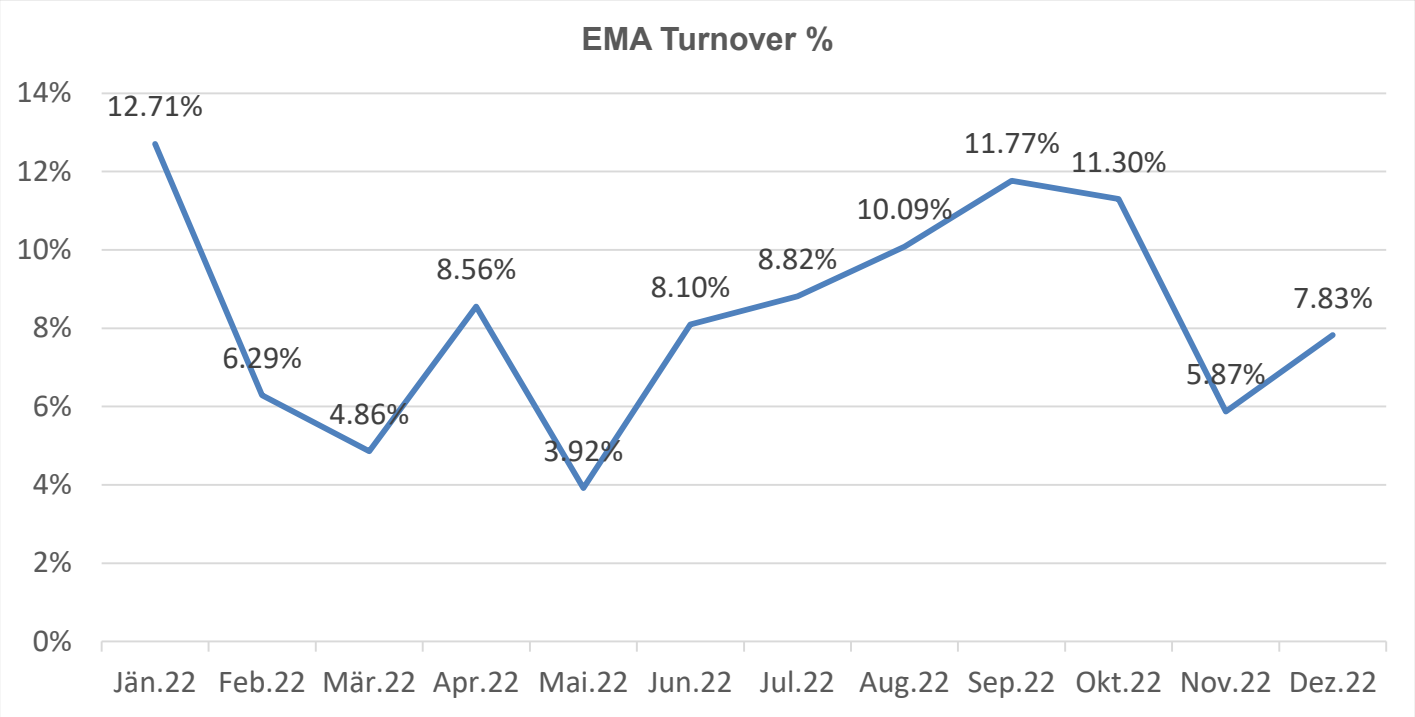
(link to return to reference)

8. Appendix G – EMAs Starters and Turnover Comparison (WTE, Jan 2022 – Dec 2022)



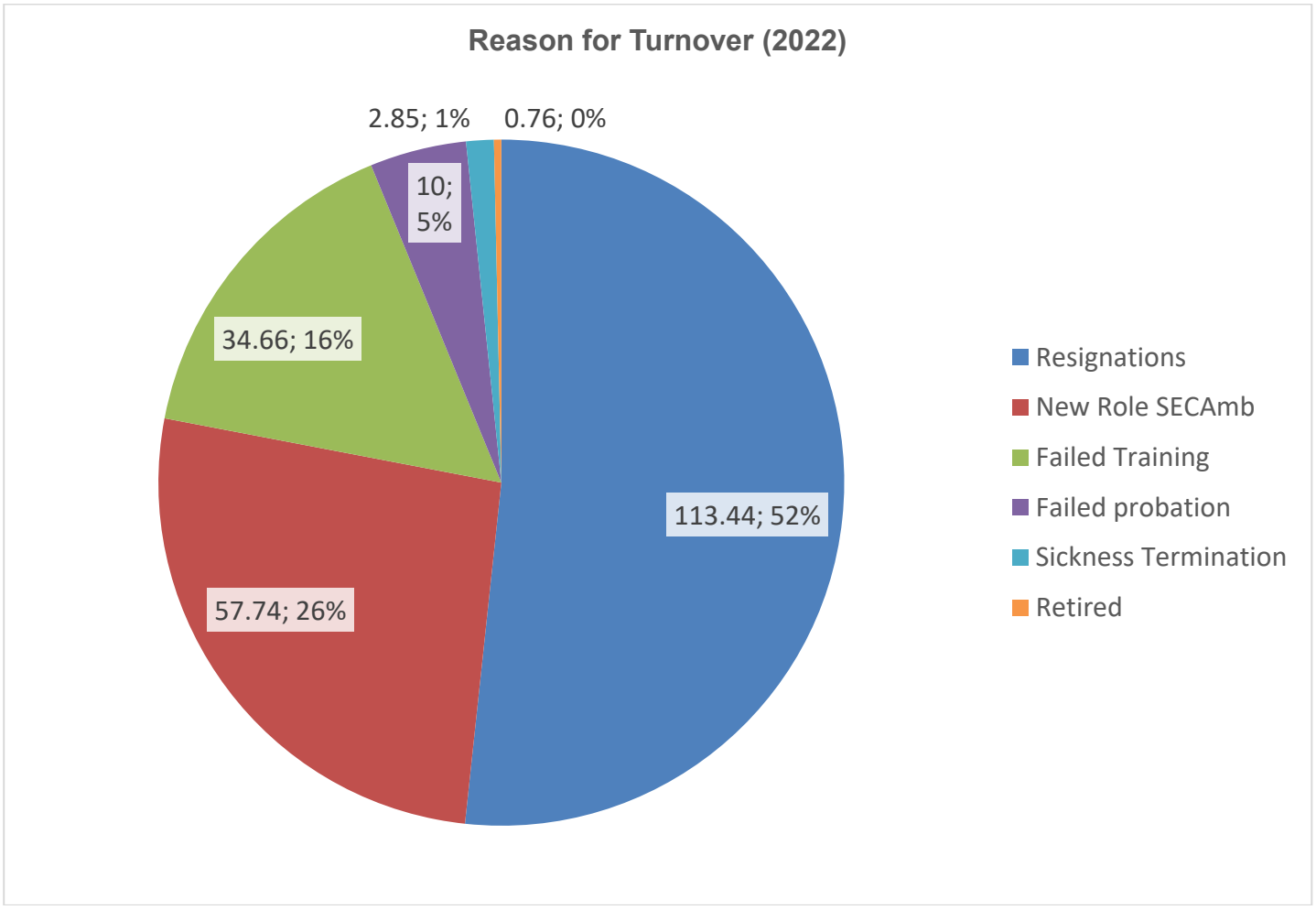
(link to return to reference)

9. Appendix H – EMA Turnover % (Jan 2022 – Dec 2022)



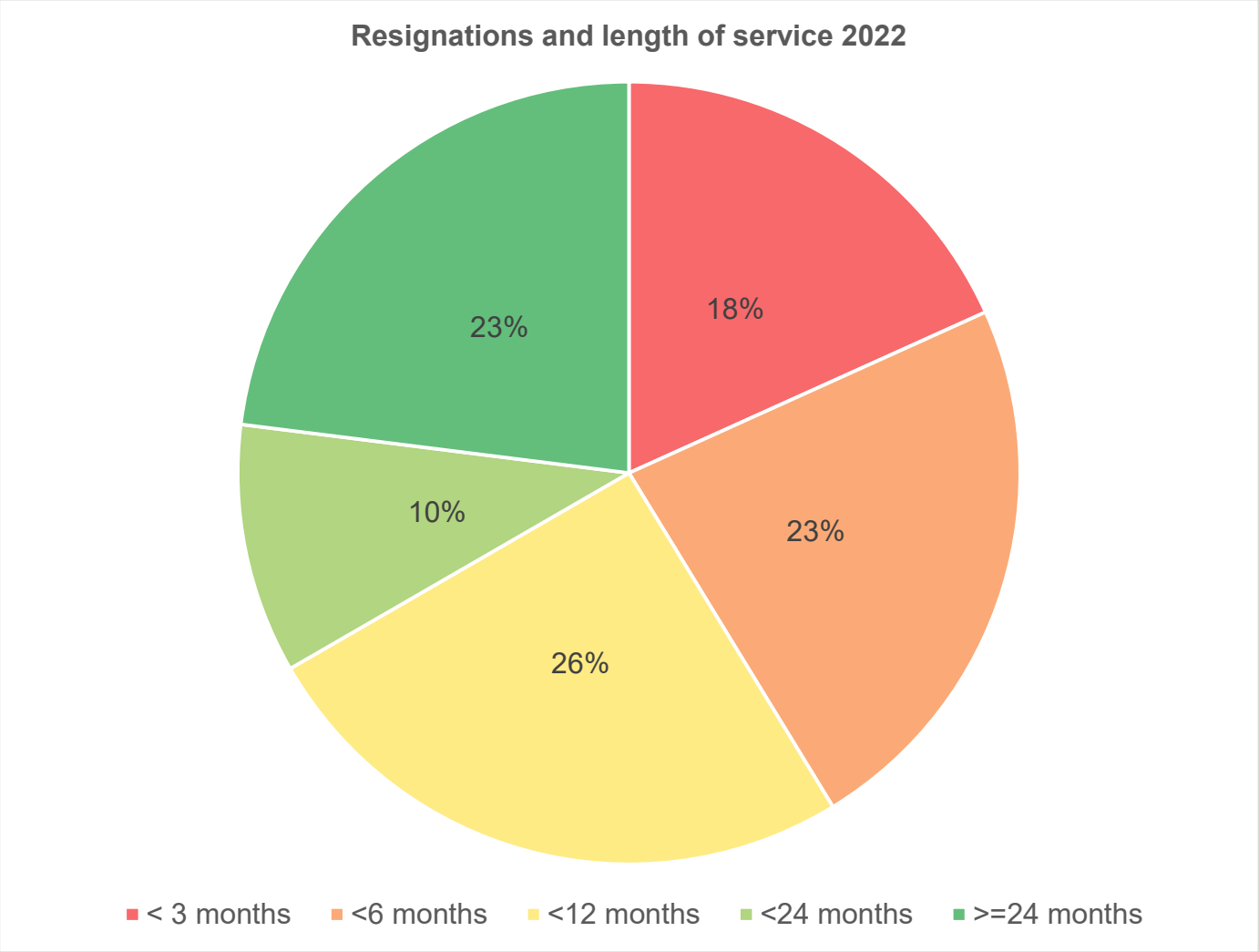
(link to return to reference)

10. Appendix I – EMA Reason for Turnover (2022)



(link to return to reference)

11. Appendix J – EMA Resignations (2022)



(link to return to reference)

12. Appendix K – "5 Whys" Style Evaluation of EOC Call Handling Performance Issues

Looking at EMAs in post as a key driver of performance, the following issues are identified, with those items going forward to projects highlighted in red:

- We do not have enough EMAs in post
  - We are not collecting enough recruits
    - Our pay in respect to living costs is not competitive
    - We are not seen by a lot of potential candidates as an attractive employer or an attractive sector
    - We are getting enough applications now
    - We are getting enough interviewees
    - We are not getting enough trainees
      - There were not enough recruits coming through training.
      - We are not filling courses
        - We are having significant issues with a timely employment compliance check turnaround
    - We are failing more trainees on the NHS Pathways course
      - There was an issue with trainees failing the course from an early assessment, following changes introduced by NHS Pathways. The course has been revised and this is being evaluated.
  - We are not keeping enough EMAs
    - We are losing EMAs due to burnout
      - There is too much work for the capacity we have available
        - We are not meeting productivity targets (UHU)
          - Service pressures
            - We have patients unable to access healthcare through formerly accessible routes (GP, A&E, 111 etc.)
            - We have Health Care Professionals (HCPs) unable to get through to SECAmb via the designated HCP line and are contacting 999 directly
              - This has necessitated the development of an Inter-Facility Transfer (IFT) Desk
              - System-wide service pressures
          - Duplicate calls
            - Duplicate calls increase when we are not meeting patient needs in a timely manner.
          - Patient presentations have included lower acuity symptoms and more complex calls, requiring longer assessments
          - Productivity targets were set pre-COVID and require review
        - Not enough recruits, sickness (explored earlier)
    - We are losing a lot of EMAs through "positive attrition"
      - A lot of EMA slots are held posts for secondments
      - A lot of EMAs join Field Operations as ECSWs (Emergency Care Support Workers) or other roles across then Trust
        - The pay is better
        - The options for progression are better

- A lot of EMAs become resource dispatchers
    - The pay is better
    - The workload is not seen as challenging
- A lot of EMAs join the training team
    - The pay is better
    - The hours are better

- We are not employing staff with the requisite resilience for the role
    - We are employing some staff with significant mental health and personal issues
        - We are an attractive organisation for candidates who seek a role in healthcare as a means of self help
            - We have a low barrier of entry and accessible
                - We are not scrutinising candidates looking for this role as a means of self help
                    - We are not undertaking psychometric testing
            - Although we are telling candidates, it is not in the nature of all candidates to listen and understand
        - We are not filtering out candidates with significant mental health issues
            - Under legislation we have to be an inclusive employer, but we have not set out occupational exclusions that would disqualify a candidate for application.
                - We are not conducting psychometric testing
                    - There was no appetite for psychometric testing. We have conducted numerous working groups, but have been blocked from an equality and diversity perspective

Looking at sickness as a key driver of performance, the following issues are identified:

- We have too many EMAs unable to work because of sickness
    - Service pressures causing burnout
        - EMAs are taking on the “baggage” of demand, leading to “moral injury”
            - EMAs are not being given the trust and environmental safety to support their duties
    - We have staff that are susceptible to degradation in mental health associated with their pre-existing condition, as indicated above
    - We continue to be impacted by COVID symptom related absences
        - We continue to use modified absence management frameworks brought in during the COVID pandemic.
            - These are the agreed frameworks set out by Trust, via HR and staff side

Looking at rota effectiveness as a key driver of performance, the following issues are identified:

- Rotas are ineffective
    - Rotas were created 10 years ago and are incompatible with current demand
        - Patterns include 5 consecutive shifts
        - There are short turnarounds from day to night
        - Staff don’t want to work nights
            - Nights are not pleasant to work for our staff

        - Night work goes against conventional circadian rhythm
        - We haven't tried advertising exclusive night working
    - There have been attempts to arrange rota reviews, but they have stalled
        - Most recently, Banstead rota staff who have allocated leave need individual consultation because of legacy issues

(link to return to reference)

13. Appendix L – EOC Call Handling Improvement Plan - Gannt Chart

	Task Name	Jan 1	Jan 8	Jan 15	Jan 22	Jan 29	Feb 5	Feb 12	Feb 19	Feb 26	Mar 5	Mar 12	Mar 19	Mar 26	Apr 2	Apr 9	Apr 16	Apr 23	Apr 30	May 7	May 14	May 21	May 28	Jun 4	Jun 11	Jun 18	Jun 25
		Jan				Feb				Mar					Apr				May					Jun				
1	RAID Log																										
2	EOC Call Handling Improvement Plan																										
3	Recruitment																										
4	Meet with Employee Resourcing and Training and Development																										
5	Time to hire turnaround																										
6	Review and reduce time to hire turnaround																										
7	Implement actions to reduce time to hire																										
8	1 month review Checkpoint																										
9	Implement any additional actions to reduce time to hire																										
10	2 month review Checkpoint																										
11	Training course efficiency																										
12	Review training course efficiency and maximise rate of return																										
13	Implement actions to improve training course efficiency																										
14	1 month review Checkpoint																										
15	Implement actions to improve training course efficiency																										
16	2 month review Checkpoint																										
17	Night working recruitment pilot																										
18	Retention																										
19	Meet with Human Resources and EOC Management																										
20	Psychometric Testing																										
21	EOC Call Handling Retention Premia																										
22	Develop BC Template																										
23	Sign off of BC template at SMG																										
24	Complete Business Case																										
25	FBP / Project Accountant Review																										
26	Other departments review																										
27	Exec Sponsor and ADF review and support																										
28	Finalise Business Case																										
29	Present to next BCG																										
30	Submission to EMB																										
31	SEMA uplift pilot																										
32	Evaluate sickness and turnover of SEMA cohort																										
33	If feasible, implement actions to increase SEMA cohort																										
34	1 month review Checkpoint																										
35	If feasible, implement actions to increase SEMA cohort																										
36	2 month review Checkpoint																										
37	Process / Efficiencies																										
38	Triage Cut Off Tool																										
39	Inter-Facility Transfer (IFT) Desk																										
40	Evaluate the benefits of the desk to date																										
41	Train next cohort																										
42	2 month review Checkpoint																										
43	Other Considerations																										
44	Schwartz Rounds																										

(link to return to reference)

Item No	87-22

Name of meeting	Trust Board
Date	2 February 2023
Name of paper	Finance Report
Executive sponsor	Martin Sheldon Interim Chief Financial Officer
Authors	Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Finance Management), Kevin Steer (Head of Financial Accounting & Compliance), Rachel Murphy (Financial Manager - Projects, Business, and Investments)
Synopsis	This report provides an update on the Trust's Financial Position for Month 9 as at 31 December 2022. The Trust is reporting a year-to-date deficit of £2.4m, £1.4m greater that the original plan of £1.0m for the year to date. The forecast breakeven position for the year to 31 March is based on two current workstreams: 1. We have made substantial progress to reduce overspends and identify savings, vis the costs review programme we have rolled out and continue with all the Directorates. The work to date has identified at least £6.0m of savings (compared to the revised deficit of £8.9m). We will continue the work and are confident we will be able to identify the remaining £0.9m to reduce the year end deficit to £2.0m. We will continue the review work with each Directorate for the remainder of the year to maximise the recurrent savings. 2. We are also reviewing all non-recurrent opportunities to reduce the overall deficit to breakeven. We will update the Trust Board once we are confident of all the issues and risks. The break-even forecast position is a requirement of the SE Region, our challenge is to close the gap to close to breakeven, if possible. We also need to emphasise recurrent savings over non-recurrent. Whilst our cash position at the start of the financial year was higher than planned due to the timings of receipts and payments since then we have been eroding our Cash Reserves. Our current Cash Balance decreased by £0.7m to £34.2m in the month and remains £2.8m (7.6 per cent) below plan despite Capital expenditure being £6.4m less than plan, and it is predicted to drop to £33.0m by year end. This emphasises the need to return to generating cash surpluses to rebuild our cash reserves and review and constrain our current Long Term Capital Plan during the current planning process.
Recommendations, decisions, or actions sought	The Board are asked to note the financial performance against plan, the steady improvement to recover this year's outturn position and the medium-term impact on Cash Reserves. The detailed work on the financial recovery continues and will be reported in a revised assessment each month through to year end.

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies,	**N/A**

policies, procedures, guidelines, plans and business cases).	

2022/23
Finance Report to the Board of Directors
9 Months to 31 December 2022

Contents

Executive Summary

Values are shown in millions and are subject to rounding.

	Year to December 2022				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Income	£222.9m	£226.8m	£3.9m	✓	£297.0m	£305.4m	£8.4m	✓
Expenditure	£227.4m	£228.6m	(£1.2m)	✗	£304.9m	£307.5m	(£2.6m)	✗
Flexibility/Savings Required^	(£3.5m)	£0.0m	£3.5m	✓	(£7.9m)	(£2.7m)	£5.2m	✓
Trust Surplus / (Deficit)	**(£1.0m)**	**(£1.8m)**	**(£0.8m)**	✗	**£0.0m**	**£0.6m**	**£0.6m**	✓
System 'Control' Adjustments	£0.0m	(£0.6m)	(£0.6m)	✗	£0.0m	(£0.6m)	(£0.6m)	✗
Reported Surplus / (Deficit)*	**(£1.0m)**	**(£2.4m)**	**(£1.4m)**	✗	**£0.0m**	**£0.0m**	**£0.0m**	✓
Efficiency Programme	£3.4m	£0.9m	(£2.5m)	✗	£5.6m	£3.3m	(£2.3m)	✗
Cash	£37.0m	£34.2m	(£2.8m)	✗	£40.9m	£33.0m	(£7.9m)	✗
Capital Expenditure	£27.5m	£21.1m	£6.4m	✓	£36.1m	£31.8m	£4.3m	✓

^Planned Flexibilities were expected from non-recurrent methods; the reduction in the forecast is a result of Directorate financial recovery reviews.

*Reported Surplus / (Deficit) represents the system (Control total) position, reconciliation provided separately

Year to date

- The Trust is reporting a £2.4m deficit for the year to December 2022, £1.4m adverse to plan. The impact of the £1.3m reduction from the 999-contract is being mitigated by a combination of additional income and reduced expenditure following Directorate reviews.

- Formal Efficiency savings remain £0.9m year to date, which is £2.5m adverse to plan. This is because of the lack of a structured Trust-wide delivery plan. This year the issue is being addressed by the Directorate Financial Recovery reviews which are currently ongoing. As a result, we are confidence we can reduce the reforecast year end deficit to £2m and are looking at non-recurrent means to achieve the SE region required overall breakeven position for the year.

- The cash position dropped by £0.7m in month to £34.2m. This is £2.8 below plan; the Trust is currently pursuing a further £6.7m of receipts relating to both the 111 and 999-contract income.

- Capital expenditure of £21.1m is £6.4m lower than plan due to slippage on Medway Make Ready centre and delays in fleet spend.

Forecast Outturn

- As required by SE Region we have reported an overall forecast break-even as planned. They are aware that is dependent on us identifying £2.0m of non-recurrent measures to compensate for the income withdrawn by Surrey ICB in September 2022.

- The present Directorate Financial Recovery review process is making significant inroads into identifying cash releasing savings in year. This has resulted in approximately £6.0m of savings reduction from the reforecast year end deficit of £8.9m.

- Continued focus on ensuring all areas meet their agreed savings targets is in progress to generate the further savings required to meet the breakeven forecast position.

- Planning for 2023/24 continues and this will be update by a separate Report.

Financial Recovery

- The Trust is engaged in a Directorate Financial Recovery process, the table below summarises the current actions being undertaken:

Ongoing Cost Control	Other saving opportunities

• **Executive Directors review challenges are in progress. The third phase meetings are from 23rd – 30th January, with regular monthly follow up meetings covering:**
  • **Achievement of financial plan**
  • **Further improvement of financial forecasts through a deep dive of current run rates**
  • **Monitoring current vacancies**
  • **Recurrent cash releasing savings**
  • **Stopping unfunded and non-essential business cases.**
	• Review and analysis of balance sheet flexibilities to determine ability to support the position non-recurrently.

The following provide further detail of the elements of the financial position.

1. Income

	Year to December 2022				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
999 Income	£199.6m	£198.2m	(£1.3m)	✗	£265.9m	£264.1m	(£1.8m)	✗
111 Income	£14.9m	£19.4m	£4.6m	✓	£19.8m	£29.2m	£9.3m	✓
HEE Income	£1.1m	£1.3m	£0.2m	✓	£1.4m	£2.0m	£0.6m	✓
Grant Income	£0.0m	£0.3m	£0.3m	✓	£0.0m	£0.3m	£0.3m	✓
Covid Income	£5.6m	£5.6m	£0.0m	✓	£7.4m	£7.4m	£0.0m	✓
Other Income	£1.8m	£2.0m	£0.2m	✓	£2.9m	£2.4m	(£0.4m)	✗
Total Income	**£222.9m**	**£226.8m**	**£3.9m**	✓	**£297.4m**	**£305.4m**	**£8.0m**	✓

- 999 income less than plan because of the Integrated Care Board (ICBs) proposed block contract value, which is overall likely to be approximately £1.8m less than planned (£1.3m year to date).

- 111 income greater than plan due to the agreement reached with commissioners in funding additional resources and SVCC (Single Virtual Contact Centre). This supports the additional expenditure currently seen in 111
    - SVCC (Single Virtual Contact Centre) funding is £3.3m and is subject to us meeting the recruitment of the required call handling staff to join the South-East SVCC in January.
    - Agreement has been reached where Vocare will take circa 3,000-3,500 calls per week (c.15%) between 6.00am to 10.00pm to help support our call answering performance whilst we plan for the SVCC
    - It is noted that the demand in December 2022 has seen a significant increase following concerns of Strep A, and the cold weather impacting people's health; this is being seen nationally across all providers and continues into the new year.

- HEE income increased due to additional placement and salary support allocations as per HEE schedules.

- Grant income received from councils for Banstead Make Ready and Birdham Place ACRP.

- Other income variance dominantly relates to SORT (specialist operational response team), this is forecast to be £0.8m below plan (£0.5m year-to-date). This is linked to being able to train staff, and the corresponding expenditure, such training has been impeded due to the delays in recruiting trainers and the lower than hoped applicants to the role. Mitigating this is additional income in relation to International Paramedic Recruitment. Both sources of income are reflective of relevant expenditure. An additional £0.2m was received in respect of the work undertaken for the 999 Intelligent Routing Platform (IRP).

2. Expenditure

By Directorate	Year to December 2022				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Chief Executive Office	£2.5m	£2.8m	(£0.3m)	✗	£3.3m	£3.7m	(£0.4m)	✗
Finance	£21.0m	£20.6m	£0.3m	✓	£28.1m	£28.0m	£0.1m	✓
Quality and Safety	£2.2m	£2.1m	£0.0m	✓	£2.9m	£2.9m	£0.0m	✓
Medical	£9.2m	£7.9m	£1.4m	✓	£12.7m	£10.8m	£1.9m	✓
Operations	£136.3m	£131.7m	£4.6m	✓	£181.9m	£177.2m	£4.7m	✓
Operations - 111	£14.9m	£22.0m	(£7.1m)	✗	£19.9m	£29.8m	(£9.9m)	✗
Planning & Business Development	£21.4m	£21.6m	(£0.2m)	✗	£29.0m	£28.3m	£0.7m	✓
Human Resources	£3.7m	£3.8m	(£0.1m)	✗	£4.9m	£4.9m	£0.0m	✓
Total Directorate Expenditure	**£211.2m**	**£212.5m**	**(£1.3m)**	✗	**£282.6m**	**£285.5m**	**(£2.9m)**	✗
Covid	£3.6m	£4.2m	(£0.6m)	✗	£4.8m	£5.9m	(£1.1m)	✗
Depreciation^	£7.7m	£7.0m	£0.8m	✓	£10.2m	£9.5m	£0.8m	✓
Financing Costs	£1.8m	£0.9m	£0.8m	✓	£2.3m	£1.5m	£0.8m	✓
Corporate Expenditure	(£0.3m)	£4.0m	(£4.3m)	✗	(£2.5m)	£2.4m	(£4.9m)	✗
Total Expenditure	**£223.9m**	**£228.6m**	**(£4.7m)**	✗	**£297.4m**	**£304.8m**	**(£7.4m)**	✗

^Depreciation excludes Rights of Use Asset depreciation, currently show n as part of directorate values (e.g. ambulance leases)

Year to date performance against plan

- Total year to date expenditure of £228.6m is £4.7m adverse to plan. The full year forecast of £304.8m is expected to exceed plan by £7.4m.

- The net overspend is driven by the higher than planned costs in NHS 111 of £7.1m, because of the increased demand, which partly corresponds to the additional income mentioned above. The extra pressure is due to the considerable requirement of agency clinicians and overtime to facilitate safe service delivery while resourcing is in a more challenged position while abstraction levels remain high. The year-to-date average abstraction is tracking at 35.6 per cent including sickness of 18.1 per cent. The Trust has reached an agreement with Commissioners to secure the investment required up to March 2024 to sustain the expansion in the service arising from increased demand.

- Further mitigation is realised through the savings generated from reduced operating unit hours as total Operating Unit pay expenditure, was £2.5m below plan. The overall provision of hours continues to be challenging and was below plan by 17.6 percent in December, the worse in the year. This means the year-to-date provision of frontline hours was 12.1 per cent adverse to plan.

- Planned provision of substantive staff hours declined to 11.4 per cent below plan year to date since recruitment remains increasingly challenging together with higher than planned attrition rates. Although, we saw a slight improvement in abstraction levels in quarter three, the year-to-date abstraction remains high at 33.6 per cent compared to the plan of 31.0 per cent. This is because sickness levels including Covid of 10.8 per cent, exceeds target by 2.8 per cent.

- The year-to-date mix of hours led to an overall productive hourly rate (based on hours 'on the road') of £37.68, (£38.25 including incentive payments that ceased from 1 September).

This is 6.8 per cent adverse to plan due to the increased abstraction levels, partially offset by 11.1 per cent favourable private ambulance rate.

- The overall lower than planned recruitment is driving the corresponding underspends across other expenditure categories notably, education and training costs of £1.1m and related reduction in travel spend.

- Higher spend on clinical supplies of £0.8m relating to the timing of replacement of scoops, carry chairs and modems in LIFEPAKs is mitigated by various spend categories, notably establishment (largely telephony & radio communication) and finance costs.

- Depreciation and Rights of Use are also below plan by £1.8m due to delays in both capital projects and new (ambulance) leased assets.

The table below shows the Trust expenditure as categorised by NHS England as part of the Provider Financial Return (PFR).

NHSEI Categories	Year to November 2022				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Pay/Staff Costs	£156.3m	£164.4m	(£8.1m)	✗	£204.7m	£218.4m	(£13.7m)	✗
Depreciation (including Rights of Use Assets)	£14.5m	£12.7m	£1.8m	✓	£19.5m	£17.3m	£2.2m	✓
Premises Costs	£12.4m	£12.2m	£0.2m	✓	£16.6m	£16.5m	£0.1m	✓
Transport Costs	£12.7m	£12.3m	£0.4m	✓	£17.5m	£16.4m	£1.1m	✓
Purchase of Healthcare (PAPs;IC24;HEMS)	£10.9m	£10.4m	£0.5m	✓	£14.6m	£13.9m	£0.7m	✓
Supplies and Services	£6.7m	£7.5m	(£0.8m)	✗	£8.9m	£9.8m	(£0.9m)	✗
Establishment	£4.0m	£3.2m	£0.8m	✓	£5.4m	£4.4m	£1.0m	✓
Education Costs	£2.0m	£0.9m	£1.1m	✓	£3.1m	£1.6m	£1.5m	✓
Operating Lease Expenditure	£1.7m	£1.3m	£0.4m	✓	£2.4m	£1.8m	£0.6m	✓
Finance Costs	£1.4m	£0.9m	£0.5m	✓	£2.0m	£1.5m	£0.5m	✓
Clinical Negligence (CNST)	£1.4m	£1.4m	£0.0m	✓	£1.6m	£1.5m	£0.1m	✓
Gains / Losses on Asset Disposal	£0.0m	(£0.3m)	£0.3m	✓	£0.0m	(£0.3m)	£0.3m	✓
Other	(£0.1m)	£1.7m	(£1.8m)	✗	£1.1m	£2.0m	(£0.9m)	✗
Total Expenditure	**£223.9m**	**£228.6m**	**(£4.7m)**	✗	**£297.4m**	**£304.8m**	**(£7.4m)**	✗

Full year performance against plan

- £9.9m of the full year adverse staff cost variance of £13.7m relates to the additional resources agreed for 111 after budget setting corresponding with income as detailed in page 5.

- Depreciation and Rights of Use are forecast to be £2.2m lower than planned due to delays in both capital projects and new (ambulance) leased assets.

- Higher projected supplies & services spend is due to the replacement of scoops, carry chair and 4g modems in LIFEPAKs in compliant with safety standards.

- Transport costs and Operating Leases are expected to be below plan due to the steady reduction in fuel prices together with maintenance costs and the purchase of fleet vehicles rather than the leasing planned.

- Lower than anticipated education costs correspond with the recruitment challenges and high levels of attrition.

3. System 'Control' Adjustments

Reconciliation to system reported position	Year to December 2022	Forecast to March 2023
Trust Surplus / (Deficit)	(£1.8m)	£0.6m
System 'Control' Adjustments:		
Gains on Sale of Assets	(£0.3m)	(£0.3m)
Grant Income	(£0.3m)	(£0.3m)
Remove Impact of Donated Assets	£0.0m	£0.0m
Reported Surplus / (Deficit)	**(£2.4m)**	**£0.0m**

- The above table shows the adjustments made to the Trust's financial position to the system reported position.

- This is a requirement from NHS England and removes those elements that are not influenced by the system, for example the sale of land and buildings.

4. Efficiency Programme

	Year-to-Date				Annual	Delivery Gap - Jan 2023 to Mar 2023	
	Plan	Actual	Variance		Plan	Actual	
	£000	£000	£000		£000	£000	
Directorates							
Medical	301	6	(294)	⊗	402	(396)	⊗
Operations	1,897	248	(1,649)	⊗	3,412	(3,164)	⊗
Planning and Business Development	252	23	(229)	⊗	452	(429)	⊗
Finance & Corporate Services	713	561	(153)	⊗	985	(424)	⊗
Trust Board & Exec Directors	77	46	(31)	⊗	105	(59)	⊗
Quality and Nursing	63	0	(63)	⊗	87	(87)	⊗
HR	113	11	(102)	⊗	155	(144)	⊗
Total	**3,417**	**896**	**(2,521)**	⊗	**5,598**	**(4,702)**	⊗

The delivery of the original efficiency target is high risk, but we are focusing effort on the Financial Recovery reviews to identify savings plans.

- The Trust's efficiency target for the financial year of £5.6m represents 1.9 per cent of operating expenses.
- Year-to-date achievement remains £0.9m, which 73.8 per cent below plan.
- The £2.5m shortfall is due to non delivery of planned operational efficiencies.
- 16 per cent of the efficiency target of £5.6m are fully validated and will be achieved recurrently. The delivery of the £4.7m outstanding improvements remain challenging but mitigations are in place to realise them non recurrently or through the newly initiated review process. £1.6m schemes are scoped with £3.1m proposed and under development.
- Greater focus on this area is in place to drive productivity improvements and to promote an efficiency improvement culture.
- Engagement with stakeholders is in progress and we will have a new process focussing on sustainable efficiencies for next year as part of the 2023/24 planning process in line with the Trust's Improvement Journey.

5. Covid

	Year to December 2022				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Covid Income	£5.6m	£5.6m	£0.0m	✓	£7.4m	£7.4m	£0.0m	✓
Covid Expenditure	£3.6m	£4.2m	(£0.6m)	✗	£4.8m	£5.9m	(£1.1m)	✗
Surplus / (Deficit)	**£2.0m**	**£1.4m**	**(£0.6m)**	✗	**£2.7m**	**£1.5m**	**(£1.1m)**	✗

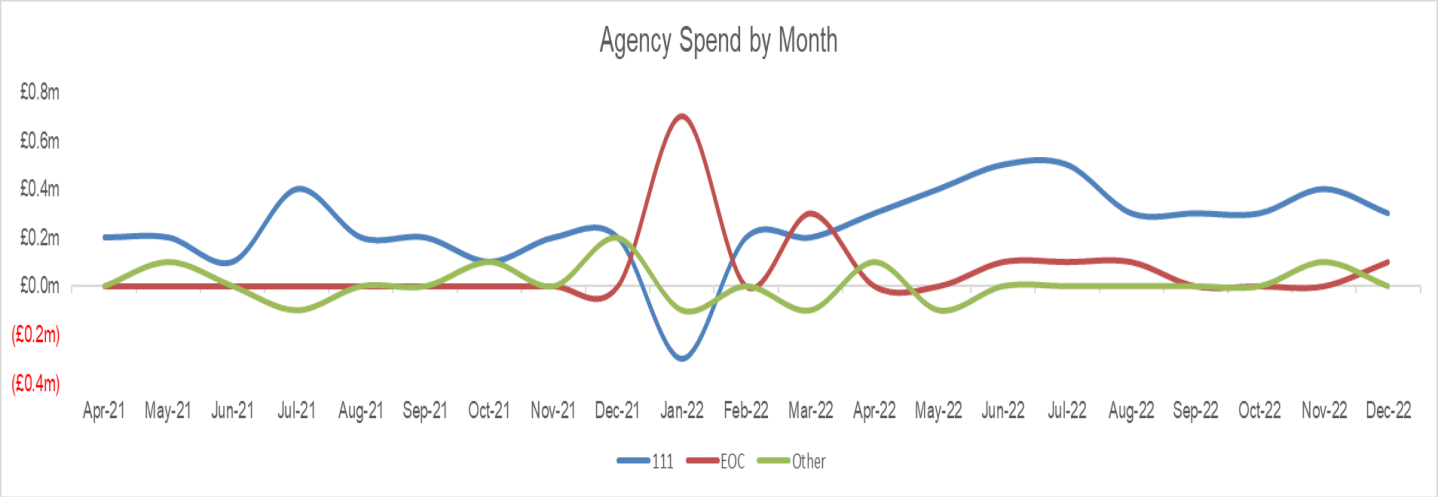
- Covid spend is £0.6m worse than plan and expected to be £1.1m adverse to plan by the year end. This has reduced the £2.7m surplus expected to support the underlying deficit by circa 40 per cent.

6. Agency

	Year to December 2022				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Agency Expenditure	**£4.0m**	**£3.7m**	**£0.3m**	✓	**£5.5m**	**£5.5m**	**£0.0m**	✓

- Overall spend with agencies was less than expected in the Trust but significantly higher in NHS 111 (£3.3m of total). Agency expenditure is currently 2.3% of the Trusts total pay costs.

- The plan for agency was calculated on expected usage at the same staff pay rates



7. Cash and Balance Sheet

	£000 Previous Month	£000 Change	£000 Current Month
NON-CURRENT ASSETS			
Property, Plant and Equipment	112,652	(222)	112,430
Intangible Assets	2,703	(157)	2,546
Trade and Other Receivables	0	0	0
Total Non-Current Assets	**115,355**	**(379)**	**114,976**
CURRENT ASSETS			
Inventories	2,304	109	2,413
Trade and Other Receivables	16,280	(1,263)	15,017
Asset Held for Sale	657	0	657
Other Current Assets	0	0	0
Cash and Cash Equivalents	34,865	(704)	34,161
Total Current Assets	**54,106**	**(1,858)**	**52,248**
CURRENT LIABILITIES			
Trade and Other Payables	(36,336)	1,486	(34,850)
Provisions for Liabilities and Charges	(7,140)	0	(7,140)
Borrowings	(11,017)	91	(10,926)
Total Current Liabilities	**(54,493)**	**1,577**	**(52,916)**
Total Assets Less Current Liabilities	**114,968**	**(660)**	**114,308**
NON-CURRENT LIABILITIES			
Provisions for Liabilities and Charges	(12,459)	0	(12,459)
Borrowings	(22,278)	720	(21,558)
Total Non-Current Liabilities	**(34,737)**	**720**	**(34,017)**
TOTAL ASSETS EMPLOYED	**80,231**	**60**	**80,291**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	108,908	0	108,908
Revaluation reserve	5,810	0	5,810
Donated asset reserve	0	0	0
Income and expenditure reserve	(32,648)	0	(32,648)
Income and expenditure reserve - current year	(1,839)	60	(1,779)
TOTAL TAX PAYERS' EQUITY	**80,231**	**60**	**80,291**

- Non-Current Assets are down by £0.4m in the month represented by new assets under construction of £1.0m net of monthly depreciation of £1.4m.

- Trade and other receivables are down by £1.3m being the reduction in prepayments of £2.4m, mainly because of the clearance of £2.1m Heathrow Trucks prepayment. This is offset by £1.1m increase in accrued income where the Trust is anticipating further ICB funds. Trade receivables remained at £0.5m with receipts offsetting new invoices.

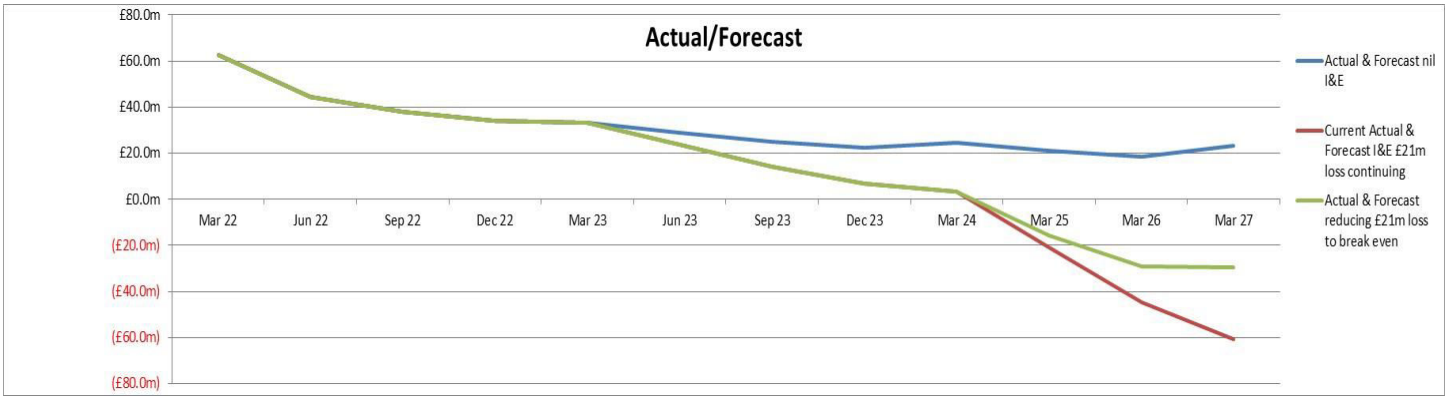
- Cash was down £0.7m with both income and payments dropping from last month but the net impact including reduction in borrowing balances meant a small cash reduction.

- Trade and other creditors were down £1.5m which was made up of the offset to the £2m prepayment clearance for Heathrow Truck invoices in trade payables. Offsetting this was a £0.5m in various payables including income tax and pension payables and deferred income.

- Borrowings are down by £0.1m short term and £0.7m long term with the net decrease of £0.8m payments for the month on DCA and Building leases.

- The movement on the I&E reserve represents the Trust's reported deficit.

8. Cash Forecast



- Forecast cash for the remainder of 2022/23 and then forecast or future years 2023/24 through to 2026/27 based upon:

- The forecast 2022/23 I&E is showing the Trust surplus position of £0.6m (excluding the system control adjustment) based upon the revised plan submission where the Trust has reduced its planned improved target response times. For the top blue line above a breakeven I&E position has been assumed for all future years. The middle green line reflects a £21m loss for 2023/24 reducing losses to nil over the forecast years whilst the red line assumes the forecast losses of £21m for next year continuing. The block income arrangement has continued to date for this new financial year.

- Capital forecast cash spend, net of disposals, of £25.2m for 2022/23 down marginally to £24.5m in 2023/24 decreasing to £19.0m for 2024/25. This is based upon the revised 22/23 plan submission, and this is reflected in the cash projection to March 2027. For 2022/23 the capital plan has considered the £12.4m of strategic estates expenditure on Make Ready Centres with £7.3m on fleet expenditure, £1.2m on other estates plus £0.5m on IT. There is forecast only a small amount of PDC income this year of £0.3m in relation to IT. Medway MRC continues to account for a significant amount of the forecast spend in 22/23 with further £48.4m for MRC expenditure in subsequent years. For vehicles, the majority of DCA spend will be via leases which now come unto the balance sheet as Right of Use (ROU) assets. This now excludes 57 DCAs originally planned as ROU but now are purchased in line with additional spend limits. This will change the timing of cash outlays to current months rather than over the lease term. This reduction of leased assets means the forecast is for new ROU assets of £9.7m to be created with the cash impact being spread over the lease term normally 5 years for DCAs.

- For 2022/23 there is property disposal income of £1.1m for the sale of Sittingbourne AS in April and Littlehampton AS in previous months, while the sales proceeds for four further ambulance stations of £4.5m has been pushed out until 2023/24. The remaining £8.1m of disposal income for a further seven ambulance stations have now been pushed out into future years.

9. Working Capital

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	18	
Debtors % > 90 Days	5.0%	51.0%	
Trade Creditor Days	30	37	
BPPC - Value of inv's pd within target (ytd)	95.0%	89.9%	
Cash (£m)	37.0	34.2	

- Debtor days at month end are 12 ahead of target despite accrued income for block income not received.
- Debtors % over 90 days are below target due to historic overdue invoices of £104k from NHS Horsham and Mid Sussex CCG for divert charges and £64k from NHS Lewes High Weald Havens CCG for disputed A&E charges. Both CCGs are no longer in existence, and both have been absorbed into the new NHS Sussex ICB.
- Creditor days are off target by 7 days for the month. This includes purchase order receipts not yet matched to invoices of which the main balances are Crawley Head Quarters rent under investigation, and balances with PAPs and Heathrow Truck Centre awaiting invoices.
- The BPPC for value of invoices paid is improved in the month but remains behind the year-to-date target largely because of issues with last year end invoices for IC24. Year to date, 18 invoices totalling £5.3m failed the BPPC test causing this shortfall and if we adjust for these failures the percentage would have been 95.5 percent. Invoices are now processing on time and meeting BPPC targets.
- Cash is below plan at month end despite some catch up block income as this was largely offset by increased capital spend because of DCAs being purchased rather than leased. There is still an amount of non-payment of block income expected which is currently accounted for under accrued income within trade debtors.

10. Capital

	Year to December 2022				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Estates	£0.5m	£0.1m	£0.4m	✓	£0.8m	£1.2m	(£0.4m)	✗
Strategic Estates	£12.6m	£8.7m	£3.9m	✓	£13.1m	£12.4m	£0.8m	✓
IT	£0.4m	£0.4m	£0.0m	✓	£0.7m	£0.4m	£0.3m	✓
Fleet	£2.0m	£2.6m	(£0.5m)	✗	£2.5m	£7.3m	(£4.9m)	✗
Clinical Operations	£0.7m	£0.1m	£0.6m	✓	£1.1m	£0.3m	£0.8m	✓
Total 'System' Capital (CDEL*)	**£16.3m**	**£11.9m**	**£4.3m**	✓	**£18.3m**	**£21.8m**	**(£3.4m)**	✗
PDC Funded	£0.2m	£0.0m	£0.2m	✓	£0.3m	£0.3m	£0.0m	✓
Right of Use Assets (Leases)	£11.0m	£9.1m	£1.9m	✓	£17.5m	£9.7m	£7.8m	✓
Total Capital	**£27.5m**	**£21.1m**	**£6.4m**	✓	**£36.1m**	**£31.8m**	**£4.3m**	✓

*CDEL - Capital Delegated Expenditure Limit

- Capital expenditure for the year to date was 23 per cent below plan. The further delay to Medway MRC and anticipated leased vehicles.

- The full year forecast capital spend is £31.8m compared to the plan of £36.1m. The underspend of £4.3m is caused by the items listed in the table below.

	ICB Capital allocation	National Funding (PDC)	Right of Use Capital (Leases)	Total
Original Plan	£18.3m	£0.3m	£17.5m	£36.1m
Changes to CDEL:				
Reduction in ROU as per NHSEI	£0.0m	£0.0m	(£3.9m)	(£3.9m)
Increase for DCAs	£3.0m	£0.0m	£0.0m	£3.0m
Grants	£0.3m	£0.0m	£0.0m	£0.3m
Disposals	£1.1m	£0.0m	£0.0m	£1.1m
Reduction for overplanning	(£0.9m)	£0.0m	£0.0m	(£0.9m)
New CDEL	**£21.8m**	**£0.3m**	**£13.6m**	**£35.7m**
Underspend				£0.0m
Move DCAs from ROU to purchase			(£3.9m)	(£3.9m)
Capital forecast	**£21.8m**	**£0.3m**	**£9.7m**	**£31.8m**

- The main risk to meeting the year end capital expenditure forecast is the delivery of the Chertsey improvements works at £1.0m and the remainder of the spend on Medway MRC of £3.6m before the end of March 2023.

- The Trust applied for national funding for the purchase (not lease) of additional DCAs. This 'funding' will just be an increase in CDEL without any cash.

11. Risks

Risk	Impact	Likelihood	Score
While the Trust currently has adequate liquid resources to meet its short-term plans, there is a need to generate cash surpluses to ensure sufficient funds for future investment to sustain and improve our services.	>£1.0m <=£1.5m	Likely >50%<=80%	12
Risk of not achieving recruitment necessary to meet the requirement to join the Single Virtual Contact Centre (SVCC)	>£1.0m <=£1.5m	Possible 50/50	9
The impact of higher than planned sickness rates require additional overtime to meet the on-day demand to fill rotas, putting pressure on already limited Covid recovery funding.	>£1.5m <=£2.0m	Possible 50/50	12
Ability to reduce the number of staff in the 111 CAS (Clinical Advice Service) in line with that agreed with commissioners and therefore not decreasing the forecast run-rate.	>£0.5m <=£1.0m	Possible 50/50	6

- The table above shows those risks to achieving this year's financial target. The severest risks are linked to the forecast position and mitigations that are currently being worked through as part of the Trust's Improvement Journey.

SECAMB Board

Finance and Investment Committee (FIC) Escalation Report

Overview of issues covered at the meeting on 19.01.2023.

The main focus of this meeting related to the financial sustainability BAF risk.

Item	Purpose	Link to BAF Risk
Financial Performance	Acknowledging the (£8.9m) risk to the plan, to seek assurance that the right mitigating actions are in place to recover the position and that these are being implemented effectively.	Risk 16 – Financial Sustainability

The committee reviewed the current financial position at Month 9. The Trust is reporting a year-to-date deficit of £2.4m, £1.4m greater that the original plan of £1.0m for the year to date. Substantial progress has been made to reduce overspends and identify savings via the costs review programme rolled out with all the Directorates. This has identified circa £6m savings (compared to the revised deficit of £8.9m). The executive expressed confidence that we will identify the remaining £0.9m to reduce the year end deficit to £2.0m with the aim of maximising the recurrent savings. There is focus too on non-recurrent opportunities to reduce the overall deficit to breakeven. In terms of cash, this is £2.8m (7.6%) below plan and predicted to be at £33m by year end, and the Board should note that we still have no signed contract for 2022/23.

While the committee is assured by the grip and focus demonstrated by the significantly improved position, it remains concerned about the medium to long term as we still lack a robust efficiency programme. The CFO confirmed that he is in discussion with NHS England to help in this area, linked to our emerging approach to continuous improvement.

The committee also challenged the executive to provide assurance at the next meeting on 21 February that the savings / control on expenditure has not adversely impacted patient quality. In the meantime reassurance was given.

In summary, the committee is assured that the right mitigating actions are in place to recover the financial position and that these are being implemented effectively. However, further assurance has been sought related to any impact on patient quality.

Planning 2023/24	To seek assurance that the executive is proactively approaching the planning process; learning from previous years; has a clear timeline to contract signature; and that there is a process to ensure capital projects are prioritised effectively.	Risk 16 – Financial Sustainability

The executive has a clear approach to aligning Trust priorities with the planning for the coming year, using our new approach to quality improvement that the Board endorsed in December. This aims to ensure our objectives help to improve, quality, performance and/or finance. The final priorities and delivery plan will come to the Board in April, along with the budget for the year. The current focus is on the workforce plan, which is coming to WWC in February.

The committee is assured by this approach to planning which is being done in collaboration with internal and external stakeholders.

Medway MRC	Noting the issues escalated to the Board on 15 December, to seek assurance that robust contract management is in place which will ensure this project is completed on the agreed date, in line with the critical path.	N/A

The executive is ensuring that together with the management agent / contractor a completion date is agreed and mitigations are in place to reduce the delay. The project is expected to be overspent by about £440k, which for a project of this size is relatively marginal. There is good financial governance through the business case process to ensure clarity and control over additional expenditure.

The committee has increasing confidence in the grip demonstrated by the executive and has sought to ensure the new timescale agreed is realistic. It is acknowledged that there are lessons to be learned and the committee will consider this as part of the post project review. The people aspect of this project is being overseen by WWC.

Procurement Self Assessment & Action Plan	To seek assurance that there are clear management actions in place to respond effectively and timely to the issues identified in the self-assessment and separate Internal Audit.	N/A

The committee received the plan that was developed from the Commercial Continuous Improvement Function (CCIAF) self-assessment process. This also addresses the management actions from the separate Internal Audit; the report is still in draft but expected to conclude Minimal Assurance.

The committee challenged the confidence in delivering the plan, in particular the timeframe as it is all within six months. The CFO reinforced his confidence, explaining that the timeframes which were developed by the team are challenging, but achievable. The committee will check progress at each meeting and will receive a repeat to the self-assessment in six months' time.

A request was made for a report setting out all of the procurement controls / processes so that the committee can test the extent to which the controls are fit for purpose and appropriate for this organisation. Longer term, it has asked for a review of all the corporate overheads to explore opportunities to collaborate with others so that we continue to ensure good value for money. The committee will take this strategic view once the basics are addressed.

Business Case Process	to seek assurance that the new approach will improve the process, and that this includes clarity on how investments will be prioritised at the same time as maintaining financial control.	Risk 16 Risk 256
A verbal update was provided from the CFO, confirming that EMB is reviewing all business cases to ensure prioritisation. We will then transition to a new improvement case process that will be designed in the coming weeks for the start of the new financial year. The committee will review the process at its February meeting, including how cases will be followed through to ensure stated benefits are realised.		
Fleet Summary & Strategy Update	To seek assurance that the fleet strategy and associated replacement plan is being implemented and that there are adequate controls in place to address the issues with the FIAT DCAs.	N/A
The committee received a good paper setting out the on-going areas of focus and work of the Fleet Department, alongside the current position in relation to our fleet replacement part and concerns raised on the Fiat Ducato DCA in line with the National Specification. It also outlined the work underway to refresh the strategy to inform decisions around our future fleet, sustainability, workforce and capital investment in 2023/24. In summary the committee is assured that the current fleet strategy and associated replacement plan is being implemented and that there are adequate controls in place to address the issues with the FIAT DCAs. It looks forward to reviewing the revised strategy in March, and it has asked that this includes greater clarity on how we ensure we meet our clinical requirements, for both staff and patients.		
Enabling Strategies	To confirm the timeline and approach for the revision/development of the relevant enabling strategies	N/A
The executive confirmed that the following enabling strategies will be revised during Q1 2023/24: • Green • Estates • Digital • Procurement		
Specific Escalation(s) for Board Action	There are no specific issues to escalate to the Board, although the Board is asked to note the position with the current contract (unsigned) and assurance the committee is seeking in relation to the financial controls not adversely impacting quality.	
In Q3 the Trust's Improvement Director undertook a **Board Effectiveness Review**, which included a review of this committee. The findings and recommendations continue to be considered in the planning and delivery of the committee meetings. Below is a summary of progress to-date.		

Recommendations	Progress to-date
All authors to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	Ongoing – each agenda item is now clearer about the purpose and assurance questions.
To ensure the cycle of business is explicit to the whole membership and any omissions are recorded and carried forward	The COB is included for each meeting and used to inform the planning for each meeting.
Consider how the BAF (specifically any financial risks) can structurally link to the work of the committee	Each agenda item cross references to the relevant BAF risk(s) and the BAF is used, along with the IQR, Improvement Journey, and COB when planning for each agenda.
The Exec team need to consider where the joining up of finance, performance and quality occurs and how this reports into the governance stream.	Work is ongoing to revise the executive management governance framework. A proposal is due to be discussed at the leadership team meeting on 15 February 2023.
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.	The finance report has been revised to make it clearer; positive feedback was provided at the meeting in January related to the clarity of the report. Further feedback will be sought at the Board meeting on 2 February.
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.	Reference to this risk was captured in the FIC report to Board in December. It will seek assurance at its meeting in March, in light of the discussions with commissioners ahead of the contract from April 2023.
Consider where strategies are published and how all Board members are updated on delivery and how accountability is demonstrated to the public.	All enabling strategies are received by the Trust Board for approval and published as part of the papers. The current enabling strategies will be included in the Board section of the website.
Ensure the executive team understand the reason for the patient level costing and why this is higher than the benchmarked services in the report.	A session to be scheduled with EMB in Q4

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	88-22

Name of meeting	Trust Board
Date	02.02.2023
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

This report summarises the progress made through the Improvement Journey (IJ) portfolio during period of January 2023. The BAF risk (ID: 257) remains scored as a 12 as previously reported until CQC confirm sufficient progress has been made in relation to the Section 29A warning notices.

Due to a late report in December and 2-week period of higher Annual Leave through the holiday season, as well as 2 Industrial Action days, there has been disruption in the regular reporting to the Improvement Journey Steering Group. As a result, this report focusses on the on-going work that has been undertaken to continue to sustain improvements made within the Warning Notices scope, as well as the detail developed by the executive leads and programme leads to support an updated framework for measuring our progress against the Must Dos (See Appendix 1 within the report for the detailed descriptors, KPI and action plans against each Must Do).

We have 61 requirements to demonstrate compliance against as a combination of Must Do (15), Should Do (27), and RSP Exit Criteria (19). Over this quarter, our objective is to evidence significant progress and compliance against the 15 Must Do. As seen in section 4.6 in the report, the 15 Must Do continue to align strongly with our Improvement Journey Framework, with our greatest areas of focus being Quality and our People and Culture.

Alongside our regulatory drivers, the Executive are in the process of developing the Annual Plans and delivery plans for 23/24, building on the work done by the Board and with the Councill of Governors in November and December. A first draft of the Improvement Journey plans for 23/24 combining CQC requirements, RSP, and Strategic priorities, will be developed ready for review at the end of February.

The Leadership team has also reviewed its approach to Continuous Improvement to help us enable delivery of these plans on a sustainable basis. A Continuous Improvement Team formed from cross-directorate colleagues will have oversight of the delivery plans for improvement and will provide the necessary infrastructure for monthly reporting to EMB and Board on our progress against our 23/24 objectives for improvement. This will build on the Quality Improvement methodology the Board approved in December. A total of 32 colleagues have already undertaken the first QI training session in January. This CI team has already started to work together on the prioritisation of plans for next year working cross-directorates, and the objective is to be fully resourced by 1st of April.

In parallel, the Improvement Journey team is working close with the newly appointed Head of Quality Compliance on the development of a Quality Compliance Assurance Framework that allows the Trust to routinely survey against the CQC Domains and KLOEs, providing internal assurance and self-assessment against our compliance position. This combined approach of developing sustainable infrastructure for continuous improvement, as well as compliance assurance, will be essential to ensure SECAmb can navigate through it's recovery and into a stability phase in H2 of 23/24.

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.