South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 5th December 2022

Present:

David Astley	(DA)	Chair
Brian Chester	(BC)	Public Governor, Upper West
Leigh Westwood	(LW)	Public Governor, Lower East
Chris Burton	(CB)	Staff Governor (operational)
Martin Brand	(MB)	Public Governor, Upper West
Andrew Latham	(AL)	Public Governor, Lower West
Linda Caine	(LC)	Public Governor, Upper East
Kirsty Booth	(KB)	Staff Governor (non-operational)
Nicholas Harrison	(NH)	Staff Governor (operational)
David Romaine	(DR)	Public Governor, Lower East
Ann Osler	(AO)	Appointed Governor – Upper West
Mark Rist	(MR)	Appointed Governor – Fire Service
Angela Glynn	(AG)	Appointed Governor – University of Brighton
Colin Hall	(CH)	Public Governor, Upper East
Amanda Cool	(AC)	Public Governor, Upper West
Lisa Bell	(LB)	Appointed Governor – Sussex Police

In attendance:

Siobhan Melia	(SM)	Chief Executive
Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee, Chair of Operational Performance Committee
Paul Brocklehurst	(PB)	NED
Michael Whitehouse	(MW)	NED and Chair of Audit Committee and Senior Independent Director
Tom Quinn	(TQ)	NED
Liz Sharp	(LS)	NED
Harvey Nash	(HN)	Newly elected Governor
Peter Lee	(PL)	Company Secretary
David Ruiz-Celada	(DRC)	Director of Planning and Organisational Development

Apologies:

Nigel Robinson	(NR)	Public Governor, Lower West
Patricia Delaney	(PD)	Public Governor, Lower East
Stuart Dane	(SD)	Staff Governor (operational)
Michael Tebbutt	(MT)	Public Governor, Upper East
Subo Shanmuganathan	(SS)	NED
Chris Gonde	(CG)	NED

Absent:

Sinead Mooney	(SM)	Appointed Governor – Local Authority

Minute taker: Julie Harris (JH) Assistant Company Secretary

Item No.	Introduction and matters arising
119/22	**Introduction**
120/22	**Apologies for Absence** As above
121/22	**Declarations of Interest** Liz Sharp noted she was a member of the Royal College of Nursing.
122/22	**Minutes from the previous meeting, action log and matters arising** The minutes were taken as an accurate record of the meeting. The action log was reviewed with no outstanding actions
	Statutory duties: performance and holding to account
123/22	**Chair and Chief Executive's report** SM provided some reflections on the last six months, including: • relentless improvement focus, • collaborative endeavour, • good evidence of progress, • still work to do (performance), • cultural challenges, • courageous conversations occurring within the organisation. SM continued providing an overview of the progress to date surrounding the four warning notices in terms of what we have done thus far and areas with more work to do on: • Board effectiveness (embedding the voice of colleagues in leadership decisions, improvement on internal communications) • Quality of information (development of data strategy, structured reporting of quality indicators) • Risk, clinical governance, and quality improvement (risk register and outstanding policies, enhance the harm review process) • Culture of bullying (zero tolerance) SM reviewed the four pillars and associated strategic goals. SM provided an overview on the IT outage: • Major network failure at Crawley • Programme of works already underway to replace these following 17 November 2021 • Exec + strategic decision to bring this forward on 11 November • Softcat (implementation partner) underestimated work involved and over committed resource that they did not have • Target completion time 10pm on 11 November missed • Second target completion 12pm on 14 November missed • Completion of works at 11:30 am 15 November • Technical debrief process started – completion 11 December

	SM provided an overview on the impending industrial action, including: • Royal College of Nursing (small number at SECAmb) • Unison may be re-balloting • GMB – need to give us 14 days' notice, no information provided thus far – speculation is something may occur on 20 December SM offered an operational update, noting we cannot judge actions taken or people's action, and that patient safety is at top of mind, tact and diplomacy, do our best to work with partnerships, regular touchpoints with union partners. Sensitive situation, taking the leave from national and regional colleagues, no confirmation of any date of action at this time. MB question the use of balanced score cards, foundation on how to approach the development work. BC questioned the timeline surrounding re-establishing the leadership/workforce. SM confirmed that the engagement at SECAmb is very good, with 62% response on staff survey, noting that Facebook has been replace with Yammer (corporate but human side – to engage with professionalism) with large uptake, clear rules of engagement in line with Trust values. DA summarised the cultural challenges, the internal improvements that the board must undertake. NH noted his concerns surrounding the IT outage and felt that it was underplayed, looking for assurance that proper investigations are taking place – not only the CAD system, massive impact on the organisation, patient safety, too risky to use. Questioned if the IT system is suitable. MS agreed that this was a quite an event (surprise event), known that the technology is not good, replacement has been worked on for over a year (with Cisco Systems), cascade effect due to switch failures – accelerated the replacement with Cisco system. A few supply issues ensued as well. MS noted the resiliency of the ambulance service in challenging times – although we can cope using paper based, it caused strain on the staff. Looking into Cloud computing, SigSigma ways of working – new standard we want to adopt in a cost-effective way. MW added he is seeking external assurance we are in a strong position. MB reflected on his experience at London during their IT upgrade. MS noted that the structure the system is based on needs to be resilient before we look at upgrading the technology. PB explained the issues surrounding the outage in November 2021, noting the central issue was the network, thus the decision was made to change Fortinet to Cisco, but prior to the change in network, the second failure occurred. PB concluded that we are in a much better state. BC questioned where this risk sat on the profile. PB confirmed that there was no expectation for failure prior to the upgrade to Cisco. MS added that we did not 'wait a year' but that several steps were put in place to systematically make the change. LW questioned whether the effect on the volunteer force would be considered in the investigation. MS agreed there was an issue with the volunteers and that this has been highlighted as a risk. MB reflected the historical experience in London during the 2013 industrial action and questioned what paramedics will do. SM confirmed discussions with AACE surrounding the actions being taken nationally, across all the professions (including paramedics), details to follow.

	Statutory duties: performance and holding to account
124/22	**Board Assurance Committees' escalation reports to include the key achievements, risks and challenges:** **Audit Committee** MW highlighted the work underway surrounding the warning noticed, partial assurance was given to freedom to speak out, culture, etc., noting many actions have been taken since the date of this report. **Performance Committee** HW noted the outcome of the effectiveness review that the performance committee will be disbanded and integrated into other committees. **Workforce and Wellbeing Committee** KB questioned the culture programme with EOC/111 and lack of traction, seeking assurance that this is being taken seriously. LS noted that at the recent WWC meeting this was of particular focus, more listening activities occurring, exit interviews, increased turnover, formal actions in place to manage and move the culture to a different place. SM confirmed that things have moved fast since the summer, quality of papers have ameliorated and requested more up to date reports being provided. PL confirmed that due to the board meeting was pushed back the latest reports were not presented to the Board and thereby cannot be provided to the CoG. AL challenged this point, noting that several CoG members were at the WWC and questioned why the papers were not shared earlier. **ACTION – Next WWC report to ensure it addresses the concerns surrounding the culture programme with EOC/111** AL sought assurance surrounding appraisals being completed, with increased uptake to 85% standard target. KB sought assurance from the WWC surrounding the effects of backlog marking at Crawley College and recruitment pipeline. TQ confirmed that senior level conversations are occurring, working on the Crawley issue. KB questioned the impact of the Medway move on the organisation including the timeline, delays, etc. MB agreed that the project to date has not been managed well, builder slow and non-responsive (including agent), and confirmed that this has been escalated to EMB. Project was due for completion in July, delayed until December, managing agents requested further delay until January 2023. MB noted that the biggest issue is the move of staff, and we will be in a better position in a couple of weeks to determine the exact date of the move. MB noted his confidence that within the next couple of weeks there will be a report provided that will give assurance that we have a grip on the situation. **Quality and Patient Safety**

	TQ noted the introduction of the quality summit that was introduced this year, positive step, help to inform quality improvement plans, no formal escalations to the board from the September meeting, much progress has been made since the September meeting – medicines management team, quality of papers provided. NH questioned the process surrounding PSIRF. **Finance and Investment Committee** HW confirmed that the issues surrounding the 111-call answer performance is due to call taker taking more time with the patients (good for patient experience). MS noted that this is not a service that we are contracted by the commissioners to do therefore are not being paid for it. Planning for next year has begun already to define services the commissioners want, scenarios, provide a set of offerings. HW provided an update on the FIAT situation, noting there is still an issue with the vehicles being overweight (problem of our own making – spec'd an internal kit that is increasing the weight). FIAT assessments continue (50% completed), eight new vehicles with updated saloon – change in LifePac location. DRC provided context around the weight issue, safety features (reduction in trip risks), future trajectory of procurement. NH questioned the escalation surrounding overtime, obsessed with incentives in EOC/111 and questioned the financial impact. MS confirmed that incentives are being exited (operations have been exited already). NH questioned the reliance on the incentivized shifts (lowest paid people in the organisation), forcing the workforce to increase their hours to make up the loss. MS confirmed that they are the last group of people exiting the incentives. NH suggested a Band up – fair pay, fair reward for doing an extremely difficult job.
125/22	**Improvement Journey Update and Next steps** DRC provided highlights on the improvement journey including warning notices, feedback from peer-review with system partners, progress against the target evidence focusing on evidencing significant improvement against the Warning Notices. DRC provided a summary of the areas that we have been focusing on. • WN1: Developing trust priorities, Leadership • WN2: Make Data Count, constructive challenge, patient to board reporting • WN3: Incident and harm process, risk management, quality improvement • WN4: Acting more swiftly, no tolerance of inappropriate behaviour, culture transformation DRC continued the overview to include the development of trust priorities, alignment framework, before and after of the IQR, addressing staff concerns (you said, we did approach), closing Facebook and starting Yammer, summary of key improvements, growing the FTSU team, risk management roadmap, high level patient journey through SECAmb (and associated risks), thematic harm analysis following quality summit (delayed attendance, patients injured whilst in our care), emerging QI methodology, next steps with a goal to shift to be more strategically driven (four strategic goals, board strategic priorities 23/24).

	MB questioned the cultural leadership programme and action plan and how the improvement journey fits into this. DRC confirmed that the cultural leadership programme will the be our foundation going forward. MB questioned organisational overload (CQC timeline, longer term tasks, what you do when, what you do well (balance)). MS supports the mechanism of the improvement journey in terms of strategy and tactics and noted that the processes have been enhanced into day-to-day functions. MS also agreed that one of the mistakes made was the disbandment of the PMO. AL congratulated the board on the work done thus far and encouraged pushing down the organisational plan to the grass roots of the organisation so they could live the change and increase engagement. AL further suggested removing the treacle for positive change initiatives (such as the falls programme). MB suggested empowering (using tolerances), lower down on the echelon to instil change. SM noted that this was not an organisation that was happy to make any decisions and agreed that encouraging people to make decisions has worked well in the last six months, and it's time for those people to step back and encourage others to make decisions – Empower should exist at the heart of it.
126/22	**Finance – Situational awareness** MS provided an overview of the situational awareness on our finances, nuances of the south-east environment (distance the target, worst performing sector in the country, biggest risk at ICB was SECAmb, lack of understanding). MS confirmed that SECAmb is currently in a £2.7M deficit position, and if we are carrying on with what we are, we will be in an £8.5M financial position. As such, everyone will be in a cost improvement position next year and will be pushing the organisation hard to achieve the £8.5M recurrently. Current aim is to have 80% of our planning done by end of December. There is a lack of understanding of what the commissioners want, need, willing to pay for. MB questioned whether we should exit 111. MS confirmed that we are currently assessing 111 and felt that we are delivering an enhanced service and would not rush a decision as there are benefits that our 111 is providing to the 999 service, but we need to look to modify the 111 rather than eliminate it. MB further questioned performance requirements versus funding provided. MS confirmed that the procurement process, estates management and business case process need to be improved and this is underway – need to solve the underlying problem (rather than throwing money at it). MB noted that we need people to be focused on improvement rather than spending money. DR questioned our contract obligation to the FIAT fleet. DRC provided a response surrounding the contract obligation as well as the standards of the FIAT vehicles, noting positive feedback on the new saloon specification of the 8 new vehicles we have received. MS noted a bigger issue coming down the line – which is the green agenda – which could be an opportunity to come up with the better initiative. DRC confirmed that this is the case. AL questioned the forecasted deficit. MS confirmed no one is meeting the financial standards/targets at the moment – we are by-product of the whole system – there is just so far we can go and depend on the system as a whole to meet all the targets. For

	example, the last funding for Covid has just been completed, so from now on we shouldn't' be spending any money on covid initiatives. KB sought assurance surrounding financial sustainability and a framework such as the FSSG. MS agreed but advised that the framework in place must be one that sticks.
Statutory duties: member and public engagement	
127/22	**Membership Development Committee Report** BC took the report as read, membership is down, need to improve, 50% current membership are staff, 50% are part of the community. Plans are in place to reengage within the community, tasking governors with providing opportunities in their areas. MB recommended to add an action for all governors to submit opportunities by end of January. **ACTION – all governors to submit area engagement opportunities to the Council by end of January**
Committees and reports	
128/22	**Nomination Committee Report** DA took the report as read noting that NED recruitment is underway, and the interviews are set for 9 December 2022.
129/22	**Governor Development Committee Report** LW took the report as read. MB proposed that if there are circumstances that requires an extra-ordinary meeting, that a mechanism be put in place.
130/22	**Governor Activities and Queries Report** LW took the report as read, noting that external activities need to be ramped up.
General	
131/22	**Any other business** None
132/22	**Questions from the public** None
133/22	**Areas to highlight to Non-Executive Directors** - Culture - Engagement - Finance - Industrial action
134/22	**Review of meeting effectiveness** - Noted the change of the agenda, reflection that it promoted discussion and holding to account.

	Date of next Formal Council of Governors Meeting: 23 FEBRUARY 2023

Status Key Code: C- Complete, IP - In progress, S - Superseded

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST
Trust Council of Governors Action Log

Key

Closed
Due

Meeting Date	Agenda item	AC ref	Action Point	Owner	Completion Date	Report to:	Status: (C, IP, R)	Comments / Update

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.

17	The initiative was very positively received, with really positive feedback from all those 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 Q3 and we are an outlier for this metric when compared to our colleagues nationally.
37	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.

Southeast Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee Escalation Report

Overview of issues covered at the meeting 07.12.2022

Item	Purpose	Link to BAF Risk
External Audit / Annual Report	To seek assurance on the approach to the development of the Annual Report and the External Audit Plan	N/A

There is a clear plan in place for the development of the Annual Report, and this is being adjusted to reflect the national timetable recently confirmed. In light of the governance and risk management challenges in the past year, the committee asked to see in March an early draft of the Annual Governance Statement.

KPMG provided its indicative External Audit Plan and summarised the key issues and risks. The plan was supported and the committee is confident that the financial statements will be produced by the finance team in good time.

As has been the case since 2020, there is no requirement to audit the Quality Account. However, the committee supported the plan outlined by the Director of Quality and Nursing to ensure external assurance is provided on the quality priorities.

Internal Audit Plan	To receive the outcomes of the internal audit reviews most recently completed	Risk 15 - ETD

Since the last meeting, two reviews were completed in line with the annual plan. Data Quality and AQIs received Reasonable Assurance. However, there was a Partial Assurance outcome for the review into Stat Man Training. The committee expressed some concerns about the gaps in control identified and noted that these are being picked up by the Workforce & Wellbeing Committee (WWC) which will oversee delivery of the management actions – please refer to the separate WWC report to the Board.

Counter Fraud	To seek assurance that the Trust has effective counter fraud arrangements.	N/A

The committee continues to be assured with the counter fraud arrangements in place. It explored once more the ongoing issue related to staff working in secondary employment while sick, and challenged whether more could be done, pro-actively. There is an IA review of policy management in Q4 and the committee asked RSM to ensure it specifically covers the policies related to secondary employment and working while sick, to ensure we are doing all we reasonably can.

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

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

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

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

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

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

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

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

Rota Implementation (RC-1a & b): Improve staffing allocations delivered through new rotas by day/hour according to demand/activity, delivering improved staff experience, more efficient utilisation of limited resources, timely responses to the highest-acuity calls, and improved patient outcomes and experience.	Director of Operations	TBC	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*	15	15	10	Director of Planning

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

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

Appendix 2 - SPC Icon Description

			
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
	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.

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

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.
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				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.

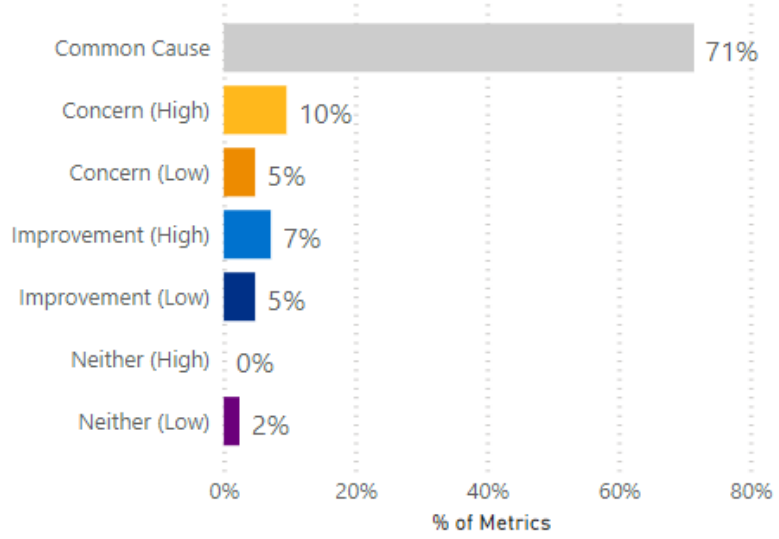
QUALITY IMPROVEMENT

Overview (1 of 3)

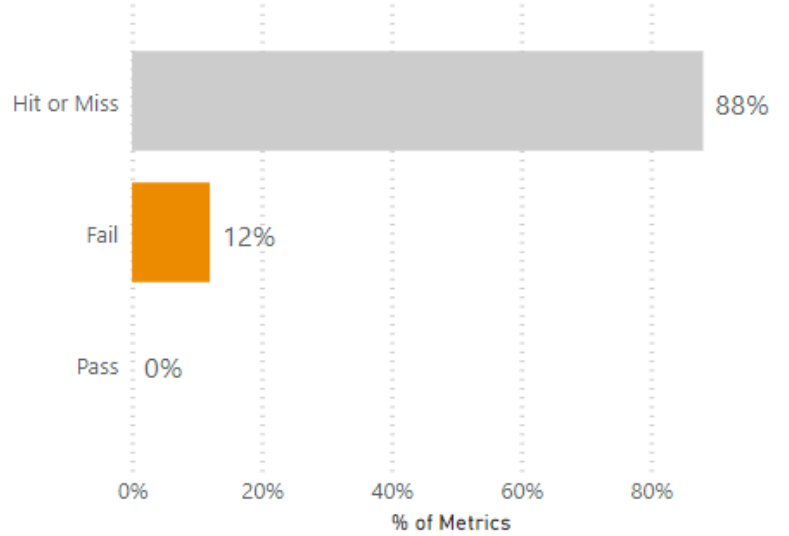
Trend improvement vs previous period

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		

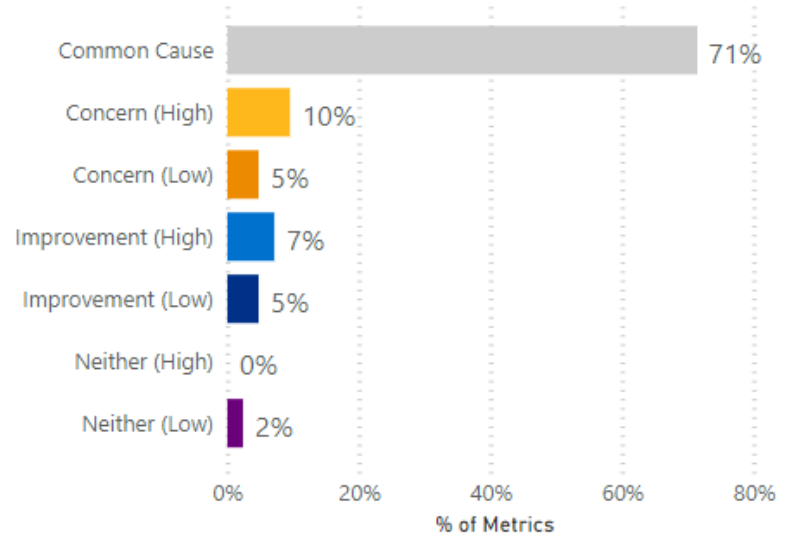
QUALITY IMPROVEMENT

Overview (2 of 3)

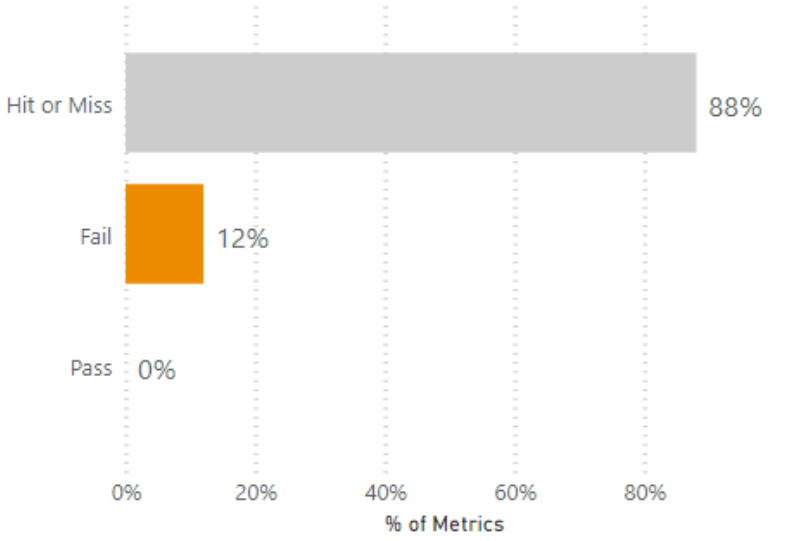
Trend improvement vs previous period

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%		

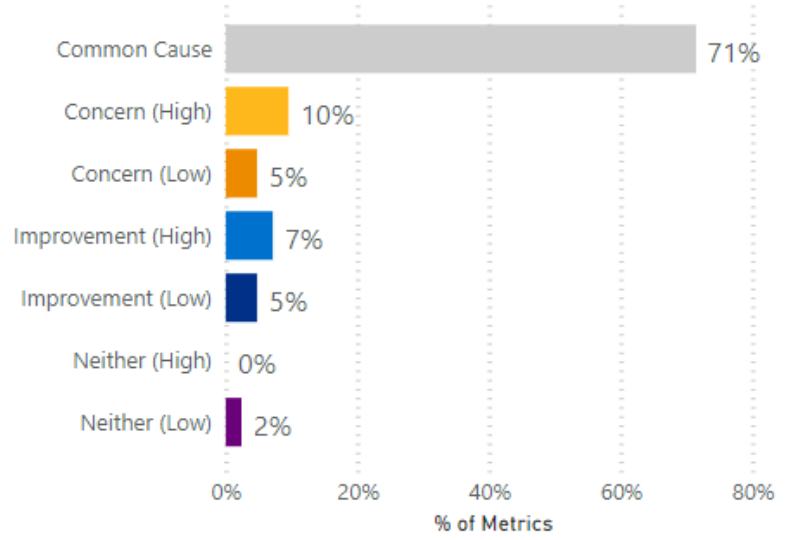
QUALITY IMPROVEMENT

Overview (3 of 3)

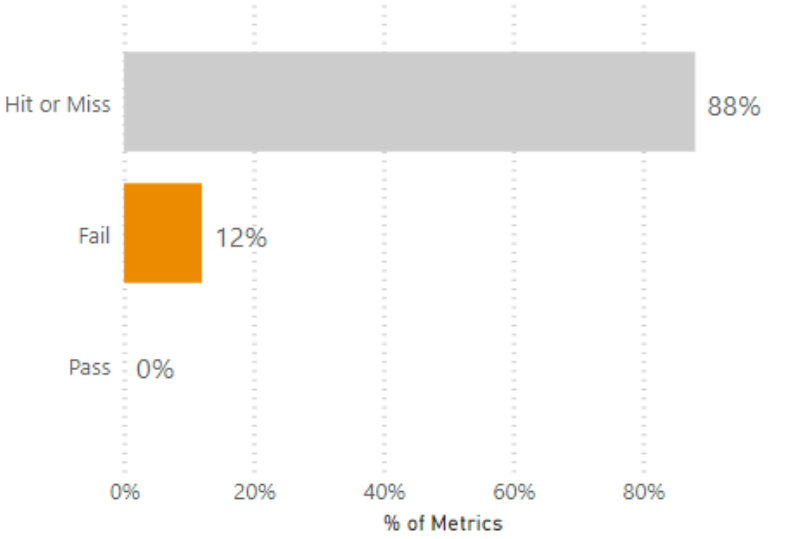
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary

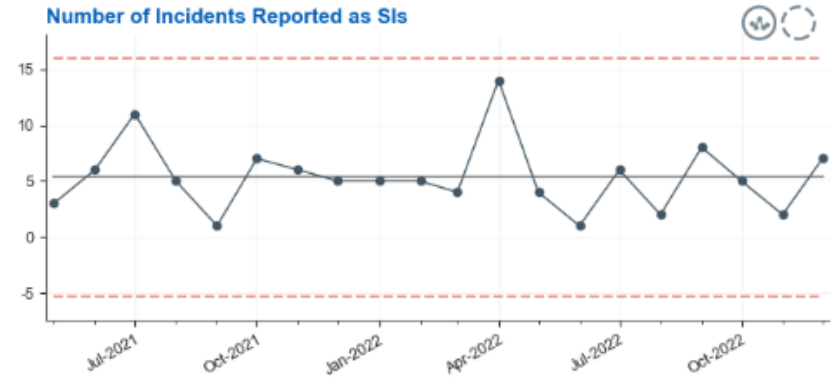


Health & Safety

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

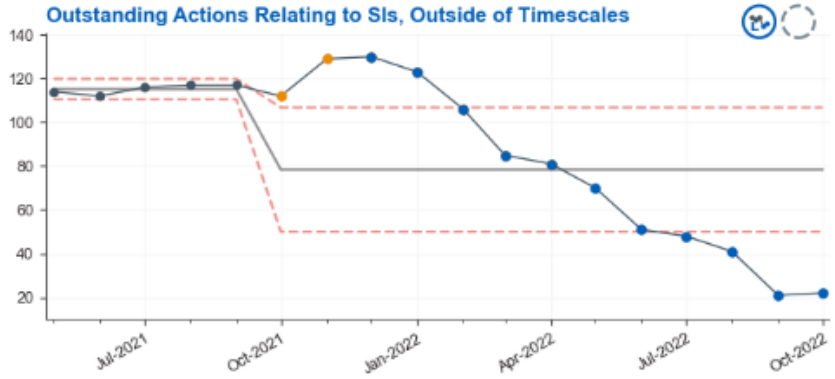
Dept: Quality & Safety
IP: Quality Improvement
Latest: 7

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

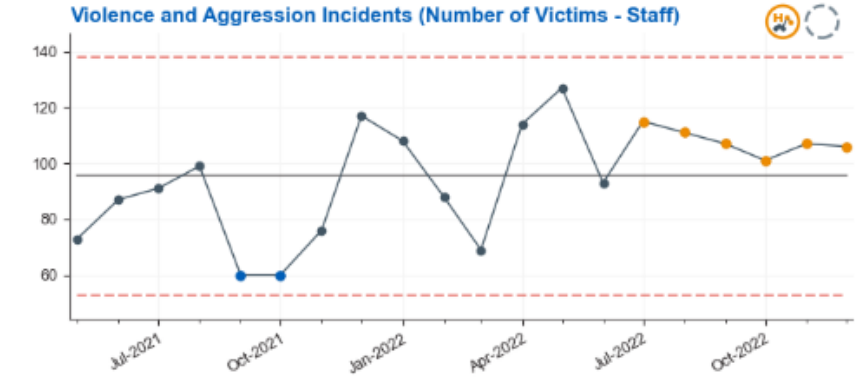
Common cause variation, no significant change.
Assurance cannot be given as a target has not been provided.



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

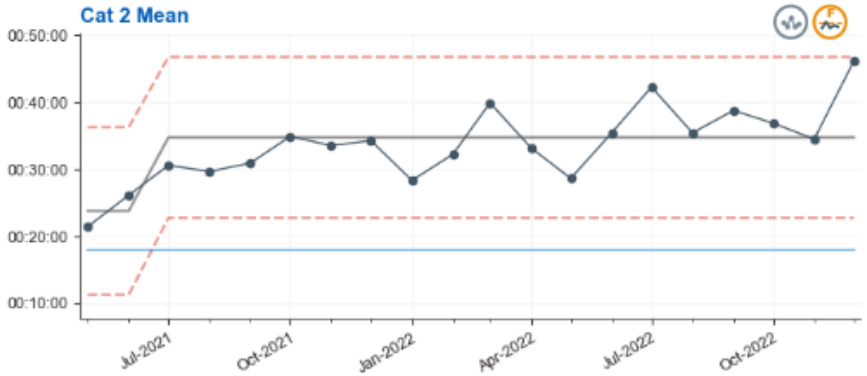
Dept: Quality & Safety
IP: Quality Improvement
Latest: 4.38

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

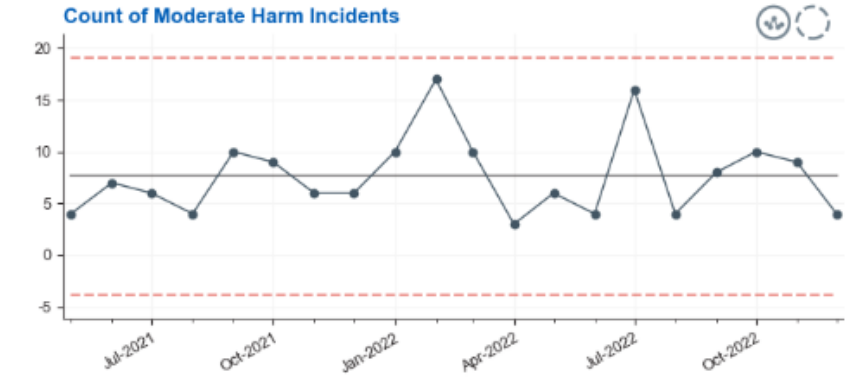
Harm (2 of 2)

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.

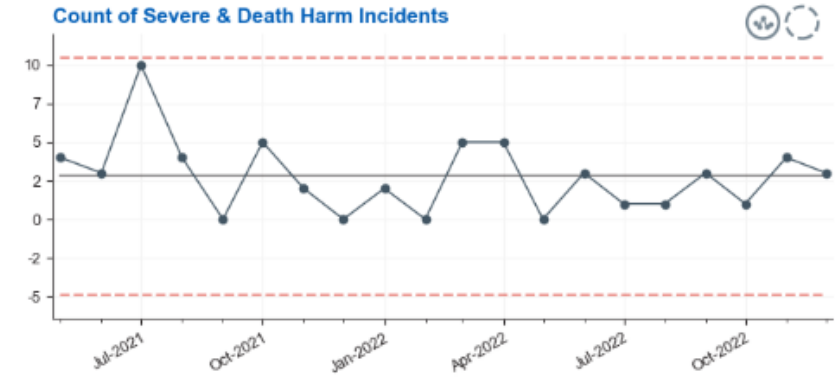
QS-31
Dept: Quality & Safety
IP: Quality Improvement
Latest: 244

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

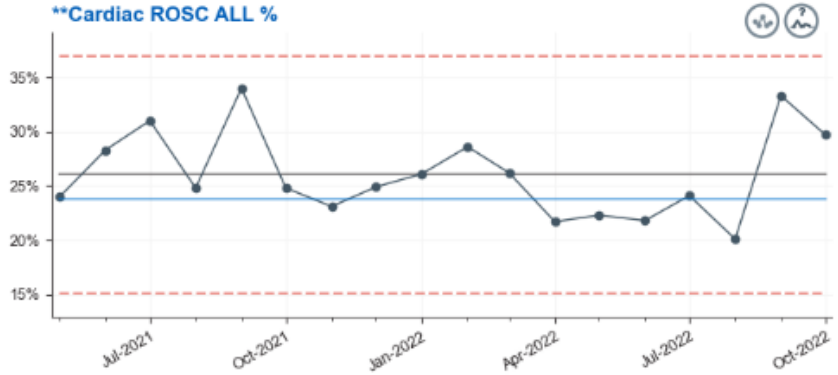
- **(QS-31)** The Trust are still seeing an uplift in incidents category of pharmacy this to do with community pharmacist Consultation Service and PHARM+ concerns, whereby the pharmacy is not following the contractual agreement if they are unable to assist the patient. System-wide discussion are underway 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.

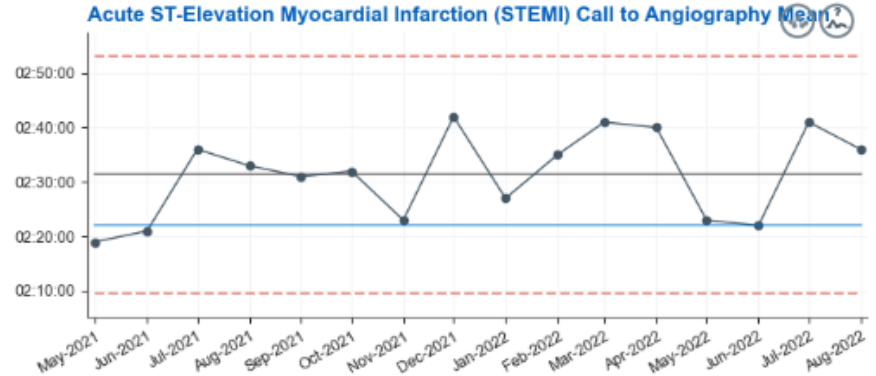
QUALITY IMPROVEMENT

Impact on Patient Care - Cardiac



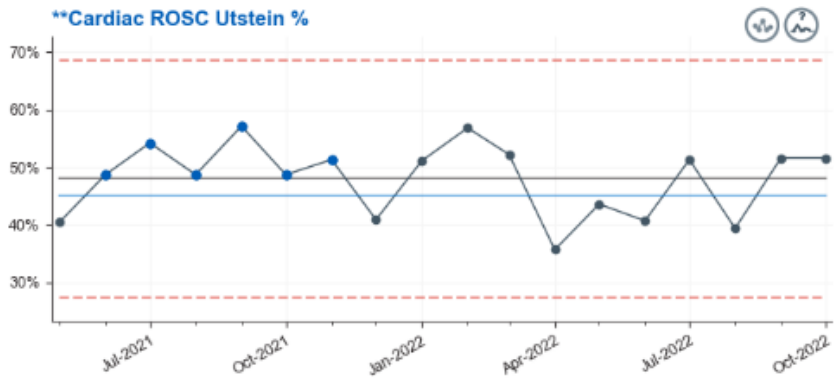
M-2

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.



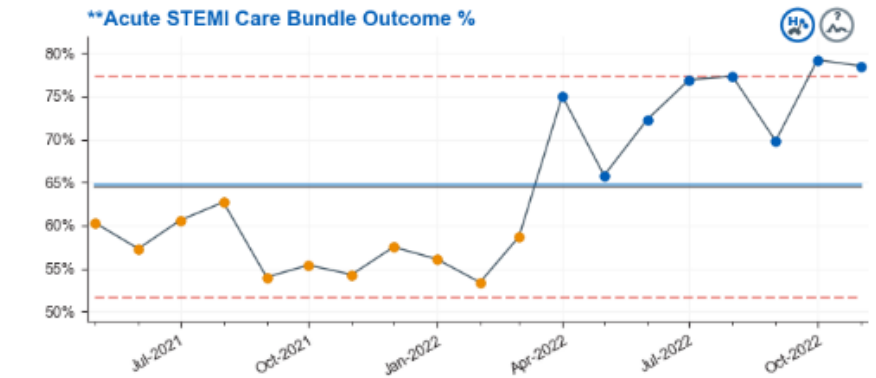
M-6

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.

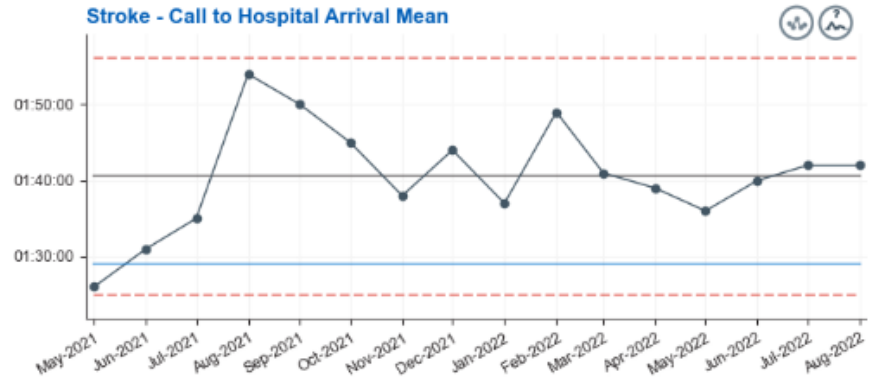
What actions are we taking?

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.

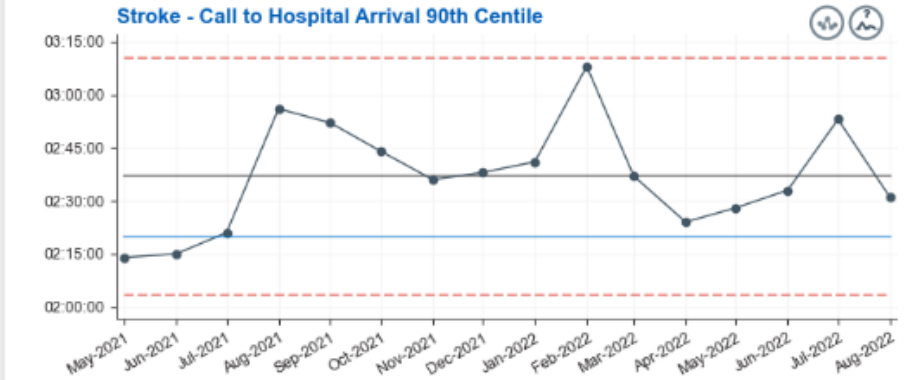
QUALITY IMPROVEMENT

Impact on Patient Care – Stroke



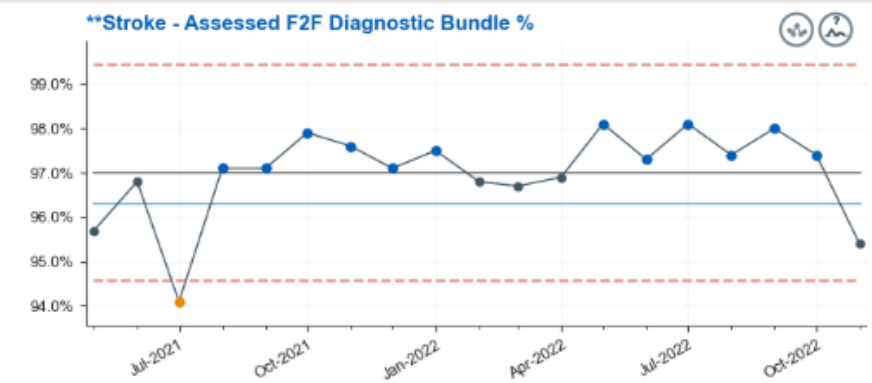
M-8

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.

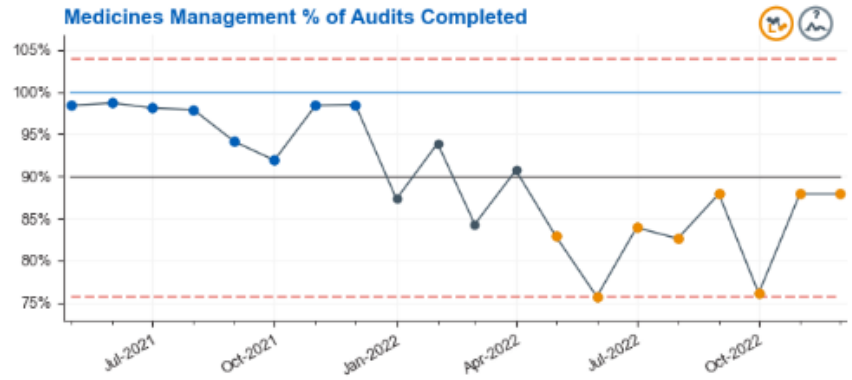
QUALITY IMPROVEMENT

Medicines Management

MM-1

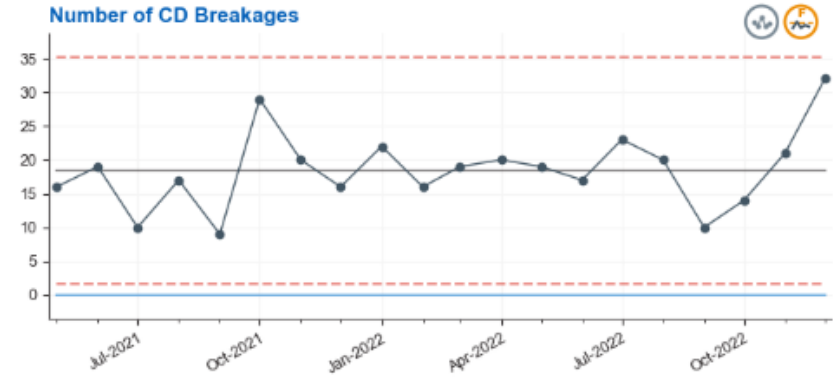
Dept: Medicines Management
IP: Quality Improvement
Latest: 171

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



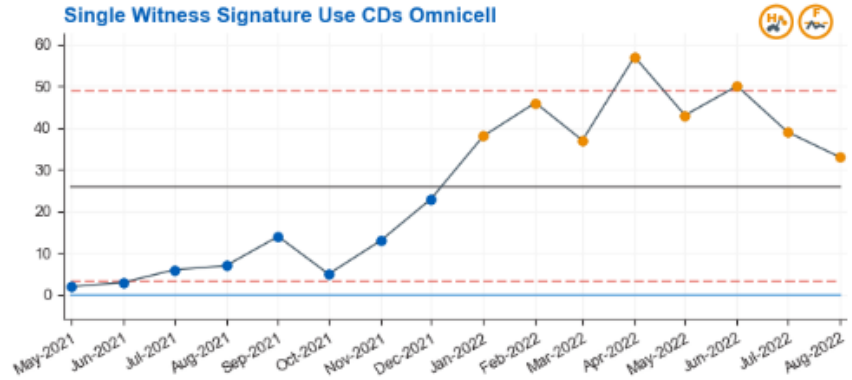
MM-7

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.

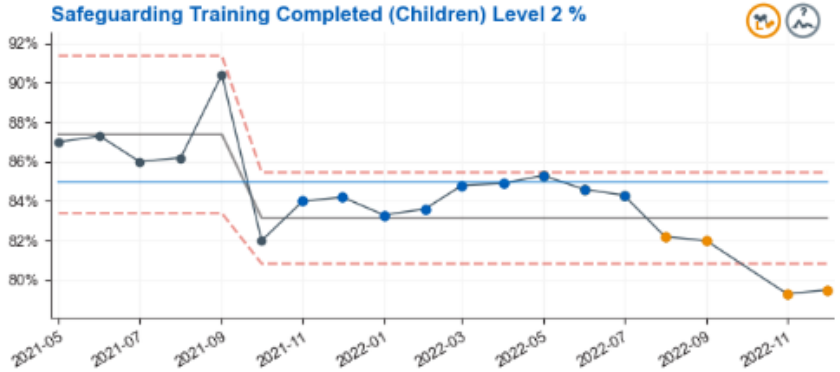
What actions are we taking?

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

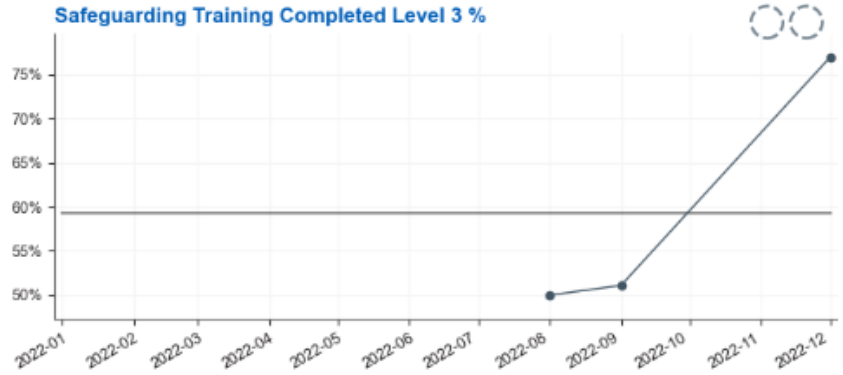
Single Witness Signature: OTL reporting is moving to central platform and CD single signatures will be picked up as part of this.

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

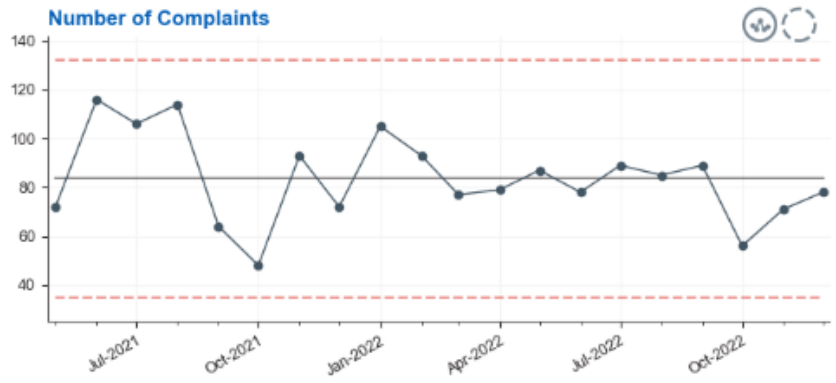
- No update or change to report in the narrative on L2 Safeguarding Children since previous IQR report. L2 training is not part of this year's training requirement (only rolled out every 3 years).
- From the 22nd of September to the 1st of December 22 the Safeguarding Team have trained 392 staff in Level 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

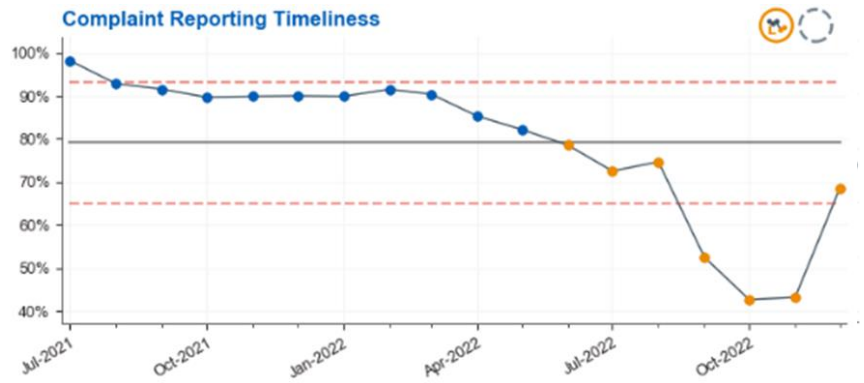
Patient Experience



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

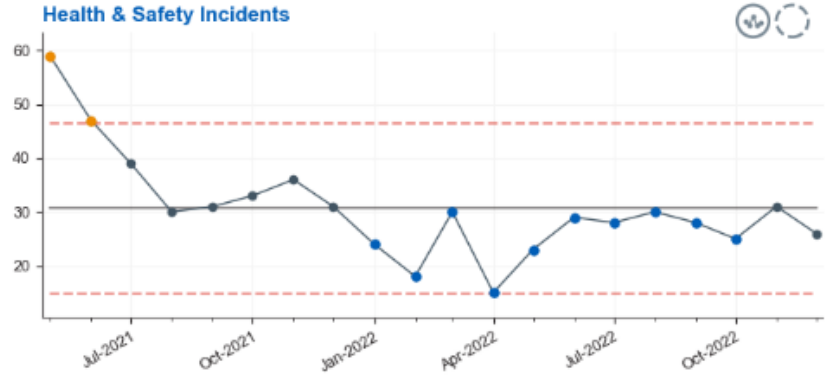
- The number of complaints received by the organisation is consistent.
- Staff attitude complaints have remained constant at between 63% – 66% for the past five months and an average of 65% for the past 18 months.
- Since May 2022, timeliness of complaints has seen a downward trajectory. This was initially 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.

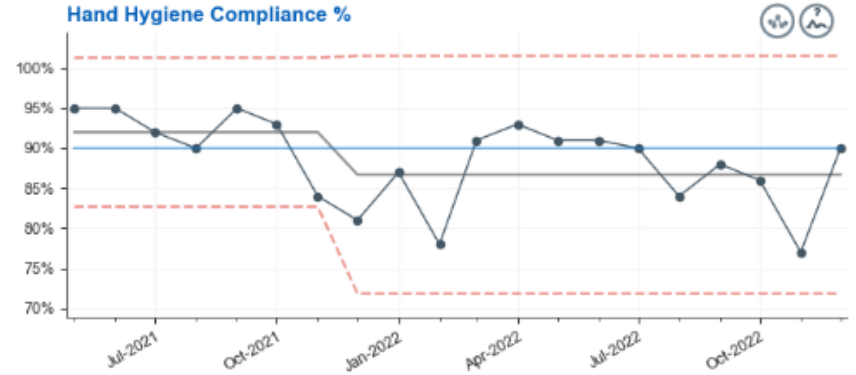
QUALITY IMPROVEMENT

Safety in the Workplace



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 26

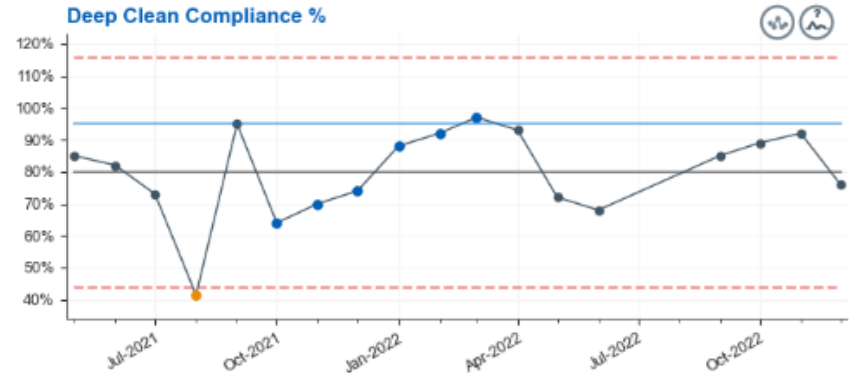
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



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.

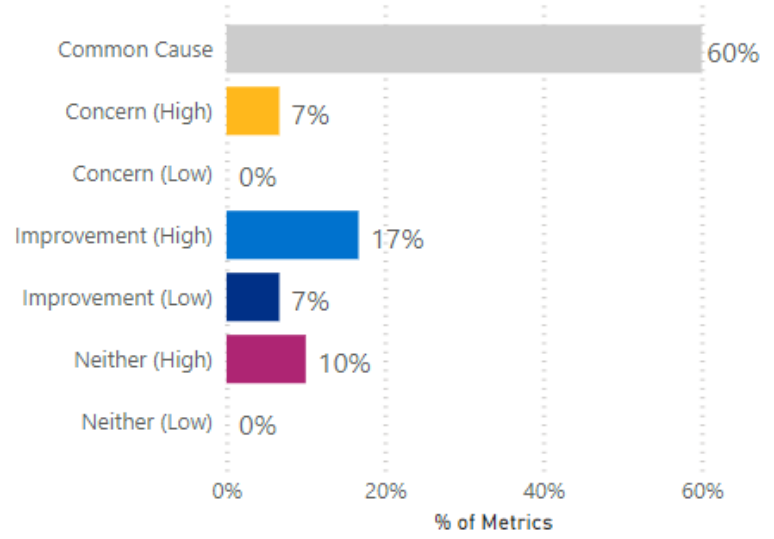
PEOPLE & CULTURE

Overview (1 of 2)

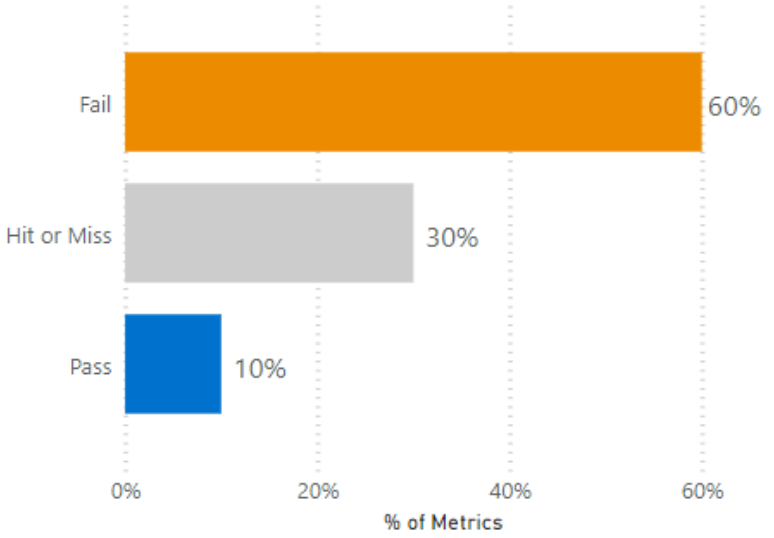
Trend improvement vs previous period

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%		

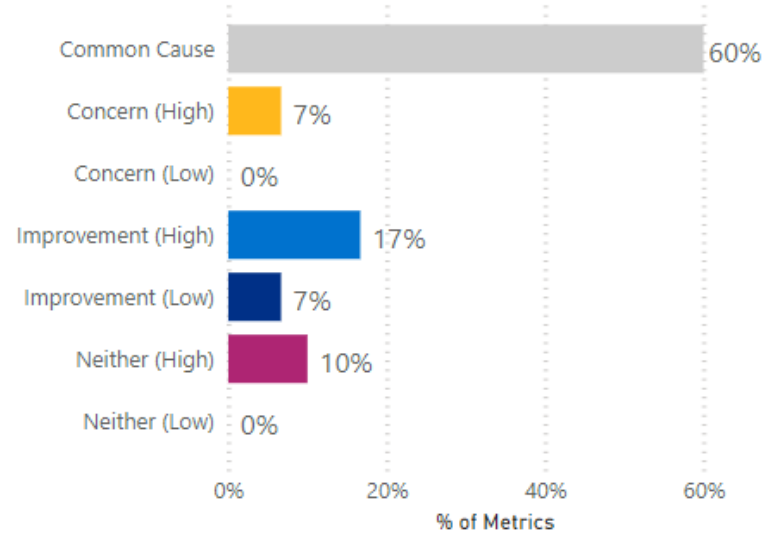
PEOPLE & CULTURE

Overview (2 of 2)

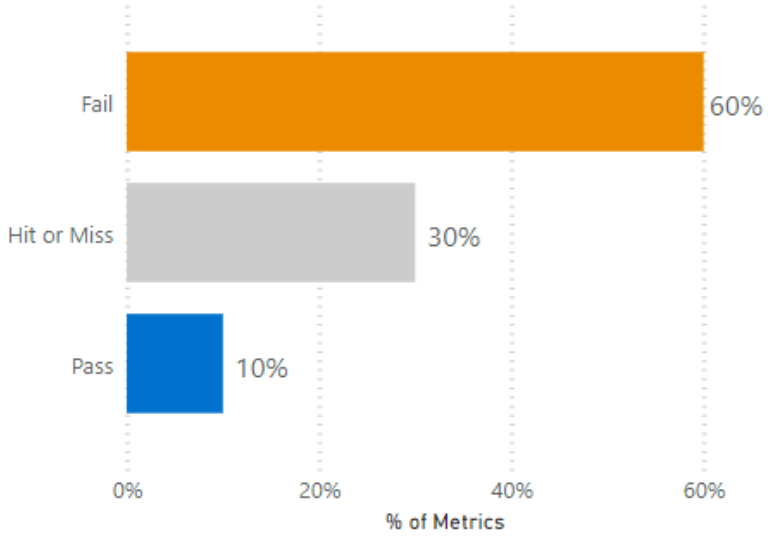
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



Culture

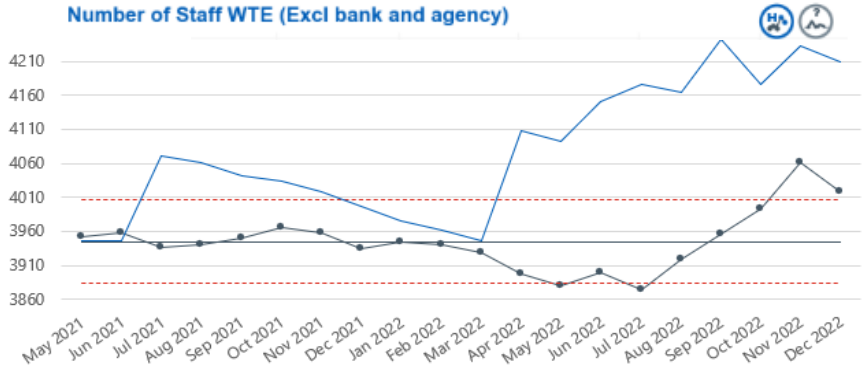
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Dec-2022	10		-0.47	10.45	21.37		
Collective Grievances Open	People & Culture	Dec-2022	2		-1.44	1.5	4.44		
Count of Grievances Closed	People & Culture	Dec-2022	13		-1.59	9.75	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

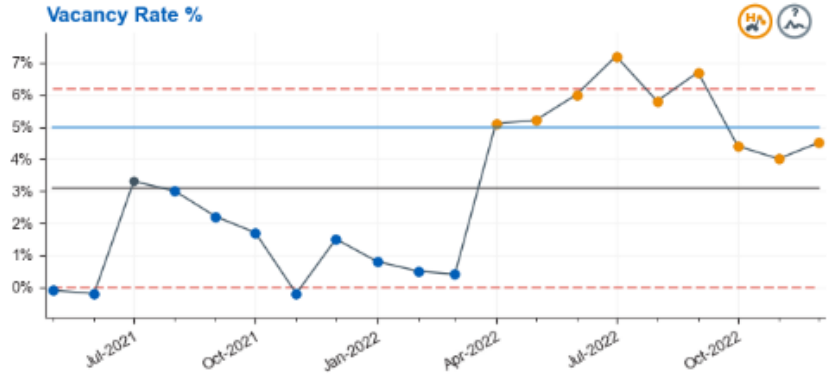
Dept: Workforce HR

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

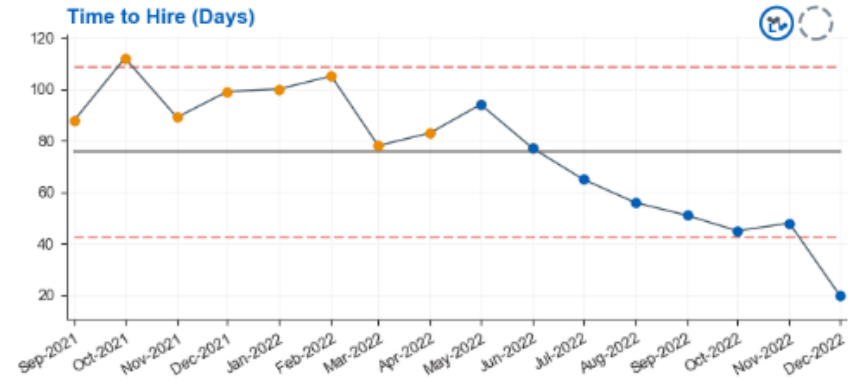
Dept: Workforce HR

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

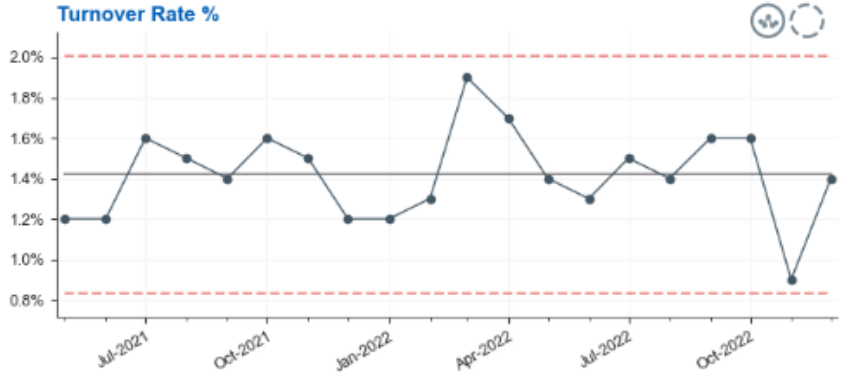
- Increased recruitment for operational roles is helping to achieve level of WTE despite leavers in the directorate continuing.
- Time to hire has reduced significantly due to the reduction in new starters for the month of December – 19 compared to previous month of 119.

What actions are we taking?

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

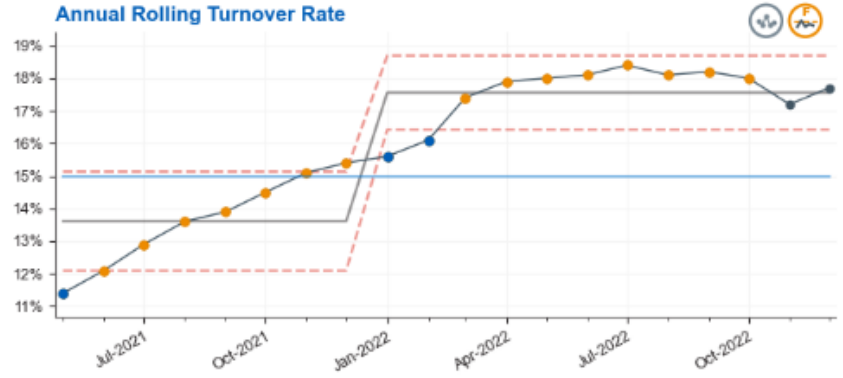
PEOPLE & CULTURE

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.

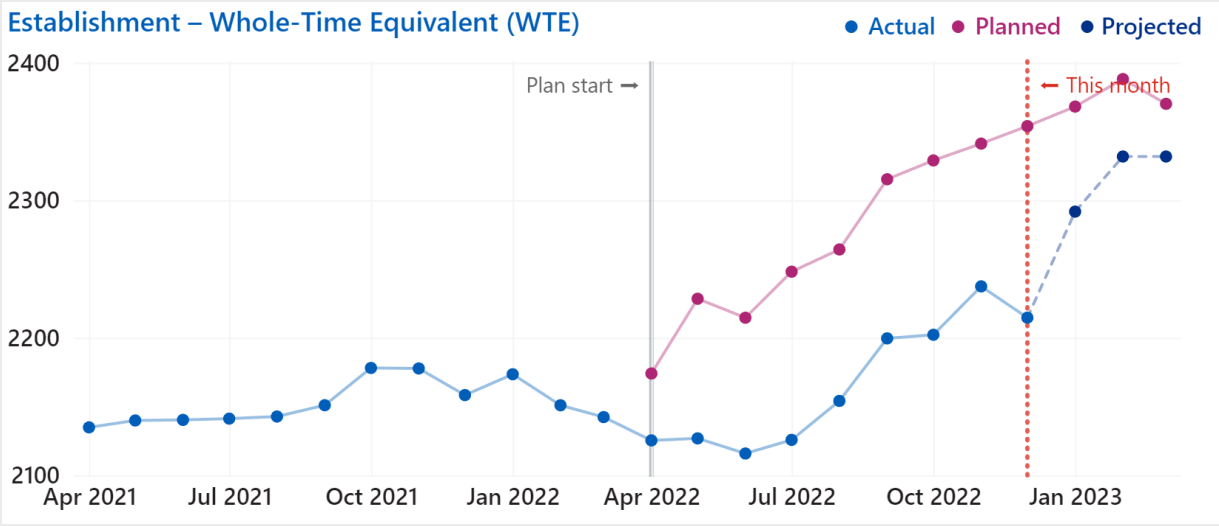
What actions are we taking?

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)

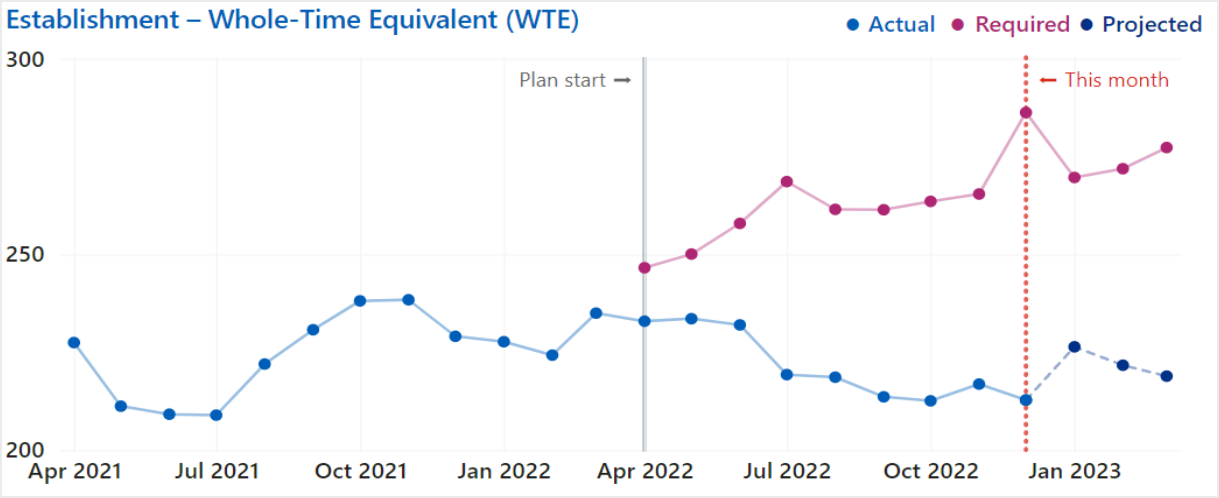
(999 Frontline)



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.

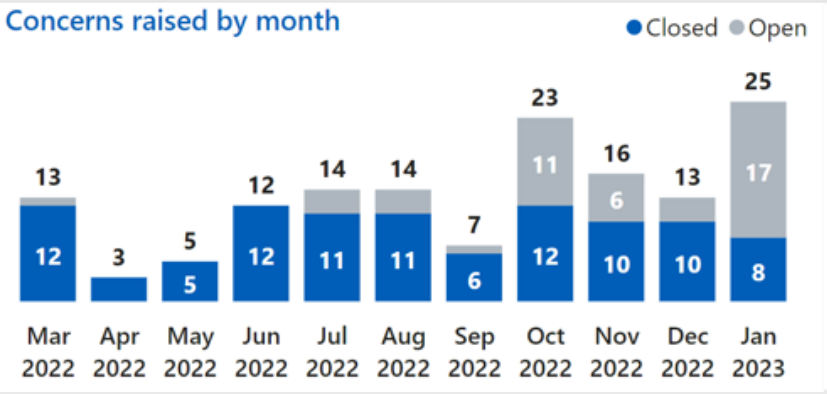
EMA attrition has been 61% higher than planned Year-to-Date with 124 leavers vs 77 WTE by December 2022.

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.

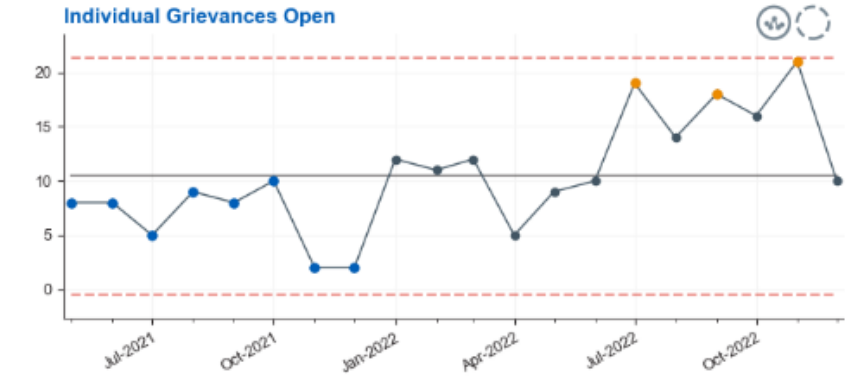
Please see the Call Handling Action Plan paper prepared for the Board on 2 February 2023.

PEOPLE & CULTURE

Culture (1 of 2)



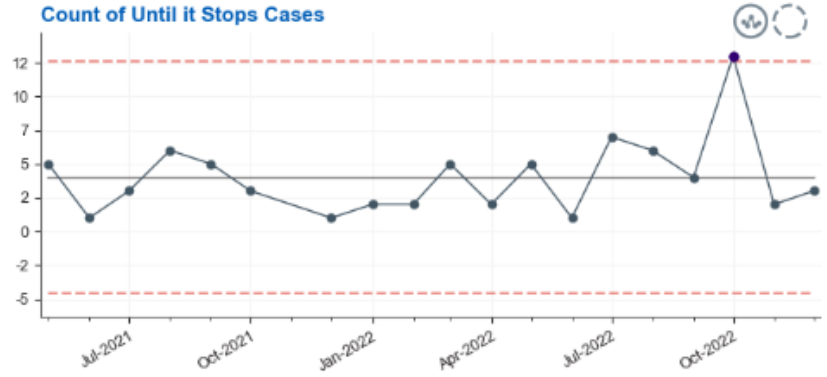
QS-27



WF-10

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

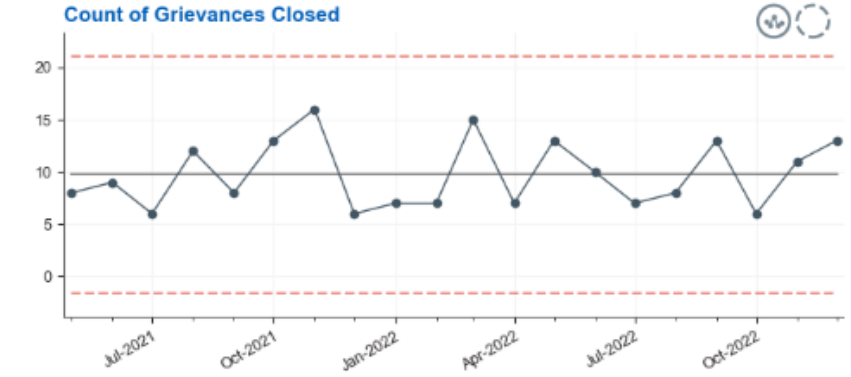
Common cause variation, no significant change.
Assurance cannot be given as a target has not been provided.



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.

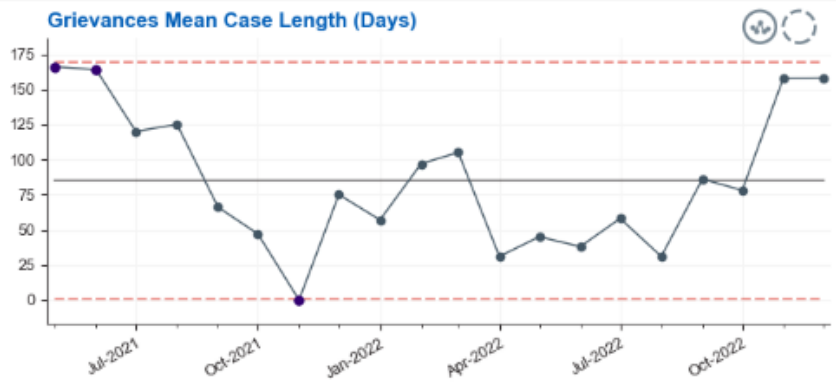
What actions are we taking?

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)



WF-44
Dept: Workforce HR
IP: People & Culture
Latest: 158.12

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

Note: Until it stop cases relate to inappropriate sexualised behaviours

Summary

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.

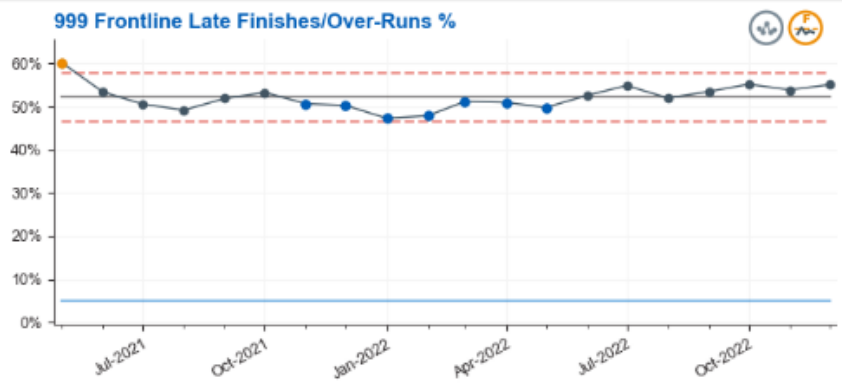
What actions are we taking?

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.

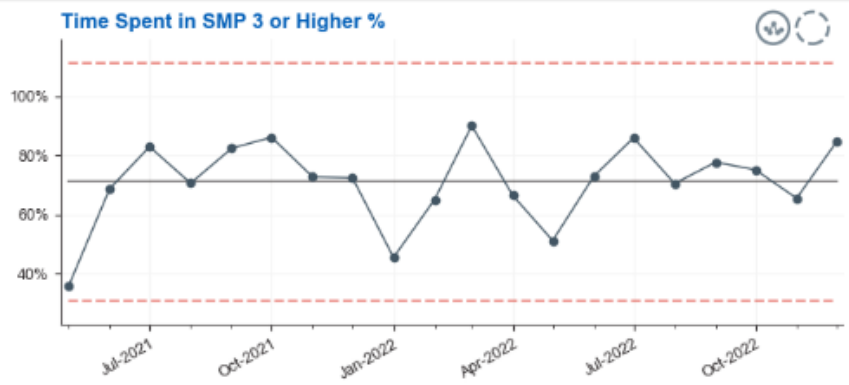
PEOPLE & CULTURE

Employee Experience



999-15

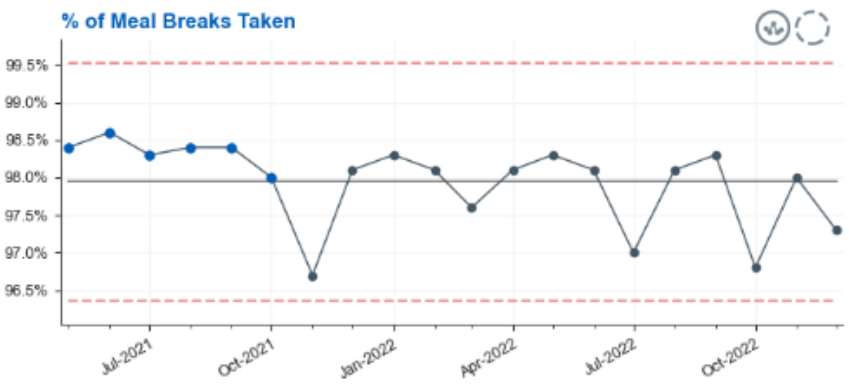
Dept: Operations 999
IP: People & Culture
Latest: 55.1%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



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

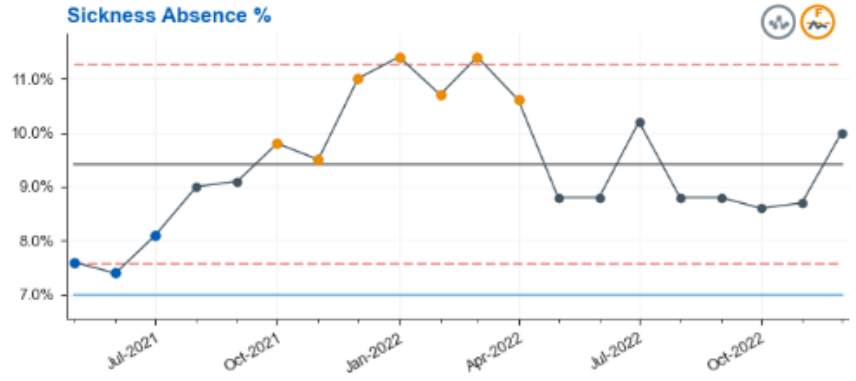
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- This is biased towards frontline road staff, and we will be developing further Employee experience dashboards to cover call-centres and corporate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

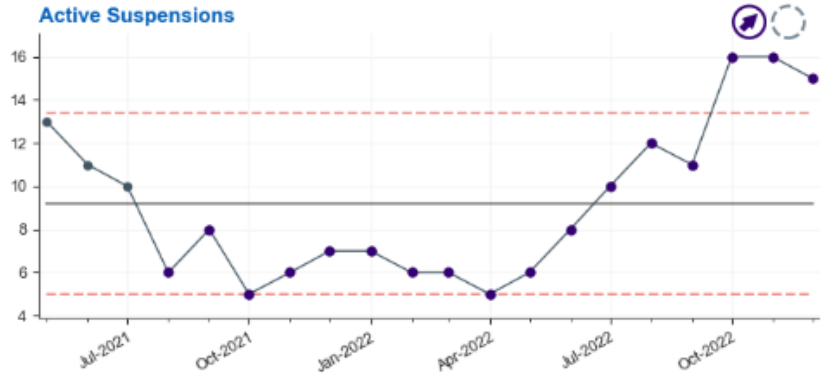
What actions are we taking?

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.

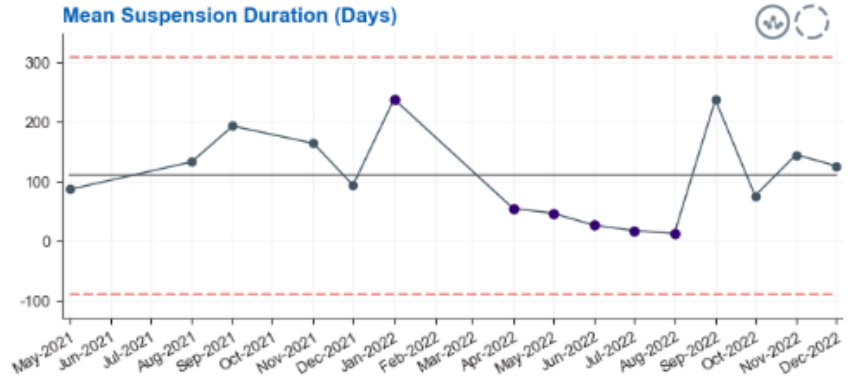
PEOPLE & CULTURE

Employee Suspensions



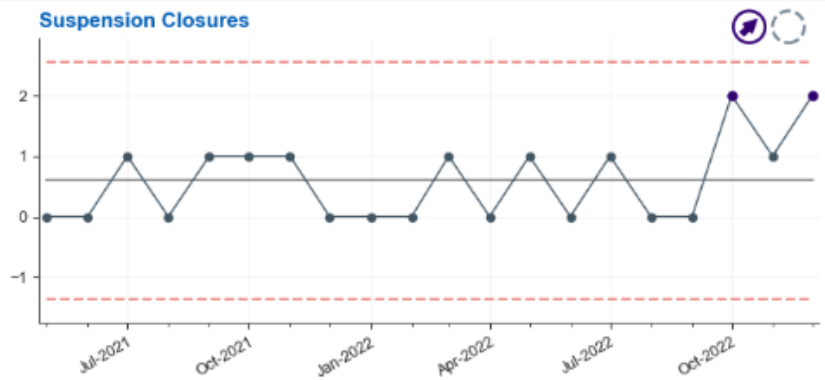
WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 15

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?

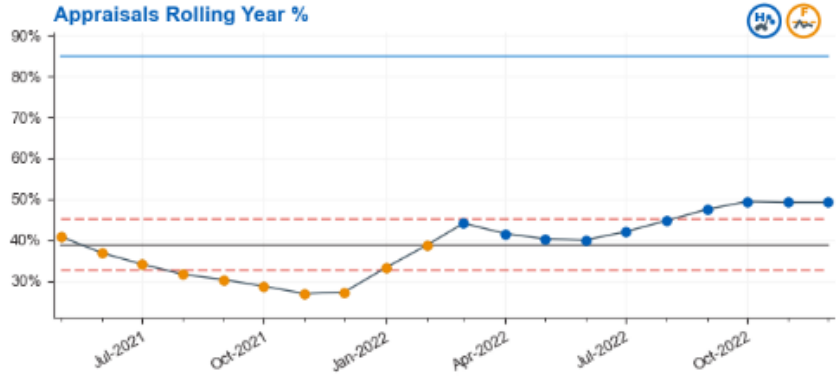
Suspensions: cases continue to be reviewed on a weekly basis by the HRBP Team with the Executive Directors.

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

	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.

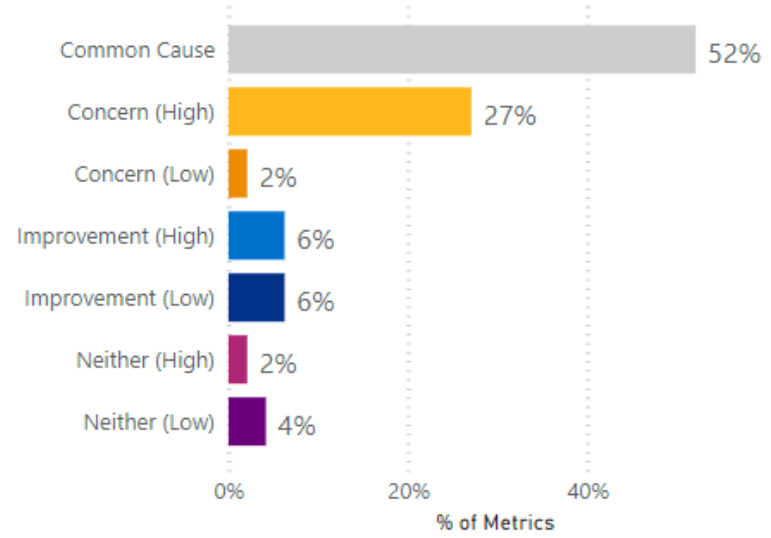
RESPONSIVE CARE

Overview (1 of 3)

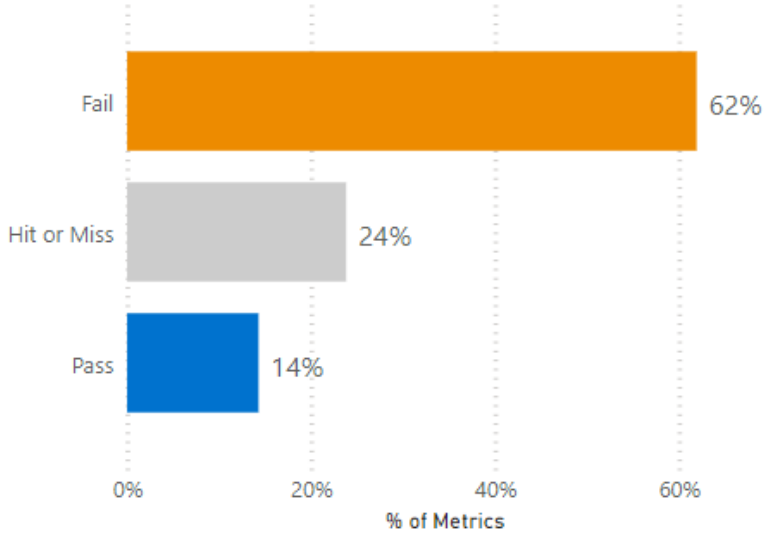
Trend improvement vs previous period

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		

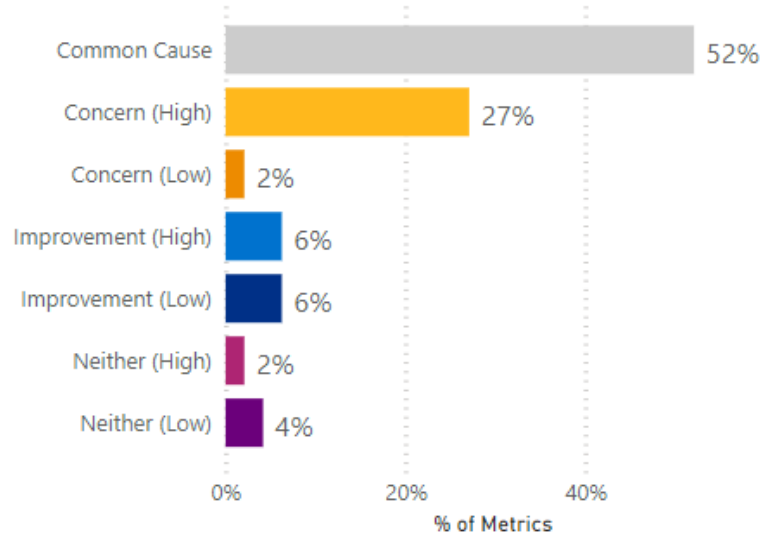
RESPONSIVE CARE

Overview (2 of 3)

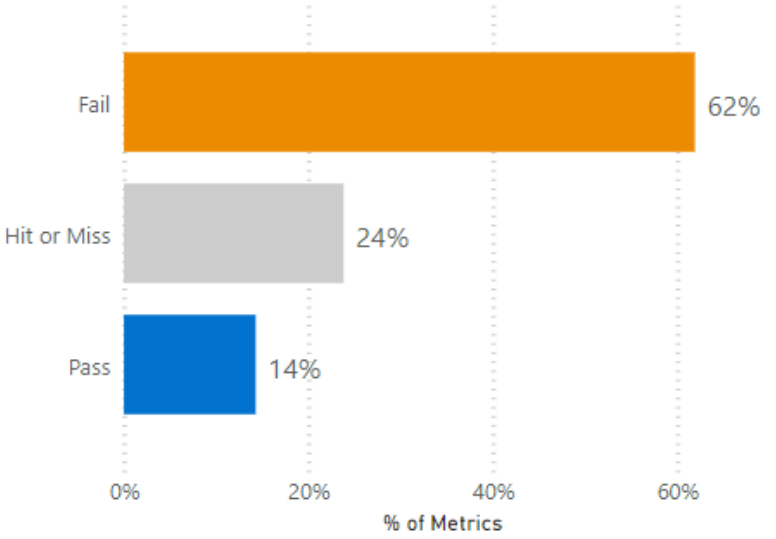
Trend improvement vs previous period

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		

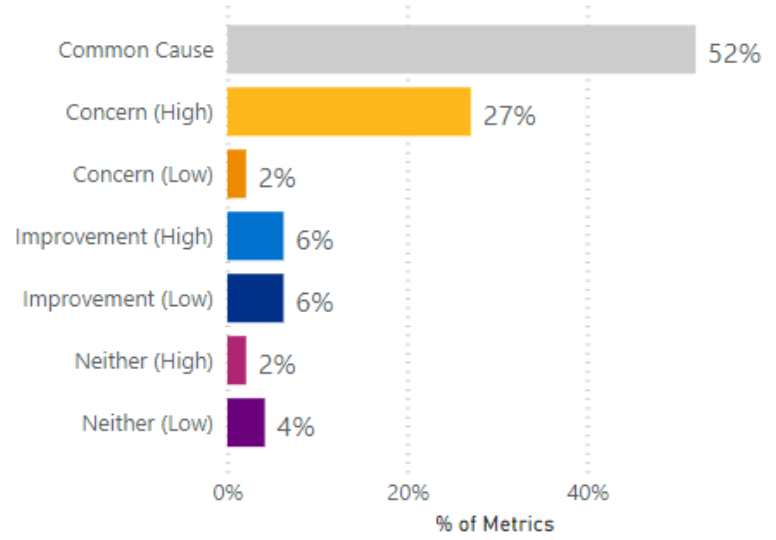
RESPONSIVE CARE

Overview (3 of 3)

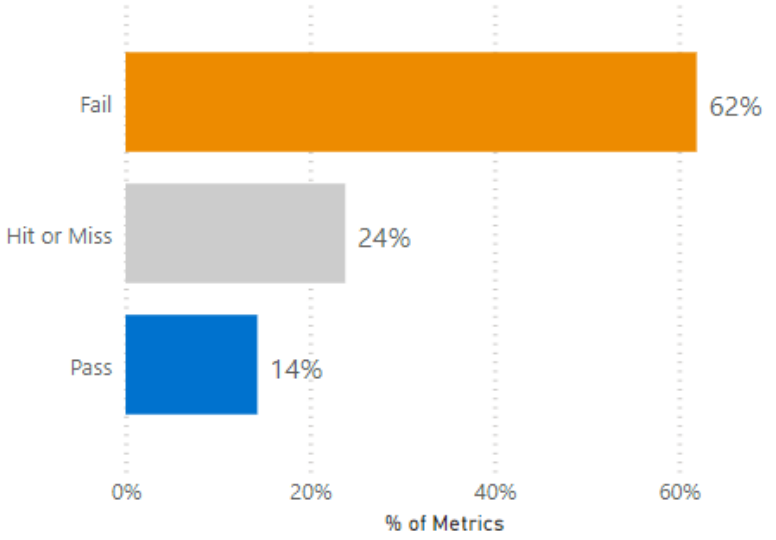
Trend improvement vs previous period

Trend degradation vs previous period

Variation Icon Summary



Assurance Icon Summary



999 Frontline

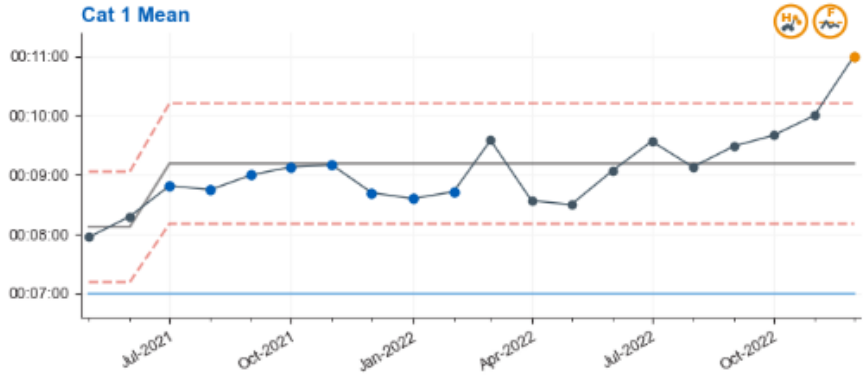
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Dec-2022	01:18:55		01:16:08	01:17:49	01:19:31		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Dec-2022	02:03:15		01:52:59	01:56:14	01:59:29		
Responses 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

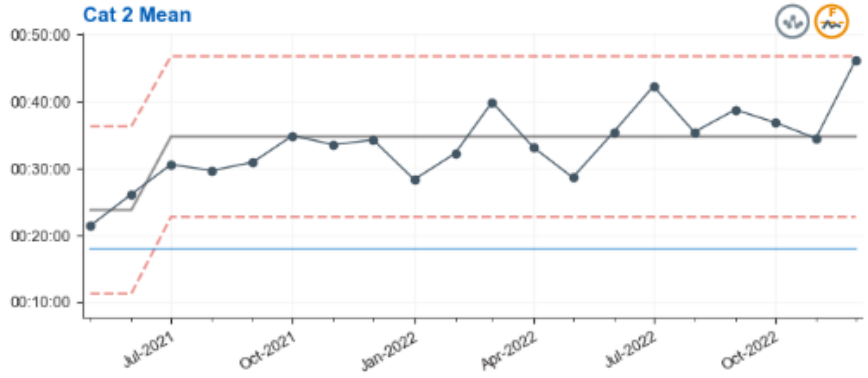
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Dec-2022	9.4%	13%	7.64%	9.58%	11.52%		
See & Treat %	Responsive Care	Dec-2022	33.9%	35%	30.18%	31.77%	33.35%		
See & Convey %	Responsive Care	Dec-2022	56.6%	55%	55.93%	58.65%	61.37%		
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

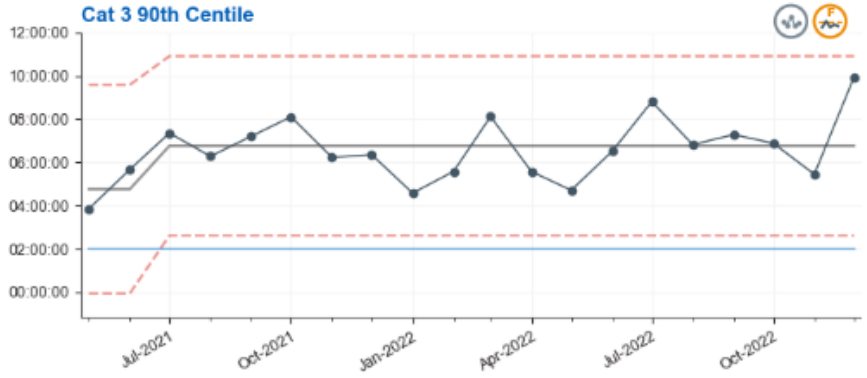
Response Times



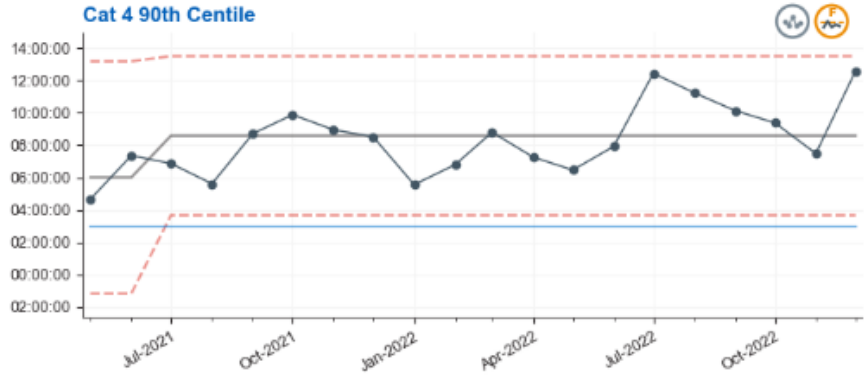
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:11:00
Target: 00:07:00
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.



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.

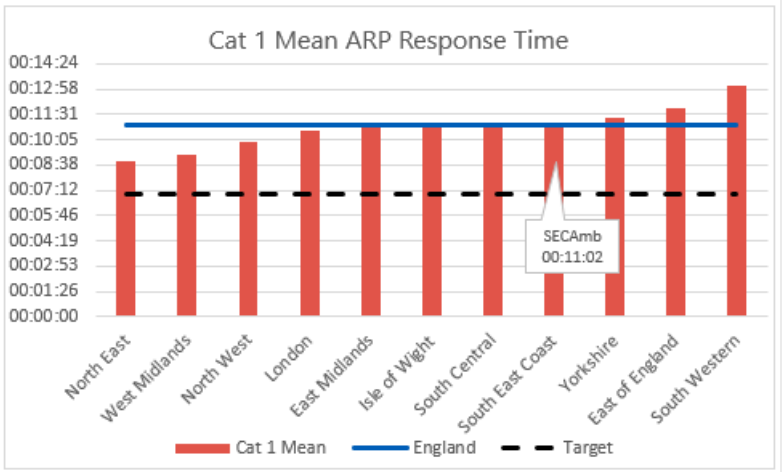
Summary

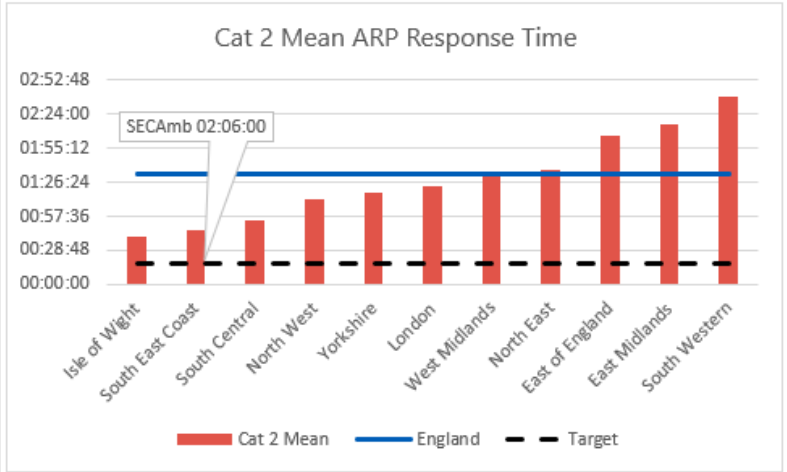
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- This performance has been strongly impacted by the fluctuating demand and resource availability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

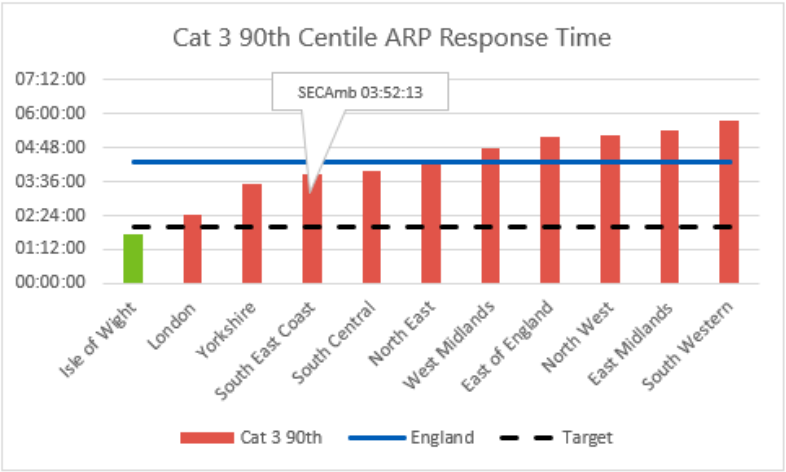
What actions are we taking?

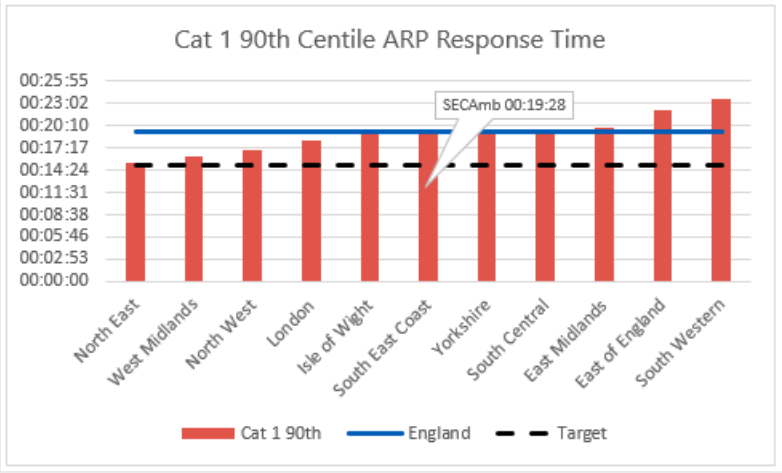
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (96.51% for Dec).
- A specific programme of improvement initiated with focus on optimising Hear and Treat 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.

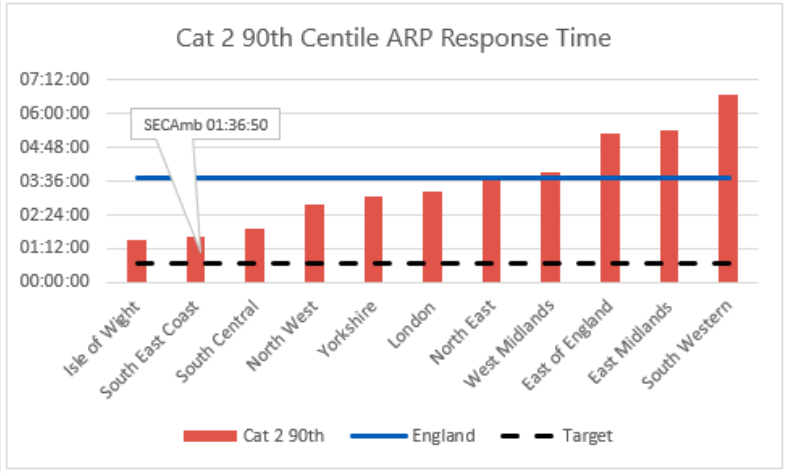
ARP Response Time Benchmarking (December 2022 Data)

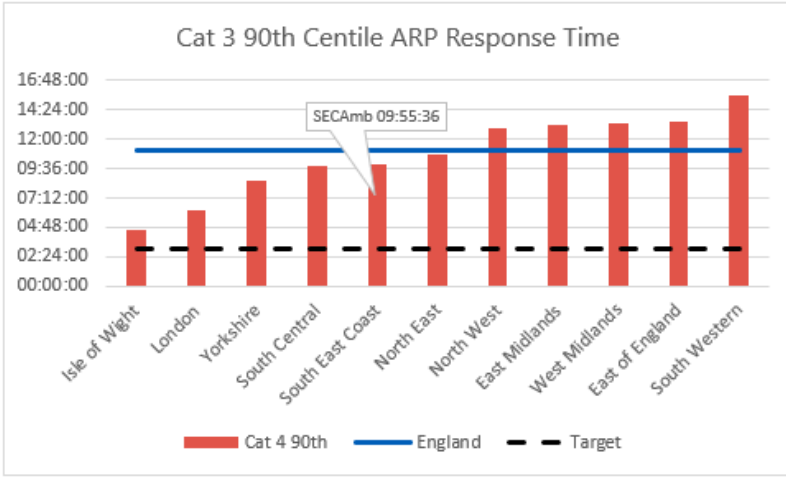










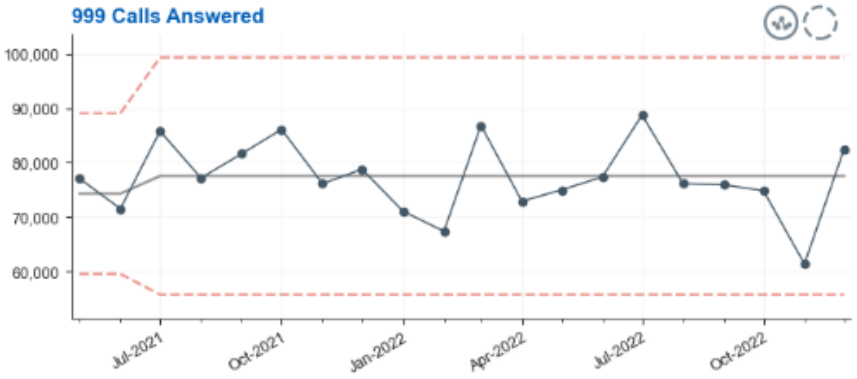


Summary

- **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

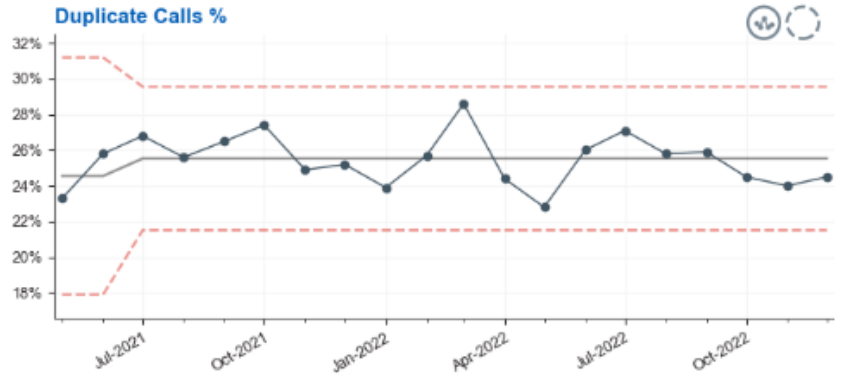
EOC Emergency Medical Advisors



999-10

Dept: Operations 999
IP: Responsive Care
Latest: 82494

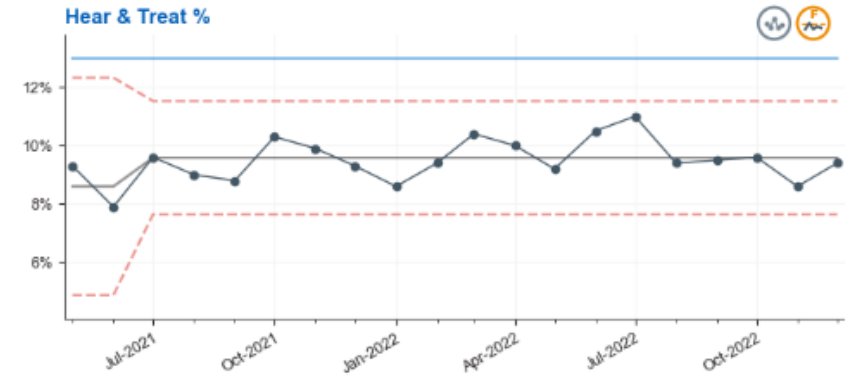
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-33

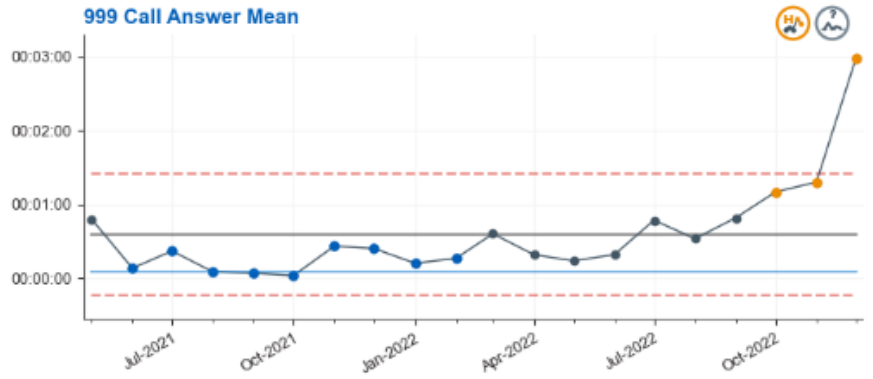
Dept: Operations 999
IP: Responsive Care
Latest: 24.5%

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

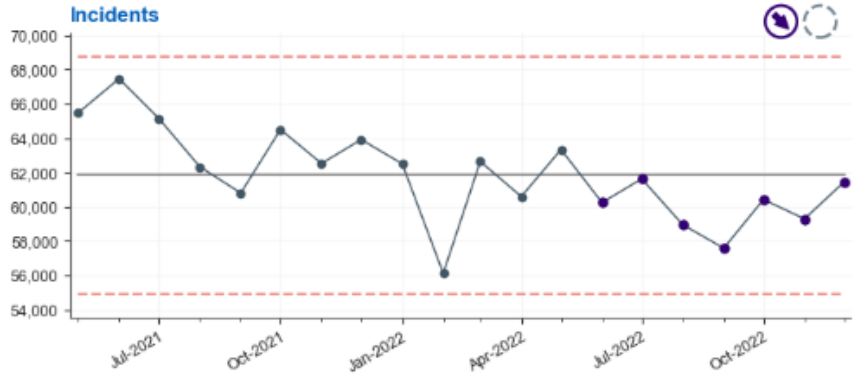
- This narrative relates to the overall efficiency and effectiveness of the call-taking functions within EOC.
- Call answer mean time has shown a steeper increase in the past two months leading to the special cause variation being noted – this is strongly aligned to the EMA resourcing levels over the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

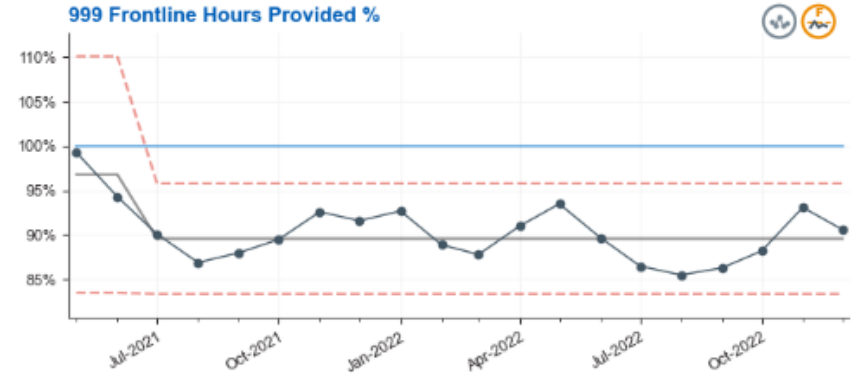
RESPONSIVE CARE

Utilisation

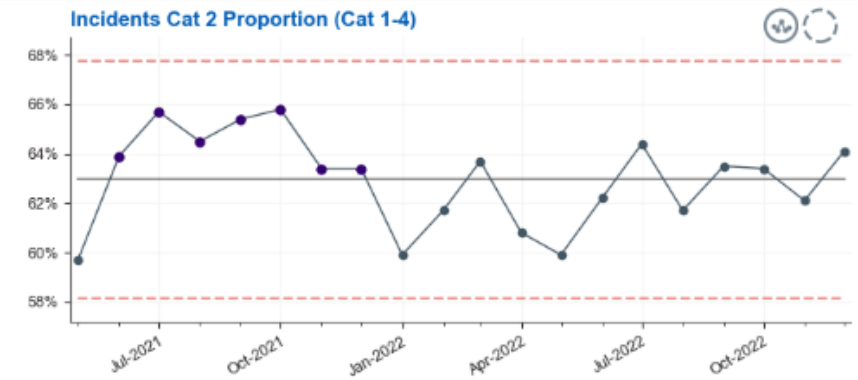


999-10
Dept: Operations 999
IP: Responsive Care
Latest: 61458

Special cause variation where DOWN is neither improvement or concern

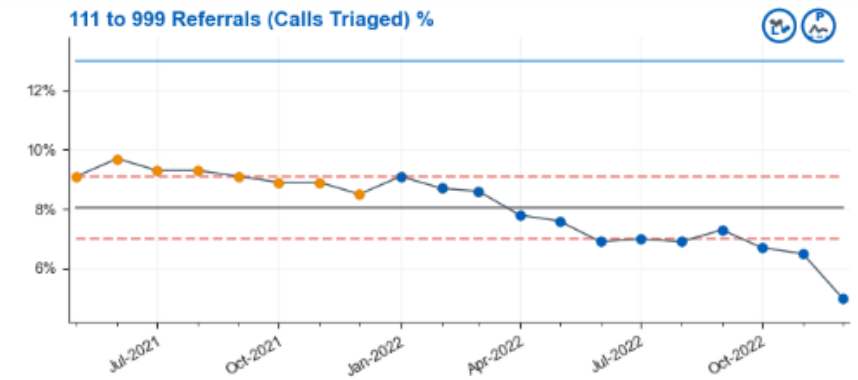


999-12
Dept: Operations 999
IP: Responsive Care
Latest: 90.6%
Target: 100%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



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

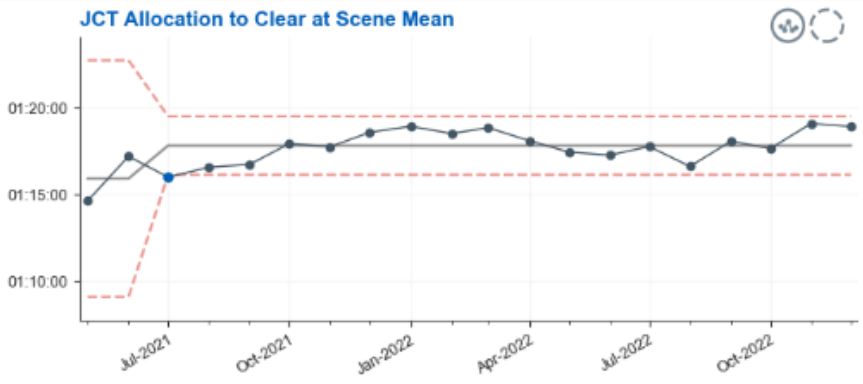
999-17

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

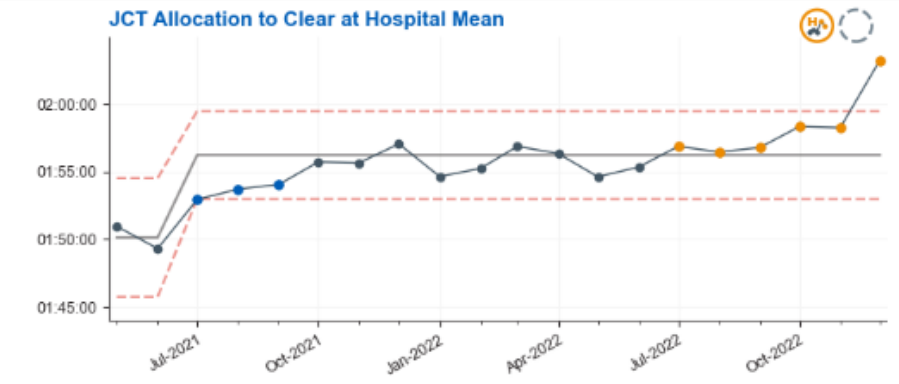
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



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

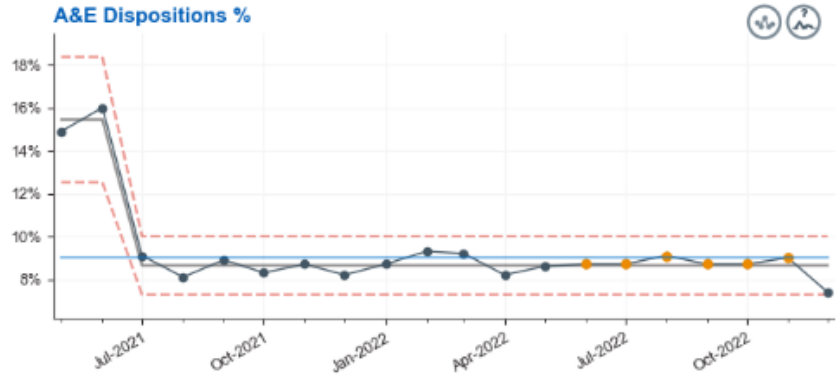
- The efficiency of front-line clinical staff whilst on scene directly contributes to the ability of the Trust to respond to incidents.
- The data within this summary is designed to provide a coordinated suite of indicators demonstrating a number of metric trends. For example, the Paramedic Practitioner 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

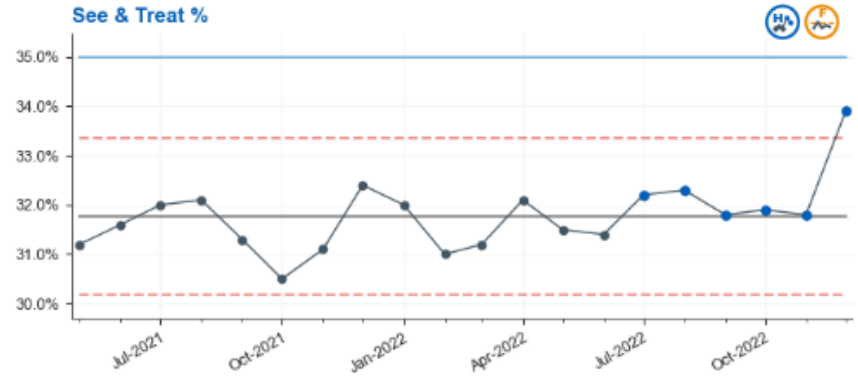
RESPONSIVE CARE

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.



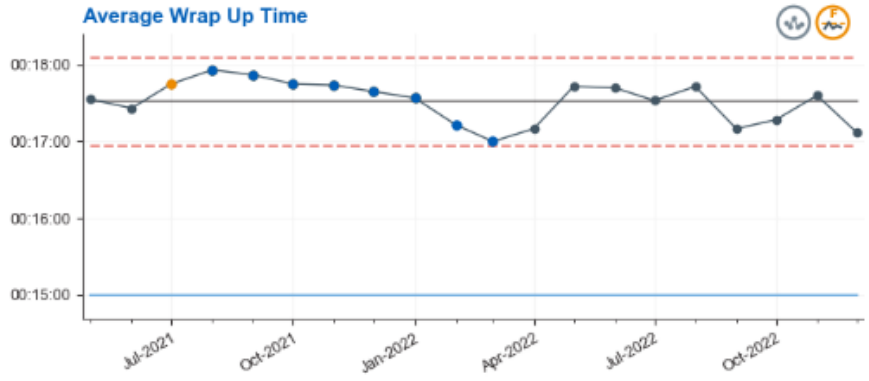
999-9

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

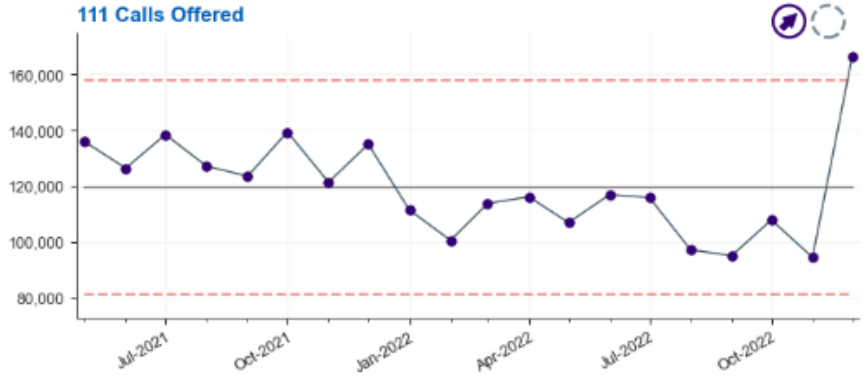
- SECAmb services (999 and 111) are key components of the emergency and urgent care health system in the SE region – this narrative provides an overview of the metrics which describe this component
- The ***111 to ED dispositions*** have been maintained at a low level since the introduction of ED disposition 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



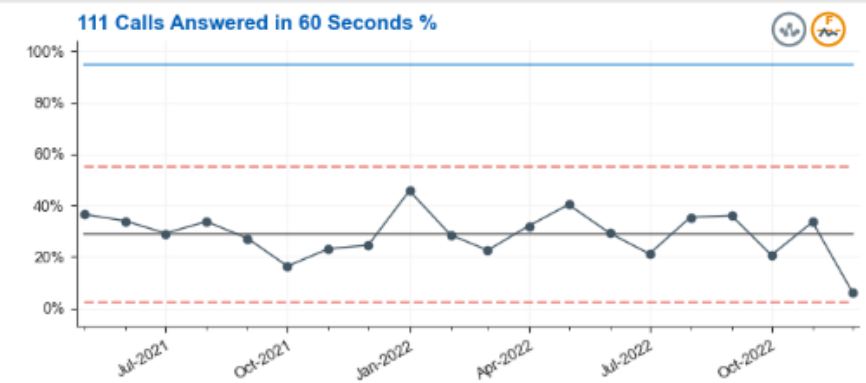
111-1

Dept: Operations 111
IP: Responsive Care
Latest: 166547

Special cause variation where UP is neither improvement or concern

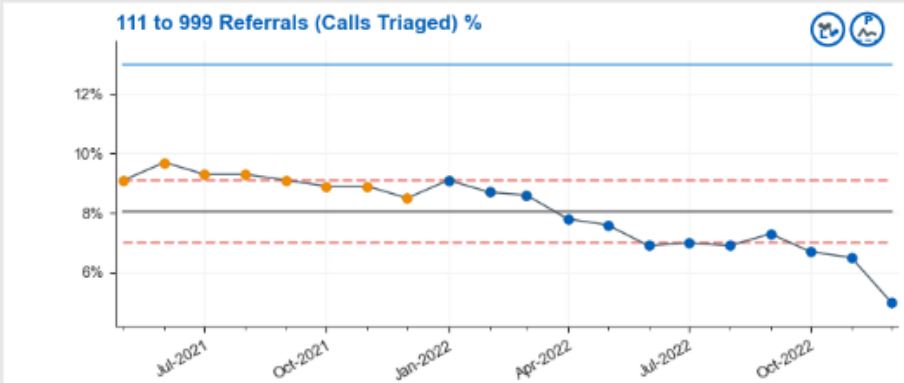
111-3

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

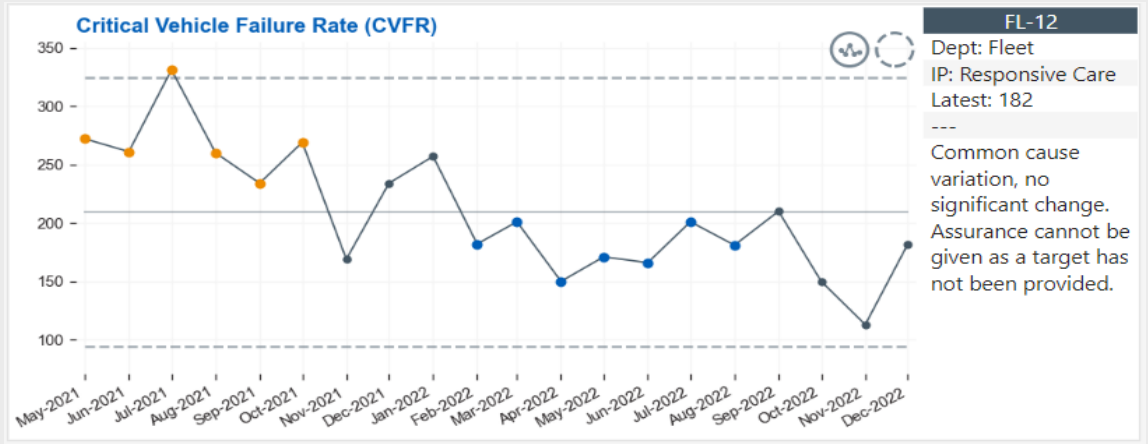
- The call activity and demand in 111 is significantly above that which SECAmb is contractually commissioned and remunerated for however this is impacted by the % of abandoned calls and therefore potential duplicates.
- The service's responsiveness remains poor, as reflected in the sustained low level 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

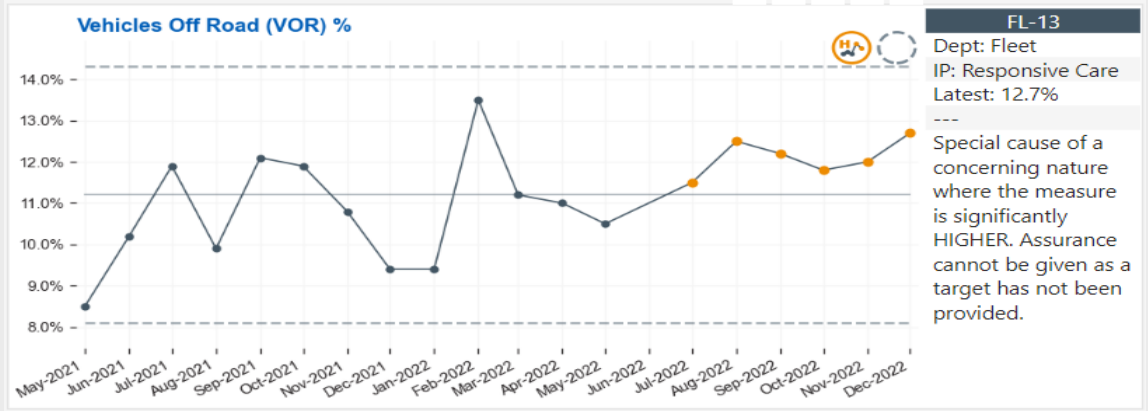
RESPONSIVE CARE

Support Services
Fleet and Private Ambulance Providers



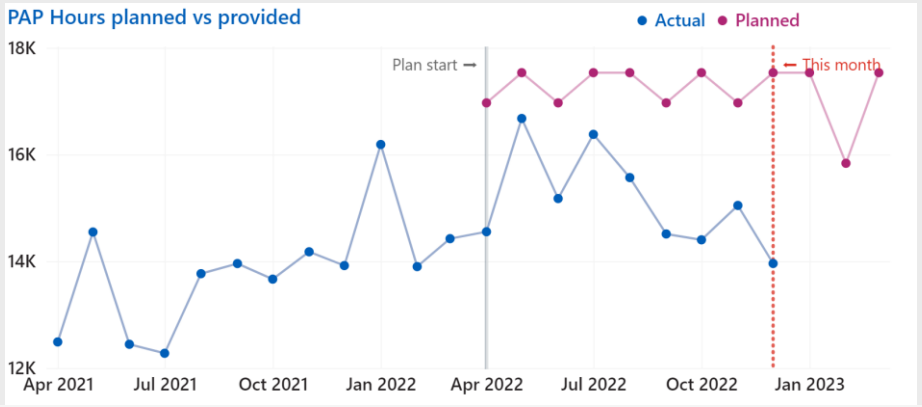
FL-12
Dept: Fleet
IP: Responsive Care
Latest: 182

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.

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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.

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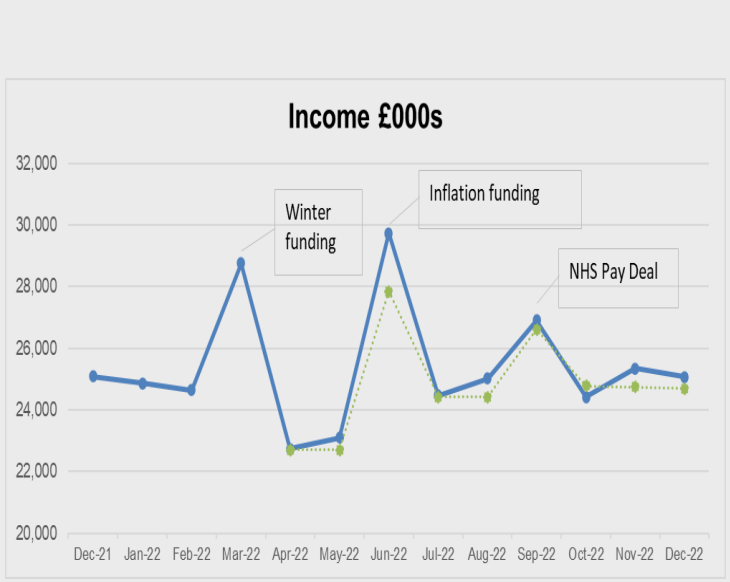
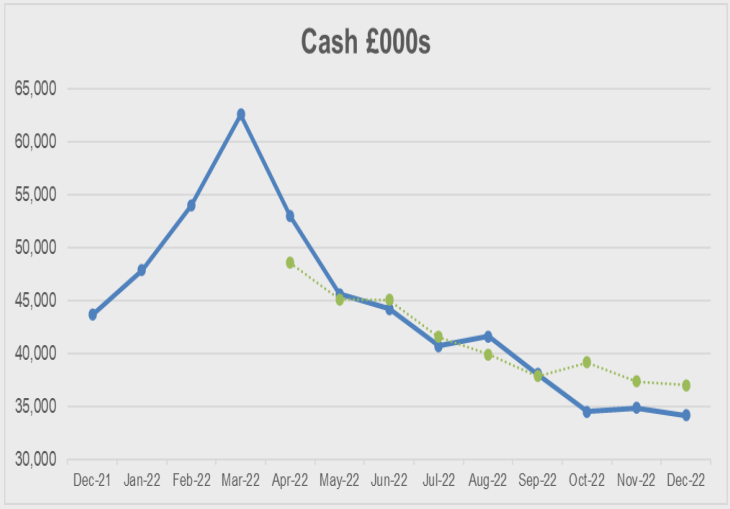
What actions are we taking?

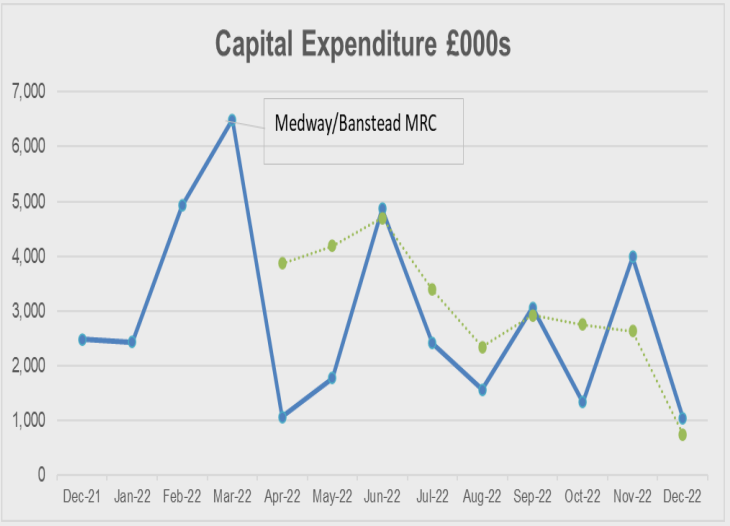
1. The Trust identified a £8.9m savings target in October 2022 to achieve a break-even position, the Trust is engaged in a financial recovery plan to achieve these savings, as at December 2022 £6.2m of savings have been identified, leaving £2.7m; The Trust is looking at a further £0.9m of savings, with 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

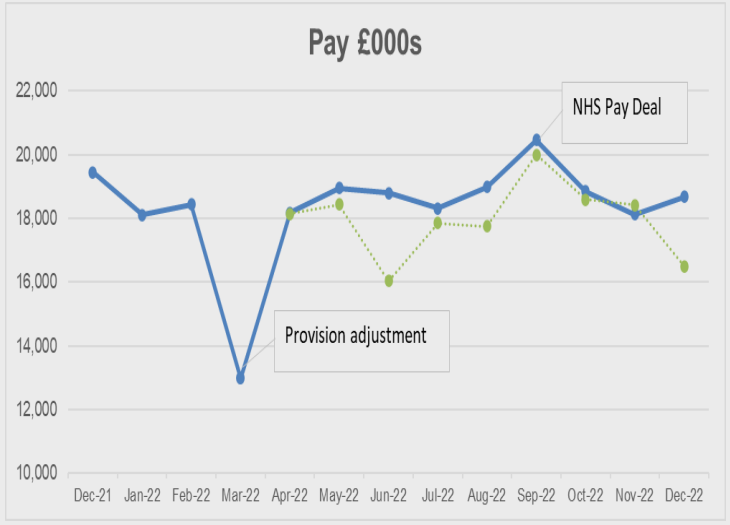
SUSTAINABILITY & PARTNERSHIPS

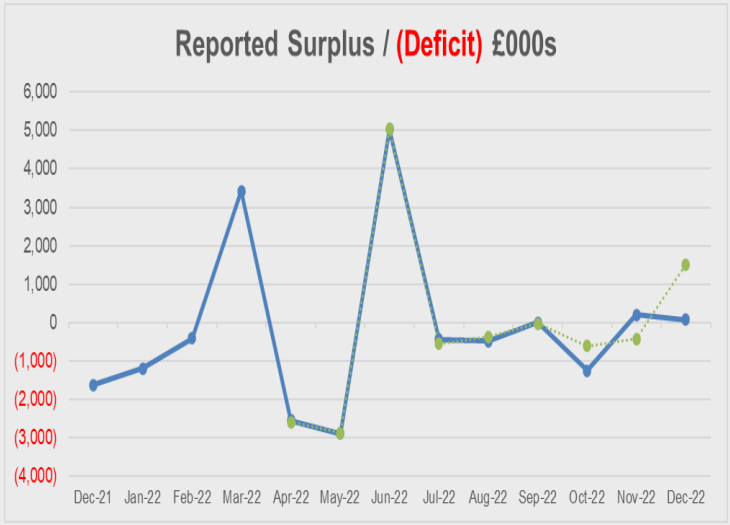
Delivered Against Plan











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.

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Appendix

Appendix 1: Glossary

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

SECAmb Board

QPS Committee Escalation Report

Overview of issues covered at the meeting on 24.01.2023

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.

Southeast Coast Ambulance Service NHS Foundation Trust

WWC Escalation Report to the Board

Overview of issues covered at the meeting 23.11.2022.

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

	assessing the actions against the relevant metrics.	

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

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

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

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

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

Operations Directorate – Teams A Workshop 1

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

Operations Directorate – Teams A Workshop 2

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

Operations Directorate – Teams F Workshop

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

Change to Meeting schedules

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

Reporting route for this programme

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

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

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

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

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

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

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

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

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

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

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

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

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

An audit on statutory and mandatory training was undertaken by the Trust's internal auditors in September 2022. The conclusion deemed that the controls in place at the Trust to manage statutory and mandatory training is deficient. Some areas of good practice were identified including Key Skills training, training

delivery during/post COVID and training alignment with the NHS Core Skills Training Framework (CSTF). The report identifies several instances of a lack of key controls, inadequate control design, and ineffective control operation; including the absence of a Statutory and Mandatory Training Policy, which is felt to have contributed to a lack of clarity over roles and responsibilities, inconsistent processes and procedures, and a lack of accountability and consequences for training non-compliance.

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

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

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

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

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

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

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

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

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

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

Specific Escalation(s) for Board Action	**Staff Health & Wellbeing** The committee felt that the Board has good visibility of aspects of Culture and Leadership, such as the C&L Programme, Sexual Safety etc., but has less visibility on Staff Health and Wellbeing. As mentioned, a request has been made to include metrics in the IQR in due course and, in the meantime, it is suggested that at its meeting on 2 February the Board receives a paper setting out the vision and approach to ensuring the wellbeing of our people.
	Training & Development In the context of the growing list of training needs for staff, the Board needs to be sighted on the various aspects so that it can take an informed view on how this is prioritised in the training plan(s) for 2023/24 and beyond. The committee suggests that a report is received by the Board at its meeting on 2 February, setting out the requirements with a proposed order of priority.

South East Coast Ambulance Service NHS Foundation Trust

Membership Development Committee Report

1. Introduction

1.1. The Membership Development Committee (MDC) is a committee of the Council that advises the Trust on its communications and engagement with members (including staff) and the public and on recruiting more members to the Trust. The MDC meets three times a year. All Governors are entitled to join the Committee, since it is an area of interest to all Governors.

1.2. In this report, we focus on membership updates and summaries of the top items from the MDC meetings and those that report into the MDC (Staff Engagement Advisory Group, Patient Experience Group, Community Resilience, Culture and Development, Wellness and HR).

2. Membership update

2.1. The total staff membership including bank members as of January 2023 was just over 4,800.

2.2. Current public membership by constituency (at 08th February 2023) is 9217. Break down data provided as follows.

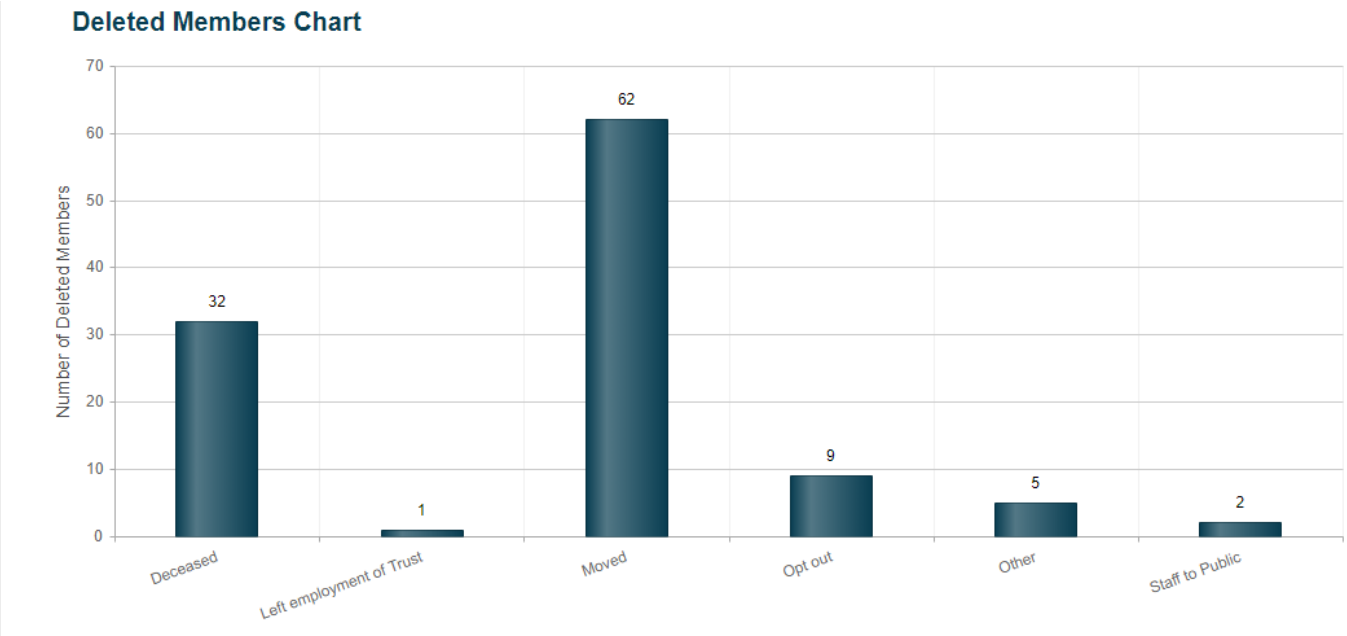
Category or Consituency	Active	Inactive	Suspended	Total
Total Membership	**9217**	**0**	**0**	**9217**
Public Constituencies	**9217**	**0**	**0**	**9217**
Out of Trust Area	425	0	0	425
Lower East SECAmb	1840	0	0	1840
Lower West SECAmb	1421	0	0	1421
Upper East SECAmb	3320	0	0	3320
Upper West SECAmb	2211	0	0	2211

3. Membership history report

The table below shows memberships that have been deleted since 1st December 2022 to 8th February 2023.

Category or Consituency	Deleted (excluded from PR)
Total Membership	**221**
Public Constituencies	**111**
Out of Trust Area	1
Lower East SECAmb	26
Lower West SECAmb	11
Upper East SECAmb	38
Upper West SECAmb	35

The chart below shows why members are being deleted from the membership database from the beginning of December 2022 to the 8th February 2023, with moving addresses as the main reason. A high percentage of this number was identified by the return of newsletters to Nexus House.



4. **Membership recruitment update**

4.1 Our approach for 2023 was proposed and agreed at the recent MDC meeting as follows:

- Governors to research their constituency for local events, with event information returned to Jodie Simper to contact event organiser.
- To attend local events in each constituency area to enable Governors to meet and sign-up new members within their area.
- Attend as many events as possible with a Blue Light vehicle, to help interaction with the public.
- Increase presence on social media, adding a sharable post to LinkedIn, Twitter, and Facebook.
- Speak to shopping stores such as Tesco, Sainsburys to have a pop-up stand
- Set up a sub-committee to look and update governor tool materials, making it relevant and eye catching. The Committee consists of Martin Brand, Linda Caine, Colin Hall, David Romaine

5. Membership Engagement Update

5.1 The next newsletter is due to go out in May 2023 with a behind the screens focus of when you call 999, Your Mind Matters Campaign, Governor updates from the formal CoG and getting ready for the next Governor Election. SECAmb has an entry for this year's UKFSC - Emergency Serives Yacht Racing Regatta, trends that emergency services treat often in the Spring time and a push on getting email address to reduce paper newsletters being sent out and returned in the post.

5.2 The following members newsletter will be due out in the Summer and any suggestions for content for future editions are more than welcomed.

5.3 We have moved back to in person formal Council meetings which are held in public. The public, members and staff members are welcome to join to observe these meetings and ask questions at the end.

5.4 Thanks to those Governors who observed the recent Board meetings. The feedback has been extremely vaulable

5.5 We will continue to advertise these meetings to members. Recordings of the meetings are availiable on our website.

6 Staff Members' Views

6.1 Assistant Director of Organisation Development and Culture, Yvette Bryan attend the MDC to provide an update on the work going on.

A large piece of work that the team focuses on is culture and the culture of the organisation. This year there has been a huge amount of work on the Until it Stops campaign, which is focused on eliminating sexual harassment from the organisation. There has been a series of workshops for mangers, upskilling managers to recognise when there is sexual harassment in the inclusion space. So far over 400 managers have completed the workshop and it is expected to start seeing the change in how staff experience life at SECAmb. Development workshops have recently been commissioned for our frontline staff around a culture, values, and behaviours which is based on civility and respect.

6.2 Leadership and Management Development remains a key focus of the team. In July 2022 we launched the first line managers program fundamentals which runs monthly. Five cohorts have currently attended, and the plan for the next two years is to get all the first line managers through the program. A plan is being worked on to accelerate more managers through as early as possible before moving onto the next level of management and leadership development for our middle leaders and our senior leaders. This is all part of the Made at SECAmb initiative to develop our leaders in the Trust. There is now a development of workshops for all managers focusing on improving attendance so that managers understand how to deal with absences, improve attendance and work through the processes to raise concerns.

6.3 A series of forums are being worked on for the leaders with the hope to have three this year as well as running a leaders' conference in the Autumn. A leaders' conference was meant to happen in September last year but unfortunately was postponed due to the passing of Her Majesty the Queen.

6.4 The emphasis on improving compliance to achieve the statutory and mandatory training target continues. An internal audit was taken and there is now an improvement plan that has arisen from that. One of the key management actions put in place is a statutory and mandatory training policy. Hopefully this is signed off and launched by April this year.

6.5 Appraisal completions are not achieving target. Over the last year a new appraisal platform was rolled out using ESR. Phases one and two have been completed, which is the corporate directorates and phases three and four are halfway through, which is the Operations directorate. An evaluation is being completed and over the next few weeks. There will be adjustments and changes to ensure the platform is fit for purpose. A range of resources have been developed to support the managers and staff with the appraisals and an appraisal hub has been created which sits on the intranet The Zone. There are some fantastic videos and resources that walk the staff through of how to complete their appraisal.

7. **Emma Saunders, Employee Experience & Engagement Manager attend the MDC and gave a verbal progress update of what was discussed in the previous MDC**.

7.1 The new employee experience and engagement strategy is based on a blueprint that has been created by NHS England. The Trust had managed to work through the process rapidly but has had to put it on pause when work started on the Comms and Engagement strategy within the communication team. This was put on hold due to the confusion around whether there should be two separate strategies for comms and engagement and employee experience and engagement or a combined strategy. An external consultancy was brough in called, Hood and Wolfe, to unpick the confusion between what the two separate departments are working on. The conclusion is that there should be two separate strategies, the reason being that comms and engagement strategy is working to improve the two-way communication between workforce and the leadership of the organisation. It's looking at how that communication travels throughout the different parts of the organisation, whereas the employee experience and engagement is looking at the psychological connection with the organisation. It is still paused as there is a desire for both strategies to be presented to the organisation at the same time to not cause the same confusion again and is clear to the entire leadership of the organisation.

7.2 Working with Hood and Wolfe as a team looking at stakeholder engagement across the organisation and what has been developed so far. A proposal from Hood and Wolfe has been put through on how the stakeholder engagement is going to move ahead, possibly planned for March and the framework will be shared at the next GDC.

7.3 The engagement and development (TED) pilot with the NHS England – What the TED pilot aims to do is put ownership back to the teams and with the mangers to empower teams and managers to improve their own team effectiveness, team working and team engagement. The plan has been developed to start to rollout with HR, OD, Corporate and Medical directorates over the first couple of phases, that will be a select team trialling the tool and seeing how it works. That way any improvements can be made before rolling out to Operations. Phases three, which is Operations should be starting around Autumn time, this is not confirmed as yet.

7.4 Inclusion Learning & OD team changes:

- Emma Saunders – Employee Experience & Engagement Manager
- Jen Palmer-Violet – OD & Engagement Advisor
- Matt Thompson – OD & Engagement Coordinator
- Andy Davis – Learning & Development Manager
- Carolanne L'etendrine – EDI Manager (Programme Lead)
- Charlotte Haynes – Learning & Development Advisor (PT)
- Sharna Watts – Interim OD Advisor

8. Assistant Director of Wellness and HR Excellence, Ian Jefferys gave a presentation on Exit Interviews.

8.1 Around three years ago the old methodology to conduct staff exit surveys used Survey Monkey, as did a lot of other organisations. A link was sent to the leaver and they were asked to fill out the form which took up to 45 minutes to complete, if they got round to doing it at all. This was sent from an automated system which was usually sent to the leavers SECAmb email address once they had left SECAmb. Only 17% of leavers would complete the survey and there was a high level of negativity. A new approach was introduced around a year ago which was built on Microsoft forms, this has a much more internally focus. As soon as it is known about the resignation, it is the managers responsibility to encourage the colleague to have an exit interview with an independent person, such as the line managers manager through to a chaplain or one of the non-executive directors or the more senior roles

right through to the network chairs and the deputy chairs or a freedom to speak up guardian. It is a much more facilitated process designed to get the colleague to share much more meaningful information. There are very specifically tailored questions, for which a lot of research was done to look at what was the most appropriate information to capture that would then be useful to convert into a meaningful retention plan. This is more organisationally led and not just seen as a HR initiative. The Trust now has a 50% completion rate of exit interviews, meaning a more meaningful data but it is a long way off the target of 85%.

8.2 The exit interview data informs retention and our decisions, what the data tells us:

- Dismissal – 4
- Employee Transfer – 9
- End of Fixed Term Contract – 3
- Retirement – 36
- Redundancy – 3
- Resign (Adult Dependants) – 1
- Resign (Better Reward Packages) – 5
- Resign (Child Dependants) – 5
- Resign (Health) – 21
- Resign (Incompatible Working Relationships) – 15
- Resign (Lack of Opportunities) – 34
- Resign (Other/Not Known) – 27
- Resign (Relocation) - 27
- Resign (Training/Education) -13
- Resign (Work Life Balance) - 46

From the exit interview data, the majority of people are feeding back that it is a work life balance that is the main reason for leaving. Whilst the Trust is an organisation that embraces people's rights to flexible working, it is a legal right from day one, how that is made a reality, particularly in operations is a real challenge. For many years, each operational centre has capped the number of flexible working that will allow. The Trust is doing a lot more now, designing roles to be more flexible in the first place so that it can be facilitated. Looking at staff that had flexible arrangements initially due to having small children, for example, now those children have grown up can we look at changing the arrangements so we can offer other people the flexible working because having a cap is really restrictive. Another number on the chart to look at is retirement, it is not possible to fill the vacancy quick enough due to our recruitment model. Recruitment starts with Emergency Care Support Workers, developing them up through the ranks can take years to do. A lot of people are leaving due to health reasons and some of that is stress and mental health related. One of the main things to come out of this data is that people are not leaving because of money.

8.3 New questions being asked at exit interviews are about how comfortable staff are to talk with their line manager, line managers receptive to having those conversations. A high number of the leavers are comfortable to talk to their line managers. One of the questions that is asked is 'whether you would consider returning to SECAmb in the future' and this is a really important question and one that we now need to look on how we engage with those people after they've left, 79% of the colleagues that leave this organisation say that they would consider returning if things changed. But as yet there isn't a mechanism for ensuring that the Trust keeps these people up to date.

8.4 The Retention Plan, a plan has been developed for the next 18 months and it follows a simple model that is much easier to engage with our colleagues and managers. It focuses on what we are going to do, how we are going to do it and what are we going to see differently.

NHS England set the Trust a 30% improvement over a 18 month period, which is quite a significant challenge. A lot of colleagues talk about lack of development opportunities, they don't understand the pathway through the various roles. We are looking at how we can put together a career road map explaining the different parts of the journey, the different things that people need to learn, the qualifications that they need and then how we can support that to help them progress through the journey, as well as providing opportunities.

What will we do?	How we will do it	When we will do it	How we will know if we have made a difference
Vision: Best place to care, the best place to work **Three Main Outcomes:** 1. Retention is this responsibility of all line managers 2. Every leaver/potential leaver has a face to face Exit Interview / Stay Conversation 3. We reduce turnover by 30%	**Great Leadership:** • Our managers ensure that every opportunity is taken to engage with their people (team meetings, bulletins, 121's (monthly), appraisals (annually), wellbeing conversations (annually), exit interviews 80% target), and listen to, and act on, the feedback received. #improvementjourney	Oct 2022 (Ongoing)	Retention will be seen as a priority for all managers and leaders. Managers will welcome feedback from colleagues as part of their personal development journey. We will see a marked decline in leavers because they will feel valued. We will have real time information (data and feedback) with which to make decisions that better the working lives of our colleagues. We will be closer than ever to meeting our ARP targets because we have more people and more flexibility. We should have an extra £165,000 to put towards other Trust initiatives/business cases.
	Great Working Practices: • We work towards being a truly flexible organisation balancing the needs of our people with those of our patients. Rota review, flexible working, agile working, bank, shift swaps, flexi time, working from home, annualised hours, compressed hours.	Oct 2022 (Ongoing) with significant improvement seen by Mar 2024	
One Priority Area – 5 Strands: One SECamb *(Culture Improvement Journey)* 1. Great Leadership 2. Great Working Practices 3. Great Recruitment and Induction Processes 4. Great Processes and Procedures 5. Delivering the EMB Stretch Target	**Great Recruitment and Induction Processes:** • New starters have everything they need to start their first working shift; new starters know where to go if they need information; new starters are engaged early on with SECAmb strategies and plans	Dec 2022 (Ongoing) with a reduction in failing probations seen by Dec 23	
	Great Processes and Procedures: • Ongoing development of HR Business Intelligence and Data Analysis to support informed decision making, and future plans;	Ongoing during 22/23 (dashboards) and from 23/24 for data analysis)	
Four Passions: 1. Putting the welfare of our people and patients at the heart of what we do 2. Providing the tools to support our managers and leaders to better support their people 3. Making SECAmb a great place to work 4. Ensuring the voices of our people are heard and acted upon.	**Delivering the EMB Stretch:** • Introduction of new employee benefits (Perkbox/Local Discounts/Financial Wellbeing/Recommend a Friend/Salary Sacrifice) • Development of the Operations Career Roadmap • Targeted support for OU's (Exit Interviews and Retention) • Consideration of a Recruitment and Retention Premia for hard to recruit/retain roles and where market forces dictate: a. 111 Health Advisor b. EMA c. Paramedic	April 2023 and ongoing	

9.0 Patient Members Views: Victoria Baldock Presentation to MDC

9.1 The Patient Experience and Engagement (PEE) are looking to improve the way we engage with the patients and service users and take forward patient experience in the Trust. As such, there is a new Patient Experience and Engagement action plan in place, underpinned by numerous actions which make up a couple of bigger pieces of work.

9.2 999 Patient Experience Questionnaire

We are going to launch a Patient Experience Questionnaire (PEQ) for the 999 service, like the one already used for our 111 service. This will help us to understand patient experience, what works well and where improvements are needed. This survey is expected to launch before the end of March 2023.

To scope out this programme of work we have been building relationships with various external organisations both inside and outside of the NHS, this has helped to provide valuable insight into how we want the PEQ to look.

The survey should be accessible to as many groups as possible and used by a wide number of patients / their families / carers and we are exploring possibilities such as: putting QR codes in the back of ambulances to take patients to the digital survey, sending an SMS to a number of randomly picked numbers who have used our 999 service each week, advertising on our website (on a dedicated Patient Experience section) and including signposting in letter correspondence and email signatures from our Patient Experience Team.

The information from the PEQ will feed into several different forums within the trust including our bi-monthly Patient Experience Group. It will also feed into a new community forum (launching by end of March 2023), involving patient representatives. In these meetings the information and themes and trends from the PEQ will be presented and the groups will work to identify any Quality Improvement projects required.

9.3 How Will We Engage

An options appraisal paper is being completed to analyse the most effective process for implementing the 999 PEQ. The current preferred option is to use an external company's services called We Love Surveys (WLS). This company run our 111 PEQ and utilise an SMS function in which the survey link is sent to 1,200 people each week. This method has proven successful in hearing from a vast number of patients.

We would also be looking to use the same SMS option offered by WLS for our 999 survey, to set us up with the best chances of engaging with a wide number of our patients and service users early on, however we are aware that this may exclude some people without the capacity to use a digital option.

Whilst a paper copy of the survey has been considered, engagement with external ambulance trusts has informed us that this would be very admin heavy and the current Patient Experience Team do not have the capacity to fulfil the work involved with this method of engagement. To mitigate this gap, contact details will be shared on the survey to allow those that need additional support to get in touch with us so that we can discuss their requirements on an individual basis. This may even include going out to their home to ask the questions and record their answers on their behalf.

We are also meeting with the Mental Health Nurse Consultant for SECAmb to discuss the best way of ensuring we hear from our vulnerable groups and mental health patients and ensure they have a voice too.

9.4 PEQ – The Information Governance Element

There are some IG issues regarding this option which require further exploration. In the 111 service an automated message is played to those calling through to advise they may be contacted via text message to participate in a survey, however this is not possible to replicate in the 9's as it's an emergency line and could cause delays to urgent treatment.

There is some consideration required around the nature of the calls received by the 999 service and whether it would be appropriate to send the survey out, as those receiving it may have experienced a traumatic event or they could be a passer-by that contacted the service on behalf of the patient that is of no relation / connection to them personally. Whilst the nature of the calls received in 999 is generally going to be an emergency, we want to hear from all of our patients and it is not possible to pin point each person who may be triggered by sending a text message for the survey to. We are however, waiting for input from the BI team to advise if we can exclude numbers from cases which have resulted in dispositions involving deaths.

Our IG lead will discuss this with the Information Commissioners Office (ICO) in February 2023. The outcome we hope for, is that if we do everything possible to let our patients know we may contact them for a survey, like advertise on our website, via social media, poster in ambulances etc., the SMS survey link should be achievable. We will also offer an opt out option, in which an opt out link can be added to the text message and would take the patient / service user to a web page to remove their number from the list in future and automatically adds them to a black-list on the platform so they would never be contacted again.

WLS do not store mobile numbers and the Application Programming Interface (API) refreshes. They use a Microsoft based platform and are UK based.

9.5 PEQ – Our Requirements

WLS can offer several helpful additional services as a low cost and once everything is decided and ion place, the launch would be expected to take approximately 3-4 weeks. The below is the current list of requirements we are looking to include:

Requirement	Comments / other information
A section at the end of the questions to advertise community forum and volunteer work on QI projects within SECAmb	'If you would like to attend our new community forum and come and share your journey through the healthcare systems or you are interested in getting involved in a volunteer capacity with our future QI projects please email: engagementteam@secamb.nhs.uk'
PEQ to be translated into our top 6 languages used through language line	The service WLS use to do this charge by the word and it is higher for Arabic languages and slightly lower for European languages. They would need a final word count for the English version of the survey and to know which additional languages are required to be able to provide a quote. Top 6 languages: Polish (979), Arabic (906), Romanian (826), Mandarin (717), Russian (654) & Bulgarian (499)
SMS text service to 1,200 random numbers a month	Awaiting confirmation from IG team as per slide 6
Accessible and user friendly	Large text, dark in colour, easy to read font (Arial)
Access to online reporting portal to access the data through Excel answer tables and fixed pie and trend reports	We will not use their Power BI team to give us a dashboard or results at a glance, but instead utilise our own internal BI team who will receive the raw data to produce analysis. This will be a cheaper option and also mean it's easier for us to align the complaints and compliments to the patient experience work as they currently produce reports for the PET
Our branding to be added to the web page	WLS happy to work with these
Annual review with WLS to ensure we are happy with all elements of service provided	They can be very flexible around this and meet more often. We will begin by meeting more regularly and phase this into an annual review. Questions from the survey can be changed anytime, although they normally ask for around 10 working days notice to allow them to book the changes into the schedule for their technical team to implement

9.6 PEQ – Next Steps

- Ongoing completion of an Equality Impact Assessment (EIA). This is a working document which will continuously be updated throughout the project
- Share these programmes of work with our Healthwatch partners and public governors for input
- Options appraisal paper / business case once a quote is back from WLS
- Meet with BI team to discuss plan and support required
- Complete a Quality Impact Assessment (QIA)
- Complete Data Protection Impact Assessment (DPIA) once we have information from ICO
- Patient Experience and Engagement & PALs teams to add a link in their email signatures to direct people to the PEQ once set up and something similar on the bottom of letters of correspondence to signpost people

9.7 Community Forum / Patient Participation Panel

We are looking to launch a forum made up of patients / their families / carers in which they will be invited to share their experiences.
from their journeys through our 111 & 999 systems. This is another way of gaining feedback from the people that use our service and an opportunity for the patient's voice to be heard and help us to identify service improvements and future Quality Improvement projects. We expect to launch this programme before the end of March 2023.
We are also looking to invite patients to volunteer to work with us on QI projects and in other areas throughout the Trust.
To plan this programme of work we have been in contact with several external organisations and even attended their patient forums to support the following elements:

- Meeting agenda and structure
- ToR (to include group membership, for which we are looking to involve mainly members of the public and very small number of SECAmb representatives)
- A volunteer agreement (we have something similar below which may need adapting, to include payment reimbursement details and IG requirements / agreement)

https://www.secamb.nhs.uk/wp-content/uploads/document_library/2015/09%20-%20September/Policies%20and%20Procedures/Volunteer%20Charter%20SECAmb%202015.pdf

- Where we want the information from this meeting to feed into and what we will do with it

How the forum will look:

The forum - How will it look

- Agenda example below
- QI project updates example below
- Where the information will feed into, diagram below
- We will invite a member of the Board to each meeting to ensure there is a connect from the patients voice up to the highest level within the organisation
- The idea is to keep SECAmb representatives to a minimum and allow the patient voice to be heard. We can have a few regular patient representatives as well as ad hoc members attending this group

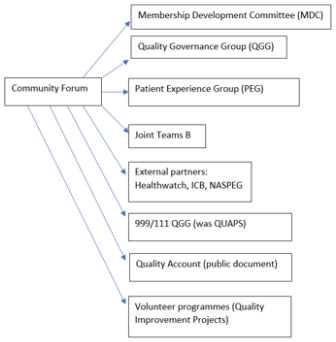
Agenda example:

	Item	Presented by	Papers
1	**Welcome and Introductions** **Apologies:**		
2	**Review of Minutes / Actions from the last meeting**		
3	**Online PEQ Update** E.g., Themes and trends, repeated words, information around the alignment of the PEQ data and compliments and complaints. Any technical / resource issues there have been technical and resource issues which have affected the volume of text messages being sent out and the responses		
4	**QI Project Updates** Taken from information from previous Community Forum: A table to show what you told us and what we did		
5	**Feedback from Patient Experience Group** E.g., Budget information / feedback from QI projects		
6	**Patient Representatives to share their thoughts / ideas / experiences**	**Patient Representatives**	
7	**Events**	**ALL**	
8	**AOB**	**ALL**	

QI Project Updates example (IC24):

QI Project Title	Update
Automated Comfort Messaging	This project is focussed on fast, timely and effective communication with our patients via the use of text messaging which reduces the need for manual comfort calling. Patients are notified of any delays to a call-back via text. Certain groups of patients can respond to cancel a call-back from the service with a reason for the cancellation provided. Since September we have now added 2 additional reasons (E&F) to give patients to accommodate other reasons for cancellation. CANCEL A - Symptoms resolved or subsided CANCEL B - Went to A&E CANCEL C - Called 999 CANCEL D - Saw own GP or another service CANCEL E - Self-care or Self-management CANCEL F - I don't want any further contact from the service/ prefer not to say why We've also changed how a call-back is cancelled by only activating a cancellation when a reason is selected.

Where the information will feed into:



Next steps:

- EIA, QIA, DPIA completion
- Membership Development Committee 6th February 2023 to go out to public governors about all PEE work and see if anyone is interested in getting involved or providing feedback
- To attend the bi-monthly Integrated Care Board (ICB) Stakeholder Engagement Advisory Group (SEAG) which involves key partners delivering local health and care, who come together to discuss the way the Health and Care Partnership is engaging relevant stakeholders in all their work and to share information, outcomes and learning from this work. The group includes Healthwatch Kent, Patient Participation Group chairs (based in GP practices), representatives from the community and voluntary sector as well as the local authorities and NHS.

If anyone is interested in being involved in the Patient Experience and Engagement work or if you have any ideas or want to provide some feedback please do get in touch with Victoria Baldock via email or Teams.

10 Community Engagement Update Dave Wells, Head of Community Engagement, gave a verbal update on the volunteers at the MDC

10.1 Currently there are 325 Community First Responders. In January they attended 280 C1 calls, 710 C2 calls and 91 C3 calls. The volunteers knocked 13 seconds off the performance, although performance isn't the most important thing, it does equate to patient outcome. So that 13 seconds made a difference to the patients getting a clinician there in a timely fashion. Looking at February, already, the difference they are making on the C1 impact is 17 seconds to the positive, which is fantastic development.

10.2 The falls scheme. The two pilots, Polgate in Hastings and Gatwick are both continuing to run well, we are now looking to extend this further. There another 90 CFRs across the Trust patch that have been trained up to deliver falls care to our patients with a view to get them up off the floor to prevent deterioration and hopefully in the long hospital admission. The Trust has taken delivery of another 90 raiser chairs that will be issued to the volunteers as their

personal issue, and they can keep in their car along with a lifting and handling belt to help them move patients. As of April, any new volunteer that joins the Trust as a community first responder will automatically get falls training as part of their training.

10.3 Emergency Responders, are now trained up and live with the Ashford team which is proving very successful. Hopefully by the end of February we will be live with the Tangmere team. Hard data will be provided at the next MDC including what sort of difference they are making to performance and patient outcome.

10.4 As a Trust we own 159 Defibs which are out in the community, all the rest are managed through the guardians on the circuit. These defibs are being checked on a regular basis and are rescue ready should they be required for a patient.

10.5 We have received funding from NHS Charities Together, there is now a large team, we have gone from six up to 12 – that now gives us a community resilience lead, one per two operating units to look after our volunteers; making sure they are engaged with properly and making sure they get the support and training they need to do their job properly. There are plans to recruit another 150 community first responders and then the year after that a further 150 bringing us up to around the 600 mark.

SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST

Council of Governors

Nominations Committee Report

23 February 2023

1. Introduction

1.1. The Nominations Committee (NomCom) is a Committee of the Council that makes recommendations to the Council on the appointment and remuneration of Non-Executive Directors (NEDs) and considers NEDs' appraisals, including the appraisal of the Chair.

1.2. This report provides an overview of the activities of the NomCom for the Council.

2. NED recruitment

2.1. Interviews and stakeholder panel occurred in December 2022 and subsequently Max Fuller has been appointed as the new Non-Executive Director.

2.2. Person requirements were as follows:

- The new Non-Executive Director should be able to make a significant contribution to SECAmbs response to the challenges to ensure that patient services and their enduring quality is maintained. Specifically, the successful candidate should.
- Demonstrate proven practical expertise in strategy formulation and product development and managing associate risks to ensure successful delivery.
- Have a good track record in engaging with and managing multiple stakeholders often having conflicting expectations.
- Have proven experience in delivering successful Organisational change and transformation understanding the principles of good Organisational design; and
- Demonstrate significant contribution to successful cultural change and staff engagement.

3. NED reappointment

3.1. NomCom reviewed the NED succession planning, noting two currently sitting NEDs (Howard Goodbourn/Tom Quinn) in a position to be re-appointed for a further three years to provide organisation continuity and agreed to recommend same to the Council of Governors.

4. CEO recruitment

4.1. Recruitment for the substantive CEO position is currently occurring with interviews and stakeholder panels scheduled in February 2023. The approval of CEO appointment is expected to be presented at the 23 February 2023 Council of Governors following the Appointment and Remuneration Committee meeting to be held on 22 February 2023.

5. Recommendation

5.1. Council is asked to note this report and the NomCom are happy to take questions or comments.

David Astley
Chair (on behalf of the Nominations Committee)

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor Development Committee

23 February 2023

1. Introduction

1.1. The Governor Development Committee is a Committee of the Council that advises the Trust on its interaction with the Council of Governors, and Governors' information, training and development needs.

1.2. The duties of the GDC are to:

- Advise on and develop strategies for ensuring Governors have the information and expertise needed to fulfil their role
- Advise on the content of development sessions of the Council
- Advise on and develop strategies for effective interaction between governors and Trust staff
- Propose agenda items for Council meetings.

1.3. The Lead Governor Chairs the Committee and both the Lead and Deputy Lead Governor attend meetings.

1.4. All Governors are entitled to join the Committee, since it is an area of interest to all Governors. The Chair of the Trust is invited to attend all meetings.

1.5. The GDC met online on 12 January 2023. The minutes of these meetings are provided for the Council as an appendix to this paper.

1.6. Governors are strongly encouraged to read the full minutes from the GDC meeting.

1.7. The GDC meeting in October covered: feedback from the previous CoG and Annual Members Meeting, a discussion on the current formal for Council of Governors meetings, raising the profile of the Council of Governors, the agenda for the February Council meeting, observation opportunities, and Governor training and development requirements.

2. Items of note

2.1. The full minutes are provided, and Governors are strongly encouraged to read them in full.

2.2. Formal and informal development opportunities for Governors were presented and that plans were underway for observation opportunities with 111/999/Field ops.

2.3. The Council of Governor Self-Assessment to be launched in February 2023 and completed within 30-days.

2.4. It was suggested to have an in-person meeting on the same day as MDC.

3. Recommendations:

3.1. The Council is asked to:

3.1.1. Note this report; and

3.1.2. Read the minutes provided.

3.2. All Governors are invited to join the next meeting of the Committee on **8 March 2023, 2-4pm on MS Teams.**

Julie Harris (On behalf of the GDC)

See below for the minutes of the GDC meetings

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 12 January 2023

Present:

Leigh Westwood	(LW)	Lower East SECAmb Public Governor & Lead Governor
Brian Chester	(BC)	Upper West SECAmb Public Governor
Patricia Delaney	(PD)	Lower East SECAmb Public Governor
David Romaine	(DR)	Lower East SECAmb Public Governor
Andrew Latham	(AL)	Lower West SECAmb Public Governor
Martin Brand	(MB)	Upper West SECAmb Public Governor
Angela Glynn	(AG)	Appointed Governor
Julie Harris	(JH)	Assistant Company Secretary
Ann Osler	(AO)	Upper West SECAmb Public Governor
Lisa Bell	(LB)	Appointed Governor

Apologies

Kirsty Booth	(KB)	Non-Operational Staff Governor (Chair)
Colin Hall	(CH)	Upper East SECAmb Public Governor
Sinead Moody	(SM)	Appointed Governor
Linda Caine	(LC)	Upper East Public Governor
Vanessa Wood	(VW)	Appointed Governor

Minute taker (from recording):

Jodie Simper (JS) Corporate Governance and Membership Manager

Item No.	Item
Introduction and matters arising	
100/22	**Welcome and introductions** LW welcomed everyone to the meeting
101/22	**Apologies for Absence** Kirsty Booth — Non-Operational Staff Governor (Chair) Colin Hall — Upper East SECAmb Public Governor Sinead Moody — Appointed Governor Linda Caine — Upper East Public Governor Vanessa Wood — Appointed Governor
102/22	**Declarations of interests** None
103/22	**Minutes of the Meeting 20.10.22 & Action Log and Matters Arising** Minutes have been accepted with minor edits
Main business	
104/22	**Feedback from December's Council Meeting** - **Part One** BC noted that the venue was incredibly poor, microphone difficulties, quality of projection of the presentations was poor, lack of interaction, and requested that the slides be shared in advance. MB noted the extreme detail and effort in producing the presentation and noted that a hard copy would be appreciated. MB requested a change in seating arrangement to support a more conducive engagement. PL noted that the CoG needs to be clearer as to what they need, i.e., presentations in advance, what is expected. BC requested the CoG being fully consulted/engaged in Trust activities (improvement journey, interim CE).

	MB added that the CQC report noting there should be a mechanism in place where we can have a special meeting (when something happens outside the sequence of the meetings) to ensure engagement of the governors. PL noted that that process already exists in the standing orders as part of the constitution. HN recommended adding that section in the Governor's Handbook and seconded the remarks surrounding the presentation slides/microphone/poor venue. **ACTION: JH provide the section of the standing order (denoting mechanism for special meetings) to the CoG and add to the Governor's Handbook** CH suggested that we move the meeting to every two months to ensure timely sharing of information. CH further suggested that leadership (Chair/CEO) nominations provide a presentation to Governors. PL suggesting reinforcing the key statutory duties of the council of governors prior to discussing any changes to the frequency of meetings. MB noted that there should be two different process (emergent and business as usual) and suggested that moving to by-monthly meetings would have a better opportunity to raise their issues. BC agreed that we need to get back to the role of the governor, and if we don't know what is going on, we can't even call a meeting. We need to be effective and practical moving forward. PL confirmed that in terms of recruitment of NEDs is for the council of governors itself to determine the process, there is a process in place, that is already pre-delegated to undertake a robust process that is agreed in advance. PL also confirmed the current CEO appointment has been launched and that communications will be promulgated to the CoG in the next day to ask for their support in terms of the stakeholder group for that appointment. LC spoke to meeting fatigue and wanted to ensure that there would be value to the extra meetings if we decide to add them. HN spoke to the joint Trust board/CoG meetings and suggested that we could add on a CoG meeting on that day or add more online meetings. **ACTION: JH and PL to meet and ensure that the CoG meetings are scheduled in line with the Trust Board meetings.** PL added his reflection to be mindful of the approach not to have directors in the room other than non-execs to avoid questions being directed to the directors to ensure that the council challenges and seeks assurance from the board through the NEDs, asking the right questions, holding to account.
105/22	**Draft Council of Governors agenda for 23 February's meeting** BC suggested adding an agenda item to discuss the process of governor engagement – getting the view of council as a body corporate. PL referred to the joint meeting in May 2022, as well as the session in November/December and noted that there has been engagement with the council as part of that joint board and council meeting. BC mentioned that racing through a whole pile of slides is not the same as having an interactive discussion with the governors. **ACTION: JH to ensure that the CoG communicate clear requirements for any future presentations.**

	MB reflected on the last joint Council/Board meeting and reiterated the poor viewing of the presentation noting that due to the fact that it was not readable could have affected the interaction. PL suggested that departmental presentations should be done after the meeting closes. MB questioned if there is reporting from the board about patient safety, not just in terms of strikes, but in the context of what is going on in the wider health service. HN suggested a presentation surrounding morale/turnover/attrition. HN mentioned that all news relating to SECAmb was previously shared with the Governors and requested this be reinstated and also requested that as soon as something occurs within the organisation, the information is immediately shared with the Governors. **ACTION: JS to ensure that all media releases, news stories, etc. regarding SECAmb be shared with governors.** PL suggested that the board reports be used as reference documents to ascertain areas of focus such as 'patient safety', industrial action, recruitment and retention, culture, etc. MB suggested a session on organisational risks as well as have executives 'off the record' discussions during the Part 2 of the meeting. PL suggested that we include the Board Assurance Framework as a good addition to the council papers. **ACTION: JH to add executive armchair discussions to Part 2 of the CoG agenda – with the first with Matt Webb to discuss our relationship with ICBs and how we connect into that framework.** MB suggested presentations surrounding the development of ICSs noting we are not sighted as we should be collectively – on the wider NHS context. PL suggested we include Matt Webb on the next Part 2 session. BC agreed. MB questioned the plan in terms of event participation. JS confirmed that she will gather the information get in contact with the organisers and set up the diary.
Standing agenda items	
106/22	**Governor training and development requirements:** - For discussion regarding priorities - Training and development opportunities for discussion - Observation opportunities with 111/999/Field Ops - Observing and reporting on NED committee meetings JH provided the overview of the current training plan and requested any input, noting that more observations shifts will be made available the coming year.

	BC and HN highly suggested that everyone undertake observations shift opportunities. HN added that opportunities with safety and quality visits should also be made available. HN questioned the availability of committee observations. JS confirmed that the list of opportunities will be forthcoming.
107/22	**Next Governor Development Day (timings and content)** BC confirmed that Part 2 are typically for subjects not meant for the public domain but that training sessions were introduced for the Part 2. **ACTION: JH to use Part 2 of the next meeting to provide a session (armchair discussion) with Matt Webb.**
108/22	**Review Governor Handbook (Induction)** JS introduced the governor handbook and requested any input. MB provided input on governor commitment and council of governor meetings. HN suggested that the Lead Independent NED there as well. BC provided input on the document as well. BC noted that part of the role of the governor is advising on the annual plan and quality accounts and requested that this be built in some way going forward as part of the process. **ACTION: JH & PL to discuss how to build in how the governors can advise on the annual plan and quality accounts going forward.**
109/22	**Self-Assessment Launch** JH introduced the self-assessment to be launched in February and requested any input. MB suggested we add a question surrounding meeting timings. GDC agreed.
PART 2 – Other business	
110/22	**Any other business** JH questioned the future meeting dates. BC suggested that we move to in person meetings having GDC and MDC on the same day.
111/22	**Review of meeting effectiveness** **The next GDC meeting takes place on 8 March 2023 on Teams.**

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Governor Activities and Queries

23 February 2023

1. Governor activities

1.1 This report captures membership engagement and recruitment activities undertaken by governors (in some cases with support from the Trust – noted by initials in brackets), and any training or learning about the Trust Governors have participated in, or any extraordinary activity with the Trust.

1.2 It is compiled from Governors' updating of an online form and other activities of which the Assistant Company Secretary has been made aware.

1.3 The Trust would like to thank all Governors for everything they do to represent the Council and talk with staff and the public.

Date	Activity	Governor
15.03.2022	Inhouse NHS Providers training for Governors	Kirsty Booth Nick Harrison Linda Caine Ann Osler Mike Tebbutt Stuart Dane David Romaine Martin Brand Colin Hall Alison Fisher Andrew Latham Howard Pescott Matt Morris Patricia Delaney
22.03.22	Attended a training course - Governwell: NHS Finance and Business Course	Chris Burton
01.04.22	I have been spending time talking to crews about how they are feeling and how they are finding/ coping with the current pressures the Trust is under as I come across them as a CFR and as a St. John Ambulance volunteer in	Andrew Latham

	Brighton at the ED at RSCH where I have been both waiting to unload patients we have been deployed to by SECAmb and also volunteering in the ED directly for the Hospital.	
11.04.22	Attended the NHS Provider Governor Focus Conference	Stuart Dane Trish Delaney Martin Brand
May 2022	Governors provided feedback on the Quality Account draft	Sent to all Governors.
13.05.22	Site visits available to NHS 111 service in Ashford to learn about the service. Tour of the site and an introduction to staff members handling calls. Observe and engage with staff members including call handlers and clinical support roles, spending time with each discussing their roles and contribution to the organisation.	Linda Caine Colin Hall Patricia Delaney Leigh Westwood
May 2022	Governor site visits to EOC East and West 999 centres. Tour of the site and an introduction to staff members handling calls. Observe and engage with staff members including call handlers and clinical support roles, spending time with each discussing their roles and contribution to the organisation.	Vanessa Wood Linda Caine Colin Hall Patricia Delaney Nigel Robinson ACC Lisa Bell David Romaine Anne Osler
May 2022	Governors observed NED committees and reported back to Council on this.	Stuart Dane Kirsty Booth Chris Burton Linda Caine Andrew Latham David Romaine Leigh Westwood Patricia Delaney
15.05.22	Observed at WWC	Kirsty Booth
20.05.22	Gave a talk to local group about CFR'ing, SECAmb and falls and encouraged them to sign up as members of the Trust. Various informal chats to front line staff about their motivations and concerns about the Trust.	Andrew Latham

26.08.22	Station visits to Chertsey, Tongham, Farnborough and Polgate to guide staff opinion on items that are important to them.	Chris Burton
16.10.22	Brooklands 999 Show Governors attended the Brooklands 999 show to encourage visitors to sign up as members of the Trust. Various informal chats with frontline staff occurred surrounding their concerns about the Trust.	Brian Chester Ann Osler Martin Brand
17.11.22	Talk about SECAMB, Trust membership, CFRing and community Falls at Warlingham WI Approx. 70 people present.	Andrew Latham
26.01.23	New Governor Induction	Harvey Nash Peter Shore Leigh Westwood Sam Bowden Colin Hall Barbara Wallis

2. Governor Enquiries and Information Requests

2.1. The Trust asks that general enquiries and requests for information from Governors come via Julie Harris and her team. An update about the types of enquiries received and action taken, or response will be provided in this paper at each public Council meeting.

07.03.2022 – Patricia Delaney

Question: Reading the bulletin, I noticed how much the assaults on staff had escalated during the pandemic, and that there is now a campaign “Work without Fear” commencing soon.

Alongside this, I noted that the JRU’s were being set up. I wonder what the composition of the JRU team would be? and if a mental health worker was included, especially if aggravating factors included drug/alcohol/ and mental ill health ? If so, it would be interesting to see if the number of assaults reduced., and if it correlated with the composition of the JRU. And also that how the addition of an extra worker would physically fit inside the ambulance without inhibiting patient care.

Response (Alexander Wilson) 08.03.22: The JRU comprises of a police officer and paramedic. The idea being. We self-allocate to either police incidents or ambulance generated calls that require both services. We do not have any specialist mental health worker, and we are very clear that we are not a mental health resource. By the very nature of mental health,

sometimes needing police assistance, we do attend mental health jobs. I think there is a massive need for a mental health car with a paramedic and mental health specialist, but we have tried before but getting funding from the mental health teams has proved hard.

I would be very against sending a police officer to every mental health presentation as they are not required and mental health is a health issue, not a policing problem. It's a normal SRV, attempting to minimise the need for multiple ambulance or police resources. If needing conveyance, we can convey in care if clinically appropriate or yes, we request a DCA.

We attend incidents that require both services ranging from, but not exclusive to assaults, sudden deaths, mental health (only when need for police) RTC, concern for welfare, domestics, jobs in public places, crew request for police assistance, mental capacity assessment support. We want to provide a quicker response for when ambulance need police, or vis versa. We also want to speed up response times to these categories of calls and aim to close them down a lot quicker.

So, we are not a project as such any more... in Kent we have been set up for over 3 years now, and the unit is very well embedded into operations.

08.03.2022 – Kirsty Booth

Question: I would like to seek assurance that any changes to the Paddock Wood estate prior to the changes in guidance for COVID have been thought out and discussed in consultation with the teams that use those sites. I visited Paddock Wood last week and there are some changes being made to the offices where Procurement used to work, this has become a hot desk area for quite a few teams, the office in that room used to be used for 121s etc has now been locked with swipe card access only. If the space is being re-purposed, can you seek assurance that affected staff have been consulted with?

Response (Gio) 08.03.22: Background on the change of room use –

The procurement office is managed by Paul Ranson, head of procurement. Paul kindly gave staff at PW the use of the office as a 'hot desk' room, whilst his staff were working from home during the pandemic. The small private office was Paul Ranson's office and was always locked prior to Paul changing his base due to the pandemic. Paul Ranson and Mark Eley have discussed the use of the office and have agreed Mark will use this as a local base to work from. The swipe access has been changed as you will appreciate that as deputy director of operations Mark keeps a lot of confidential papers in the office. The use of the main Procurement office has not changed and is accessible by all and is still available as a hot desk room.

10.03.22 – Nigel Robinson

Question: As some of the burden of COVID eases and business returns to a new normal there may be an issue about which your reassurance would be beneficial please.

The trust continues to publicise how busy it is daily, whilst also having to defend incidence of delayed attendance at emergencies of various categorisations or at hospital ED's.

Yet in amongst this heightened level of public and media awareness and scrutiny, the trust continues to support public entertainment events by providing SECAMB officers, vehicles, and crews for those events.

1. Does the trust continue to have an appetite and resources for providing this service?

2. What statutory legislation is there that requires the trust take on these roles and thereby maintain its legislative compliance?

3. Is this type of commitment morally defendable whilst facing such high call volumes and seemingly a shortage of vehicles and crews in the event there were to be a challenge from public, media or other another body?

Response (Emma Williams) 23.03.22: 1. The Trust has a requirement to be involved in public events in terms of planning and in some situations, attendance via a command/operational response (see the answer to question 2). In addition to this statutory position, several very large events require additional medical cover and SECAmb have had been contracted to deliver this service. More recently the Trust has declined to undertake this additional work, however there are a small number of historic contracts that are being reconsidered at this time.

2. The Trust has a statutory requirement to engage with partners across the region with regards to event planning and delivery – details of these requirements can be found in two industry standard guides:

- Green Guide: Guide to Safety at Sports Grounds, compiled by the Sports Grounds Safety Authority (SGSA), a non-departmental public body in the United Kingdom funded by the Department for Culture, Media and Sport (DCMS).

- The Purple Guide to Health, Safety and Welfare at Music and Other Events, written by The Events Industry Forum in consultation with the events industry and the Health & Safety Executive. 3. We are reviewing SECAmb attendance at all events from both the statutory and contractual basis, particularly considering the current challenges to resourcing and performance. Where we have committed contractually to provide additional services this position is being re-evaluated in terms of the medium- and longer-term planning. Nigel met with Dir of operations 21.04.22 to talk through this.

24.03.22 – Colin Hall

Question: I have seen other ambulance services sending equipment to Ukraine. How is the Trust providing meaningful aid towards what is happening in Ukraine?

Response (John O'Sullivan / John Griffiths): SECAmb has engaged in the following:

- Two decommissioned/de-branded Mercedes vehicles are being made available to go to Ukraine with all emergency systems still intact and kitted out with patient carrying devices (as per normal).

- We have identified a charity (TBD) that can get them out to Poland and into the Ukraine and the checks for this to happen are still ongoing.

- We are in the process of Identifying all consumables that are running out of date in the next couple of months with the aim of sending them out to the Ukraine either on the back of the ambulances or separately, depending on timings.

24.03.22 – Query from Council meeting

Question: Can we have an update on the review of the Fiat vehicle concerns raised by some colleagues regarding seatbelt placement.

Response (John O'Sullivan / John Griffiths): On 30 March a forensic engineer will be visiting SECAmb (commissioned by Stellantis – the parent body of FIAT) having done a full review of all vehicles, will present a report which will provide the scientific approach to how to position yourself in the vehicle (utilising all adjustment on seat and steering wheel). This report will form the basis of a personal risk assessment for all the staff that have self-declared under op instruction 465. On 30th March the forensic engineer will be presenting these findings as well as take people through the stepwise approach on the FIAT itself.

13.04.22 – Matt Alsbury-Morris

Question: Want to raise what I consider to be an urgent Quality & Patient Safety issue... according to the email below, signed by Fionna Moore, the SECAMB Public Access Defibrillator database has been turned off. To my knowledge, it's replacement doesn't have any of the data in. The email below claims 'Data Protection' limitations on giving details to the British Heart Foundation. This law doesn't apply to the 30+ sites our charity provided as a charity doesn't have data protection rights... but that's a different issue.

To my knowledge the database held the location & access details to 3,000+ Public Access Defibrillators (at least in 2017/18 it did) that the public were directed to in the case of a 999 cardiac call.

The Circuit, which they have advised is the replacement, is not stocked with the relevant data... I know this as the site is live at https://www.defibfinder.uk/ and this doesn't show our Responder Charity sites...

Every Responder group & charity I'm aware of is in uproar this evening on social media given the last minute ask to now put that data in manually - and wait 2 days whilst the BHF setup our organisational accounts etc. Which creates a great patient risk in my view... for data SECAMB already had.

Can we please urgently seek clarity from the non-Execs what assurance they have that the board is managing the patient risk from the removal of over 3,000 public access defibrillators from SECAMB's Computer Aided Dispatch systems?

It would be good to have some assurance that this is not causing patient harm.

Response (Tom Quinn): For your information, the Trust's management plan for PADs was considered by the Quality & Patient Safety (QPS) Committee at its meetings of 18th March 2021. It was clear that while the BHF Circuit aimed to catalogue all PADs and who was responsible for their maintenance, SECAmb was responsible primarily for the maintenance of

the PADs that were owned by the Trust (Phase 1). Management of the wider pool of PADs not owned by the Trust (Phase 2) was not something SECAmb were commissioned to undertake.

QPS received an update at the 18 November meeting. Phase 1 was complete, with confirmation that all Trust owned PADs had been identified and confirmed as 'rescue ready'. It was confirmed that, in terms of patient safety, there had been no reported incidents related to PADs not working.

Dr Fionna Moore's 11 April 2022 communication to all (known) PAD guardians across the Trust footprint asking them to register their PAD with The Circuit, stated that the Trust's local database is no longer active. I have confirmed with Emma Williams, Executive Director of Operations, that this database is no longer being updated, and therefore the 'rescue readiness' of any PAD not owned by the Trust, if not already registered on The Circuit, cannot be verified. The responsibility for registration of non-Trust PADs is the responsibility of the owners. BUT this does not mean that PADs previously registered with the Trust have all been erased from the CAD, merely that their status cannot be verified until they are registered with The Circuit.

The Trust works closely with The Circuit to ensure that owners are communicated with, that permission is given to register on The Circuit, and that sites where there is no response from the PAD owner, or maintenance of rescue readiness remains unclear over a period of time, such PADs are removed from the CAD.

On the basis of the above, I confirm I am assured that:

- SECAmb owned PADs are rescue ready, and
- The Trust is working with The Circuit through an agreed process to ascertain the state of readiness and maintenance of all the other (non-Trust owned) PADs that were previously registered on the local database.

10.05.22 – Chris Burton

Question: There is an Operational Team Leaders position (Band 7) vacant at Haywards Heath. It is believed that SECAMB will only offer this position with staff that are willing to work full time (1.0WTE) or part time (0.5WTE). This would hinder members of staff who for example have the right qualifications but cannot commit, due for instance, to childcare issues? I question whether this would unfairly discriminate against women getting management positions? I suspect the reasoning behind this would be that one day here or there may not be enough to commit to the role of bronze command and inhibit the amount of contact the staff in the OTL`s team would have with the OTL

It is of concern, if the Chair of WWC has agreed to this?

I would be grateful if we could receive some assurance in this matter.

Response (AIC): Sent to AIC for fact checking first. Having checked with recruitment team they have confirmed that OTL positions are primarily advertised as full time only or part time (18.75hrs) when this is requested to back fill a vacancy left by a colleague who previously had

part time hours. Having been made aware of a recent communication regarding ops positions overall being a minimum of 18.75hrs a week we have asked for a equality impact analysis to be undertaken on this.

17.06.22 – Nigel Robinson

Question: I feel compelled to write to you direct and copy in colleagues such is the continuance of real concerns over the suitability of the Fiat as a DCA. The Fiat may well be a most suitable vehicle and well designed and equipped. However, such are the comments all around this particular chassis, if that is the case, then a reassurance programme is urgently required.

I risk stating the obvious here and I sincerely apologise as I know you are very knowledgeable, but this matter appears to be gathering momentum and is just not going away. Now whilst it is accepted that this boarders on an operational matter, one also feels compelled to consider the overall governance of the equipment and vehicle provision. A provision that is part of the core day to day business and one which impacts across the trust and the public we serve. This is especially so if the trust may not be getting this matter quite right.

I understand the whole subject of vehicle provision is now an emotive and subjective issue, but the ongoing comments, apparent issues for staff and colleagues is simply just not going away and that worries me.

Senior staff reassurance may be missing the issues at the heart of this matter or not listening?

I have captured a few comments below from colleagues, staff, associates in other trusts, hearsay and reports. These and the private e mails I have been sent, leave me and a number of colleagues worried things are not as they should be – hence this e mail to you for your consideration please.

Some comments;

1. It is difficult to perform CPR in the back of the vehicle

2. The driver's seat cannot be properly adjusted

3. The seat belts cannot be worn safely

4. Consideration is being given to cutting holes in the dash so that people at 6'+ can sit in the driver's seat

5. If I do not drive the vehicle I will be put on other duties

6. If I do not drive the vehicle I will be dismissed

7. The equipment cupboards and essential kit in the back is in the wrong place

8. The equipment stowed within the cab is unsecure and may cause injury if we are involved in an RTC

9. I should bring a cushion to work so I can reach the vehicles control pedals

10. Clearly the writers of final reports have never experienced patient care duties in the back of a Fiat DCA

11. The Lord Rogers report was flawed, the outcome fell short

12. Depending on the weight of the crew / patient the vehicle may exceed its SWL

These points are not all of those travelling around the trust and the UK. They are certainly not here for a blow by blow analysis, they are merely examples of some issues being raised and heard of. Were 50% dismissed as grumbling and rhetoric there are still enough remaining for concerns to be raised. One wonders if this matter should be scrutinised by the NED's corroborated by comments from the front line, vehicle maintenance and do a real 'deep dive' into a matter that is truly bothering the trusts most valuable assets – its staff.

I feel I should almost apologise for adding to the rumour mill by sending this email to you but truly David this is a worrying matter and even if the comments are all proven to be unfounded, not factual etc then lets see the staff be told that by officers acting as ambassadors for the trust, in as many an open forum situation as possible. That may be an opportunity to build on officer v staff morale as well!

23.06.22 – Colin Hall

Question: I wonder if someone can clarify if the article in Health Service Journal (https://www.hsj.co.uk/workforce/trust-rows-back-on-too-tall-or-too-short-dismissal-threat/7032631.article) is the Trusts management of this issue… are Execs actually proposing to sack workforce due to a fleet issue? Rather than resolve what is potentially an issue with the van (a quick Google will show you that people have had similar issues with camper van conversions of the same chassis for years… so not limited to ambulances!)

Can we please raise a formal governors question on what the NEDs are cited on regarding the mitigating actions being taken? Is this limited to what we've seen, or have they been given further assurances? Also, have the NEDs had the impact to workforce & service delivery (and therefore patient quality / safety) quantified as to the impact on an already under resourced & stretched workforce as a direct impact of these fleet issues?

Response (David Ruiz-Celada): Response from Director of Planning - David Ruiz-Celada:

1. It is difficult to perform CPR in the back of the vehicle

[A] The Trust moved away from carrying our CPR in a moving vehicle a long time ago. The model is to complete a resus through to completion on scene and only transport patients post Return of Spontaneous Circulation (ROSC) and then the norm is for a Lucas device to be fitted to the patient which can be used during transportation. Evidence shows that manual CPR in a moving vehicle is practically ineffective.

2. The driver's seat cannot be properly adjusted

[A] The independent high-court expert witness (automobile forensic investigator and engineer) confirmed the vehicle is compliant, meets all safety standards and adjustability requirements

for UK and European legislation. There most-likely is a training gap in the full range of adjustability of the seat which is part of the individual assessments we will be rolling out.

3. The seat belts cannot be worn safely

[A] Part of the above report clarifies that the seatbelt will fit on the shoulder for 90% of the population, but that does not mean that 10% are un-safe if the seatbelt goes under the shoulder, as the seatbelt is there to protect life and will be effective in any position. The pyrotechnics within the seatbelt mechanism would trigger in the event of collision, pulling back from any position. We reviewed this evidence during a demonstration day with our union colleagues who also raised this as a concern and they have accepted the report and the safety of the seatbelt. What we have identified as a next step is a risk-assessment / training package to be delivered individually to colleagues who have raised concerns with the seatbelt (around 10% of our driving workforce), so that they can find the best fit for them in the cabin. We have been given a step-by-step approach by the independent expert on how this is achieved. We recognise there may be a handful of colleagues who after this process, will still have issues like knees hitting the dashboard, or not reaching the pedals. This can be because of a range of reasons, and likely to be very specifically due to their body-type and the van cabin, and see below on 5 and 6 on the current process we are going through to support colleagues who end up finding themselves in this position. It's important to stress that we have no way of guaranteeing any other vehicle would not have similar issues, maybe for a different cohort of staff, however the Fiat Ducato is very widely driven and the most popular van in Europe, therefore we expect this to be a situation that impacts a very small minority of colleagues. Any process we follow will be in accordance with the Equalities Act 2010 to ensure protected characteristics and vulnerable groups are not discriminated because of our choice of fleet.

4. Consideration is being given to cutting holes in the dash so that people at 6'+ can sit in the driver's seat

[A] We will not consider making modifications to a safety-approved cabin that are not approved by the manufacturer and the relevant regulator.

5. If I do not drive the vehicle I will be put on other duties

[A] This may be an outcome, however as per the recent discussions with Union colleagues at JPF, we are pending a full Equality Impact Assessment to be completed which will identify the appropriate mitigations, and reasonable adjustments, which may be applicable for colleagues who either refuse to drive, or can't drive, any one of our vehicles, as this process needs to be built around any fleet vehicle. An EIA panel which includes union colleagues and the EIA team are developing this together on Wednesday 22/06/22, and we are seeking comparable situations from other industries (aviation, bus operators) as well as external EIA support from our lead commissioner, to ensure robustness of the approach. The process extends and must be consistent with reviewed a reviewed recruitment approach.

6. If I do not drive the vehicle I will be dismissed

[A] As above.

7. The equipment cupboards and essential kit in the back is in the wrong place

[A] We are reviewing the layout of the clinical setting in the back following a visit by the Driver User Group to Stafford to review the new full-specification DCA from WMAS. This is a continuous improvement process and future fleet design is influenced by the feedback we are receiving. The membership of the Driver User Group is as follows:

- Head of Fleet & Logistics (Chair)
- Fleet Services Manager
- Fleet Commissioning Manager
- Fleet Administrator
- Driver Training Manager
- Clinical Education Manager
- Operational Unit Manager West
- Operational Unit Manager East
- Risk and Incident Lead
- Health and Safety Manager
- Union JPF members
- Make Ready Centre Manager East
- Make Ready Centre Manager West

8. The equipment stowed within the cab is unsecure and may cause injury if we are involved in an RTC

[A] We know there are items which need securing following receipt of the report from the expert; primarily, the fridge and torches. Fleet are working on a solution and will ensure new builds are ok and a retrospective modification programme is being worked up which may see an alternative torch fitted on existing vehicles. The extinguisher securing is going to be moved through 180 degrees which will prevent the catching on trousers. Again this will happen for both new builds and in-house modification.

9. I should bring a cushion to work so I can reach the vehicles control pedals

[A] Individuals will need to go through a personal assessment to ensure a safe driving position is achieved and achievable. OH are involved in this process and recommendations for individuals may vary, i.e. use of a lumbar support cushion may be a recommendation for colleagues who require additional support due to lower back conditions.

10. Clearly the writers of final reports have never experienced patient care duties in the back of a Fiat DCA

[A] The expert is a forensic vehicle engineer with significant experience in vehicles and working with a range of emergency services. The SME input was achieved through two days of working

with staff-side colleagues, discussions with staff at the station that housed the visit, H&S colleagues, the Driver Standards Manager, the Driver Training Manager (clinician), Fleet representatives with years of experience in designing from scratch and the Head of Fleet and Logistics (who is a current and practicing Paramedic). We did not engage the expert to advise on the merits of the van conversion as a clinical setting but advise on the safety of the vehicle and specifically to advise in regard to the issues raised with the seatbelt. Please refer back to the Driver User Group as the forum where we are seeking to get feedback from colleagues on challenges around the vehicles, and how they are addressed now and in future builds.

11. The Lord Rogers report was flawed; the outcome fell short

[A] The Lord Carter report in 2016 looking at unwarranted variation in ambulance services built on his previous report looking at the same types of issues in acute trusts. There was extensive engagement with key parties in relation to the report (and recommendations) including AACE and trade unions. For further assurance, we have requested evidence from the National Team who led on this of clinician input into the Lord Carter report as well as considerations for accessibility and EIA which would have supported the definition of the National Specification.

12. Depending on the weight of the crew / patient the vehicle may exceed its SWL

[A] The work is currently ongoing to understand what capacity is available post conversion for the new-builds. Carter specification stated that this should not exceed 95% of the Gross Vehicle Weight (GVW) of the plated vehicle (currently 4250kg) for a van conversion in its base specification. This allows for 5% of GVW to be managed by Trusts. We will not accept vehicles that are not compliant with the carter spec. Some of our internal options add weight and some remove weight, and the 95% calculation already includes 6 passengers and equipment, fully topped fluids, etc. The margin of 212.5kg is there to ensure that variations in weight by passengers, and other variations inclusive of safety features we have decided to include in our options as an example, never take the vehicle over 100%. We are building a one off full-spec vehicle to test out build before committing to further purchases, and we are seeking legal contractual advice on our position if the vehicles exceed 95% from convertor, as we may be able to refuse the vehicles, however we would not be allowed under the NHS Contract to procure other vehicles without dispensation (we are pending the legal view on this point)

23.06.22 – Colin Hall

Question: I note although I was assured the ongoing problems with the Fiat Ambulances would be an agenda item, it has failed to appear on the agenda. Is there a reason for this? As this is a problem which may have a detrimental effect on the service provided by the trust may I request it is included on the agenda for the meeting on June 6.

Response (Julie Harris): Discussion surrounding the Fiat Ambulances will occur during the QPS NED report. You will note the following that was included on their March report to the board. If the Council have any questions on this matter, it would be appropriate to engage during the NED QPS report.

11.07.22 – Colin Hall

Question: The outstanding questions are: -

1 How many staff are at this time not driving the Fiat ambulances?

2 How many paramedics are required by the trust in order to have the optimum number?

3 Are you still waiting for a copy of the report that I requested a copy of.

Response (John Griffiths/Andy Rowe): We should have 70% registrant of 2555 so current vacancies = 356 but 150 are filled by pap so 206, however we should have 1788 registrants for 70% but these are filled by lower grade clinicians.

Regarding the RTC on the 5th January 2022 I can confirm that I continue to be the link between the Kent Police investigation and SECAmb. I have had 2 meetings in person with the Senior Investigating Officer, one in January and one a couple of weeks ago. I have provided the SIO with the information he requested since the RTC and our colleagues in IT and Driver Training Manager, have assisted with a reconstruction several months ago.

Their investigation is progressing, and they are now at the stage of writing their detailed forensic collision investigation report which will form part of the overall investigation. This part will always take a lengthy amount of time and I do not envisage getting any update from them before the end of this year.

Kent Police are unable to update me on anything further and all information they have requested from us, remains confidential as part of their investigation.

No internal investigation will take place until after the Police investigation is complete.

The number of staff currently not driving the Fiats is circa 360.

11.08.22 – Chris Burton

Question: I hope I am correct in addressing this e-mail to you, in hope that you may be able to disseminate some information to the appropriate NEDs.

I have recently been lucky to visit many of the stations across the whole of SECAmb.

During my travels and chats with crews, some general items have consistently been foremost.

1.One item that is common over all counties is some inconsistencies with equipment and uniform etc arriving on stations for new front-line staff to start their duties.

Some equipment / uniform has been late / not sent out to appropriate stations, sent to the wrong stations and staff iPads not sent out with the software for EPCR, loaded .

2.Operational team leaders (OTLs) are saying they are not trained in tech' to load the new iPads correctly. I wonder if we could ensure the all the soft tech is loaded properly by tech support, prior to issue.

Additionally, I would also like receive assurance that OTLS and Operational Managers secamb-wide have joined up thinking regarding local and corporate induction of new recruits.

Lastly, I was fortunate to see Chertsey Make Ready Station in post flood condition. It was a sad sight. Can the NEDs please receive assurance that all appropriate actions are taken to

ensure Chertsey Station is refurbished in a timely manner (including newly painted floors). It is imperative this station is returned to service again quickly , because it causes unnecessary pressure to surrounding stations. (i.e extra staff personal cars and equipment on stations with limited capacity.).

Although these could be deemed as operational issues, I feel that assurance from the NEDs would be appropriate.

I would address this to the Welfare and workforce committee.

Response (Andy Rowe): This a known and shared frustration and to improve this we are writing a business case and change template for a one stop shop at Telford place.

We are meeting this week to merge onboarding and corporate induction into one.

With regards to Chertsey - we are hoping to move back into a better upgrade faculty business case depending.

19.12.2022 – Chris Burton

This question is a subject that the NEDs need to discuss with Martin Sheldon, Director of Finance.

Q1. In view of the increasing burden of Primary care work that SECAmb is undertaking, are the NEDs confidentially assured the Executive have the RIGHT STAFF in place and are clearly aware and highlighting these operational demands, when negotiating with the commissioners?

Context: Currently, I estimate we are undertaking approximately £28million services for which we are not being paid.

This is due to lack of public access to services like Mental Health, Recognition of life extinct duties, end of Life (palliative), Life line calls, social needs calls and chronic wound care etc.

It is my firm belief that we could save substantial sums of money by sign-posting the public to referral services more appropriately at point of access i.e., 111/EOC operators, so saving the dispatch of an emergency ambulance for a primary care need.

To quote Martin Sheldon " We will only promise what we can deliver, and we will only deliver what we are paid for!"

Response: directed to Martin Sheldon and Chair of the Finance Committee. I'm certain there is work we currently undertake that we aren't getting paid for. The plan is to start identifying where we are varying from the standard contract through the planning round and discuss with our Commissioners.

Recommendations

2.2. The Council is asked to note this report.
2.3. Governors are reminded to please complete the online form after undertaking any activity in their role as a Governor so that work can be captured. The new form will be circulated in

due course.

Julie Harris
Assistant Company Secretary
(In the absence of a Lead Governor)