South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

06 April 2023
10.00-13.30

Trust HQ
Nexus House, Crawley

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
01/23	10.00	Welcome and Apologies for absence		-	DA
02/23	10.01	Declarations of interest		To Note	DA
03/23	10.02	Minutes of the previous meeting: 02 February 2023		Decision	DA
04/23	10.03	Matters arising (Action log)		Decision	PL
05/23	10.05	Chair's Report		Information	DA
		Well Led Self-Assessment		Information	DA
		Board Development Programme 2023/24		Decision	PL
06/23	10.20	Audit & Risk Committee Report		Information	MW
07/23	10.25	Chief Executive's Report		Information	MS
Strategy					
08/23	10.40	Strategic Priorities 2023/24		Decision	DR
09/23	Primary Board Papers	a) **Board Assurance Framework** b) **Integrated Quality Report** c) **Improvement Journey**			
Delivering Quality					
10/23	10.55	**Keeping patients safe**	Board Story		RO
			Patient Safety Incident Response Framework		RN
			Q2 Learning from Deaths Report		RO
	11.25	**Break**			
Focus on People					
11/23	11.30	**Improving Culture**	Board Development – Culture		DA
			Comms & Engagement Strategy		PL
			Annual Staff Survey – Findings / Response		AM
			Freedom to Speak Up – National Review		RN
			People Committee Report		SS
Delivering Modern Healthcare					

12/23	12.30	**Operational Performance & Efficiency**		EW
Delivering Sustainability & Partnerships				
13/23	12.50	**Achieving Sustainability / Working with Partners**	Partnerships Report	DR
			Finance Report	MS
			Finance & Investment Committee Report	HG
Board Effectiveness				
14/23	13.20	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
15/23	13.25	Any other business		DA

After the meeting is closed questions will be invited from members of the public

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 02 February 2023

Trust HQ, Nexus House

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Siobhan Melia	(SM)	Interim Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
David Ruiz-Celada	(DR)	Executive Director of Planning & Business Development
Emma Williams	(EW)	Executive Director of Operations
Howard Goodbourn	(HG)	Independent Non-Executive Director
Liz Sharp	(LS)	Independent Non-Executive Director
Martin Sheldon	(MS)	Interim Chief Finance Officer
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Rachel Oaten	(RO)	Chief Medical Officer
Robert Nicholls	(RN)	Executive Director of Quality & Nursing
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

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

Chairman's introductions

DA welcomed members, those in attendance and those observing this meeting in person or via MS Teams. He thanked Fionna Moore who retired in January for her work at Trust and the wider NHS.

Acknowledging today is Time to Talk Day, DA committed his personal support to this and SM will refer to the Trust's Mind Matters campaign in her report.

77/22 Apologies for absence

There were no apologies, save for MW who will be joining at about 12.00.

78/22 Declarations of conflicts of interest

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

79/22 Minutes of the meeting held in public 15.12.2022

The minutes were approved as a true and accurate record.

HG referred to the reference at the bottom of page 4 to 'Star 6' and asked if this is considered a good idea. EW agreed to review and confirm what action is needed.

80/22 Action Log [10.07-10.10]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

81/22 Chair's Report [10.10–10.15]
DA used his report to set the context for today's meeting building on the Effectiveness Review undertaken by SL. He reminded the Board on the use of the Assurance Cycle to draw key conclusions and actions and is pleased to see an increasing number of actions demonstrating follow through.

DA referred to the recent Board workshop which will inform the Board's development programme for next year and highlighted that culture and way we do things must support a positive experience for our people. The values are key to this and DA suggested that we need to do more to continually reinforce these.

Lastly, DA referred to the leadership visits and asked the Board to keep in mind the themes as part of today's meeting.

82/22 Chief Executive's Report [10.15–10.39]
SM took the Board through some of the key points from her report, highlighting the following:

1. Launch of the Mind Matters mental health campaign. SM explained that the executive had a session with the Consultant Mental Health Nurse to explore whether we are doing enough to support the health and wellbeing of our people. It was from this that we agreed to this campaign. SM asked Board members to look at the Zone where there is a wealth of advice and support available. The campaign will tun for four weeks and there is a variety of materials including a printed card to go to every member of staff, providing details on how to access support.
2. The Yama platform was launched in December and people are engaging in meaningful way. SM confirmed that the Christmas Stars initiative helped promote the platform and our renewed efforts on staff recognition. We spoke at EMB about the annual awards, and using feedback we need to do more throughout the year, like Christmas Stars.
3. Industrial Action – the report describes the strikes and our approach. We are meeting GMB tomorrow to discuss the approach to Monday's strike. RCN has a slightly different process, and we will work with our union colleagues to continue to balance the need to ensure safety and the right of staff to strike.
4. Improvement Journey – we have used the good work to develop this approach based on strategic priorities and will shape further improvements for the coming year and beyond. We had a positive session with the CQC to demonstrate progress with the Warning Notice.
5. Since the report was drafted the UEC Recovery Plan was published, and SM confirmed the key headlines:
    - Increasing capacity in UEC pathways specifically for the ambulance sector.
    - Growing the workforce – more clinicians in 111
    - Discharges from hospital – new stepdown pathways and funding in SC
    - Expanding services in the community building on service models established in 2022.
    - Allowing patients to access right care first time – 111 will be the first port of call including access to urgent mental health support; therefore a national review of 111 is needed to increase capacity.

DA thanked SM for this update and opened to questions.

SS referred to 999 call answer times, as we are an outlier asked about actions we are taking, as it seemed that despite all the action call times continue to increase. SM confirmed that there is a separate paper on this later on the agenda but in headline terms, we are dealing with the root cause with an urgent

intervention supported by an external partner to improve culture, which will in turn improve retention and call answer performance. This acknowledges the current plans aren't working and realisation that we need rapid support to bring about change. SM added that she does not think we have the capability internally to make the changes in EOC that are needed. DA suggested we pick this up later on the agenda.

PB asked how we intend to use the national UEC Recovery Plan to inform our priorities. SM explained that EMB has time next week to develop its priorities following the recent engagement sessions, to include how we are set up to deliver.

CG asked about how we are supporting staff during the cost of living crisis. SM responded that we have information and sign posting on the Zone. We are looking at ways to mitigate specific issues such as impact of travel. AM added there is a new area on the Zone which gives some really good information and we also held a joint session with unions to explore ways we can help e.g. paying expenses quicker.

In summary, DA thanked SM for her updated and the introduction of the UEC Recovery Plan. The Board takes encouragement from this plan and it seems to be a net increase in funding in UEC. When we talk with commissioners, we must use the opportunity this affords.

83/22 Primary Board Papers

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

84/22 Keeping Patients Safe [10.39-11.19]

RN referred to extreme corporate risks related to medicines, which were discussed in greater detail at the last meeting of QPSC. There are 18 risks in total and we will be reviewing these on 20 February with the regional Chief Pharmacist, to give an external view. The medicines business case was agreed in principle yesterday, which provides an interim solution to the estates issues the medicines distribution centre faces.

In terms of BAF risk 256 (QI), RN confirmed that we have started work on QI and the project on keeping patients safe in the stack; this was the project identified from the Quality Summit last year. It also reviews our approach to welfare calls.

Referring next to the IQR, RN explained that we continue to make progress with SIs and open actions. As of 1 February we had eight breaches SIs and SIX breached open actions. In terms of incidents, we are above the tolerance level we set (20%) so RN is involved as part of the process of escalation to discuss with incident owners what additional support they require to close the open incidents.

Lastly, we had 57 incidents related to health and safety and RN outlined the trends.

DA then opened up to questions.

SS referred to a report at QPSC about the issues at the medicines distribution centre, and noting the interim solution asked what is happening to establish a long term plan given the lease at Paddock Wood is due to expire in two years. MS responded that we have an immediate plan, as referred to, and also a medium to long terms plan. The immediate plan includes starting additional recruitment to address the issue of capacity. Then the move to the ground floor will address the current estates issues. Longer term we have some more work to explore decisions on the lease, linked to our estates strategy and what is affordable in terms of capital investment.

LS also asked about medicines and whether RN and RO can review all the risks on medicines as this issue shouldn't have escalated in the way it has. LS reinforced that the Chief Pharmacist and all our clinical leaders must always be heard.

TQ asked if the e-prescribing issues will be covered by the review of risks RN referred to. RN confirmed that it will.

Following on from the challenge by LS, SM asked for assurance on how we have worked with our Chief Pharmacist on the development of the business case. MS expressed some surprise by LS's comment about hearing our Chief Pharmacist as he has met with her most weeks since he joined in September. There was initially some reluctance from the Chief Pharmacist to accept the interim solution for fear it will impact on the longer-term plan; MS confirmed that he gave assurances this would not be the case. The risk escalated more recently, not because of the development of the business case but due to lift failing and there being a COVID outbreak. MS provide assurance that the estates business case for the medicine's distribution centre will be in the capital plan.

DA thanked MS for this reflecting that while this issue has been around for a long time it sounds now like we have a plan.

HG confirmed that there are three failing processes in the IQR two of which have a target of zero, controlled drugs breakages and signature witnesses. The third is NHSP audits. HG also expressed concern about the number of RIDDOR incidents. RN responded on RIDDOR that we have better reporting; we recently reviewed health and safety processes and governance, which was positive. DR and RN are now part of the H&S Group to support its review of incidents and mitigating H&S risks.

On NHSP audits EW explained that this is for EOC EMAs. The target is 100% related to licence compliance and training. We are currently at 86% due to redeploying auditors to call handling. But we have kept NHS Pathways informed which they accepted in December due to the pressures we had.

The following action was agreed to cover the gap in assurance about RIDDOR.

Action
WWC to review the root cases of RIDDOR report; the actions we have taken in response; and how we benchmark with our peers.

Noting the highest rated risk on our risk register is Risk 25 (Industrial Action) the Board received a summary from EW on the approach to derogations and how we have ensured appropriate resources. This included stopping all non-essential work and diverting all patient facing staff to the EOC and front line. These days were also helped by a reduction in activity of about 30%, due to the public response. Ironically, therefore, on the strike days we have seen some of our strongest performance.

<u>Learning from Deaths Report</u>
RO introduced this report explaining that of the 60 cases reviewed none were found to have received very poor care. Where identified, adequate or poor care related to delays. One was an SI. On the issue HG raised about marking our own work, this has been escalated nationally to seek a peer review / consistency.

TQ referred to SIs and engagement with system partners on harm reviews. He suggested that if we can use this model for learning for deaths, it will help. He reinforced the need integration of learning, which QPSC identified at its last meeting.

HG noted that the report shows that consistently male deaths are much higher than female deaths, and he asked why. TQ responded that this is consistent across the research / literature as men die earlier and often more dramatically. He confirmed that gender disparities are well recognised. RO agreed that this is seen across the country.

Quality and Patient Safety Committee (QPS) Report

TQ noted the discussion earlier on medicines so won't cover this again. He summarised the other issues covered at the mast meeting and the conclusion of the committee.

Attached to the report is the Cardiac Arrest Annual Report. This is a really positive story and we saw for the first-time survival to discharge from hospital in double figures, which is better than most. That said the picture year to-date is less positive. TQ also referred to PAD sites linked to pour role in public health. There are 100s of sites where we don't have clarity on location / rescue readiness.

DA opened up to question and DR felt that the IQR doesn't suggest any deterioration in survival to discharge this year. He therefore can't triangulate the data with what QPSC was told by the Consultant Paramedic. TQ responded that the care bundle for STEMI is not the same as cardiac arrest and so there is some deterioration with reported outcomes of survival from discharge from hospital. TQ is satisfied that the key pillars for improving survival are reflected in the report but expressed concern about a lack of community engagement e.g. training in CPR, and also the importance of call answer. RO added that we are not an outlier, in fact are better than most related to outcomes. We are exploring how we can bring a resus strategy to life, which will be reviewed as part of the development of a new clinical strategy. The Board noted that this will be overseen by QPSC.

EW reinforced that we must always keep in mind the need to engage commissioners as we not currently commissioned to do everything we are discussing. DA agreed and asked that we utilise our internal expertise in crafting a new clinical strategy in collaboration with commissioners / ICSs.

85/22 Improving Culture [11.19-11.38]

AM outlined from his report to the Board some of the work to improve culture, linking to the relevant parts of the BAF, IQR and Improvement Journey. He highlighted the following:

1. Industrial Action – this has been discussed earlier and AM added the major thing next week is that the RCN will be taking action too. The risk score remains extreme given the potential for even more action than has already been confirmed.
2. Turnover in EOC. AM reinforced the need to increase recruitment.
3. International recruitment work continues and this has been overall a success. But one concern relates to a particular group which we are working through and will appraise the Board in due course. We are engaged on this with HEE and HCPC.
4. Workforce plan is behind target and so will add to the pressure on the plan for the coming year. A series of actions are being taken to improve sickness management working with West Midlands to understand what they are doing; they have the lowest sickness among ambulance services.
5. Sexual training workshops - additional sessions are being added. There has been good attendance and continues to be mandatory for all managers.
6. ER cases – more decisive action has been taken related to misconduct breaches. We are encouraging and supporting managers to be divisive and brave in decision making.
7. ACAS mediation – this has started and included how JPF is working.

SS commended the work to support staff health and wellbeing. Related to Until it Stops, SS noted that 26% of managers are still to complete the training. AM responded that this is right and we are targeting those that are not yet scheduled; each director has a list and will intervene as needed to ensure attendance.

Action
At the Board meeting in April, an update to be provided to confirm the percentage of managers yet to undertake the Sexual Safety training; the figure reported in February was 26%.

SS then referred to appraisals and asked why compliance has decreased. AM responded that we were on target up until November. He wasn't able to give a definitive explanation and agreed to provide an update at the next meeting of WWC.

There was a discussion about FTSU cases and the extent to which managers are being active in trying to resolve concerns and intervene early. The Board acknowledged the need for balance so it is always easy to raise concerns, and at the same time understanding the root causes of why issues are being escalated. The Board agreed earlier resolution will be better for all concerned.

Concern was expressed about 999 late finishes /overruns, as reflected in the IQR. EW outlined some of the contributory factors, but accepted this is an issue we must improve. DA reminded the Board that there is an open action from the last meeting and WWC is scheduled to review this at its meeting in two weeks' time.

[Break 11.38-11.47]

86/22 Operational Performance & Efficiency [11.47-12.35]

Board Story

Laurence Sopp, OUM joined for the Board Story. DA welcomed Laurence who is talking about how we approached the issue of handover delays at local hospital. Laurence explained that Medway was one of the busiest and most troubled re handover delays and this caused tension in our working relationships and impacted adversely on patient safety and staff welfare. In light of this there was deliberate focus on personal relationships and developing key contacts. We also publicised the good work we did to explain to the hospital that we do well in keeping people out of hospital using see and treat and using local pathways; to address the perception that too many people are brought to hospital by ambulance. In addition, we increased visibility of the OU leadership team and this had led to a sharing of risk. Daily calls were introduced to keep on top of issues and taken together this helped changed the culture of tolerating patients waiting a long time in ambulances / corridors. We ensured a large presence at emergency departments to support colleagues to do the right thing. Since then we have seen a 54% drop in hours lost; a 90% drop in 60 min breaches; and 13% reduction in late overruns. OTLs now spend less time at emergency department and more time with staff. There is much greater moral in the OTL team as a result. Laurence confirmed that it has been more difficult to draw direct correlation with improved performance but there has been some improvement in the C2 mean.

DA thanked Laurence for this insight which brings to life the discussions we have had re delays, moral, and shift overruns. This demonstrates effective leadership.

RN asked if we have shared this learning with other OUs. Laurence confirmed that we have shared with the East region and discussed at Teams B (East and West) meetings.

AM asked Laurence about the discussion we had earlier about local resolution of staff concerns to improve number of issues escalated through FTSU. Laurence explained that he has an open-door policy and reinforces with unions that he wants to hear immediately if there are issues; so that he does not hear concerns first when a grievance is raised.

EW reflected that this highlights the importance of local engagement, leadership and decision-making. Commissioners are talking about this improvement and how we have achieved it, which is down to brave and decisive leadership with Laurence engaging directly with the Chief Operating Officer at Medway.

LS asked about patients and their experience now. Laurence responded that the experience is markedly improved as there are far fewer now waiting in corridors or ambulances.

DA thanked Laurence for helping set the context for rest of this agenda item.

EW then summarised her report highlighting the following:

- BAF Risk 14 – Performance standards are consistently off where we should be and EW will pick up call answer separately. However, compared with our peers we are the second-best performing services for C2 and middle of the pack for C3 and 4. EW reflected that ARP is fundamentally about having the right level of resources to meet demand.
- Industrial Action – having had the discussion earlier EW summarised the mitigations, confirming that we saw 14% Hear and Treat.
- Efficiency targets such as job cycle time are critical to quality, and the Clinical Advisory Group is helping by reviewing what is happening on scene compared with what is expected so we can ensure better clarity. There is a push to use referral pathways to reduce the number of people needing to be taken to hospital but there is inconsistent availability across the region.
- SVCC has been in the pipeline for some time and is taking longer than expected. The IT and governance is more complex than initially thought, but we are still scheduled to go live at the end of March, subject to funding / workforce.

MS referred to the SVCC BAF risk, explaining that as we are net exporter of calls, we will expect an increase in cost as will be invoiced for it / cross-charged.

The Board explored how we managed to increase Hear & Treat and how we can use this learning for the future, e.g. increasing clinicians in the EOC. EW clarified how we managed this, by taking people from their day jobs during the strike days, and explained that we have modelled what we clinical resource we would need in EOC; the main issue is attracting clinicians to the EOC. However, we are exploring portfolio work providing for clinicians to work in the EOC from their own OU. There is much interest in this, especially as we will be focussing their time on the queue in their OU. EW confirmed that the increase to 14% was from 9% so very significant.

TQ agreed that it is positive to see an increase in Hear & Treat, but challenged the Board to narrate this in the context of impact on patients. He asked how we are supporting people in the trial and how we evaluate the rotation, including training. EW reassured the Board that the clinicians undertaking this work have PACCS training.

Action
QPSC to explore the plans to increase Hear and Treat to seek assurance it is done safely to the benefit of patients.

RN referred to one of the common themes from Sis relating to our operating model; itself a BAF risk. He asked what the plan is to review this. EW responded that this will be informed by clinical and people strategies, and the learning from the H&T trials and learning from Industrial Action. DA asked that we have a clear timescale on this. DR agreed and suggested that we clarify this as part of the development of a new

Trust strategy. DA acknowledged we won't resolve this now but asked the executive to reflect on a practical timescale, as part of the strategic priorities and plan for 2023/24.

PB asked if we are ready to go live with SVCC in March. EW responded that we have been working hard on this across operations and IT. We also have national contingency now that works in a similar way. SVCC is more automated, but there is more work to do.

Action
FIC to test the state of readiness to go live with SVCC in March.

Call Answer Performance
EW outlined some of the steps being taken to improve call answer as set out in the paper, explaining that the main challenge is retention; the IQR is showing over 40% attrition. Sickness levels and performance since the strike in late December has improved, given a better balance of resource and demand.

EW also drew the Board's attention to IFT desk that commenced in January; this is when calls identified come straight through leaving EMAs to answer calls. We are looking to do same for HCP calls that also don't require NHS Pathways.

EW accepted the need for pace, but also felt that this longstanding issue needs to be addressed sustainably through the root case, as SM referred to earlier, related to culture.

PB noted the significant increase in mean call answer and EW confirmed that related to high sickness; the mean currently is 22 seconds but at the end of yesterday was 5 seconds indicating an increase in staff and less demand / duplicate calls. Nationally there is a similar trend.

[MW arrived 12.39]

SS reflected that there is a high number of FTSU cases from EOC 111 and the highest number of wellbeing referrals, and asked in light of this why the paper doesn't mention management and leadership. EW responded that the fundamentals training aims to better equip managers.

SM referred to the IQR and the early warning sign for call answer performance where slide 40 shows declining performance since August. DR added that slide 26 triangulates this with a spike in December, and so the information is there. DA felt that this is an illustration to the Board that despite the improvements in the use of data from Making Data Count, more work is needed.

DA summarised that this issue has clear attention of the Board. It acknowledges the work supported externally to get to the root cause (culture) leading to the issues in EOC. Resolving this is mission critical. We will therefore need to keep close to the progress of actions and impact. We are not assured yet and need to see improvement in this area across the metrics given the significance to patient care and staff wellbeing.

Action
The steps to improve the culture in EOC to remain a standing agenda item for WWC, to ensure there is sufficient progress with the actions and that this is achieving the impact needed. WWC will report it level of assurance to the Board and the Board will request formal updates directly, as required.

87/22 Achieving Sustainability / Working with Partners [12.45-13.07]
MS took the Board through the main risks, clarifying that the SVCC risk from a financial perspective is relatively low.

BAF risk 17 links to financial sustainability, which was discussed in detail at FIC. MS explained that we are dealing with the in-year issue as set out in report. Planning is ongoing and we are working to develop a 24-month plan with ICB colleagues. MS is confident with how planning is going and commended his executive colleagues for their approach to the financial pressures in closing the deficit. The third stage is the long-term plan, but this will follow in due course.

MS also referred to the Cyber BAF Risk. There is a training session for the Board after the meeting and he reinforced that while the IT team is very good at managing risk behaviours of everyone are important as we can't just rely in IT.

Finance Report

MS then took the Board through the finance report and the review undertaken across directorates to close the gap; we are now on track to achieve at a £2m deficit. We are looking too at non recurrent means to address this £2m which links to a gap in funding (withdrawn in year). YTD is about £2.4m so slightly off plan but MS is confident we can recover this to £2m. Cash management needs more focus at Board and MS explained that in the planning round we are trying to mitigate eroding our cash to there is less impact on capital investments where the focus will be fleet, IT, then estate, in that order.

DR confirmed that the vehicle off road rate has increased linked to Fiats being less reliable and issues with availability of parts. Fleet will be more overtly reported under sustainability and partnerships going forward. DA commended the use of real data like this to ensure robust analysis to drive decisions.

There was discussion about needing a different more sustainable approach to cost improvement / efficiency. The Board noted that this is an area of focus for FIC.

MW asked for assurance that our approach to financial management is such we don't take short term decisions to balance budget at the expense of the longer-term sustainability. MS confirmed we are not taking short term decisions and that nothing adversely affects quality, which we will be confirming in an assurance report to FIC.

FIC report

The Board noted the report and the key issues arising have already been covered. The committee escalates the fact that the 999 for this year is not signed and the importance of ensuring the contract next year is signed as early as possible. MS confirmed that we reached agreement on the contract but despite our efforts the ICS has not signed it. DA felt that there is a principle here and SM will escalate to CEOs of three main ICSs, on behalf of the Board.

Action
On behalf of the Board SM to escalate to the ICS CEOs the concern that the 999 contract for 2022/23 is still to be signed.

88/22 Strategic Priorities 2023-24 [13.07-13.11]

DR summarised the meeting with CQC on 31 January to present the work related to the Warning Notice and the focus now turning to the Must Dos as part of our shift to a more strategic Improvement Journey. This is the current focus.

The Board supported this and agreed that it was a positive meeting with the CQC.

89/22 Review of Board Effectiveness [13.11-13.17]

DA asked if the Board thinks we are bringing together the key risks. It felt that we are. In terms of quality of information, this is improving too but as noted further work to make even better use of data. The Board also reflected a good level of curiosity, but the triangulation could be better. Other feedback included:

- More on culture and how we look more at hotpots.
- More on strategy.
- IQR needs more work on metrics and looking through the lens of patients rather than for example ARP.
- Support to reverting back to circa 3 hours.
- Sustainability part of S&P is more narrowly focussed on finance. Need more on partnerships.

90/22 AOB
None

There being no further business, the Chair closed the meeting at 13.17

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

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
15.12.2022	68 22	The AGS to sufficiently cover the IT Critical Incident; why it happened, the impact and the action taken.	PL	25.05.2023	AUC	IP	Final Draft to be reviewed at AUC prior to inclusion in the Annual Report which the Board will receive.
15.12.2022	70 22a	QPSC to seek assurance on the implementation and effectiveness of the Falls Programme.	PL	Q1 2023/24	QPS	IP	Added to the COB
15.12.2022	70 22c	As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.	DR	Q1 2023/24	Board	IP	
15.12.2022	70 22d	In light of the special cause variation in the IQR, related to complaints responses, EMB will review the process map for complaints management and report back to Board the reasons and corrective action.	RN	Q1 2023/24	Board	IP	At its meeting on 29 March EMB received a paper setting out the process mapping undertaken by the QI team. This identified gaps in the effective management of complaints. Corrective action has been taken, including now having a substantive complaints manager supported by the new QI lead. As a result improvement has been made, demonstrated by 93% compliance in March with the expectation that from May there should be a more consistent process. The assurance paper will be taken to QPSC in April and reported to the Board in June when this action will be closed.
15.12.2022	70 22e	The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.	SM	Q1 2023/24	Board	IP	
15.12.2022	71 22a	WWC to seek assurance that the executive is striking the right balance between patient safety and staff welfare, related to shift overruns. Noting the failing process identified in the IQR	EW	16.02.2023	WWC	C	Reviewed at the meeting on 16 Feb - see Board escalation report.
15.12.2022	71 22b	DR to clarify the recruitment target of 3946 (reported in the IQR) as there was some confusion about whether this is the right number.	DR	02.02.2023	Board	C	02.02.2023: DR confirmed that this is picked up in the IQR and now includes a dynamic target
15.12.2022	71 22c	WWC to seek assurance that we are ensuring robust induction, training and support to the international recruits to ensure they are welcomed and supported in the transition to the UK and to SECAmb. Ensuring learning from when we did this 4-5 years ago when a high number of recruits left within the first 12 months.	AM	16.02.2023	WWC	C	Reviewed at the meeting on 16 Feb - see Board escalation report.
15.12.2022	71 22d	WWC to seek assurance that we are identifying strategic solutions to improve the working experience in our EOCs, to address the very high turnover rates identified in the IQR.	AM	16.02.2023	WWC	C	Reviewed at the meeting on 16 Feb - see Board escalation report.
15.12.2022	71 22e	WWC to seek assurance that we have a consistent process in place that ensures we evaluate the impact of training (using appropriate metrics) to test that it delivers what is expected, to include specifically Fundamentals and Sexual Safety.	AM	Q1 2023/24	WWC	IP	Added to COB
15.12.2022	71 22f	WWC to confirm how we intend to ensure the learning from the East Kent Maternity Review as it is applicable to SECAmb and seek assurance that there is a process in place to ensure we use the lessons from the various culture-related issues.	AM	16.02.2023	EWWC	C	Reviewed at the meeting on 16 Feb - see Board escalation report.
15.12.2022	71 22g	WWC reported to the Board in December that the Board has good visibility of aspects of Culture and Leadership but has less visibility on Staff Health and Wellbeing. It suggested that at its meeting on 2 February the Board receives a paper setting out the vision and approach to ensuring the wellbeing of our people.	AM	01.06.2023	Board	IP	This is deferred to the meeting on 1 June
15.12.2022	71 22h	In the context of the growing list of training needs for staff, WWC suggested that the Board needs to be sighted on the various aspects so that it can take an informed view on how this is prioritised in the training plan(s) for 2023/24 and beyond. The Board agreed that at its meeting on 2 February, a report is received setting out the requirements with a proposed order of priority.	AM	06.04.2023	Board	C	02.02.2023: Initially scheduled for 2 Feb, but deferred to April to give time for a review at the ETD Group. In the meantime a paper on Key Skills came to QPSC in January, giving assurance that there is sufficient links to learning from complaints and incidents in the design of the training programme. 06.04.2023: The WWC recieved the traning plan - see escalation report
15.12.2022	72 22b	An update to Board in April on the transition to SVCC and QPSC in Q1 to seek assurance on the impact of this on patient quality/safety.	EW	06.04.2023	Board	C	This is referenced in the FIC Board report and in on the agenda in Part 2
02.02.2023	84 22	WWC to review the root cases of RIDDOR report; the actions we have taken in response; and how we benchmark with our peers	RN	20.04.2023	WWC	IP	On agenda for 20 April - will be included in the Board report on 1 June.
02.02.2023	85 22	At the Board meeting in April, an update to be provided to confirm the percentage of managers yet to undertake the Sexual Safety training; the figure reported in February was 26%.	AM	06.04.2023	Board	IP	06.04.2023: Verbal update to be provided -
02.02.2023	86 22a	QPSC to explore the plans to increase Hear and Treat to seek assurance it is done safely to the benefit of patients.	RN	13.04.2023	QPSC	IP	On agenda for 13 April. Will be included in the Board report on 1 June.
02.02.2023	86 22b	FIC to test the state of readiness to go live with SVCC in March.	EW	30.03.2023	FIC	C	See FIC escalation report
02.02.2023	86 22c	The steps to improve the culture in EOC to remain a standing agenda item for WWC, to ensure there is sufficient progress with the actions and that this is achieving the impact needed. WWC will report it level of assurance to the Board and the Board will request formal updates directly, as required.	EW	Q1	WWC	IP	On the agenda for WWC on 20.04.2023
02.02.2023	87 22	On behalf of the Board SM to escalate to the ICS CEOs the concern that the 999 contract for 2022/23 is still to be signed.	SM	ASAP	Board	C	The 999 contract for 2022/23 was subsequently signed by the ICS

Kev

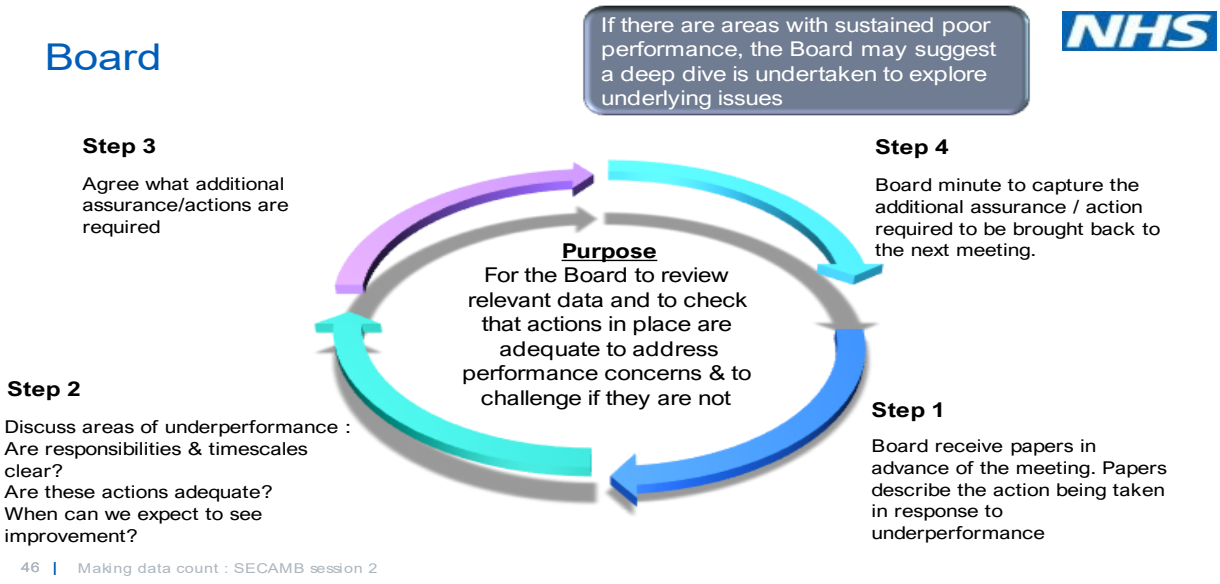
Not yet due
Due
Overdue
Closed

	Item No	05-23
Name of meeting	Trust Board	
Date	06.04.2023	
Name of paper	Chair Board Report	
Report Author	David Astley, Chairman	

Board Meeting / Effectiveness

The Board continues to review its effectiveness and this includes ensuring the focus at each meeting has a clear link with our strategic goals and related risks, using the primary board papers – the Board Assurance Framework; Integrated Quality Report; and Improvement Journey.

It has been 12 months now since our first Making Data Count Board development session, and we are increasingly making better use of the Assurance Cycle. This meeting will follow up on some of the gaps in assurance identified in recent meetings as captured in the actions.



In December, I set out the outputs of the Board Effectiveness Review, undertaken by our Improvement Director. The Escalation Reports to the Board will continue to describe how each committee is implementing the recommendations from this review. The Effectiveness Review also made recommendations for the Board itself, and progress to date is outlined below.

Also on the agenda is the Well-Led Review, which follows on from the Effectiveness Review. This was a really helpful exercise and the report sets out the Board's conclusion and the actions agreed, which in turn has informed the focus of the Board Development Plan for the coming year.

Recommendation	Progress
Consider Terms of Reference for the Trust Board. Clearly identifying the aims of the Board and referencing them as appropriate in the operation of the Board.	New Terms of Reference will come to the Board for approval at the next meeting on 1 June 2023.
To ensure the views of the council of the Council of Governors (COG) is expressed and considered at the Board	These are picked up in the Chair's Report. The Report in December covered the COG meeting the week before and aligned closely to the issues covered by the Board at that meeting. This Report includes issues from the meeting on 23 February.
Individual authors, the Chair and the Secretary to ensure papers adequately address the need to assess, monitor and drive improvements.	This is ongoing, to ensure continuous improvement.
It is recommended that further Board development takes place so that members can demonstrate that they understand how the Board sets the culture and are able to identify their personal contribution to the aim of transforming the culture.	Culture was the focus of Board development in January and February – see the separate paper on the agenda, setting out the outputs from these sessions.
Consider the addition of a Front Sheet for the Patient Story that clearly outlines any links to already recorded risks, BAF risks. The reason for bringing this story to the Board and how it supports the Trust's priorities and what quality improvement have been made.	This was introduced in December 2022.
In the summary of a discussion, the Chair to make it explicitly clear how any identified assurance gaps will be addressed	Ongoing. The minutes and action log provide evidence of this.
The chair to consider if the introduction of a disciplined framework to questions and answers will further strengthen the operation of the Board.	The Board agendas are now organised against the strategic goals and the 'primary documents' are used to guide the key areas of assurance the Board needs to explore. Making Data Count and the development of the new IQR leads the Board to focus primarily on the failing processes, as identified by the SPC charts. Executive Directors are reminded to summarise briefly the key points, therefore allowing the time for questions and challenge, using the assurance cycle included in the Chair's Report.
It is recommended that personal engagement is identified in the Development Need Analysis of the Board and addressed through the development plan.	This was confirmed as one of the outputs of the Workshop on 18 January 2023, related to the Board's Well-Led Self-Assessment. It will be addressed through objective setting for

	2023/24 and overseen by the Appointments & Remuneration Committee (for Executive Directors) and the Nominations Committee (for Independent Non-Executive Directors).
It is recommended that the Board reviews its current frequency.	The Board has reviewed its frequency of meetings and has reverted to meeting formally bi-monthly; the first Thursday of each month. In the intervening months the Board will meet informally to address its identified development needs.

Council of Governors

The Council of Governors met on 23 February 2023. The main areas of focus included Patient Safety; Culture; and Priorities for 2023/24. The specific concerns explored are aligned to the Board's agenda:

- The 111 Single Virtual Contact Centre and the impact on patient and staff experience.
- The Trust's readiness for Patient Safety Incident Response Framework.
- The learning from the IT Critical Incident in November 2022.
- In the context of recruitment and retention, the extent to which the Board and Executive is take steps to be more flexible with portfolio-type working for paramedics.
- How we ensure staff are well-engaged in our Improvement Journey, and that this reflects their feedback from the staff survey.
- Challenge to the Board about doing more to improve culture, especially in the EOC.

The Council of Governors also requested some time with the Board on strategy and strategy development; this will be the focus of the Joint Board / COG on 27 April.

Board Appointments

We have said goodbye to Siobhan Melia, Interim CEO, who has now returned to Sussex Community NHS FT. On behalf of the Board I would like to thank Siobhan for the great work she has done in the past nine months to help with our improvement journey. Simon Weldon, currently Group Chief Executive of University Hospitals of Northamptonshire Group, will be joining the Trust on 14 April 2023. In the meantime, from 1 April Martin Sheldon has been appointed the Interim CEO.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

South East Coast Ambulance Service NHS Foundation Trust

Well-Led Review 2022/23

1. Introduction & Methodology

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

Consequently, in order to provide support to the Trust, SECAmb was placed in the National Recovery Support Programme (RSP). The Trust worked with the local system and NHS England's RSP team to develop an Improvement Plan. This plan identified several actions that would lead to rapid improvements within the well-led domain. In particular, the need to have a greater understanding of the Board and the effectiveness of the Board's committees. This was undertaken in the autumn of 2022 and was reported within an earlier report.

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

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

This report is the second part of the work and reports on the well-led self-assessment.

The review was a self-assessment facilitated by Steve Lennox, Improvement Director, NHSE. The self-assessment asked each individual who routinely attends the Board to complete a rating for each of the CQC well-led key-lines of enquiry and to undertake a follow-up discussion with the facilitator on all the key-lines of enquiry (here) and a Board discussion.

The Key-Lines of Enquiry were,

1. Leadership Capacity & Capability to Deliver
2. Clear vision and credible strategy with robust plans to deliver
3. Culture of high quality, sustainable care
4. Good governance
5. Managing risk, issues and performance
6. Appropriate and accurate information
7. Public, staff and external partner engagement
8. Systems and processes for learning, continuous improvement and innovation

In addition, and as requested by commissioners, two further points were considered,

9. Review of the Board over the past two years
10. Lessons learned – understanding the context

The responses were then fed back to the Board members at a dedicated Board development session in January where discussion was facilitated with a number of prompts that had arisen out of themes from the individual interviews. The discussion then led to an overall collective score for each of the key-lines of enquiry.

The discussion also generated a consensus view as to the Board's performance over the past two years and lessons learned.

2. Terms of Reference

It was agreed to use the NHS England framework and templates for the review (here) which builds on the CQC key lines of enquiry.

3. Findings

This exercise was a facilitated reflective self-assessment and whilst the discussions were guided by the facilitator the detail and next steps were identified by the Board members. Therefore, the next steps have been described as actions (rather than recommendations). The intention was not to produce a long list of items as a number of issues are already captured within the Trust's Improvement Journey but to have a number of focussed actions that would make the biggest contribution at this point in time.

Overall, the Board members awarded themselves a rating of *requires improvement.* This reflects an improvement from the CQC rating of inadequate. This demonstrates a number of improved areas (and some of these are outlined in the following section). Every Board member recognised that the Board has significantly evolved and the quality of information and the discussion this generates now feels very different. However, the ambition to do more and do even better is reflected in the self-assessment rating.

The individual Key-Lines of Enquiry were scored as follows,

Leadership Capacity & Capability to Deliver **REQUIRES IMPROVEMENT**

Clear Vision & Credible Strategy **REQUIRES IMPROVEMENT**

Culture of High Quality Sustainable Care **REQUIRES IMPROVEMENT**

Good Governance **REQUIRES IMPROVEMENT**

Risk, Issues & Performance **REQUIRES IMPROVEMENT**

Accurate Information & Challenge **REQUIRES IMPROVEMENT** / **GOOD**

Engagement **REQUIRES IMPROVEMENT**

Learning & Continuous Improvement **REQUIRES IMPROVEMENT**

The nine agreed actions were agreed as,

1. Hold a Board discussion on clinical leadership and define what this could look like in the Trust and identify the plan within a new clinical strategy. To also consider how the Trust develops all leaders and supports the growth of talent across all working groups and how this links to the culture transformation plan
2. Board members to each hold an individual development plan that includes how they can develop their voice/presence at Board and how they receive feedback from colleagues
3. Return to the short-term strategy in a future Board forum and agree a universal understanding of approach
4. Revisit the Trust values
5. Ensure the Board returns to a future conversation on how it can improve connectivity to the wider organisation
6. To improve the assurance for EDI work at Trust Board
7. Review the role of the executive and non-executive director and embed in the Terms of Reference
8. Include developing confidence to challenge within the individual development plans
9. In terms of what went wrong, to agree the necessary action to reduce the likelihood of reoccurrence in the future

The following section outlines the main themes and issues arising from the discussion for the individual key-lines of enquiry.

3.1 Key Line of Enquiry 1: Leadership Capacity & Capability to Deliver

SECAmb Collective Self-Assessment  **Requires Improvement**

There are four sub questions to this line of enquiry (see appendix A). Overall, the individual Board members were aligned in their self-ratings for all four sub-questions. The most variation lay within the sub question "a*re there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme which includes effective selection, development, deployment and support processes and succession planning?"* with three team members describing this as inadequate and seven describing the area as good. However, following discussion the members agreed an overall rating of *requires improvement* and this was the score for the entire key-line of enquiry.

There was widespread recognition that improvements have been made in this area and there was a growing confidence within the team (this was intuitive as the Board members did not have sight of any regular metrics that assured against leadership improvement).

At interview, relationships and leadership development were the most frequently cited themes that required a continued focus. Six directors identified the need for more cross-directorate problem solving as the connectivity across directorates was not demonstrated through presentations or reports. More specifically, the connectivity across the various clinical professions was highlighted. Several Board members felt there was an unnecessary divide between the professions which could be aided by a closer collaboration between the clinical directors and their teams. This is being currently addressed. Linked to this was the need to develop strong clinical leadership within the operational teams.

At the Board discussion it was highlighted that empowered leaders are more able to speak-up and challenge poor practice from other clinicians, managers and leaders. Strong compassionate leaders at every level is fundamental to the improvement journey and would strengthen patient safety. However, there were different expectations and models of clinical leadership and it was acknowledged that the Board need to have alignment.

It was also recognised that the executive directors need to continue to strengthen the reporting to Board and in particular the quality of the narrative within the qualitative reports as this is a key driver for success in this area. This was highlighted within the Effectiveness Review and is already a recommendation for the Trust.

The Board members highlighted the need to continue to drive visibility. It was identified that this facilitates better connectivity to the work of the Trust. This is being addressed and a template is in place to record the observations from site visits so that these can be themed and shared across the Board members. Connectivity is also picked up as an action later in this written summary.

Following the discussion, two specific actions for this key-line of enquiry were identified. It was agreed to hold a dedicated discussion on leadership. This will be part of the Board development plan. In addition, each Board member has been asked to develop an individual development plan that identifies how they can optimise their contribution as a Board member.

Actions for strengthening the Key-Line of Enquiry: Leadership capacity & capability to deliver

- ACTION: Hold a Board discussion on clinical leadership and define what this could looks like in the Trust and identify the plan within a new clinical strategy. To also consider how the Trust develops all leaders and supports the growth of talent across all working groups and how this links to the culture transformation plan

- ACTION: Board members to each hold an individual development plan that includes how they can develop their voice/presence at Board and how they receive feedback from colleagues

3.2 Key-Line of Enquiry 2: Clear Vision & Credible Strategy

SECAmb Collective Self-Assessment  **Requires Improvement**

There are six sub questions to this line of enquiry (see appendix A) and this produced variation in the individual self-assessment ratings. Most notable was the difference between the executive and the non-executive with the former appearing more critical of performance with eighteen inadequate ratings against just 5 for the non-executive. However, following discussion the members agreed an overall rating of *requires improvement* for the entire key-line of enquiry.

Everyone was aware the previous strategy "Better by Design" had been retired but there was some confusion as to what had replaced it. Work is commencing on developing a new strategic direction but as the intention is to develop this through engagement it is a longer piece of work and it was recognised that a cohesive story needs to emerge as soon as possible. Consequently, at the interviews the majority of Board members cited the Improvement Journey as the current strategy and those that didn't were fully able to provide a comprehensive answer. It was agreed to return to this discussion within another Board forum.

At the time of the well-led self-assessment it was identified that the values need to have a greater profile and at a subsequent Board development session (on culture) the Board decided to revisit the values with the aim of ensuring they are as focussed as possible. This has now been captured and identified as an action.

Actions for strengthening the Key-Line of Enquiry: Clear Vision & Credible Strategy

- ACTION: Return to the short-term strategy in a future Board forum and agree a universal understanding of approach
- ACTION: Revisit the Trust values

3.3 Key-Line of Enquiry 3: A Culture of High-Quality Sustainable Care

SECAmb Collective Self-Assessment  **Requires Improvement**

There are nine sub questions to this line of enquiry (see appendix A) and this produced some variation in the individual self-assessment ratings across the Board members. Some Board members awarded good ratings for a number of the sub questions and others awarded inadequate. Overall, 37.5 of the 153 individual ratings were awarded an inadequate score. However, following discussion the members agreed an overall rating of requires improvement for the entire key-line of enquiry.

The two sub questions with the most diversity of response were 1) "*do staff feel positive and proud to work in the organisation?"* and 2) "*are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?"*. The diversity within the first question was directly related to the individual feedback Board members were receiving as part of their own individual engagement work. The diversity within the second question suggested those Board members whose roles were closer to the EDI agenda were more critical.

There was some frustration with the slow progress with the culture transformation programme, but it was recognised that this was a complex issue to address. However, whilst some Board members acknowledged the importance of the entire Board owning culture this wasn't universally demonstrated and the collective and individual responsibilities is being explored as part of the Board development programme.

Some Board members expressed the importance of the Equality, Diversity and Inclusion work in the culture transformation and did not feel sighted on the Trust's position.

The discussion recognised that the board needed to continue its emphasis on connectivity across the Trust and there was an awareness that Board discussions have not always reflected staff priorities.

It was recognised that there remains a lot to do in this area of work. But, for the Board the most pressing action was to have a suite of good metrics for measuring the impact and progress of the cultural transformation programme. This will need to form part of the work undertaken by the new Programme Director (Culture Transformation).

Actions for strengthening the Key-Line of Enquiry: A Culture of High-Quality Sustainable Care

There were two specific actions as this area will be developed further through the culture transformation programme and the Board development programme.

- ACTION: Ensure the Board returns to a future conversation on how it can improve connectivity to the wider organisation
- ACTION: To improve the assurance for EDI work at Trust Board

3.4 Key-Line of Enquiry 4: Good Governance

SECAmb Collective Self-Assessment  **Requires Improvement**

There are four sub questions to this line of enquiry. Overall, the individual Board members were relatively aligned in their ratings for all four sub questions. Following discussion, the members agreed an overall rating of requires improvement for the entire key-line of enquiry.

During the interviews, four interviewees suggested there was no collective understanding of the difference between the role of an executive and a non-executive director. It was felt that this was partly due to the inexperience of some Board members but also because some non-executives had felt the need to penetrate information to a greater depth than normal. This was expanded upon for the Board discussion and it was agreed that an understanding of the different roles was important. This is to be part of the Board development programme and has been captured in the actions.

It was felt that accountability had strengthened. The previous Chief Operating Officer role had clouded some responsibilities and since abolition it was felt individual portfolios were now much clearer. This had also led to a greater clarity of decision making. However, unitary responsibility was not always demonstrated at Board.

The discussion supported the view that Board level challenge was a fundamental component of good governance and it was essential that everyone felt able and confident to challenge beyond their home portfolio. Several Board members suggested this was not always evident and that more could be done. Consequently, it was agreed to include this aspect in the individual development plans that have arisen out of the first key line of enquiry.

Actions for strengthening the Key-Line of Enquiry: Good Governance

- ACTION: Review the role of the executive and non-executive director and embed in the Terms of Reference
- ACTION: Include developing confidence to challenge within the individual development plans

3.5 Key-Line of Enquiry 5: processes for Managing Risk, Issues and Performance

SECAmb Collective Self-Assessment  **Requires Improvement**

There are six sub questions to this line of enquiry (see appendix A) and this produced some variation in the individual self-assessment ratings. Most notable was the difference between the executive and the non-executive with the latter awarding more Good ratings across the individual elements. The non-executive awarded 28 Good ratings whereas the executive awarded 6.5. However, following discussion the members agreed an overall rating of requires improvement for the entire key-line of enquiry.

Four Board members specifically identified the improved position of risk management. The Board Assurance Framework had been revised prior to the well-led review and this review had also been well received by Board members. Some members specifically felt this had made a big difference to Board effectiveness.

The majority of Board members recognised there was still more to be done and there were different opinions on how the gaps should be addressed. This could be because the Board members are not aware of the risk methodology and direction of travel. It may be helpful to develop a strategic plan for risk management so that everyone is clear of the journey ahead and the whole Board can pull in the same direction.

The most commonly cited issue by Board members was not being confident on the totality of risk management and how risk was managed right through the service. It was felt that there was still a disconnect between the daily clinical and non-clinical risks facing staff and those being addressed by the Board.

Actions for strengthening the Key-Line of Enquiry: Managing Risk, Issues and Performance

It was recognised that there was already a strong emphasis on risk management within the Improvement Portfolio, so no additional actions were identified. However, the risk lead may wish to consider developing a strategic plan for risk management.

3.6 Key-Line of Enquiry 6: Accurate Information Being Effectively Challenged

SECAmb Collective Self-Assessment

Requires Improvement

Good

There are seven sub questions to this line of enquiry (see appendix A) and this produced the most positive responses across both the executive and non-executive. Out of the 119 possible responses, 54 of them were awarded a good rating. Following discussion, the members agreed an overall rating of requires improvement for the first four sub-questions and a good rating for the final three sub-questions for this key-line of enquiry.

The collective view was that the quality of the information had considerably improved, and this was helping to facilitate a greater enquiry by Board members and the majority of Board members felt challenge had improved. However, nine Board Members felt there were still gaps in information and some portfolios were not yet embedded in the reporting cycle (such as patient experience and estates).

It was also acknowledged that most of the Board assurance was coming from a single source and as the Board evolves there would be benefit in widening the sources for Board assurance, such as non-executive visits, external perspectives and the patient voice.

Actions for strengthening the Key-Line of Enquiry: Accurate Information Being Effectively Challenged

No specific actions were identified.

3.7 Key-Line of Enquiry 7: Public, Staff and External Partner Engagement

SECAmb Collective Self-Assessment  **Requires Improvement**

There are three sub questions to this line of enquiry (see appendix A) and this produced a fairly consistent response. Following discussion, the members agreed an overall rating of requires improvement for this key-line of enquiry.

There was wide agreement that engagement with partners had significantly improved and it was now recognised that engagement was a keystone to future success.

Five Board members identified the organisation's ability to listen as an issue. They felt it was important for the Trust to be able to clearly demonstrate it has understood concerns. Several Board members felt the Trust needed to use new technologies to engage with the workforce and this is now being considered within the work developing a new engagement strategy.

Several Board members also felt there was more to do with patients and in particular identified that there were opportunities to strengthen the engagement with the Trust Foundation membership.

Actions for strengthening the Key-Line of Enquiry: Public, Staff and External Partner Engagement

As a new engagement strategy is in development no additional actions have been identified.

3.8 Key-Line of Enquiry 8 : Learning and Continuous Improvement

SECAmb Collective Self-Assessment  **Requires Improvement**

There are two sub questions to this line of enquiry (see appendix A) and this produced some variation in the individual self-assessment ratings. Most notable was the difference between the executive and the non-executive with the former appearing more critical of performance with 7.5 inadequate ratings against just 4 for the non-executive. However, following discussion the members agreed an overall rating of requires improvement for the entire key-line of enquiry.

It was acknowledged that the Trust now has a specific lead to help advance this key-line of enquiry and this commitment gave a confidence that this area of work would improve. However some Board members expressed concerns that there was little innovation or mechanisms for innovation and this was contributing to the feelings of the workforce.

Actions for strengthening the Key-Line of Enquiry: Learning and Continuous Improvement

No specific actions for the Board were identified.

4. Board Function

The interviews and discussion also considered the role of the Board over the past few years. This was predominantly to set the scene for a reflective discussion on how the Trust returned to an inadequate rating by the CQC. However, the interviews suggested that there had been considerable reflection by many Board members with many expressing frustrations with the situation.

All Board members agreed that the Board had not demonstrated strongly in two of the three functional areas of culture and strategy. However, five Board members thought the Board had shown some strength in the third area of accountability and thought the Board had moved to a more open and transparent approach.

5. Lessons Learned

The interviews and discussion also considered a review of lessons learned by the Trust. This reflective piece was specifically requested by the Integrated Care System.

The individual interviews revealed a variety of perspectives. Unsurprisingly the pandemic was frequently cited as an issue and was identified as so consuming it challenged any opportunity to consider other issues and assurance to the Board was gradually replaced by reassurance. Some Board members felt the gap between the Board and the workforce widened during this time and new work patterns (home working) made the Board lose the connectivity. However, there was recognition that all NHS providers had similar challenges and had not found themselves in the same position.

Some unique aspects at the Trust included discussions about the Trust leadership. This was frequently cited as an issue. It was recognised that relationships across the team were not as collaborative as they could have been, and dynamics were not well managed. It was also recognised that the pandemic struck at a time when the Trust was still on a big improvement trajectory and change had not been transformational. Resulting in a reprise of old behaviours and to some extent validating the return to the old command and control culture that was so challenging for the workforce culture.

Some members expressed that, at the time of the CQC report, they were surprised at the CQC findings as they considered the Trust had maintained an outstanding position in managing the service through the pandemic and had kept staff safe. There was an inflated confidence at this time.

The Improvement Director asked the membership if the Board could be considered as complacent. The word can be emotive. But in the business world and in the context of change it takes a different form. In a complacent work environment, people are in denial about the company's underlying problems and the urgent need for reform (John Kotter, 2012) and this often follows successful navigation through a highly competitive environment or crisis that threatens the company. Such as a pandemic. The organisation's role in saving lives and responding to crisis could also serve to fuel this through the organisation's psychology.

At the membership discussion the suggestion was accepted as a possible and likely explanation as the pandemic saw grip architecture and processes for monitoring assurance become dismantled. In addition. the Trust found some questions, such as staff feelings, too challenging and unanswerable as the priority focus was staff and patient safety.

It was agreed that whatever the true cause (of which there are likely to be many) the lesson is to ensure the Trust identifies a number of measures that will help future Board members prevent a reoccurrence. This is an agreed action and will form part of the Board's development plan.

- ACTION: In terms of what went wrong, to agree the necessary action to reduce the likelihood of reoccurrence in the future

6. Conclusion

This report needs to be considered alongside the effectiveness (part 1) review. They complement each other in the way Part 1 is from an external perspective and considered the governance structure part 2 is from an internal self-assessment perspective and considered the leadership function. Whilst undertaken at slightly different points in the Trust's improvement journey they do illustrate alignment and an overall rating of Requires Improvement.

There has been a rapid improvement of the Board function and this is fully recognised by the Board members who also acknowledged further work was still required. The interviews revealed that many of the answers or solutions lay within the knowledge of the Board membership. People knew what additional corrective actions were necessary. However, factors such as time, capacity or the quality of information were cited as preventing further rapid progression.

Capacity and information quality are being addressed. But there are also a number of additional factors which could prevent a rapid progression to a good rating and these relate to stability. Neither the Board membership or the supporting structures appear stable. The impact of a turnover in Board membership could be minimised if there was an embedded strategy supported by strong delivery and governance processes. These do need addressing early in 2023/24 otherwise it could impact on future well-led review and exit from the Recovery Support Programme.

The individual interviews revealed greater alignment than at the time of CQC inspection. Answers felt informed, current and cohesive and this was reflected in the self-assessment scores and the individual discussions. However, there were two key-lines of enquiry which were slightly less comprehensive. The first was the key-line of enquiry *Processes for managing risk, issues & performance*. There was considerably more opinion on how this should be taken forward and this is possibly because Board members were not able to quote a strategic plan as to how the organisation is approaching risk management and how this will be embedded within the organisation. The other key-line of enquiry was *A Culture of High-Quality Sustainable Care* which identified a number of frustrations and challenges but there were less suggestions for corrective action. Collaboration and working across teams was frequently cited as an area that needs strengthening and this is essential for addressing the necessary transformation for addressing the requirements within a *Culture of High-Quality Sustainable Care*.

The other six key-lines of enquiry were comprehensively answered, and Board members could identify work undertaken and the challenges ahead.

It is worth noting that overall, the executive team were more critical. The executive awarded 62.5 inadequate ratings against the non-executives awarding 34. This is worth exploring within the Board development work.

Appendix A – Key-Lines of Enquiry Sub-Questions

Key-Line of Enquiry 1 - Leadership capacity & capability to deliver

Sub Questions

1. Do leaders have the skills, knowledge, experience and integrity that they need- both when they are appointed and on an on-going basis?
2. Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them ?
3. Are leaders visible and approachable?
4. Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme which includes effective selection, development, deployment and support processes and succession planning?

Key-Line of Enquiry 2 - Clear vision and credible strategy

Sub Questions

1. Is there a clear vision and set of values, with quality and sustainability as the top priorities?
2. Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care
3. Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use the services and external partners
4. Do staff know and understand what the vision, values and strategy are, and their role in achieving them
5. Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?
6. Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?

Key-Line of Enquiry 3 - A culture of high-quality sustainable care

Sub Questions

1. Do staff feel supported, respected and valued?
2. Is the culture centred on the needs and experience of people who use services?
3. Do staff fell positive and proud to work in the organisation?
4. Is action taken to address behaviour and performance that is consistent with the vision and values, regardless of seniority?
5. Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution and is appropriate learning and action taken as a result of concerns raised?
6. Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations?
7. Is there a strong emphasis on the safety and wellbeing of staff?
8. Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?
9. Cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

Key-Line of Enquiry 4 - Good Governance

Sub Questions

1. Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?
2. Do all levels of governance and management function effectively and interact with each other appropriately?
3. Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom?
4. Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person centred care?

Key-Line of Enquiry 5 - Processes for managing risk, issues & performance

Sub Questions

1. Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?
2. Are there processes to manage current and future performance? Are these regularly reviewed and improved?
3. Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken?
4. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?
5. Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?
6. When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?

Key-Line of Enquiry 6 - Accurate information being effectively challenged

Sub Questions

1. Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?
2. Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and do they challenge appropriately?
3. Are there clear and robust service performance measures, which are reported and monitored?
4. Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?
5. Are information technology systems used effectively to monitor and improve the quality of care?
6. Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?
7. Are there robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

Key-Line of Enquiry 7 - Public, staff and external partner engagement

Sub Questions

1. Are people's views and experiences gathered and acted on to shape and improve the services and culture?
2. Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups? Patients
3. Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

Key-Line of Enquiry 8 - Processes for learning and continuous improvement

Sub Questions

1. In what ways do leaders and staff strive for continuous learning, improvement and innovation?
2. How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	05-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Board Development
Strategic Goal	Delivering Quality / Focus on People
Lead Director	Chairman
Report Author	Peter Lee, Company Secretary

Board Development 2022/23
The areas of development prioritised last year included:

Making Data Count	NHS England
NHS Leadership & Culture Programme	NHS England
Effective Challenge / Holding to Account	NHS Providers
Improvement Journey	Internal
Priorities for 2023/24 - Joint Board / COG	Internal
Board Effectiveness Review	NHS England
Well-Led Framework Self-Assessment	NHS England
Culture – Our Leadership Way	NHS England / Internal

Board Development 2023/24
As set out in the separate paper, a workshop facilitated by the Improvement Director was undertaken in January to work through the outputs of the Board's Well Led Self-Assessment. This has been used to determine the areas of the Well Led Framework that the Board has identified as requiring improvement and in turn the areas of development to be prioritised for 2023/24. The proposed plan will be kept under constant review so that there is flexibility should different issues arise in-year. Unless confirmed in bold, the dates are indicative and some will require additional dates.

Well-Led / Effectiveness Areas for Development	Objective	Date
Strategy	In the context of the interim strategy as set out in the strategic priorities for 2023/24, agree the process and key principles for the development of a new Trust Strategy	**27.04.2023 Joint Board/COG**
	Determine strategic direction, e.g. 111 CAS, operating model / skill mix	**04.05.2023**
Risk Management	Exploring how risk appetite impacts on the risk management and decision making at Board. Agree a new risk appetite statement	**06.04.2023 & 04.05.2023**

	and via the BAF map the strategic risks to the new strategic objectives.	
Leadership	To define what clinical leadership could look like in the Trust and identify the plan within a new clinical strategy. To also consider how the Trust develops all leaders and supports the growth of talent across all directorates.	06.07.2023
Connecting with our people	Establish how the Board connects better with the issues faced by staff	06.07.2023
Data Analysis	To improve the way the Board uses data	07.09.2023
Curiosity	To ensure the Board learns from the past and uses early warning signs to identify where progress isn't being made / going backwards	07.09.2023
Culture	Follow up from the sessions in January and February – exploring the extent to which the Board is effectively utilising Our Leadership Way.	02.11.2023
Well Led Framework	Repeat the self-assessment to compare the findings and update the areas of development requiring priority	02.11.2023

The aim will be to use the time scheduled for the Board every other month, and the sessions will be planned with a lead executive director and a lead independent non-executive director, to ensure full Board buy-in. Some sessions will be externally facilitated and others will be more akin to a roundtable conversation. For example at the last Culture session the Board agreed to have 'curiosity' meetings, where there is a wider and more open discussion on a particular subject(s).

Recommendations	The Board is asked to support the plan and note that directors will be identified in due course to help plan / deliver each session.

Southeast Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee Escalation Report

Overview of issues covered at the meeting 15.03.2023

Item	Purpose	Link to BAF Risk
External Audit / Audit Plan	To seek assurance on the approach to the completion of the External Audit Plan	N/A
KPMG provided its 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.		
Internal Audit Progress Report / Internal Audit Plan for 2023-24	To receive the outcomes of the internal audit reviews most recently completed. To seek assurance that the annual plan will effectively monitor the organisation's risk profile	N/A
Two audit reviews have been completed since the last meeting with Procurement and Contracting providing *minimal assurance*, and Financial Systems, *reasonable assurance*. The committee noted the draft report to come next time, related to Policy Management, which is currently showing *minimal assurance.* By the next meeting the review of Risk Management will also be complete. The committee challenged the pace of improvement with procurement and contracting. While it supports the need to bring procurement closer to finance to improve resilience, further assurance is needed that the actions being taken will resolve the weaknesses in control that have been identified. The committee agreed the plan for the coming year, asking that the review related to staff appraisals is brought forward.		
Counter Fraud	To seek assurance that the Trust has effective counter fraud arrangements.	N/A
In the context of an emerging issue related to timesheet recording, the committee explored once more the ongoing issue related to staff working in secondary employment while sick, and challenged whether more could be done, pro-actively. Taken together with concern about policy management (referred to earlier), a joint committee meeting will be scheduled with the People Committee, to explore in fuller detail some of the HR-related controls. A separate review identified potential weaknesses within the process of fuelling Trust vehicles, indicating that the current systems are not robust enough to mitigate the risk of fraud and recommended that the		

Trust implement a robust management system and a more proactive approach to the cross-checking and management of Fleet fuel cards to strengthen their approach to the security of fuel cards. The committee challenged the executive to provide assurance that the control environment is effective. It will receive a management response as the next meeting. The Counter Fraud work plan for 2023/24 was reviewed and approved.		
Draft Annual Governance Statement – Outline	To seek feedback from the committee	N/A
The committee reinforced the need for the annual governance statement to reflect all the key gaps in controls in an open and transparent way with emphasis on the action taken and impact we are able to reasonably demonstrate. It will consider the full draft at the next meeting.		
Risk Management	To seek assurance that our risk management process is effective.	Risk 257 – Improvement Journey
The risk management report was received and the committee challenged whether patient quality is clear enough. The committee supports the direction the executive is taking risk management but notes that more work is needed to ensure more consistent engagement throughout the organisation. As referred to earlier, the meeting in May will receive the outcome of the risk management internal audit review.		
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. The committee challenged the target scores and target dates as being too optimistic and noted the importance of ensuring that every level of the organisation should be able to articulate the three top risks. The committee supports the plan to align the BAF with the new strategic priorities, and it will review this at the next meeting in May.		
Procurement Improvement Plan	To note the progress to date on the Procurement Improvement Plan.	N/A
The committee reviewed the procurement improvement plan and noted the progress to-date. However, as stated earlier under Internal Audit, the committee will be seeking further assurance that the weaknesses in controls are resolved effectively.		
IT Critical Incident	To seek assurance that the Trust has learnt from this incident.	N/A
The critical incident report was reviewed, noting that there have been no identified harm to patients. There are still however some issues still to be determined, most notably that cause of the incident. The committee		

would have hoped we would be clearer on this by now. It is therefore not assured and supported an external review to help provide assurance that our systems are stable, that there is a review of lessons learned, confirmation of what exactly occurred, and what needs to be done to ensure that the systems are sufficiently resilient to maintain operational capability. This will remain a standing agenda item until the external review is completed and the committee is more assured.

Information Governance Annual Report	To seek assurance that the Trust has effective information governance reporting.	N/A
The committee received the annual report which included a summary of key activities, achievements, and issues as well as objectives set for the forthcoming year. The committee agreed the report was helpful but suggestions were made to help ensure that in future it is described in plainer English.		
Freedom to Speak Up	To seek assurance that the Trust has an effective speaking up culture and systems in place to ensure investigation and learning.	N/A
The committee considered the recommendations from the National Speak Up Review of NHS Ambulance Trusts. It agreed that there have been many improvements at the Trust within the last year, but that further work is required related in particular to culture. The committee also agreed that the Trust is not using the staff networks effectively to help address the issue of culture.		
Committee TOR / COB	To provide feedback on the committee's TOR and annual cycle of business.	N/A
The TOR and annual cycle of business were reviewed with some amendments suggested to the latter.		

Specific Escalation(s) for Board Action	The committee is concerned with the increase in 'limited assurance' reviews that the control environment is not as resilient as it was. It will therefore be seeking greater assurance going forward that controls are resilient.

In Q3 the Trust's Improvement Director undertook a Board Effectiveness Review, which included a review of this committee. It concluded that the committee was effective and of the four recommendations only one is directly related.

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**
To ensure the minutes are a factual, concise summary of the discussion and try and aim for consistency across the committees	The minutes of the committee are considered to be of a good standard. Work is ongoing to try and ensure a consistent approach across committees acknowledging they are completed by different individuals.

All authors to consider the assurance required and to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	For the other Board committees we now on each agenda show the purpose and assurance question(s) for each item. This has helped report authors understand what is expected and helped committee members ensure clarity on the assurance being sought. The expectation is that over time this will ensure continued improvement in the quality of papers and in the way assurance is sought and captured at meetings. This committee has to-date not deemed it necessary to adopt quite the same approach, given the nature of its purview and well-established structure.
Consider if a gap analysis against the draft best practice guidance would help strengthen audit committee governance	The TOR for the committee is based on the best practice model (foundations of good governance third edition). It will use the relevant best practice check list, such as the NAO published in 2017, in future annual self-assessments.
To consider how the escalation report can close the loop on assurance.	The Board Committee Escalation Reports have been revised to ensure they are clearer on what the committee requires from the Board in terms of intervention. Since September 2022 the Board has been more directive with committees when it has identified gaps in assurance; this is captured in the action log and transferred then to the relevant committee's cycle of business / forward plan. When the committees are directed in this way, they will in the Escalation Report confirm how it has addressed the identified gaps, and therefore closing to assurance loop.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	07-23

Name of meeting	Trust Board
Date	06.04.2023
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 February and March 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 and the development of our new People & Culture Strategy, however other actions taken include:

- Consideration of the NHS Staff Survey results to ensure actions taken in response are in line with our emerging People & Culture Strategy
- Close on-going consideration of our financial position and the development of an internal business case process
- Reviewing the list of Trust policies, including expiry dates
- Supporting the development of the new Communications & Engagement Strategy

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 **Appointment of new Chief Executive**
On 23 March 2023, we announced that Simon Weldon will be joining SECAmb as substantive Chief Executive on 24 April 2023.

7	Simon is an experienced Chief Executive, with extensive experience in the acute and commissioning sectors across a range of Trusts in London and across the country; most recently, he has been Group Chief Executive of the University Hospitals of Northamptonshire Group. I am sure that SECAmb will benefit significantly from Simon's wide-ranging experience and that he will provide strong leadership and guidance.
8	Following her nine-month secondment as Interim Chief Executive, Siobhan Melia returned to her substantive role as Chief Executive at Sussex Community NHS Foundation Trust on 1 April 2023. I am therefore acting as Interim Chief Executive from 1 April until Simon joins us later this month and we are appointing an Interim Chief Finance Officer to take the lead for finance during this period.
9	On behalf of the Trust, I would like to take this opportunity to thank Siobhan for her support and leadership during the past nine months. She has undoubtedly helped us to make real strides forward and will leave firm foundations for Simon and the team to build on.
10	**Leadership visits** During February and March, senior leaders have continued their programme of visits to sites across the Trust, spending time out and about, listening to what's important to colleagues.
11	Following these visits, a report is collated each month, which pulls together all of the issues and the key themes raised. This is reviewed and considered at Leadership and Executive Team meetings, the themes discussed, and actions taken where possible. To complete the feedback loop, examples of where action has been taken in response to staff raising issues, are then shared back out to the organisation.
12	The graphic below, which has been shared with all staff, shows the visits undertaken during February 2023 and the key themes raised. Moving forwards, it's important that we fully embed this cycle of listening/acting/feeding back into business as usual and all key decisions. 
13	**'Your Mind Matters' internal campaign**

	During February 2023, we ran 'Your Mind Matters' – an internal campaign focusing on ensuring that all colleagues, volunteers and students were aware of the support and help that is available to support mental wellbeing.
14	The framework for the campaign was 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.
15	The campaign utilised all of our communication channels to ensure as much visibility as possible, including: • The creation and distribution to home addresses of more than 5,000 individual issue cards containing key information and signposting • The creation and installation of 650 stickers containing key information and signposting in the cabs of all Trust vehicles • The utilisation of individual staff stories, through videos and podcasts
16	Whilst detailed evaluation is currently being undertaken, anecdotal feedback so far has been very positive.
17	**Values Check-In** To support the significant work underway to improve the culture within the organisation, in particular the development of our new People & Culture Strategy, we are currently undertaking a short 'values check-in', to check with colleagues on whether or not they feel we should 'refresh' our current Trust values.
18	The check-in was prompted by consistent feedback during the past six months, through leadership visits and other forums, that colleagues found our Trust values difficult to remember and that they didn't always feel 'real' within the working environment.
19	Utilising this feedback, a potential new set of 'refreshed' values was developed, which we are currently asking colleagues to feedback on, and which are being received extremely positively so far.
20	Once the check-in period has ended, all feedback will be collated, and the results and next steps shared with the Board.
	B. Regional Issues
21	**Celebrating a decade of 111** On 13 March 2023, we celebrated a decade of running the NHS 111 service across much of our region.
22	The NHS 111 service took over from NHS Direct, a nationally run service that began in 1998. The decision was made to devolve NHS Direct services after the Department of Health commissioned Ofcom to undertake a consultation for the designation of a three-digit telephone number to access NHS non-emergency healthcare services in England.

23	Since then, our 111 team, working at times in partnership with other providers, has answered more than 10 million calls at a rate of more than 100 calls an hour. The service has also evolved to include an option to seek help and advice online with the launch of NHS 111 Online – www.111.nhs.uk.
24	I would like to thank all 111 colleagues, past and present, who have got us to where we are today. We have a fantastic service for which we should all feel immensely proud.
25	**Second series of 'Emergency Call Out' commissioned** I am pleased that the work of the Kent Joint Response Unit will be showcased again with filming for a second series of Channel 5's 999: Emergency Call Out having beginning in early April.
26	The approach to film for a second series reflects the success of the first series which proved popular with viewers and highlighted not only the direct partnership working with Kent Police, but also the amazing care being delivered by staff across the Trust, every day.
27	The second series is expected to consist of 15 episodes to be broadcast later this year. This series will also include filming in EOC to highlight the control room's vital role in responding to patients.
28	**Development of new operational centre at Medway** Work is nearing completion on our new, multi-purpose ambulance centre in Gillingham, which will consist of a Make Ready Centre, Emergency Operations Centre, (EOC), and NHS 111 contact centre and which will be the first ambulance centre in the country to bring all three functions together under one roof.
29	The first staff to move to the new centre this summer will be field operational staff from the Medway Operational Unit. Road staff will then be joined by colleagues from the Ashford 111 contact centre before EOC staff, currently based at the Trust's control room in Coxheath, will begin relocating to the new centre later this year.
30	Integrating both 999 and 111 services is a key part of our strategy to deliver more joined up integrated care and to increase efficiency. The new centre will also provide us with greater control room capacity and provide greater resilience with the ratio of staff more evenly split across our two EOCs.
31	I'm really pleased that we are getting close to the point that the new centre will become operational. Our current buildings, including our Coxheath site, are outdated and bringing our 999 and 111 services under one roof will ensure we further optimise functions between these services.
	C. National Issues
32	**Launch of Urgent & Emergency Care Strategy** On 30 January 2023, NHS England published the 'Delivery plan for recovering urgent and emergency care services' and a key strand of the Plan is a commitment to increasing ambulance capacity nationally, in terms of staff and vehicles.

33	We are still working through the detail of how this will work in practice, at a national level through discussions with ambulance colleagues and also at a regional level, through discussions with our commissioners.
34	**NHS Staff Survey results** The 2022 NHS Staff Survey results were published for all Trusts on 9 March 2023, and it was good to see SECAmb achieving one of the highest response rates for ambulance trusts in the country.
35	However, whilst we did see some green shoots in the results around being compassionate and inclusive, working together as a team and becoming a truly learning organisation, we also saw areas of deterioration compared to the previous year.
36	Focussing on our people is a key strategic objective for us and our new People & Culture Strategy, based on what our colleagues have told us needs addressing, will provide a robust strategic framework to focus the actions we need to take in this area.
37	Three areas of focus for the new Strategy were also highlighted strongly by staff through the survey results and you can hear more about the work underway in the areas below through other Board agenda items today:
38	• Recommending SECAmb as a place to work • Supporting all of us in feeling safe when speaking up • Focusing more on recognition and wellbeing
39	**Industrial Action** During February 2023, we saw two periods of industrial action as part of the national pay dispute. Ahead of these periods, we worked closely with our GMB Union branch and all staff to ensure the impact on patients during the industrial action was kept to a minimum, whilst supporting colleagues' right to take action. We are also grateful for the support received from our NHS and emergency service partners during the periods of industrial action.
40	The industrial action planned for 6 March 2023 was postponed in advance and on 16 March 2023, further industrial action planned by a number of the Trust's unions was also paused after national talks between the government and unions resulted in a new pay offer, which is currently being voted on by staff.
41	We would like to thank all our staff, our unions for their professionalism during recent industrial action and our system partners for their continued support.
	D. Escalation to the Board
42	**Operational Performance** The performance of all ambulance services nationally remains challenged, and the recent periods of industrial action have placed additional pressures on service delivery. Both 999 and 111 demand remains inconsistent.

43	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, particularly in our Emergency Operations Centres, which impacts on the level of resources available to us.
44	In Categories 2 and 3, we continue to perform reasonably well compared to our peers nationally, although no Trusts are currently achieving the national response time targets.
45	We remain a significant outlier for our 999 call answer time performance when compared to our colleagues nationally however, which is an area of concern. Work is underway to increase staffing levels where possible, as well as reviewing our call answer processes to ensure they are as efficient as possible.
46	We moved to REAP Level 3 on 30 January 2023 but continue to keep this under close review.

		Item No	08-23
Name of meeting	Trust Board		
Date	6 April 2023		
Name of paper	SECAmb Annual Plan		
Executive sponsor	David Ruiz-Celada, Executive Director Planning and Business Development		
Author name and role	Peter Inkpen, Associate Director for Planning and Performance		
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The creation of the SECAmb Annual Plan, and associated trust priorities to deliver the plan, provides direction and focus for the next 12 months across all directorates. Included in the plan is delivery against the CQC Must Do's and RSP's. Over the past few months there have been meetings and workshops with the Board, Councill of Governors, EMB, SMG, lead ICB and NHSE Regional partners, and other colleagues across all directorates to identify achievable trust priorities that deliver improvements for our patients, our people, and our partners. The priorities have been aligned to our four strategic pillars in the Improvement Journey: - Quality Improvement - People and Culture - Responsive Care - Sustainability and Partnerships This is a 1-year plan which achieves 2 things – continues to deliver the improvements we need to make following the 2022 CQC inspection, and development of a longer-term roadmap for improvement through the creation of a new long-term SECAmb Strategy, as the 2017-2022 strategy has expired. This papers sets out a the ambition to have a completed draft for our new strategy by Q4 of 2023/24, helping us inform future annual plans and priorities. The BAF for 23/24 will be updated and aligned to these priorities once approved, and the Board will regularly receive updates against these deliverables to ensure there's on-going accountability to deliver the objectives set for the organisation. Some of the KPIs require further engagement with local operational managers to define, and will be embedded in time for the refreshed BAF to be reviewed through April.		
Recommendations, decisions or actions sought	1. Approve the SECAmb Annual Plan Objectives for 23/24 2. To note that: ▪ some parts of the plan will require further development and consultation with operational teams to agree KPIs. These will be completed in April as part of the cascading of the plan and the update of the BAF for 23/24. ▪ the BAF is to be updated to reflect the in-year deliverables, and IQR updated to reflect the success metrics identified in the plan		

NHS
South East Coast Ambulance Service
NHS Foundation Trust

SECAmb Improvement Journey

23/24 Forward Planning

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

Improvement Journey

- In 2023/2024 we will continue to use our Improvement Journey as the framework to align our priorities to our Strategic Themes as below.
- The four Strategic Themes within the Improvement Journey were born from the CQC inspection in 2022, and developed in alignment with the Board Strategic Priorities approved in 2020.
- As part of the Strategy refresh in 23/24, we will review this framework, to ensure that as we move forward we have the right focus areas for our people and our patients.

Board Strategic Priorities 23/24

- Supporting our 4 Strategic Themes of Quality Improvement, People and Culture, Responsive Care and Sustainability and Partnerships, we have identified core deliverables and aspirations that support how we will deliver against each theme.
- These are a result of internal and external consultation, and help us define the ambitions and outcomes we want to deliver as a Trust over the next 12 months.
- Each ambition is supported by specific deliverables and outcomes, with an identified lead executive, and supporting milestones and KPI targets in-year.
- The Board will be aligning it's assurance cycle to this plan, to ensure there is visibility of the progress of the outcomes for our patients and people throughout the year.

We will…	Quality Improvement	People and Culture	Responsive Care	Sustainability and Partnerships
	QI1 – Build and embed an approach to Quality Improvement at all levels **QI2** – Become and organisation that Learns from our patients, staff, and partners **QI3** – Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk	**PC1** – Build a culture around our values, where everybody is respected and well supported **PC2** – Make SECAmb a great place to work, becoming the employer of choice **PC3** – Promote and embrace a speaking up culture where everybody's voice is heard	**RC1** – Deliver safe, effective and timely response times for our patients **RC2** – Implement smarter and safer approaches to how we respond to patients **RC3** – Provide exceptional support for our people delivering patient care	**SP1** – Develop a refreshed vision and strategy for SECAmb and our operating model **SP2** – Be a great system partner, establishing SECAmb as a system leaders in the UEC arena, becoming the partner of choice **SP3** – Become a Sustainable Urgent and Emergency healthcare provider

Responsive Care

DRAFT for Board Approval

Our Trust Objectives	This means that we will deliver…	By…	Exec Lead	How we will measure success…
Deliver safe, effective and timely response times for our patients	A Category 2 Mean response time that is improved and closer to National Standards	Milestones across each quarter	EW	Mean C2 response time of 34 minutes
	A Call Answer Mean time of 10 seconds	Q1	EW	Mean Call Answer time of 5 seconds
	Implementation of dispatch improvement actions to improve effectiveness of resource utilisation (RPI, cross-border working)	Q2-Q3	EW	Trust wide mean target of 84% activity completed by own desk resources, and with a reduction in variation to less than 20% between the max and min performance
Implement smarter and safer approaches to how we respond to patients	Improvements in our Hear and Treat rate to a minimum of 14%	Q1-Q4	EW	Heart and Treat of 14%
	Continued working on key/national programmes – 999 IRP, 111 SVCC, response to Manchester Arena Inquiry recommendations	Q1-Q4	EW	Volume calls taken by other in IRP / SVCC – 0% unplanned, 85% completion of Major Incident Training programme?
	Improved utilisation of all clinical resources from volunteers to specialist practitioners to achieve improved performance	Q1-Q4	RO	[TBC Field Ops and Medical Team]
Provide exceptional support for our people delivering patient care	An improvement in on-day out of service, late shift over-runs both a % of shifts and mean over-run time	Q1-Q4	EW	ODOOS target of 4% max – with all DD moving to be in line with best in class performance Reduction of LSO [TBC Field Ops & EOC Team] Mean over-run time reduction [TBC Field Ops & EOC Team]
	Integration of EOC, 111 and MRC operations in one site at Medway	Q3	MS	Successful go-live of 111, MRC and EOC operations in line with project milestones We will ask our colleagues joining the site what their experience is
	A new Ambulance design and Fleet strategy that meets our needs for the future	Q4	DRC	We will replace the manual FIAT DCAs and decide a new ambulance design to continue our fleet replacement

Sustainability and Partnerships

DRAFT for Board Approval

Our Trust Objectives	This means that we will deliver…	By…	Exec Lead	How we will measure success…
Develop a refreshed vision and strategy for SECAmb and our operating model	A new Clinical and Quality strategy that meets the needs of our patients now and in the future	Q2	RO	Strategy sign-off in Q2, as a milestone of the development of our long-term strategy
	A new long-term mission, vision and strategy, based on collaboration and co-design with our patients, people and partners	Q4	DRC	Evaluating successful involvement of our people, patients and partners Strategy sign-off in Q4 at Board
Be a great system partner, establishing SECAmb as a system leaders in the UEC arena, becoming the partner of choice	Optimised Urgent and Community referral pathways, avoiding conveyance to EDs, and improving the use of the ICS SPOAs	Q1-Q4	DRC	Reduction in conveyance to ED from scene Improved use of U&C referral pathways & increased use of ICS SPOA from EOC [TBC agreement with ICBs]
	A new internal and external governance that aligns strongly to our ICBs, helping us strengthen relationships and ways of working	Q1	DRC	New governance go live in Q1 and effectiveness evaluated in Q3
	A joint workforce plan for our systems, strengthening development pathways for our clinicians and creating long-term sustainability in our paramedic workforce	Q3	AM	Long term workforce strategy and plan agreed with ICBs Reduction in leavers in the organisation to other parts of the system
Become a Sustainable Urgent and Emergency healthcare provider	Our financial commitments as agreed with commissioners for FY 23/24	Q1-Q4	MS	Plan delivered in line with planned deficit of £5m
	Cost efficiency improvements to ensure our resources are focussed on delivering patient care	Q1-Q4	MS	Internal savings identified £9m of which at least 75% will be recurrent
	Our de-carbonisation commitments as set out by our Green Plan	Q4	DRC	Completion of electric RRV trial EV Strategy approved at Board Entonox removal improvement case approved

Quality Improvement

DRAFT for Board Approval

Our Trust Objectives	This means that we will deliver…	By…	Exec Lead	How we will measure success…
Build and embed an approach to Quality Improvement at all levels	Quality Improvements on how we keep patients safe in the EOC stack during periods of escalation and at points of discharge?	Q4	RN	Reduce level of harm experienced by our patients vs 22/23 baseline
	A QI Strategy to take the organisation forward and empower those closest to patients to lead improvements	Q2	RN	Signed off Strategy at the Board
	Training and engagement in QI for our people	Q4	RN	# of people trained # of local QI projects
Become and organisation that Learns from our patients, staff, and partners	Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF	Q2	RN	[TBC Quality Assurance Framework]
	Improvements in Out of hospital cardiac arrest survival rates from point of initial contact through to deployment of volunteers and specialist resources	Q4	RO	Increased recognition of CA in EOC Increased deployment of CFRs to CA ACQI metrics showing sustained improvement [TBC target]
	Building on existing pre-hospital maternity education and training in response to local and national cases/reports to enhance patient care and experience	Q4	RO	Decrease in concerns/complaints related to maternity cases Decrease in untoward events [TBC target]
Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk	A Quality and Performance Management Framework that runs from our Patients to the Board	Q1	EW	We will evaluate effectiveness and impact after 6 months (well led review)
	A Quality Compliance Surveillance Framework that helps us assure the improvement we are making	Q1	RN	We will evaluate effectiveness and impact after 6 months (well led review)

People and Culture

DRAFT for Board Approval

Our Trust Objectives	This means that we will …	Examples of how we might deliver this…	How will we measure success?
Ready for work	… have diverse and supportive on-boarding processes, with more flexibility and helping people stay at SECAmb	1. Engaging and rapid onboarding process 2. Delivering our clinical and non-clinical training plans for the year 3. Stay interviews at 6-12 weeks	-3% Sickness - X% Attrition in year 1 Workforce diversity [TBC WRES WDES] TTR Improvement [TBC]
Happy at work	… eradicate discrimination, harassment, bullying and incivility	1. Invest in leadership, values and civility in the workplace training for all of our people 2. Taking rapid action when serious concerns are raised 3. Reviewing our policies and processes outcome to resolve more issues locally	Number of cases resolved informally Cases closed within policy timeframes Diversity metric tbc?
Supported by work	… promote and champion an environment where everybody feels safe to speak up, be heard, and have their concerns acted upon	1. Actions as aligned to speak-up plan and NGO recommendations i.e. targeted programmes as part of the culture improvement programme 2. Ensuring everybody gets a appraisal 3. Ensuring everybody get time to focus on their development	FTSU cases with detriment Anonymous FTSU cases Asking people: Pulse survey, Staff Survey, internal culture programme Appraisal rate of 85% Mandatory training and key skills delivered to 85%
Contributing at work	… involve all of our colleagues in the decisions that will impact how we change and move forward as an organisation	1. Promote and train people on the principles of QI 2. Engaging everybody in the design of our future strategies 3. Empowering local teams to make the improvements that are right for them 4. Commitments followed through	Asking people: Pulse survey, Staff Survey, internal culture programme Number of team-led improvement programs

Next Steps

- Embed annual plan within the BAF in April – to be reviewed at Board Development in April
- Development of proactive communication campaigns on the key priorities that will be most relevant for our people, i.e. New Ambulance specification, Long Term Strategy, our clinical priorities, and Quality Improvement
- Forward plan committee scrutiny in line with the presented plan
- Gap analysis to align IQR to the identified and developing metrics, ensuring Board has full visibility of impact and evaluation of actions taken
- The People and Culture Plans have been revised to align with the new People and Culture strategy. The plan is being developed in detail by the new Programme Director for Culture and more specific timelines and KPIs will be added in April and shared with the Board by end of April.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	09-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Board Assurance Framework
Strategic Goal	All
Author	Peter Lee, Company Secretary

This is the final version of this BAF report. From April 2023 the BAF will be realigned with the strategic priorities and corporate objectives (see separate paper). The BAF will therefore be in two parts, the first part describing progress against the objectives, with part two setting out the risks using the current template. This proposal was supported by the Audit & Risk Committee.

The BAF will continue to cross reference the Improvement Journey and IQR and be used by Committee Chairs to help ensure meetings take a risk-based approach to its areas of focus. The BAF risks also inform the focus of Board meetings, as reflected on the agenda and set out in the separate cover papers.

The Board is asked to note that BAF Risk 17 – Integration of 111 & EOC has not been fully updated. It is asked to cross reference the Operational Performance Paper and note that following review by the Finance Committee, there will be a discussion in private (Part 2).

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 have been reviewed in line with the business planning cycle for 2023/24 and new priorities and annual corporate objectives are before the Board for approval – see agenda item 08-23.

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 & People Committee	Executive Managament Board & Quality and Patient Safety Committee	Executive Managament Board & Quality & Patient Safety and People 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.

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			Jan 21	Mar 21	May 22	Aug 22	Sep 22	Dec 22	Feb 22	Apr 23			
14	Operating Model	QPS	✓	✓	✓	✓		20	16	16	16	16	20	20	20	20	⇔	08	Mar-24
255	Workforce – Recruitment	WWC	✓	✓	✓	✓		20					16	16	16	16	⇔	08	Mar-23
13	Workforce – Retention	WWC	✓	✓	✓	✓		16	12	12	12	16	16	16	16	16	⇔	08	Mar-24
348	Culture & Leadership	WWC	✓	✓	✓	✓		16						16	16	16	⇔	08	Mar-25
17	Integration of 111 & EOC	QPS/FIC			✓	✓		16	16	16	16	16	16	16	16	16	⇔	08	Mar-23
256	Quality Improvement	QPS		✓				16				12	12	12	12	12	⇔	04	Jun-23
257	Improvement Journey	All	✓	✓	✓	✓		12				08	08	12	12	12	⇔	04	Jan-23
15	Education Training & Dev	WWC	✓	✓				16	12	12	12	09	09	09	09	09	⇔	06	Mar-23
16	Financial Sustainability	FIC	✓	✓	✓	✓		16	16	12	12	12	16	16	16	12	⇩	08	Mar-23
71	Cyber Attack	FIC		✓		✓		16					12	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
	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: increased rates of Hear & Treat outcomes, Job Cycle Time (reduction in variation between teams and consideration of specific components of JCT e.g. handover time) ▪ Use of REAP and SMP to help match resource with demand ▪ Integrated Plan agreed with commissioners to increase clinical workforce to 2555 WTE ▪ The Performance Cell capability is helping to more accurately forecast resource gaps and trajectory against ARP targets	**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
Stated actions help to improve the current approach/contribute to a potential 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. (-) Resource provision across all service lines negatively impacted by high sickness, vacancy, and attrition rates.	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 will 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
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	**08** (Consequence 4 x Likelihood 2)

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 37 WTE behind on its frontline workforce plan for the month of February. The projected shortfall by the end of the year is projected to be 32 WTE against the plan of 2555 WTE due to the mitigating actions taken through AAP recruitment, international recruitment and potential recruitment from PAP closure. Our EMA establishment is currently 87 WTE behind plan, However, 70 people are in training. Requirement is 265 WTE by end of the FY.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) February Integrated Plan: 37 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 32 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 ▪ Work has started to improve culture within EOC – one of our highest turnover area with support from independent consultants	**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	

(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 & Culture Strategy	Director of HR	30.04.23	Draft People & Culture Strategy on the Board agenda April.

	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 to be approved

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 & Culture Strategy	Director of HR	30.04.2023	On April Board Agenda – Part 2
(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. Work has been paused to focus on the People and Culture Strategy
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. Work has been paused to focus on the People and Culture Strategy.

	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. • Work with commissioners to close the funding gap	**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	Complete
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 and currently recruiting 4.0 WTE staff • 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

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) Post-holder in place (+) QI methodology in place and being socialised across the organisation. (+) Quality team being recruited to: 2.0 QI Facilitators; 1.0 Head of QI and 1.0 Adm	

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 Must Do and RSP exit criteria. ▪ Deep dives for each of the 4 programme workstreams have been completed in February and March to align the Annual plan for 23/24 ▪ Improvement Journey Steering Group now chaired weekly by Director of Planning and Business Development with updated TORs to include all executives (except CEO). ▪ Development of a Communications and Engagement Strategy, (development of proactive campaigns) ▪ Programme director for People and Culture has started in March – addressing one of the highest contributors to the risk on the overall programme ▪ A targeted register of evidence has been produced to support focus on outcomes of the Must Do and Should Do. ▪ Reviewed governance structure in place, working with NHSE region and lead commissioners on their involvement at our steering groups for key items. ▪ 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

(+) Following an engagement session with the CQC, the Warning Notices have been lifted. (+) A programme of IJ deep dives at each Board committee aligned to the Annual Plan priorities for 23/24 with quarterly milestones and KPIs as part of the business cycle. (+) Annual Planning cycle and organisational priorities are now aligned to the RSP and MD/SD schedule. (+) People and Culture Strategy developed in Q4. (-) Programme structure and resources due to the lack of a centralised Transformation/Programme/Improvement team. (+) Completion of a People and Culture Strategy. (+) Draft Culture and HR Performance Dashboards presented at Leadership and SMG groups. (+) Programme Director in place for this workstream, which has been a gap up to now. (+) Year-on-year sickness has improved by 3% from 11% to 8% trust wide. (+) SI and incidents trajectory for breaches and actions as reported on the IQR. (+) Training sessions for QI underway.	(-) Staff Survey results do not reflect that progress has been made in addressing the cultural challenges in the organisation. (-) Communication and Engagement on our priorities for the year remains a priority for Q1 to ensure the Annual Priorities and focus areas of improvement are appropriately cascaded to local teams. (-) Our approach to evaluation of impact hasn't been evident thus far as we've focussed on delivery. The Improvement Journey Steering Group alongside the Quality Assurance Framework (local quality visits) being implemented from Q1 23/24 will work together to address this. (-) Mean case length and case volume for ER has continued to worsen due to demand and capacity issues. (-) Lack of a written process for the internal Quality Assurance framework and how it will work in conjunction with the Quality and Performance Management Framework to provide effective evaluation of impact of the improvement plan on patient safety, patient experience, and staff experience. (-) Route for assurance of progress against actions due to responsive care group focussed on efficiency and delivery of Medway, which is not aligned to MD and RSP priorities, (-) BAF is still not reflective of the risks in a specific enough way that focusses on staff experience, and patient safety against the strategic aims of the organisation. (-) Evaluation of impact of the actions has not been evident thus far within the programme.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
(IJ Portfolio) Mock Inspection (proposed for closure)	Director of Quality	Sept/Oct (Completed)	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. **Update April 2023:** Action closed as Quality Assurance now embedded within the Quality Assurance Framework actions.
(QI-1) Improved reporting to Board to show impact of the actions on our people and patients (proposed for closure)	Director of Planning	Ongoing (Completed)	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 **Update April 2023:** Actions completed, remaining impact monitoring to be included in new actions related to updating of BAF, and alignment with Performance and Quality Management and Assurance frameworks.

Preparation for expiry of the S29A Warning Notices (proposed for closure)	Director of Planning / Director of Quality	15.10.2022 (Completed)	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. **Update April 2023:** Actions completed, Warning Notices expired and engagement session with NHSE Region, ICBs and CQC completed in January.
Board Well Led Self-Assessment	Chairman / Company Secretary	January 2023 (Completed) New milestone September 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 **Update April 2023:** Actions completed. Board receiving Board Development Plan on 6th April. Review and agreement for external well-led review is TBC.
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 (Completed)	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 existing plans to ensure focus on Must-Do's **Update April 2023:** New Improvement Journey Report format.
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. **Update April 2023:** Executive portfolios have been agreed by executive. The Executive director of Planning is proposed to become a "Strategic Planning and Transformation" executive with the development of a Transformation team to oversee the development and support delivery of the delivery of short term improvements and long term transformation in parallel to the development of the Trust's long term strategy.
A29 – Board to seek further assurance on how the People and Culture Strategy will be disseminated and shared with staff, in particular the plans for 23/24, alignment with the Staff Survey results, and how staff will be involved in implementation of the strategy and improvement plans.	Director of HR and OD / People Committee Chair	Q1 23/24	(New assurance action April 23/24)

A30 – Board to seek assurance on the mitigation plans to address the higher ER case length and associated improvement trajectories.	Director of HR and OD / People Committee Chair	Q1 23/24	(New assurance action April 23/24)
A31 – Board to receive assurances through QPSC on the new Quality Assurance Framework and Quality and Performance Management Framework on the progress for implementation and expectations for assurance reports from both initiatives to Board.	Director of Quality and Nursing / QPSC Chair	Q1 23/24	(New assurance action April 23/24)
A32 – Board to receive assurance on the improvements made aligned to MD12 and MD13 through FIC at the end of Q1.	Director of Planning / FIC Chair	Q1 23/24	(New assurance action April 23/24)
A33 – BAF to be refreshed to align to the annual priorities developed by the Board and approved at the April Board	Company Secretary	June 2023	(New assurance action April 23/24)
A34 – Board to agree approach and initial framing of the development of a new long-term Strategy for SECAmb	CEO / Board Chair	April 2023	(New assurance action April 23/24)
A35 – Board committees to be aligned as part of the cycle of business for 23/24 to the quarterly plans, and utilise the agreed KPIs to evaluate impact of actions taken.	Company Secretary	April 2023	(New assurance action April 23/24)
A36 – Model for delivery and oversight of change needs to be agreed to support long-term transformation aspirations	Director of Planning	Q1 23/24	(New assurance action April 23/24)

	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	**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 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 £8.9m deficit. The remedial action plans are underway with each directorate to deliver recurrent savings in year to significantly reduce the likely recurrent deficit to circa £2m. And will attempt to bridge the gap non-recurrently to Breakeven. ▪ We are currently on track to achieve breakeven ▪ The new directorate review process control will deliver a combination of recurrent & non-recurrent savings helping to improve long term sustainability ▪ The current version of the 2023/24 plan is targeting a (£5m) deficit with a 3% efficiency target.	**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

Sources of Assurance: Positive (+) or Negative (-)	
(+) 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. The initial 2023/24 Plan currently delivers a £5m deficit

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. ▪ An action card has been introduced to cover single device or user cybersecurity incidents ▪ Board-level Cyber Awareness Training undertaken in February	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.

Board Assurance Framework
SECTION E: Non-BAF Extreme Risks

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
28	**Drug Seeking Behaviour via 111 Electronic Prescribing Service (EPS)** *There is a risk that people seeking to obtain high risk and/or addictive medications are being enabled as a result of no mechanisms to identify this drug seeking behaviour which may lead to significant patient safety risk and Trust liability.*	15	15	06	Chief Pharmacist
29	**EPRR Incident Response** *There is a risk that the Trust's response to an incident of an EPRR nature will fall short of the requirements outlined in the Major Incident Plan and NHS EPRR Framework.* *These incidents include but are not limited to: significant or major incidents, transport accidents, multi-site incidents or business continuity incidents.*	20	16	06	Head of EPRR
136	**Process of tagging medicines pouches is not working effectively** *There is a risk medicines will not be available for the patient if paramedics are incorrectly completing paperwork following their daily assurance checks. Incomplete or incorrect paperwork leads to pouch tagging errors and there is a risk that the medicine will not be in the right place at the right time for the next Paramedic and patient due to incorrect tagging.*	15	15	03	Chief Pharmacist
304	**SECAmb's Ability to reach the Net Zero Target sent by NHS England** *NHS England have set the aim to be the worlds first net zero national health service They have set two targets* ** For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;* ** For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.* *There is a risk that significant un-quantified investment will be required to meet de-carbonisation targets, which is not currently identified within our investment plans* *There is a risk that the implications on our operating model are not fully understood, or the time required to change our operating model to achieve environmental sustainability*	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 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
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 346	**Handover Delays - Trust wide** There is a risk of delayed patient handovers as a result of acute Trusts having limited capacity to readily accept new patients from crews during periods of demand, due to lack of bed capacity, which may lead to patient harm.	16	**16**	06	Head of Strategic Partnerships
New 361	**Capacity of HR to resolve employee relations (ER) cases within timescales** HR is not adequately resourced to respond to present volumes and duration of ER cases that are likely stay at a high level. This may cause long-term psychological injury to HRBP and HRAs and line managers dealing with complex and serious cases, detract line management time away from other work, see increased turnover in the HR BP function leading to varying advice and service levels, and increased inconsistency in advice. Failure to provide assurance against ongoing improvements against the CQC 2022 report and its Well Led inspection rating will also have serious reputational damage to the Trust.	20	**16**	12	Director of HR

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.
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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

Integrated Quality Report

Trust Board – April 2023

Reporting Period: January & February 2023

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

Contents

Improving Quality of Information to Board – April 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)* 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.
- (December 2022) 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 Q1 (previously Q4) to drive improvement forward.
- **(New April 2023)** Development for the IQR will now continue following 2 periods of relative change freeze. The initial focus for the Board in June 2023 will be to re-develop the Quality Improvement metrics in conjunction with the Medical and Quality and Nursing directorates.
- **(New April 2023)** Several Targets have been included or reviewed in this iteration of the IQR, meaning more SPC icons will become apparent to the Board in the review of this version. Absolute targets of 0 or 100 are still in place where compliance requires it, and still add value as Failing processes will still indicate that even with standard variation we are not expecting our processes to be capable of meeting the required standards.

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.
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Quality Improvement

QUALITY IMPROVEMENT

Summary

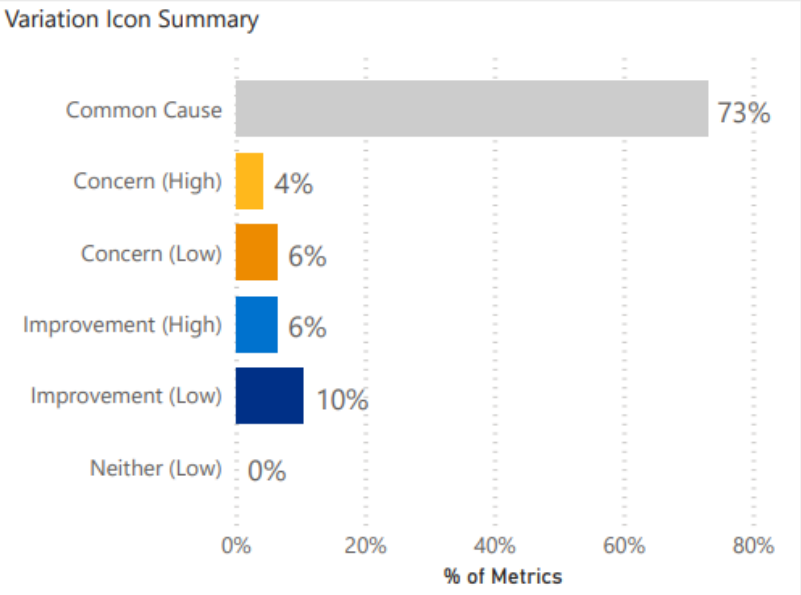
February 2023

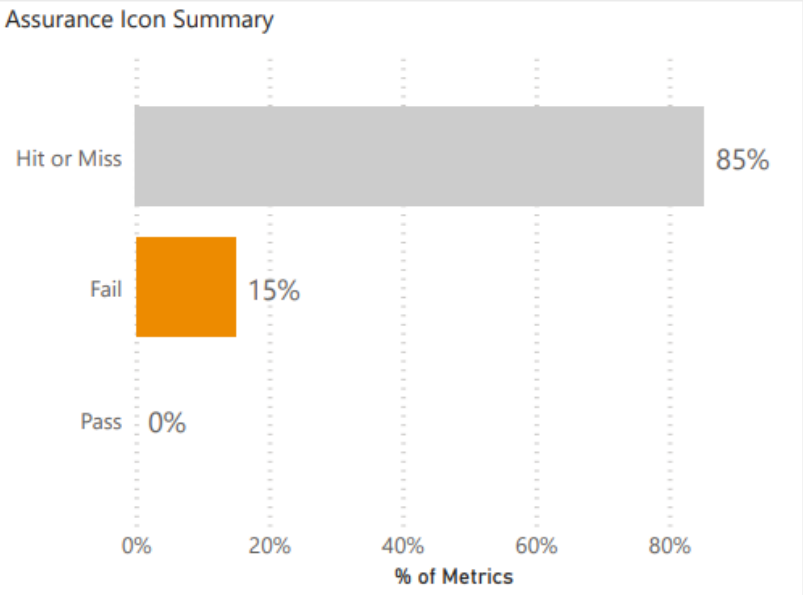
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Sepsis Care Bundle % **Acute STEMI Care Bundle Outcome % Stroke - Call to Hospital Arrival Mean Required NHS Pathways Audits Completed (Clinical) %		Count of Low Harm Incidents Count of No Harm Incidents Complaints relating to privacy and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

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

QUALITY IMPROVEMENT

Overview (1 of 3)





Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Feb-2023	172		85.56	149.4	213.24		
Number of CD Breakages	Quality Improvement	Feb-2023	19	0	1.39	19.45	37.51		
Number of Datix Incidents	Quality Improvement	Feb-2023	1196		893.74	1401.8	1909.86		
Number of Incidents Reported as SIs	Quality Improvement	Feb-2023	2		-4.66	5	14.66		
Duty of Candour Compliance %	Quality Improvement	Jan-2023	83%	100%	52.99%	85.95%	118.9%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Feb-2023	115		53.14	99.9	146.66		
Number of RIDDOR Reports	Quality Improvement	Feb-2023	8		-0.58	11.6	23.78		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Oct-2022	22		50.01	78.38	106.76		
Health & Safety Incidents	Quality Improvement	Feb-2023	28		13.7	28.4	43.1		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Dec-2022	46	0	6.21	32.5	58.79		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Dec-2022	67	0	-16.77	61.78	140.33		
Medicines Management % of Audits Completed	Quality Improvement	Feb-2023	91.4%	100%	74.58%	89.16%	103.73%		

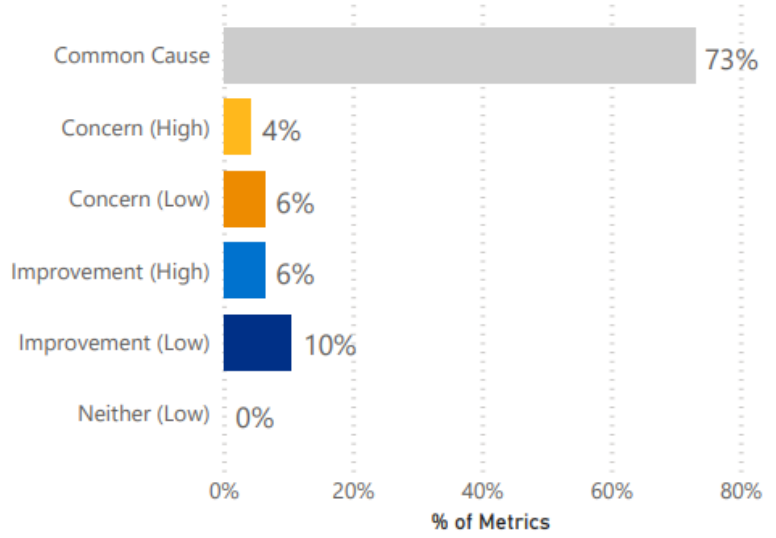
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Feb-2023	0%		-0.12%	0.03%	0.17%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Feb-2023	61%		11.38%	39.94%	68.5%		
Complaints per 1000 999 Calls Answered	Quality Improvement	Feb-2023	0.88		-189.38	104.18	397.74		
Number of Compliments	Quality Improvement	Feb-2023	214		86.45	166.72	246.99		

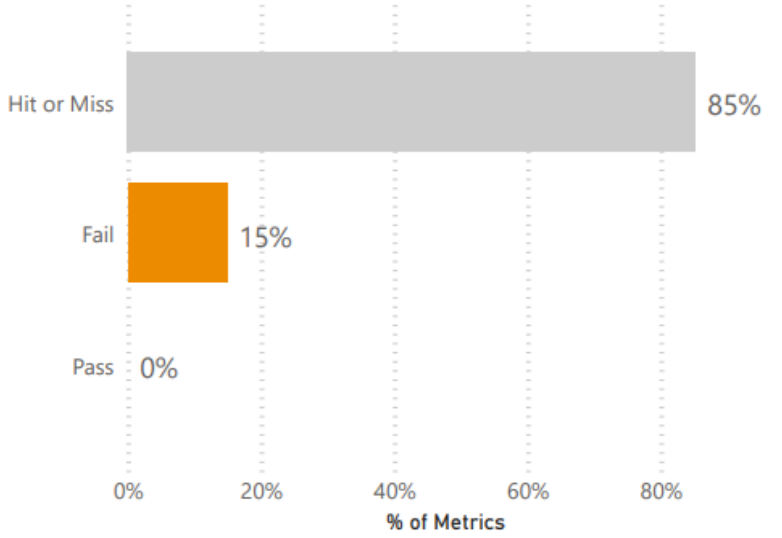
QUALITY IMPROVEMENT

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Jan-2023	55.9%	45.1%	26.35%	48.71%	71.06%		
**Cardiac ROSC ALL %	Quality Improvement	Jan-2023	24.7%	23.8%	15.25%	25.85%	36.44%		
**Sepsis Care Bundle %	Quality Improvement	Jan-2023	88%	85%	81.3%	85.95%	90.61%		
**Cardiac Survival Utstein %	Quality Improvement	Nov-2022	25%	25.6%	11.07%	27.95%	44.82%		
**Cardiac Survival ALL %	Quality Improvement	Nov-2022	9.5%	9.6%	4.3%	10.21%	16.11%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Jan-2023	70.3%	76.8%	57.84%	72.87%	87.9%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Jan-2023	75.2%	64.7%	53.4%	66.14%	78.88%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Sep-2022	02:42:00	02:22:00	02:12:19	02:33:36	02:54:53		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Sep-2022	03:49:00	03:14:00	02:48:45	03:38:20	04:27:55		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Sep-2022	01:42:00	01:29:00	01:27:15	01:42:16	01:57:17		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Sep-2022	02:43:00	02:20:00	02:03:28	02:40:20	03:17:12		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Jan-2023	97.5%	96.3%	94.92%	97.11%	99.29%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Jan-2023	93.5%	93.8%	85.92%	93.44%	100.96%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Jan-2023	84.5%	77.9%	66.55%	79.19%	91.82%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Feb-2023	58.8%		72.5%	96.6%	120.71%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Feb-2023	86.6%	100%	74.95%	85.54%	96.12%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Feb-2023	84.9%	100%	79.62%	91.65%	103.68%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Feb-2023	100%	100%	82.66%	98.23%	113.8%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Feb-2023	47.9%		23.31%	69.44%	115.57%		

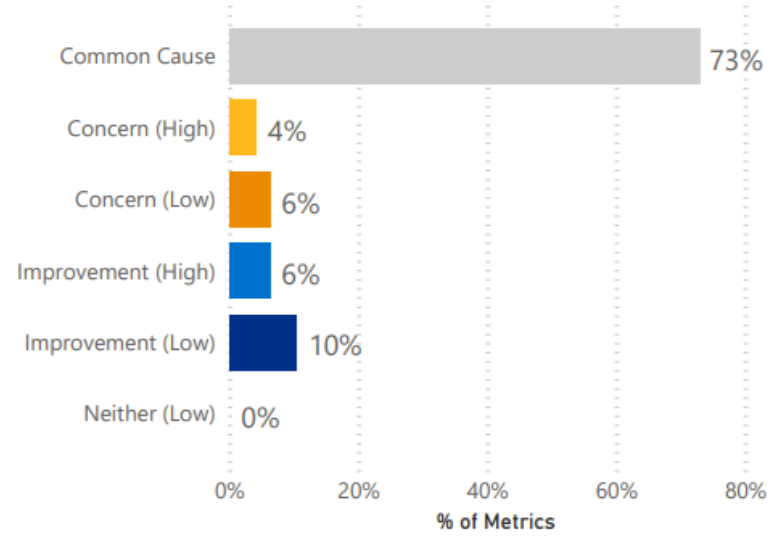
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Feb-2023	91.6%	90%	72.91%	87.05%	101.18%		
Deep Clean Compliance %	Quality Improvement	Feb-2023	95.2%	95%	43.81%	80.89%	117.98%		

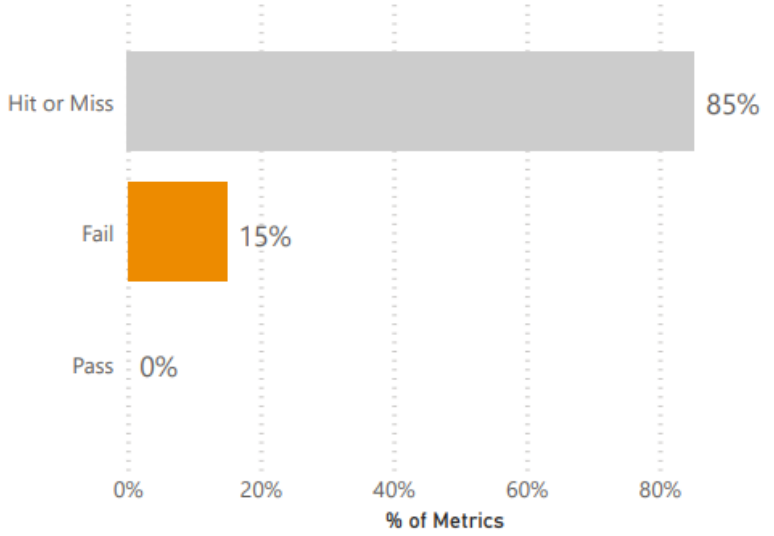
QUALITY IMPROVEMENT

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary

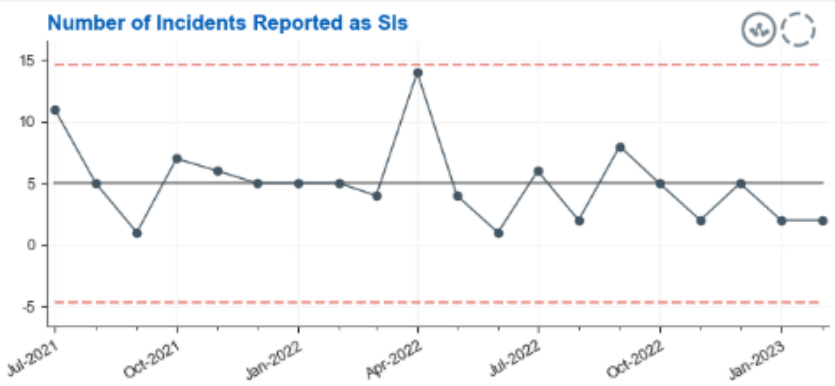


Health & Safety

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Feb-2023	78.7%	85%	80.36%	82.58%	84.79%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Feb-2023	64.3%	85%		60.46%			
Manual Handling Incidents	Quality Improvement	Feb-2023	32		11.87	28.25	44.63		
Organisational Risks Outstanding Review %	Quality Improvement	Feb-2023	38%	30%	1.35%	45.31%	89.27%		

QUALITY IMPROVEMENT

SIs, Incidents, & Duty of Candour



QS-2

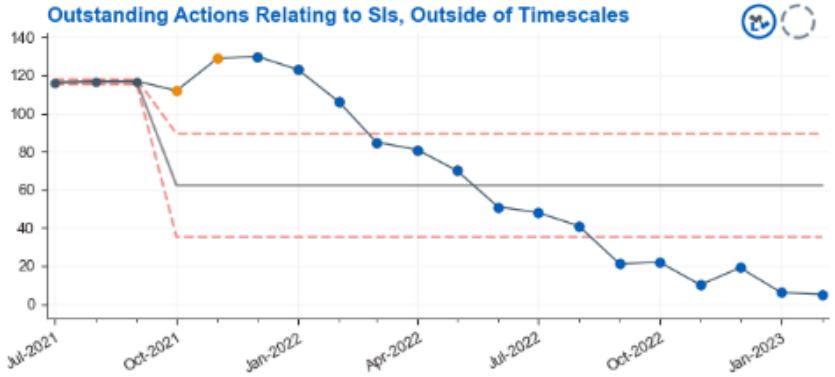
Dept: Quality & Safety
IP: Quality Improvement
Latest: 2

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

QS-1

Dept: Quality & Safety
IP: Quality Improvement
Latest: 1196

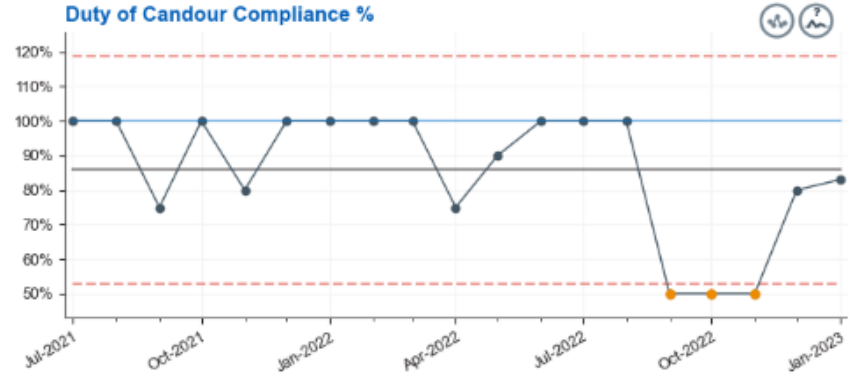
Common cause variation, no significant change.
Assurance cannot be given as a target has not been provided.



QS-17

Dept: Quality & Safety
IP: Quality Improvement
Latest: 5

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



QS-3

Dept: Quality & Safety
IP: Quality Improvement
Latest: 83%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

(QS-1) Non-SI incidents The Trust have seen a decrease in incident reporting of 10% for January 2023 and 9% for February 2023. The Trust was still logging COVID-19 track and trace incidents up until 31.03.22 , which accounted for 100-200 incidents per month. 999 have also changed their policy for the logging of SMP No Send and CTA's , which will also account for a drop in reporting numbers. It should also be noted that during periods of industrial action the Trust normally see a 9-10% decrease in reporting incidents on the Datix system.

(QS-17) SI actions – The reporting period saw a further decrease in the outstanding SI actions, and a positive step in clearing the backlog, thus enhancing the learning across the Trust. There are currently 3 breached SI actions which are all being worked on. It is the intention that these will be closed by the end of Q4.

(QS-2) SI numbers –In this reporting period we had 32 open SIs, of which 11 had breached 60 days. As of 30/03 this has reduced to 30 open SIs of which 7 have breached.

(QS-3) DoC – Improved position as processes have been reviewed and improved

What actions are we taking?

(QS-1) Non-SI incidents

- EOC/111 hold 50% of all breached Datix (all no and low harm) of which significant proportion are Pharmacy (external issues) - 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 with an immediate process for closure and notification to them being agreed, enabled by new coding set up on the Datix system to differentiate CPCS and PHARMA+ concerns.
- QIG have set a tolerance of 20% for breached incidents to reduce to 10-12% as external Pharmacy issues are ameliorated.
- A formal targeted approach is taken with breached incidents, led by Datix team supporting OUs. Position discussed at both EOC/111 and Field QUAPPS
- **(QS-2 / 17) SI actions –** There remains only 1 outstanding SI action (30/03) that will close within the next few weeks
- **(QS-3) DoC –** DoC remains a challenge as NOK or patients details are not always accurate or available from internal records or external providers. Improvement measures continue to be discussed and implemented..

QUALITY IMPROVEMENT

Harm (1 of 2)

QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 4.66

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: 0.8

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

Summary

Over January & February 2023, the Trust reported 2629 incidents, the Grade of Harm (GoH) reported is as follows

- 98.8% of all reported incidents sat in the no harm/low harm
- 0.5% 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 industrial action (IA) in January and February 2023, which impacted on incident reporting. We saw a drop in incident reporting so it is possible that incidents may be underreported.

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. The Head of Patient Safety also completed a report on IA harm in March 2023.

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: 226

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

QS-31
Dept: Quality & Safety
IP: Quality Improvement
Latest: 37

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

QS-32
Dept: Quality & Safety
IP: Quality Improvement
Latest: 2

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

QS-33
Dept: Quality & Safety
IP: Quality Improvement
Latest: 0

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

Summary

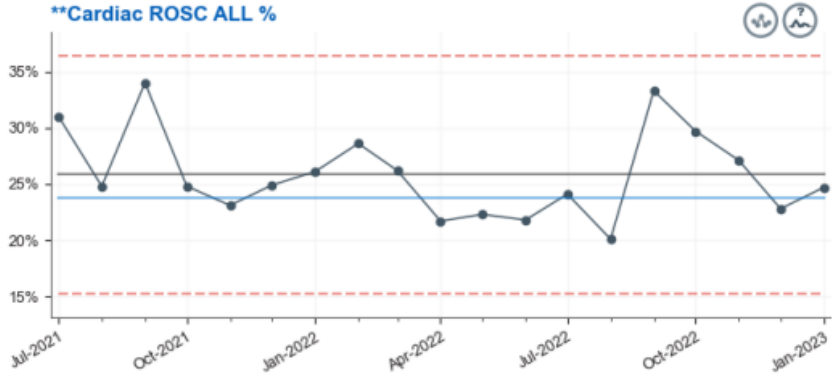
- **(QS-31)** The Trust are still seeing an uplift in KMS 111 incidents category of pharmacy this to do with community pharmacist Consultation Service and PHARM+ concerns, whereby the pharmacy is not following the contractual agreement if they are unable to assist the patient. System-wide discussion are underway involving ICB (Integrated Care Board) leads. New Datix incident coding is now in place to monitor these incidents separately, this would not be harm attributed to the Trust but will increase workload in the Trusts 111 services
- Issues with Triage while there is no overlying theme or trend in this subcategory all the harm attributed by the Trust was low or no harm for January and February 2023
- Moderate to death harm the Trust has seen a decline in this area over the last two months.

What actions are we taking?

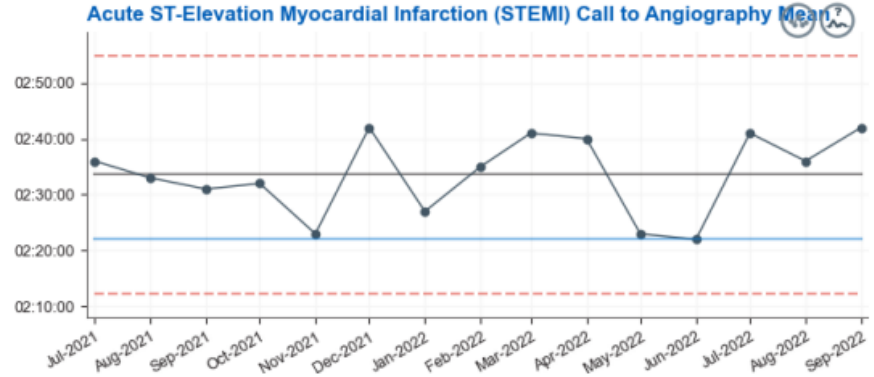
- Pharmacy issues in the community have now been escalated to the ICB with new process being agreed aiming for immediate closure and transfer of information, enabled by new Datix coding in place to differentiate between internal and external issues .
- Delays in answering 999 calls is down to demand and capacity, the Trust also had IA take place during January and February 2023. 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 and is meeting target milestones.

QUALITY IMPROVEMENT

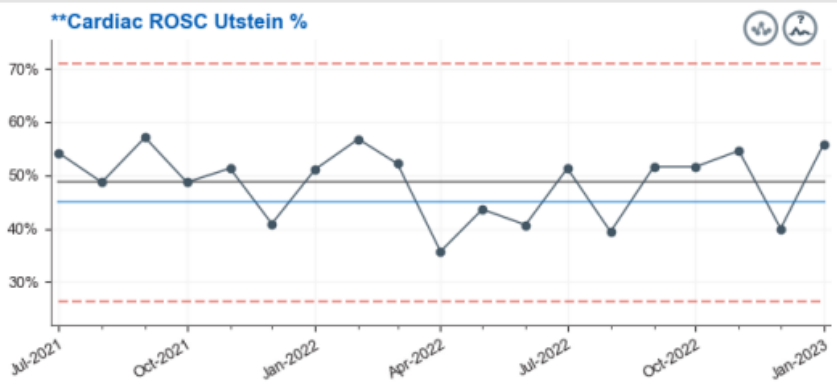
Impact on Patient Care - Cardiac



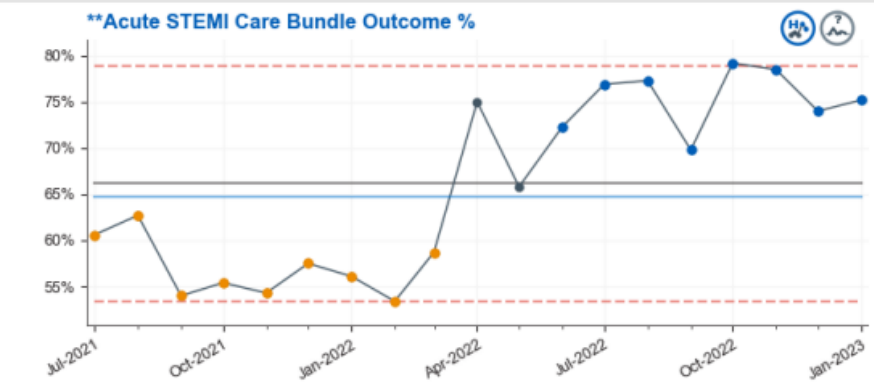
M-2
Dept: Medical
IP: Quality Improvement
Latest: 24.7%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:42:00
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: 55.9%
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: 75.2%
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 a transformation review beginning to look at the viability of another pPCI centre in Kent. This will address the long travel times there (up to 60 minutes in some areas). Reducing time on scene is consistently taught during Keyskills, CPD and for new staff. Dashboards for local OUs are still in development to audit time on scene and inappropriate requests for back-up. Direct feedback to staff supports good practice and support for cases where there is a long on-scene time.

Acute STEMI care bundle outcome

NASMeD are reviewing the evidence base of the current care bundle (which has not been reviewed for >11 years). The improvement noted above is due to a change in SECAmb's audit parameters to allow IV paracetamol as an acceptable analgesia (with approval from NASMeD and NHSE). No further actions are necessary at this time.

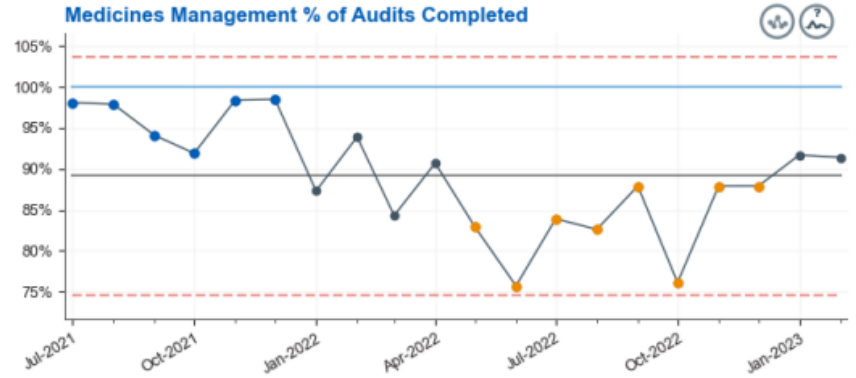
QUALITY IMPROVEMENT

Medicines Management

MM-1

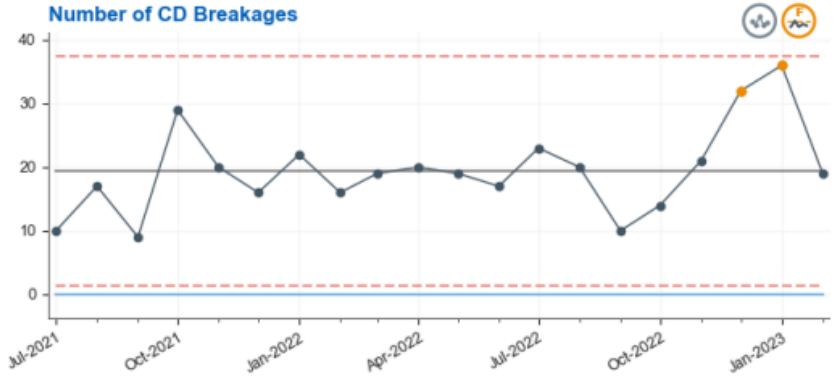
Dept: Medicines Management
IP: Quality Improvement
Latest: 172

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



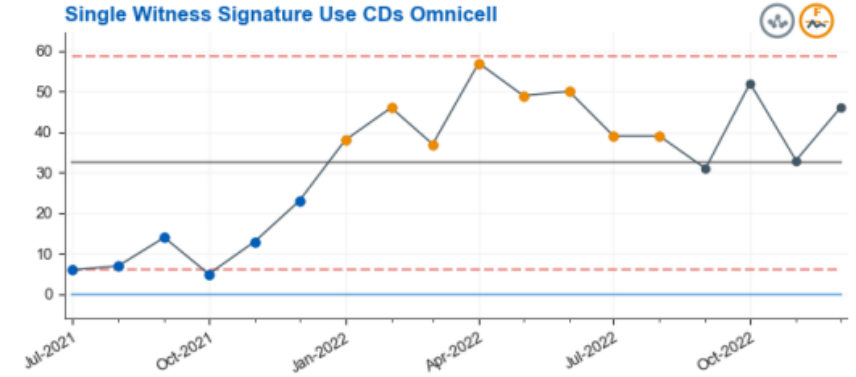
MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 91.4%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 19
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: 46
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Note: Work is ongoing 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. Key skills 2023/24 has medicines in lesson plan so this will be reported on going forward for assurance and oversight in the Trust.

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.

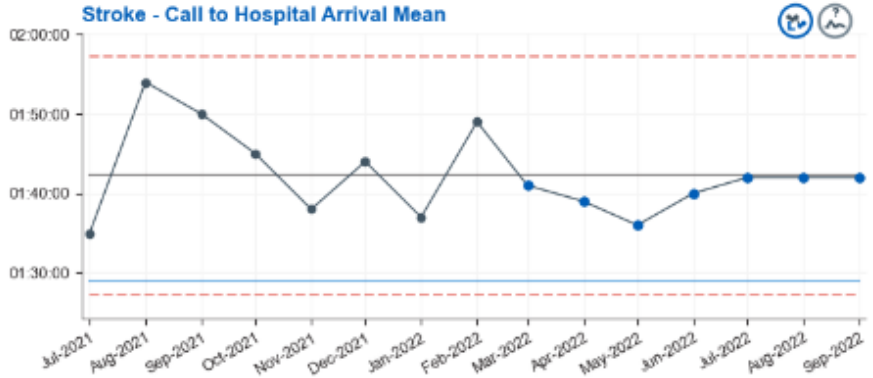
Single Witness signature for CDs work continues to address this area of activity and the reporting of it is going to go onto the weekly operational team leaders (OTL) checks. There is training around CD activity and checks being developed for delivery to OTLs a team C meeting starting June 2023.

What actions are we taking?

Medicines team have met with Power BI team and software developers to move forward with medicines data and presentation on central platforms. PGD workplan and CQC 'must dos' all progressing forward. OTL report moving onto central dashboard. Chief Pharmacist and medicines team have discussed with Power BI team further areas for reporting to be included in this report for assurance around resilience stock and medicines provision currently available in the Trust.

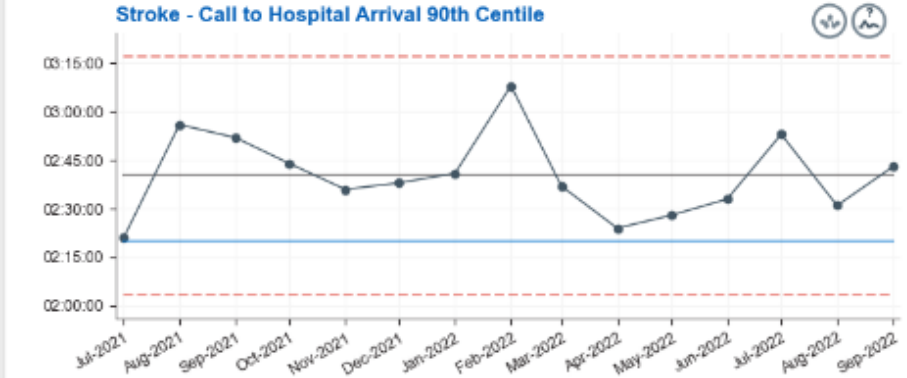
QUALITY IMPROVEMENT

Impact on Patient Care – Stroke



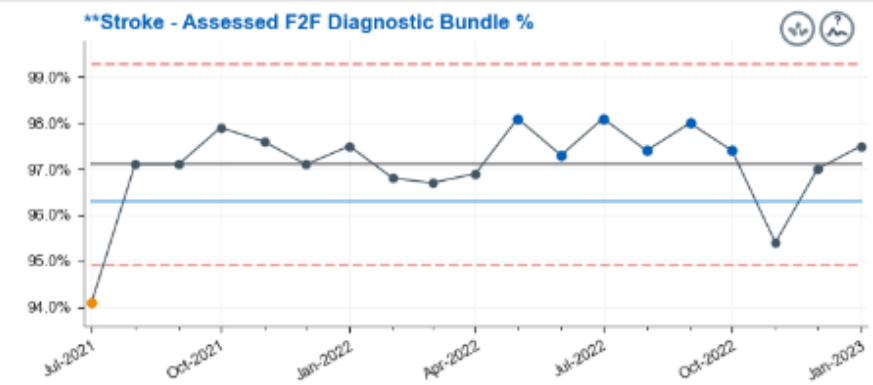
M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:42:00
Target: 01:29:00
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



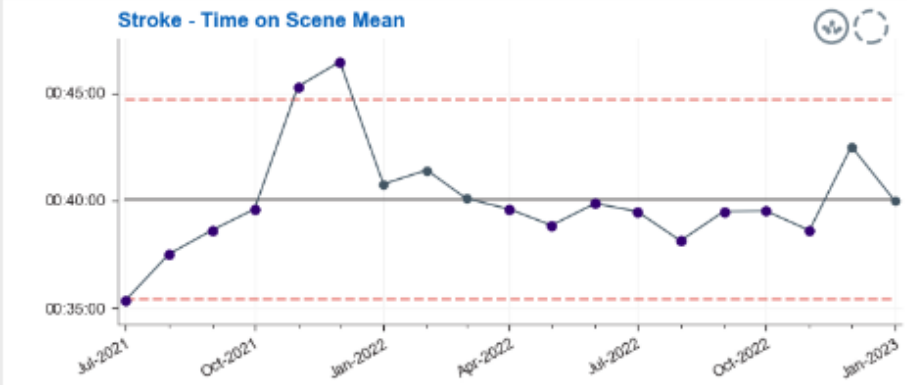
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:43:00
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: 97.5%
Target: 96.3%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-28

Dept: Medical
IP: Quality Improvement
Latest: 00:39:59

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

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.

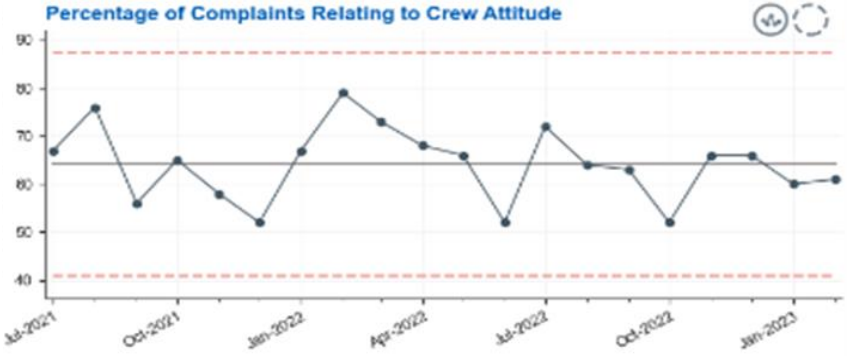
QUALITY IMPROVEMENT

Patient Experience

QS-5
Dept: Quality & Safety
IP: Quality Improvement
Latest: 56

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

QS-4
Dept: Quality & Safety
IP: Quality Improvement
Latest: 68%
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: 61%

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

Summary

- There were 233 compliments processed in January and 214 in February, these are the highest numbers processed since the Trust started to record compliments on the Datix database, in March 2017.
- The number of complaints received in January and February were 68 and 56 respectively, this was slightly below the average during the past 12 months of 75.
- Operational 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.
- Timeliness of complaints is on an upward trajectory as the backlog continues to be cleared.
- The team continue to clear breached complaints with the support of operational, EOC and 111 staff.
- There are now 26 open EOC complaints, down from 41 at the last report and only one of these have breached, the response has been drafted for review, there is one breached complaint for operations, again the response has been drafted and is with the trust legal team for review, both these should be closed by 24/03/2023. There is one breached complaint for KMS111 where we are waiting for Vocare to respond, this has been escalated to senior management.
- 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?

- Aside from the Vocare complaint over which we have no control, the breached cases should be cleared by the end of next week and there are only two OPS cases due next week where a report has not been received, these have been chased.
- A mapping exercise was completed to review the current complaint process with some areas of improvement being identified, a second team meeting is to be held to review and adapt processes.
- A mapping day for compliments is being held 20 March 2023 to review the process.
- The target to return to 95% of complaints being responded to in time is planned to be achieved by May 2023, the team are confident with the continued support from operations, EOC and KMS111 this will be achieved.

QUALITY IMPROVEMENT

Safety in the Workplace (1 of 3)

QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 28

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

QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 32

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

Health & Safety Incidents

There is no statistical change in the reporting numbers within H&S incidents that remain predominantly as incidents in relation to slips, trips and environmental factors
The staff groups most affected are field operatives (Paramedics, Ambulance Technicians, ECSW) which is not unusual as these are our largest staff groups who work in unplanned environments,

Manual Handling Incidents

There is no statistical change in the reporting numbers within MH incidents. The staff groups most affected are field operatives (Paramedics, Ambulance Technicians, ECSW) which is not unusual as these are our largest staff groups who work in unplanned environments.

RIDDOR

RIDDOR incidents reported in January 2023 were 13 with 10 reported within the statutory time frame to the Health and Safety Executive. The Trust reported 3 RIDDOR incidents late to the HSE which were due to staff not completing an incident report on time.

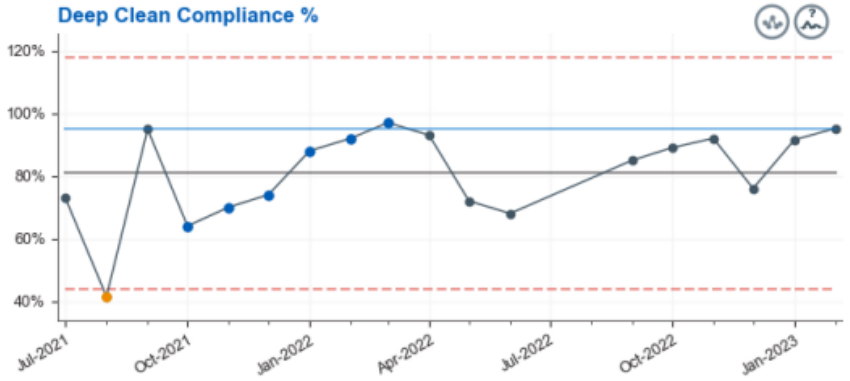
RIDDOR incidents reported in February 2023 were 8 with 6 reported within the statutory time frame to the Health and Safety Executive. The Trust reported 2 RIDDOR incidents late to the HSE which were due to staff not completing an incident report on time.

What are we doing

- The regional and Trust Health & Safety group will continue monitoring incident trends. H&S Committee now led by Exec team with H&D Lead to ensure assurance is provided on all regulatory aspects and action plans agreed and acted on.
- Benchmark across Ambulance Trusts to be undertaken to assess numbers being affected
- Reporters of RIDDOR will receive support to ensure timely responses are submitted
- Review of MH training to evaluate impact and attendance

QUALITY IMPROVEMENT

Safety in the Workplace (2 of 3)



QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 95.2%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

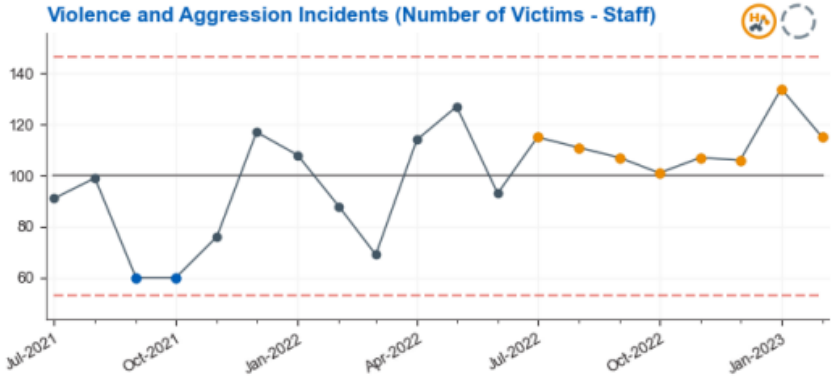
QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 91.6%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Hand Hygiene Compliance – January saw a drop in compliance to 87% but less audits were carried out during the month which could impact on the final figures. Following a request to local teams the number of audits carried out improved and compliance was back above the 90% lower limit at 92%.

What actions are we taking? - We continue to monitor the number of audits carried out across the Trust and during the second week of each month the team send out reminders to OTL's if the numbers are low. Further training on hand hygiene compliance will be rolled out as part of the improvement plan during Q1 for 2023 / 2024.

QUALITY IMPROVEMENT

Safety in the Workplace (3 of 3)



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 115

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

Violence & Aggression
Staff reported 134 violence and aggression related incidents in January 2023.
The sub-categories of these incidents are shown below:

60 verbal abuse
38 Anti-Social Behaviour
18 assaults

Staff reported 115 violence and aggression related incidents in February 2023.
The sub-categories of these incidents are shown below:
58 verbal abuse
22 Anti-Social Behaviour
15 assaults

What actions are we taking?

- Monthly monitoring at the Violence Reduction working group and Health & Safety group.
- We continue to triage all incidents and provide contact and support to staff if appropriate in reporting to police for investigation.
- Monthly partnerships are held with police to provide updates on cases involving our staff.
- Sharing of BWC and vehicle CCTV in support of prosecutions.
- Partnership working internally with frequent caller teams and history marker group to improve sanctions and processes.
- In addition to this the Trust is undertaking a comprehensive piece of work to implement the NHS Violence Reduction standards which involves several work streams.

What changes do we expect from these actions ?

- An increase in staff confidence and satisfaction that we are taking V&A seriously as a Trust

- A possible shift in trend during 2024. Comparison of data continues to show steady increases month by month in comparison to last year. Data suggests that assaults have not increased over the last 5 years, it is the reporting of verbal aggression by staff that has increased dramatically, particularly in call handling centres.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

February 2023

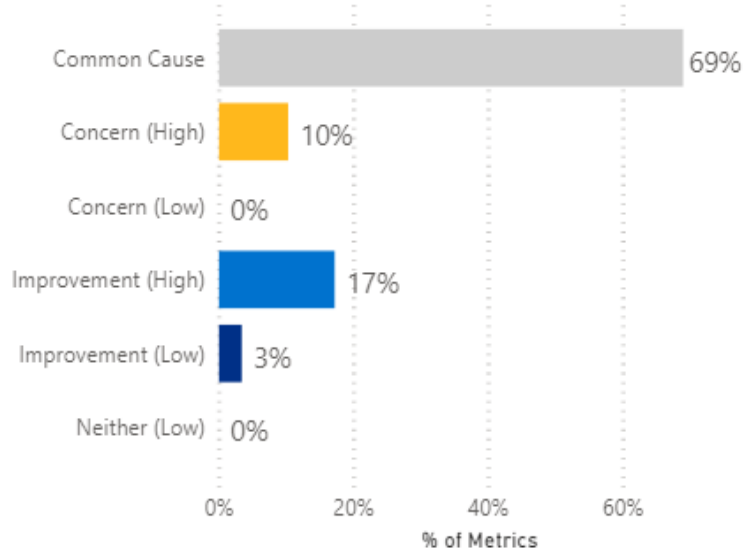
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Number of Wellbeing Hub Referrals	Number of Staff WTE (Excl bank and agency) Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Current licence details held for Operational Staff %	Number of Staff Headcount (Exc bank and agency)
Common Cause	DBS Compliance %	Individual Grievances Open Count of Grievances Closed Suspension Closures	Turnover Rate % Annual Rolling Turnover Rate Sickness Absence % 999 Frontline Late Finishes/Over-Runs % Time to Hire (Days)	% of Meal Breaks Taken
Special Cause Concern		Grievances Mean Case Length (Days) Vacancy Rate %	Until it Stops Average Case Length	

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

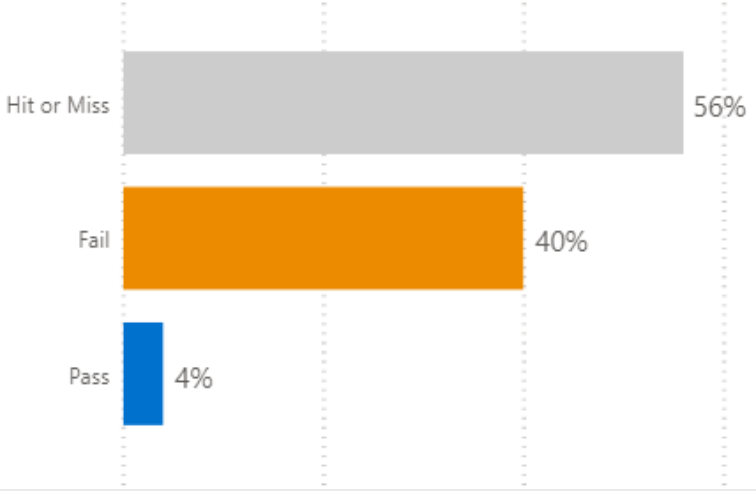
PEOPLE & CULTURE

Overview (1 of 2)

Variation Icon Summary



Assurance Icon Summary



Workforce

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Feb-2023	4109.03	4260	3889.38	3959.39	4029.39		
Number of Staff Headcount (Exc bank and agency)	People & Culture	Feb-2023	4529		4290.36	4365.4	4440.44		
Vacancy Rate %	People & Culture	Feb-2023	11.8%	5%	0.13%	3.9%	7.66%		
Turnover Rate %	People & Culture	Feb-2023	1.3%	0.8%	0.87%	1.44%	2.01%		
Annual Rolling Turnover Rate	People & Culture	Feb-2023	18%	10%	16.59%	17.61%	18.64%		
Sickness Absence %	People & Culture	Feb-2023	7.9%	5%	7.51%	9.53%	11.54%		
DBS Compliance %	People & Culture	Feb-2023	100%	90%	100%	100%	100%		
Current licence details held for Operational Staff %	People & Culture	Feb-2023	97.1%	100%	88.26%	93.66%	99.05%		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Feb-2023	79.7%	85%	61.19%	69.78%	78.36%		
Appraisals Rolling Year %	People & Culture	Feb-2023	52.2%	85%	34.27%	40.03%	45.78%		

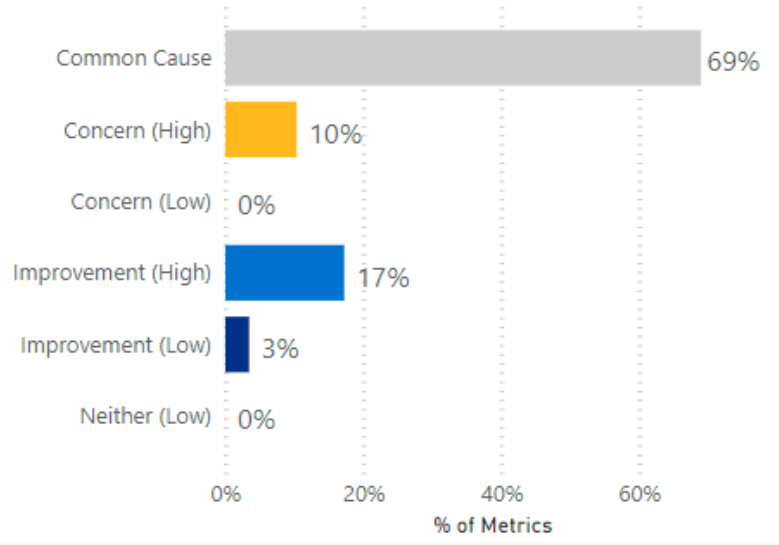
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Feb-2023	47.6%	45%	45.8%	51.26%	56.72%		
Average Late Finish/Over-Run Time	People & Culture	Feb-2023	00:38:00		00:35:30	00:41:31	00:47:32		
% of Meal Breaks Taken	People & Culture	Feb-2023	98.2%	98%	96.23%	97.93%	99.62%		
% of Meal Breaks Outside of Window	People & Culture	Feb-2023	51%		31.42%	57.14%	82.85%		

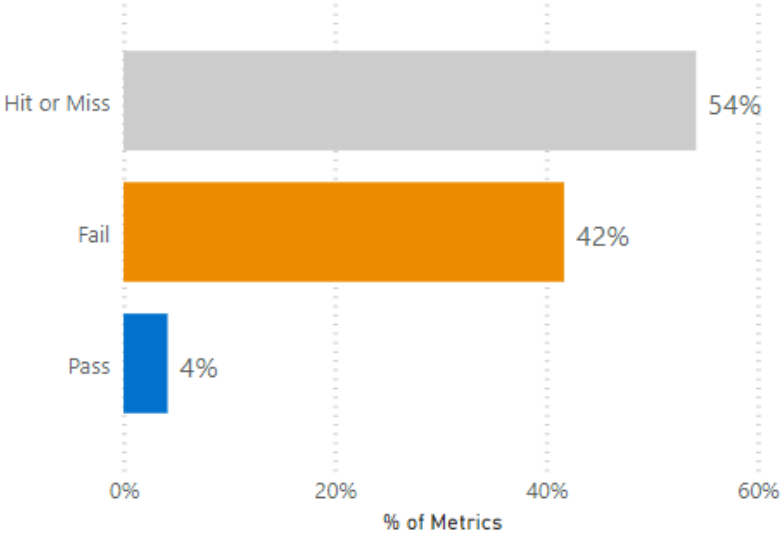
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

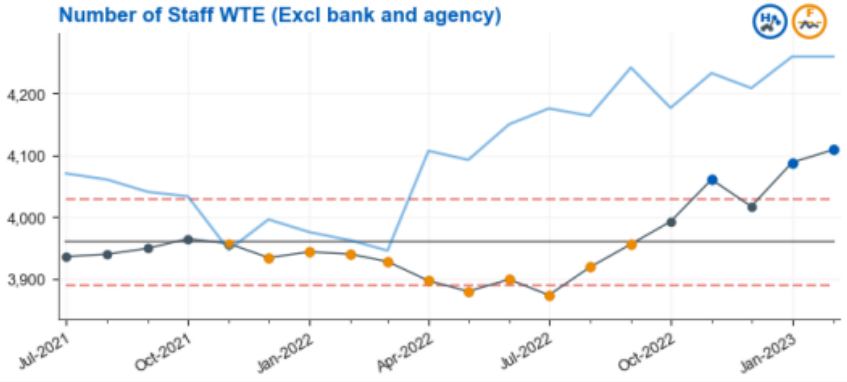
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Feb-2023	7	5	-0.57	10.35	21.27		
Collective Grievances Open	People & Culture	Feb-2023	0	1	-1.77	1.45	4.67		
Count of Grievances Closed	People & Culture	Feb-2023	10	3	-4.37	10.75	25.87		
Grievances Mean Case Length (Days)	People & Culture	Feb-2023	145.3	93	2.61	78.68	154.75		
Bullying & Harrassment Internal	People & Culture	Feb-2023	2	2	-4.27	2.45	9.17		
Disciplinary Cases	People & Culture	Feb-2023	3	3	-1.82	4.2	10.22		
Freedom to Speak Up: Total Open Cases	People & Culture	Feb-2023	29			15.08			
Freedom to Speak up: Cases Opened in Month	People & Culture	Feb-2023	8	3	-2.98	8.5	19.98		
Freedom to Speak up: Cases Closed in Month	People & Culture	Feb-2023	6		-7.81	6.75	21.31		
Policies & Procedures Outstanding Review %	People & Culture	Feb-2023	73.1%	0%		46.32%			
Count of Until it Stops Cases	People & Culture	Feb-2023	5	3	-3.87	4.11	12.09		

Health & Wellbeing

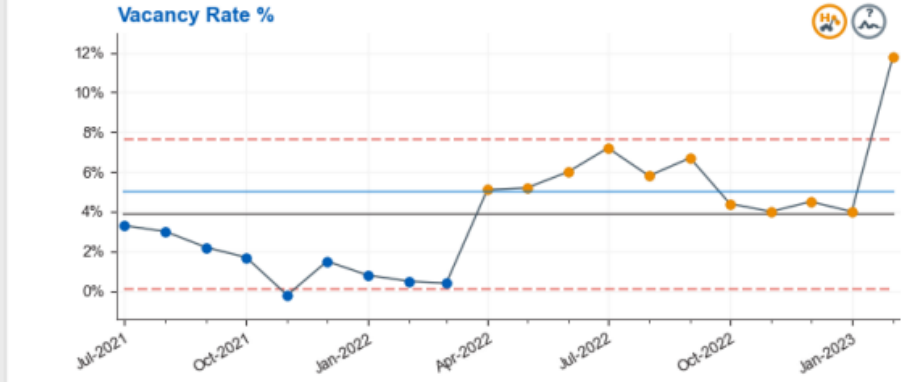
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Feb-2023	58	86	22.94	95.39	167.83		

PEOPLE & CULTURE

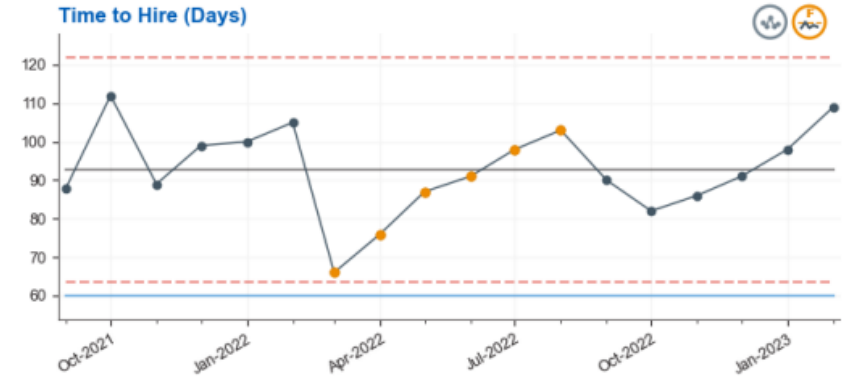
Workforce (1 of 3)



WF-1
Dept: Workforce HR
IP: People & Culture
Latest: 4109.03
Target: 4260
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-4
Dept: Workforce HR
IP: People & Culture
Latest: 11.8%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



WF-43
Dept: Workforce HR
IP: People & Culture
Latest: 109
Target: 60
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

- The number of staff FTE (or headcount) as an SPC chart does not 'fit' a workforce plan that has an increase in FTE over the last year and into 23/24, rather than a static or stable number.
- TTH is within the boundary limits but is impacted by the nature of cohort recruitment to fill 'classes' that have pre-set dates, rather than 'ad hoc' recruitment to single positions. The next TTH will be reflective of our cohort recruitment for EMAs and frontline staff with ad-hoc recruitment reported separately.
- TTH data has been unstable as shown in the chart. The feed has been amended to use today's date if no start date available. This is likely to show a worsening picture as more vacancies are counted over the coming months.

What actions are we taking?

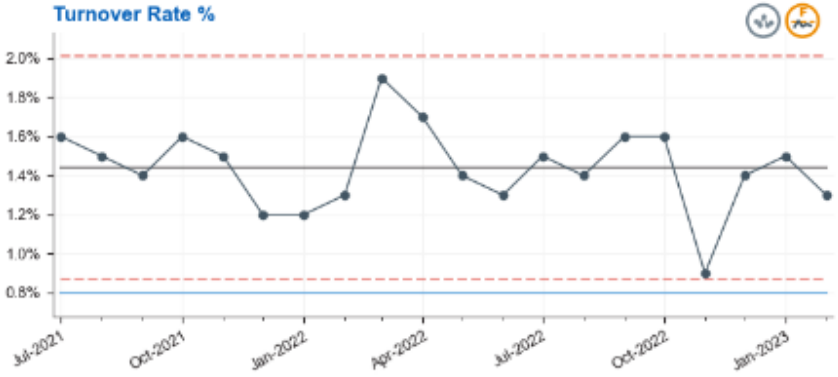
The narrative on slide 27 provides the detail on recruitment plans to meet the FTE establishment for operational roles.

A future project has been agreed to work with the Quality Improvement team reviewing the recruitment process. This will help to enhance the candidate experience and reduce unnecessary processes for both the candidate and recruitment team.

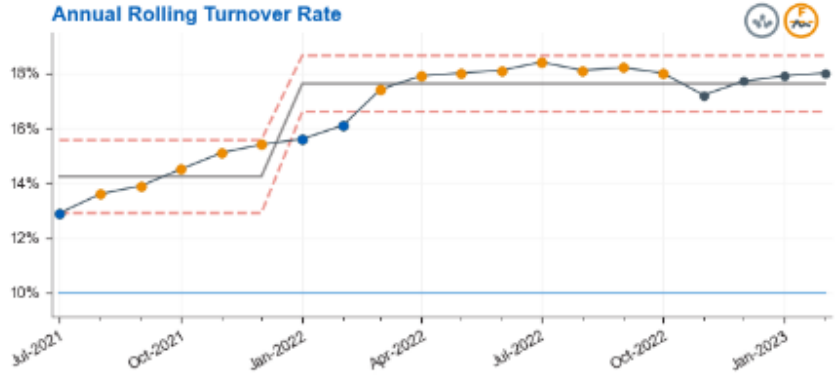
Disaggregating cohort from ad hoc recruitment will show whether improvements to compliance in cohort recruitment have transferred to ad hoc recruitment.

PEOPLE & CULTURE

Workforce (2 of 3)



WF-48
Dept: Workforce HR
IP: People & Culture
Latest: 1.3%
Target: 0.8%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-7
Dept: Workforce HR
IP: People & Culture
Latest: 18%
Target: 10%
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.

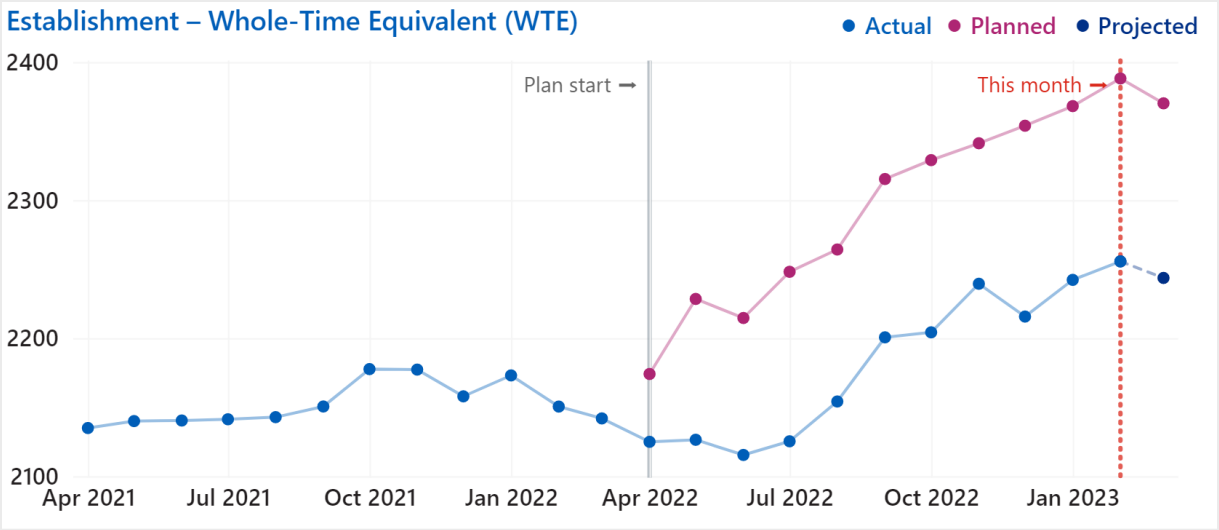
What actions are we taking?

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)

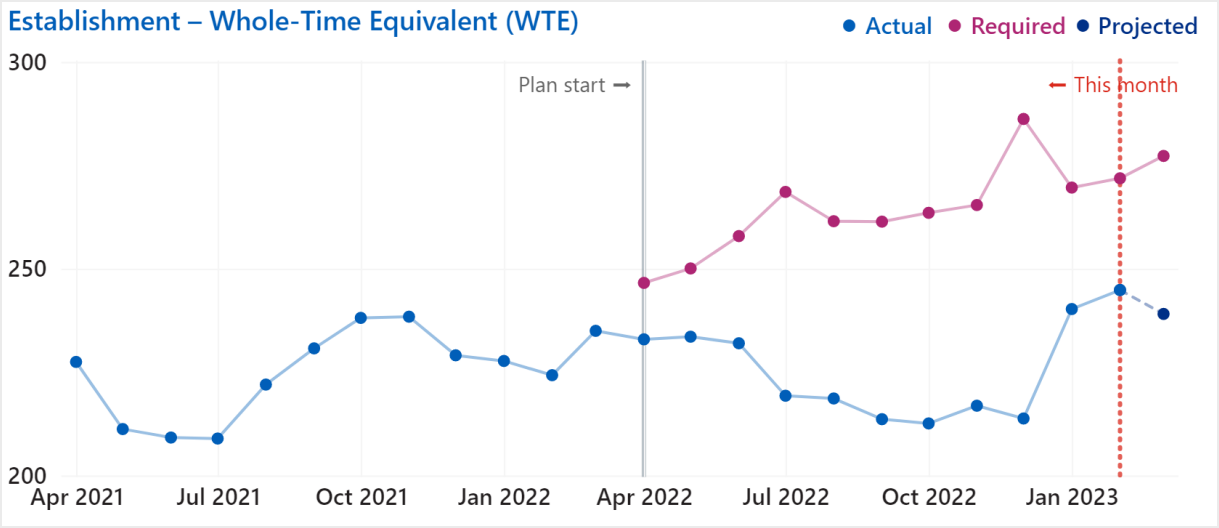
(999 Frontline)



Summary – 999 Frontline (Updated for March Board)
The Trust is currently 133 WTE behind on its frontline workforce plan and is projected to end the financial year at 136 WTE behind the financial plan. This position is 98 WTE below due to attrition being above plan in January 2023, and a high dropout rate of AAPs from a recent recruitment drive from Ireland.
Despite falling below the plan, the Trust has increased its substantive frontline workforce by 120 WTE this financial year.

Mitigating actions – 999 Frontline (Updated for March Board)
Workforce plans for 23/24 have been developed that factor in the existing gap from this financial year. The plan factors in a higher turnover rate that is inline with this years turnover rate, along with an overall recruitment target of 371 WTE.
The Trust has already made offers to 386 candidates for these positions across the year. However, not all of these candidates will start and this figure will likely result in 230 WTE of staff.

(EOC EMA)

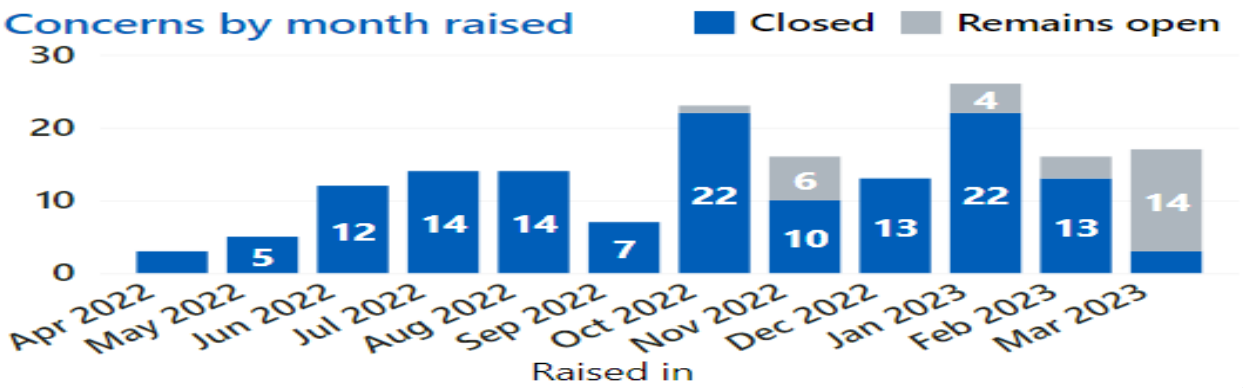


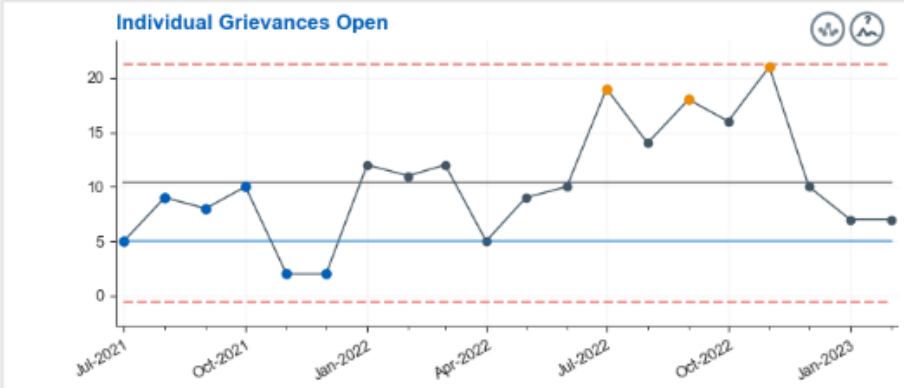
Summary – EOC EMA (Updated for March Board)
EMA establishment is currently 26 WTE behind the required level and is projected to finish the year at 38 – 50 WTE behind the plan. Attrition has significantly exceeded the planned level by 51 WTE and has required significant recruitment efforts to mitigate against this.
The Trust continues to focus on recruitment and training to bridge this gap.

Mitigating actions – EOC EMA (Updated for March Board)
A workforce plan for 23/24 has been developed which factors in the high turnover rates seen this year, and factors in additional attrition that will likely occur beyond normal levels when the Coxheath EOC relocates to Medway.
This plan requires the EOC teams to fill their training capacity consistently to 90% across the year for 11 months. This equates to 221 WTE and 257 staff that will need to be recruited and trained across the year.
As a result of the workforce plan, it is projected that the mean call answer time will be consistently at 10 seconds by the end of quarter 1.

PEOPLE & CULTURE

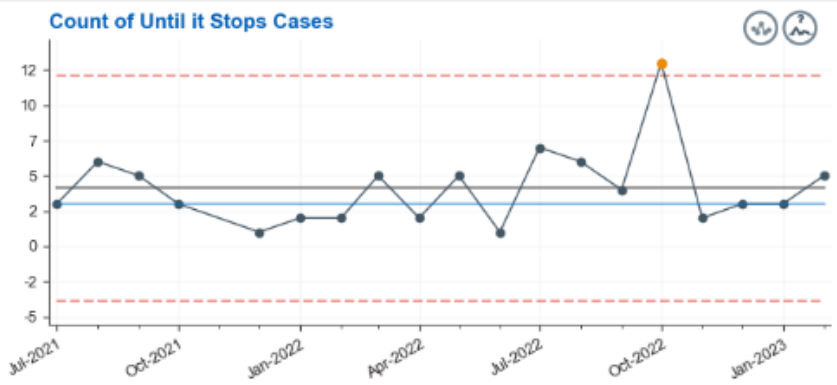
Culture (1 of 2)





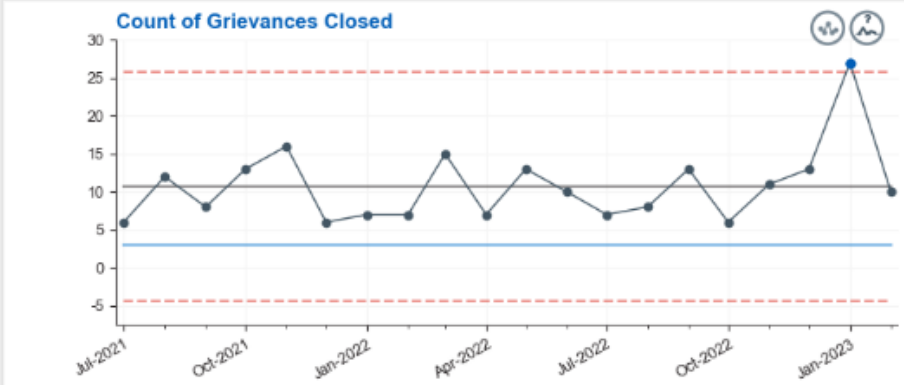
WF-10

Dept: Workforce HR
IP: People & Culture
Latest: 7
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-41

Dept: Workforce HR
IP: People & Culture
Latest: 5
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-42

Dept: Workforce HR
IP: People & Culture
Latest: 10
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Until it Stops workstream – Sexual safety workshops continue with a total 472 of 590 line managers have attended a Sexual Safety Workshop with more dates set and 40 booked onto these courses. Evaluation of the courses completed shows that nearly 70% of managers are clear on the expected behaviours, that the training was very well received, and 86% of early attendees had changed their behaviours.

Action taken on DNAs

L&D Admin email delegate and their manager to inform them that they did not attend. Delegate is advised to rebook. Line managers are responsible for investigating reasons for non-attendance. A DNA report was sent to Executive Directors and the Chief Executive Officer on 03/02/2023.

Individual Grievances /Count of Grievances– We continue to see a reduction in the number of opened grievances in month, with increased emphasis on early and rapid informal resolution.

What actions are we taking?

Until it Stops workstream- Sexual safety courses continue to be rolled out until all managers have attended, as will evaluation of learner experience and learning outcomes. Until it Stops will also folded in to the wider Cultural Transformation journey and People and Culture Strategy.

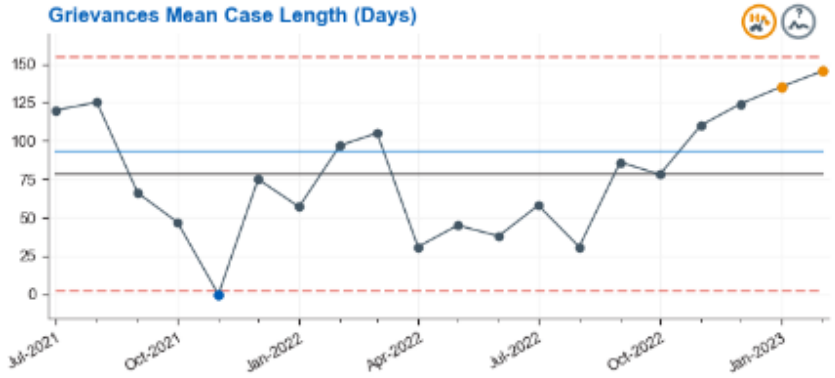
Action taken on DNAs

Reasons for not attending will be recorded on OLM

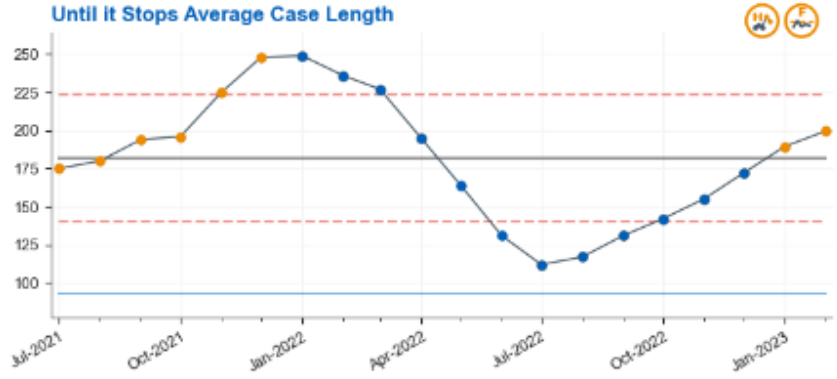
Individual Grievances/ Count of Grievances – A training course on managing concerns is under design, but the Managing Health and Attendance training course was prioritised for rollout in May. We will continue to emphasize early and rapid informal resolution over formal routes; however, we also need to bring in the additional capacity to manage the backlog of ER cases of which grievances are a part.

PEOPLE & CULTURE

Culture (2 of 2)



WF-44
Dept: Workforce HR
IP: People & Culture
Latest: 145.3
Target: 93
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



WF-50
Dept: Workforce HR
IP: People & Culture
Latest: 199.5
Target: 93
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.

Note: Until it stop cases relate to inappropriate sexualised behaviours

Summary

Grievances The impact of the increase in formal grievances noted in the January IQR is now being seen in part through extending grievance mean case length, as more cases fall under investigation.

Until it Stops: The duration to conclude cases is within boundary levels, but above target.

Investigations for both grievances and Until it Stop cases are predominantly carried out by operational managers. While the case numbers may not have dramatically increased beyond capacity, the concatenation of planning for industrial action and increased activity in managing short-term sickness absence, it is likely that investigations have been delayed..

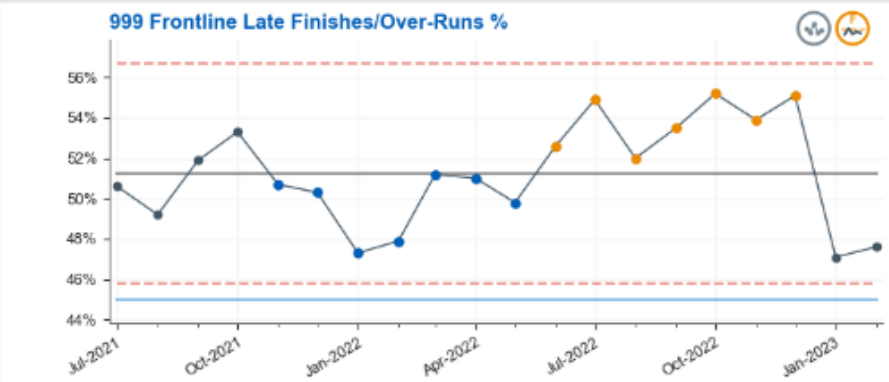
What actions are we taking?

Grievances We have been encouraging informal and early resolution to new concerns; however, there still exists a backlog of cases. The business case to bring in time limited additional capacity to investigate and manage cases as set out in the HR Review and acton plan has been presented to the EMB.

Until it Stops: We continue to reinforce the expected behaviours through the sexual safety workshops, and link the refreshed Values in the cultural transformation journey to create a psychologically safe place to work. Technical training for managers on managing employee concerns is under development and will be rolled out after the Managing Attendance course. The delivery timescale for these courses will have to be managed within abstraction and coordinated through the Education, Development, and Training Group.

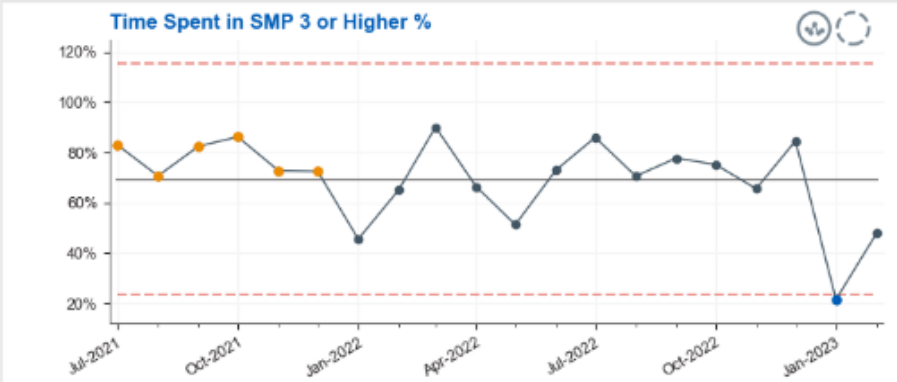
PEOPLE & CULTURE

Employee Experience



999-15

Dept: Operations 999
IP: People & Culture
Latest: 47.6%
Target: 45%
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: 47.9%

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

999-27

Dept: Operations 999
IP: People & Culture
Latest: 98.2%
Target: 98%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

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.

New targets set

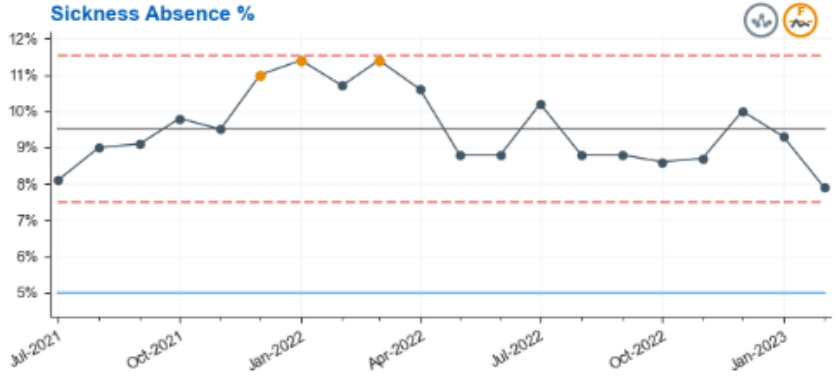
- Late finishes/over-runs for H1 to achieve a sustained Trust-level 45% and during this time, using the performance & quality framework, to develop improvement trajectories for % of over-runs and duration of over-run on an individual dispatch desk basis. This approach follows the paper presented to WWC in Feb.
- % meal breaks taken to be sustained at 98% of all crews on shift per day across the FY

What actions are we taking?

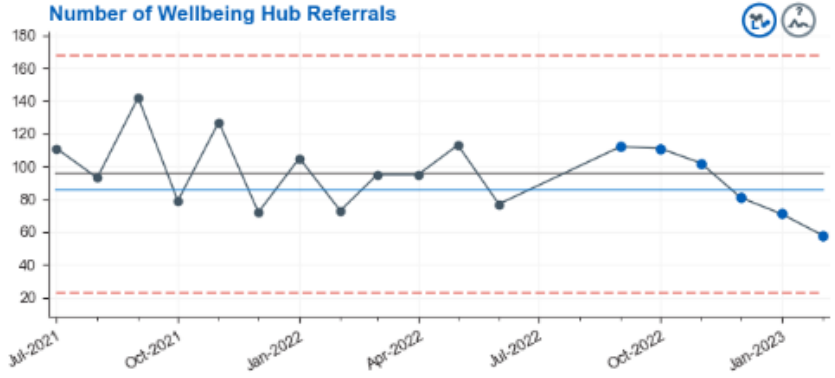
- The development of the IQR through an Operations performance and quality management framework has advanced, with the intention to drill down data to dispatch desk. A monthly cycle of review and challenge is being incorporated with involvement from all directorates.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 7.9%
Target: 5%
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: 58
Target: 86
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Summary

While SECAmb is not an outlier for sickness absence compared to other ambulance Trusts, the rate remains too high. While work on long-term sickness absence has helped reduce this, absolute levels of short-term sickness remain high.

Wellbeing referrals fell during January and February, but this was prior to the *Your Mind Matters* campaign.

Year on year sickness has reduced from 11% in February 2022 to 8% in February 2023.

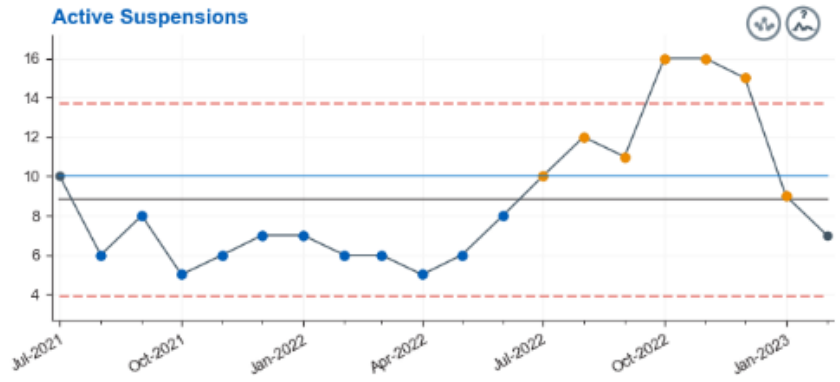
What actions are we taking?

Targeted actions plans are now in place for the seven OUs with the highest persistent levels of sickness absence rates. These are reviewed by senior Ops leaders each month. In addition, the policy is due to be refreshed in April, with the rollout of a technical training course for managers in managing attendance in May. We are also investigating changes to GRS to produce improved and robust sickness absence reporting on non-disabled causes.

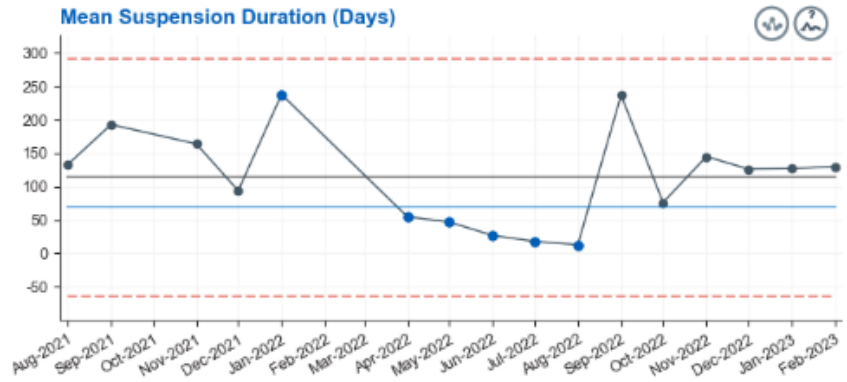
Additional funding from NHS Charities for two FTC mental health wellbeing practitioners for EOC/111 has been successful, with the Crawley post to be filled in May and Medway at the end of May. An evaluation of the *Your Mind Matters* campaign will be completed in April. We note that there are other referral routes open to staff for which we do not have access; we will look to the time from referral to treatment as a more meaningful metric.

PEOPLE & CULTURE

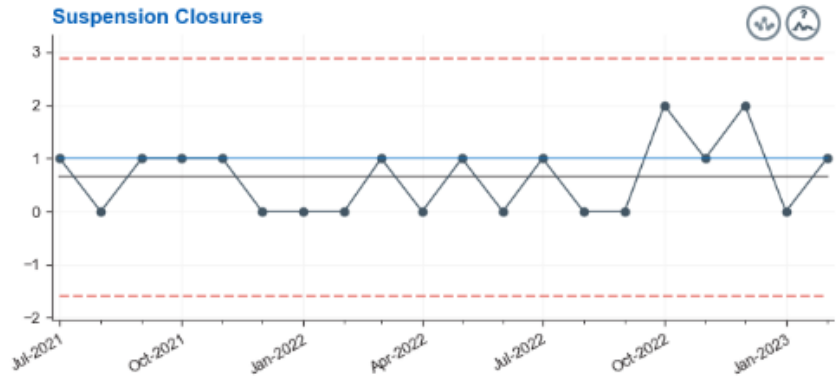
Employee Suspensions



WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 7
Target: 10
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-47
Dept: Workforce HR
IP: People & Culture
Latest: 130.2
Target: 70
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-45
Dept: Workforce HR
IP: People & Culture
Latest: 1
Target: 1
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Suspensions: Over the past month a further 4 cases have been closed, and formal sanctions have been issued. The mean duration of suspensions is kept high at 111 days by three of the 7 suspension cases where Industrial Action has impacted on management and union representation capacity to meet; these cases are expected to be resolved in April, and should take the mean duration to 65 days.

Due to small numbers which could identify colleagues, only themes are presented. Our two highest reasons for suspension remain bullying and harassment and sexual misconduct.

What actions are we taking?

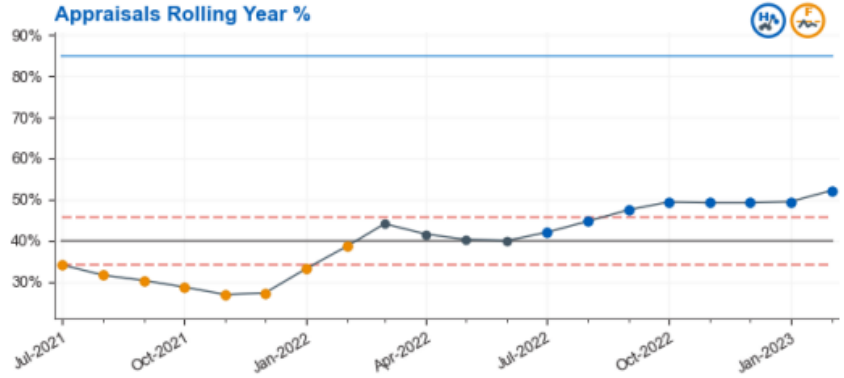
Suspensions: cases continue to be reviewed on a weekly basis by the HRBP Team with the Executive Directors of HR & OD and Operations.

Three of these cases are being managed along with Safeguarding. We have four potential gross misconduct cases due to be considered under disciplinary proceedings by the end of April 2023. This resolution should take our number of open suspensions to three cases.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 79.7%
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.



WF-40
Dept: Workforce HR
IP: People & Culture
Latest: 52.2%
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. The Deputy Director of HR and OD meets with colleagues on a rotational basis to highlight gaps in compliance.

Appraisals

- Progress on appraisal completion has not significantly improved, and users report dissatisfaction with the ESR solution.
- The data has now been changed to show employees with 12 months service or longer, rather than all employees to accurately show the gap between those who should receive and those who have received an appraisal

What actions are we taking?

Statutory & Mandatory Training

- The Education, Training and Development Group meeting planned for 3 February 2023 was not quorate, therefore the Statutory and Mandatory Training Improvement Action Plan and the Statutory and Mandatory Training Policy are to be presented to the Group at a future meeting.
- There are large gaps between ETDG meeting which needs to be addressed. The Terms of Reference need to be revisited to ensure the effective governance and assurance measures.

Appraisals

- 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.
- A Task and Finish Group has been set up with users and managers to build an immediate solution to improve appraisal rates. A longer-term solution will also need to be defined.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

February 2023

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

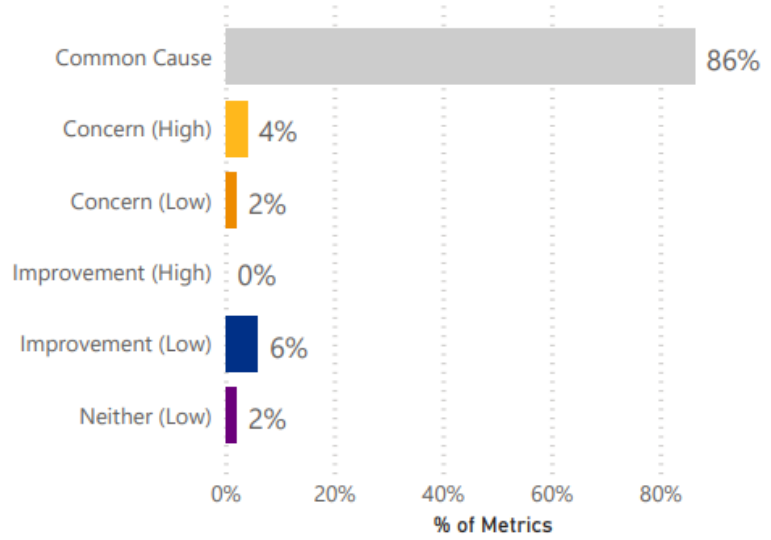
Special Cause Improvement (H / L)	111 to 999 Referrals (Calls Triaged) %			Proportion of Wrap Up Times > 15 minutes 999 Referrals
Common Cause	Cat 1T 90th Centile Cat 1T Mean Ambulance Validation %	111 Calls Abandoned - (Offered) % A&E Dispositions % Cat 3 90th Centile Cat 4 90th Centile	999 Frontline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

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

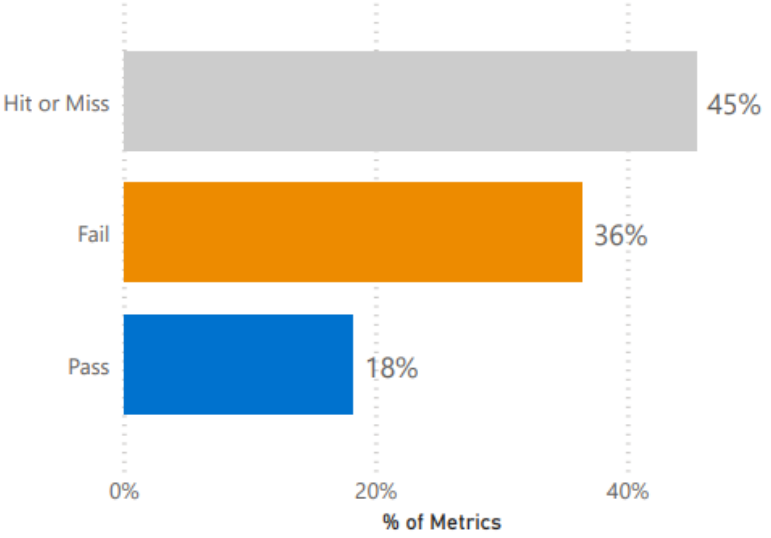
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Feb-2023	00:05:25			01:01:01			
Section 136 Mean Response Time	Responsive Care	Feb-2023	00:21:24		00:13:25	00:26:24	00:39:22		
Cat 1 Mean	Responsive Care	Feb-2023	00:08:48	00:07:00	00:07:49	00:09:08	00:10:27		
Cat 1 90th Centile	Responsive Care	Feb-2023	00:15:54	00:15:00	00:14:44	00:16:33	00:18:21		
Cat 1T Mean	Responsive Care	Feb-2023	00:10:31	00:19:00	00:09:31	00:11:03	00:12:35		
Cat 1T 90th Centile	Responsive Care	Feb-2023	00:19:34	00:30:00	00:17:42	00:20:16	00:22:51		
Cat 2 Mean	Responsive Care	Feb-2023	00:28:18	00:18:00	00:19:26	00:33:55	00:48:24		
Cat 2 90th Centile	Responsive Care	Feb-2023	00:59:04	00:40:00	00:36:46	01:09:20	01:41:55		
Cat 3 90th Centile	Responsive Care	Feb-2023	04:53:28	02:00:00	01:45:25	06:30:57	11:16:30		
Cat 4 90th Centile	Responsive Care	Feb-2023	06:02:25	03:00:00	02:40:10	08:17:03	13:53:57		
HCP 3 Mean	Responsive Care	Feb-2023	01:51:40		01:15:19	03:10:18	05:05:17		
HCP 3 90th Centile	Responsive Care	Feb-2023	04:13:54		01:37:51	07:21:58	13:06:05		
HCP 4 Mean	Responsive Care	Feb-2023	02:19:27		01:49:58	04:00:45	06:11:33		
HCP 4 90th Centile	Responsive Care	Feb-2023	05:38:14		02:59:37	09:15:35	15:31:32		

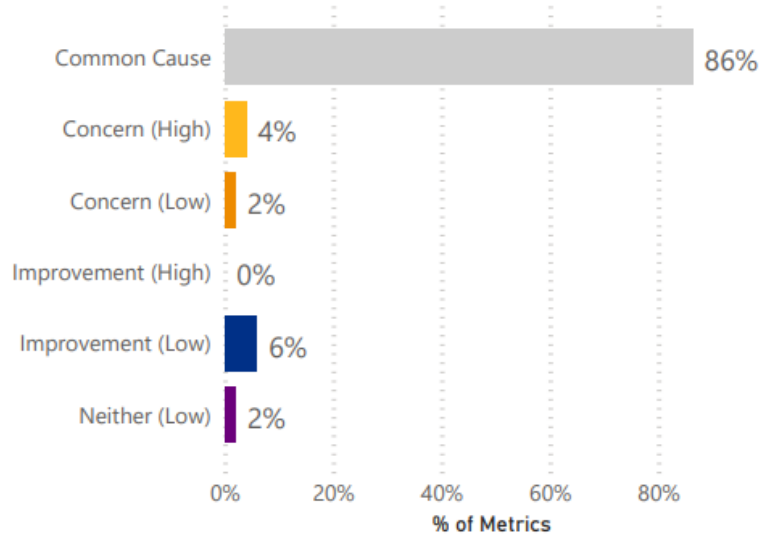
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Feb-2023	22.6%		20.39%	25.09%	29.79%		
999 Calls Answered	Responsive Care	Feb-2023	59436		53085.21	75796.15	98507.09		
999 Call Answer Mean	Responsive Care	Feb-2023	00:00:28	00:00:05	00:00:28	00:00:35	00:01:39		
999 Call Answer 90th Centile	Responsive Care	Feb-2023	00:01:50	00:00:10	00:00:53	00:01:50	00:04:34		

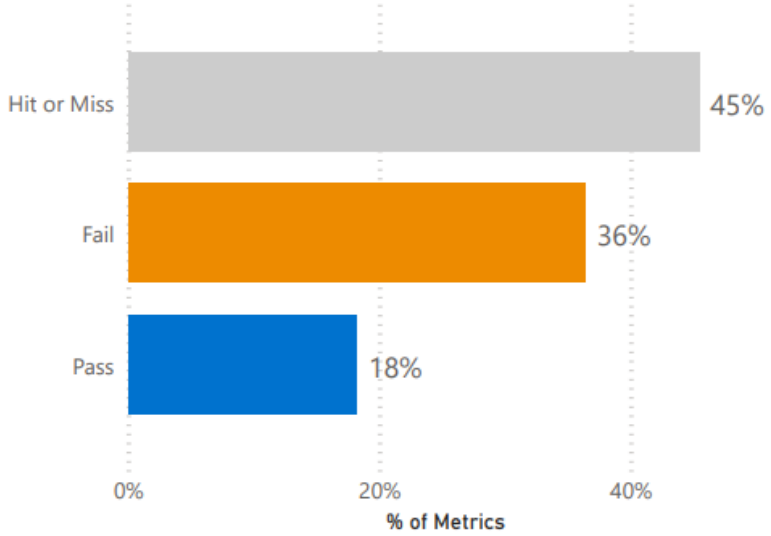
RESPONSIVE CARE

Overview (2 of 3)

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	Feb-2023	92.8%	100%	83.23%	90.08%	96.93%		
Provided Bank Hours %	Responsive Care	Dec-2022	0.7%		0.04%	0.76%	1.48%		
Provided Overtime Hours %	Responsive Care	Dec-2022	7.7%		7.25%	10.51%	13.76%		
Provided PAP Hours %	Responsive Care	Dec-2022	5.9%		4.57%	5.74%	6.91%		
999 Operational Abstraction Rate %	Responsive Care	Dec-2022	34.5%	28%		34.28%			
999 Remaining Annual Leave FY	Responsive Care	Dec-2022	17.4%			36.28%			
Vehicles Off Road (VOR) %	Responsive Care	Feb-2023	13.3%		8.82%	11.65%	14.49%		
% of DCA vehicles off road (VOR)	Responsive Care	Feb-2023	14.9%		10.63%	12.81%	14.99%		
% of SRV vehicles off road (VOR)	Responsive Care	Feb-2023	3.1%		0.78%	6.62%	12.45%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Feb-2023	124		86.03	198.45	310.87		
Number of RTCs per 10k miles travelled	Responsive Care	Feb-2023	0.78		0.19	0.68	1.18		
% of planned vehicle services completed	Responsive Care	Jan-2023	67%		55.88%	75.93%	95.98%		
% 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	Feb-2023	64%		58.66%	63.1%	67.54%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Feb-2023	6.6%	13%	6.49%	7.8%	9.1%		
Incidents	Responsive Care	Feb-2023	53681		53379.63	60790.95	68202.27		

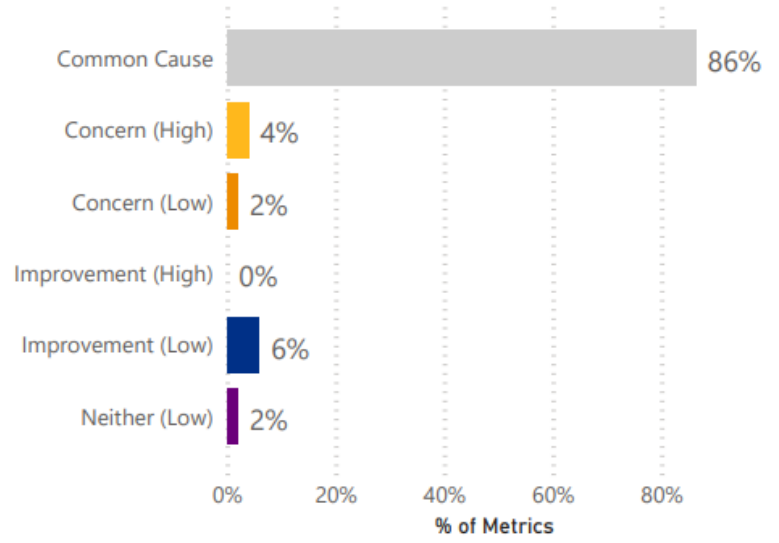
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Feb-2023	100599		72560.06	117022.8	161485.54		
111 Calls Answered in 60 Seconds %	Responsive Care	Feb-2023	35.7%	95%	-4.44%	29.61%	63.66%		
111 Calls Abandoned - (Offered) %	Responsive Care	Feb-2023	13.9%	5%	0.88%	20.93%	40.98%		
999 Referrals	Responsive Care	Feb-2023	5050		4987.86	6453.8	7919.74		

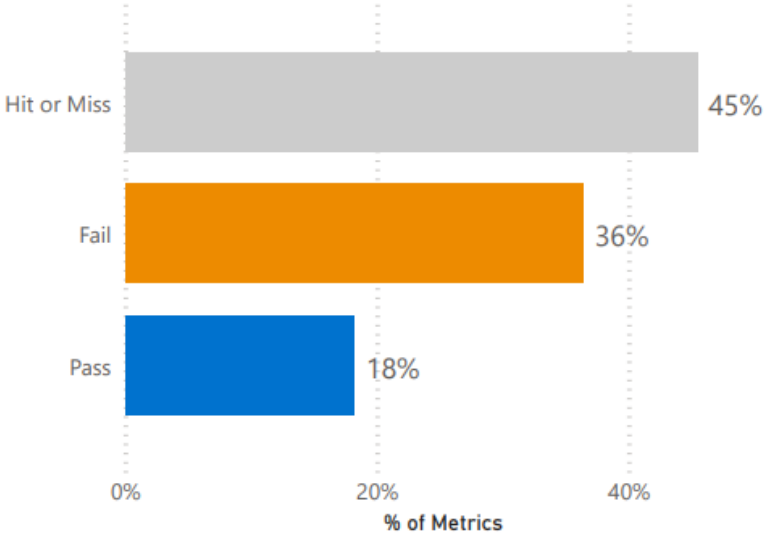
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

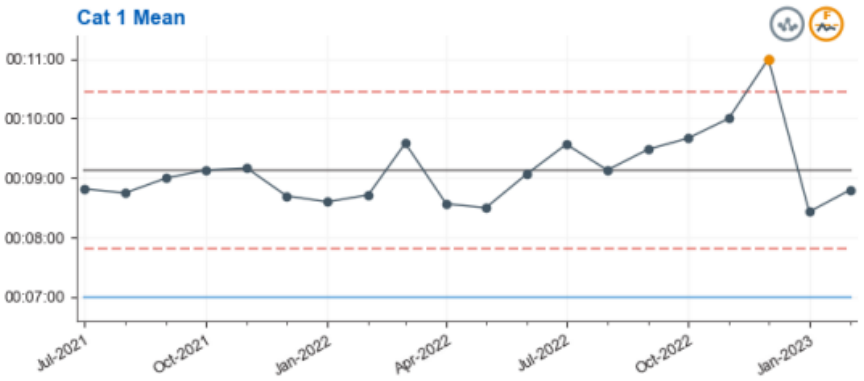
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Feb-2023	01:18:34		01:16:12	01:17:57	01:19:41		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Feb-2023	01:53:21		01:51:45	01:56:03	02:00:21		
Responses Per Incident	Responsive Care	Feb-2023	1.1	1.09	1.08	1.1	1.11		
CFR Attendances	Responsive Care	Feb-2023	1190		980.07	1380.75	1781.43		
FFR Attendances	Responsive Care	Feb-2023	191		162.28	271.2	380.12		
ECAL Mean Response Time	Responsive Care	Feb-2023	00:23:21		00:21:34	00:23:29	00:25:24		
Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	Responsive Care	Jan-2022	30.2%			30.44%			
Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	Responsive Care	Jan-2022	17.9%			46.67%			
Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	Responsive Care	Jan-2022	51.8%			22.9%			

111/999 System Impacts

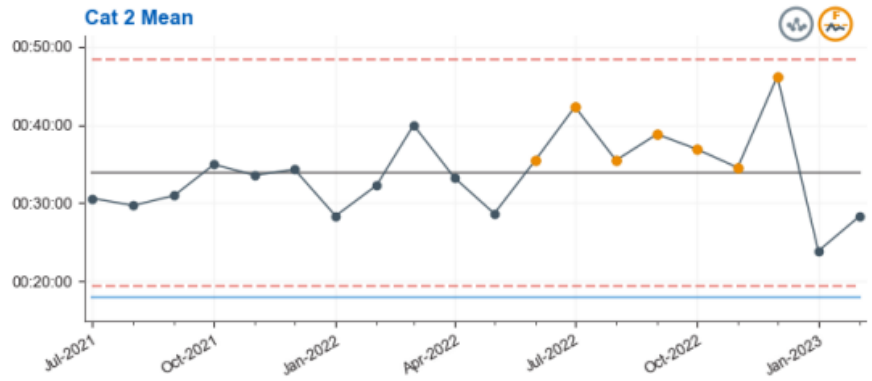
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Feb-2023	9.7%	13%	7.81%	9.59%	11.36%		
See & Treat %	Responsive Care	Feb-2023	31.5%	35%	30%	31.81%	33.62%		
See & Convey %	Responsive Care	Feb-2023	58.7%	55%	55.93%	58.5%	61.06%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Feb-2023	1%		0.9%	1.58%	2.25%		
Number of Hours Lost at Hospital Handover	Responsive Care	Feb-2023	2739.15		2445.02	4297.71	6150.41		
Average Wrap Up Time	Responsive Care	Feb-2023	00:17:17	00:15:00	00:16:53	00:17:31	00:18:09		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Feb-2023	46.2%		45.58%	48.5%	51.41%		
A&E Dispositions %	Responsive Care	Feb-2023	9.2%	9%	7%	8.75%	10.5%		
A&E Dispositions	Responsive Care	Feb-2023	7088		5750.66	7202.6	8654.54		
Clinical Contact %	Responsive Care	Feb-2023	50.9%	50%	46.04%	49.86%	53.68%		
Ambulance Validation %	Responsive Care	Feb-2023	95.5%	85%	93.44%	95.92%	98.39%		

RESPONSIVE CARE

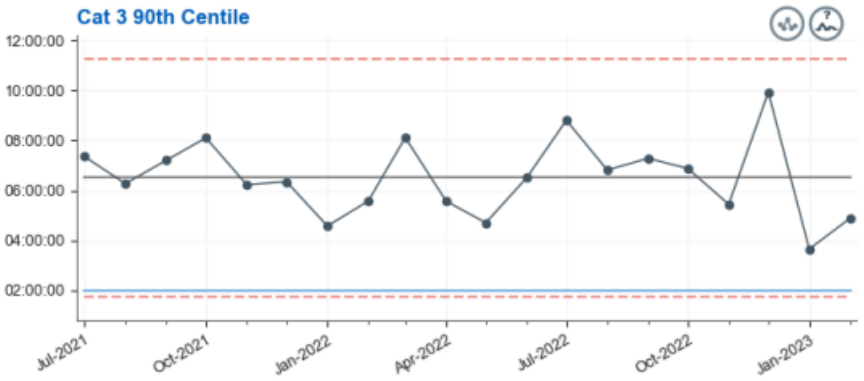
Response Times



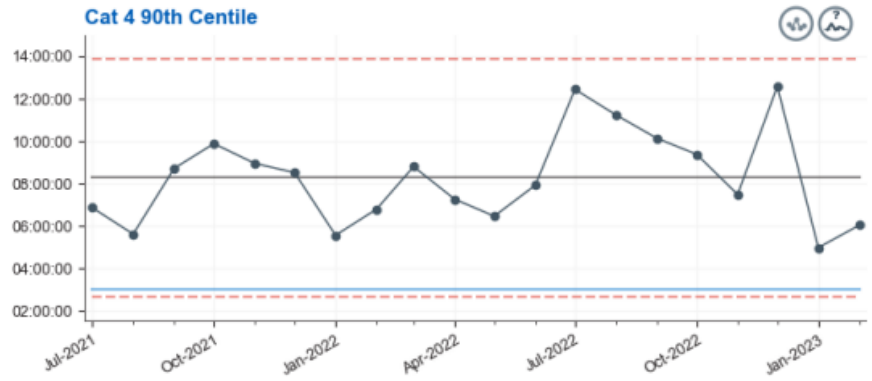
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:48
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:28:18
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: 04:53:28
Target: 02:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-6
Dept: Operations 999
IP: Responsive Care
Latest: 06:02:25
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

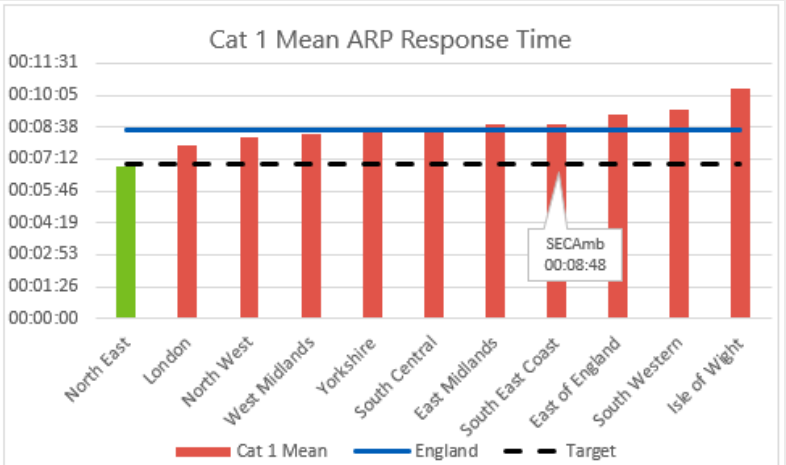
Summary

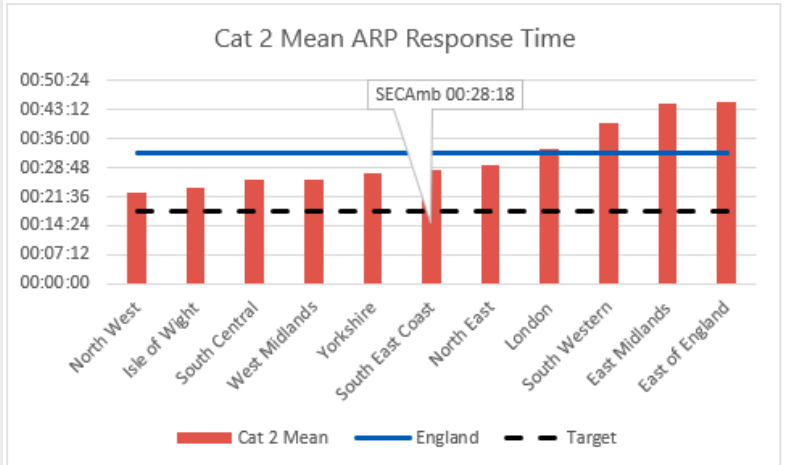
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The overall improvement during January and February has been primarily due to a reduction in demand over these two months.

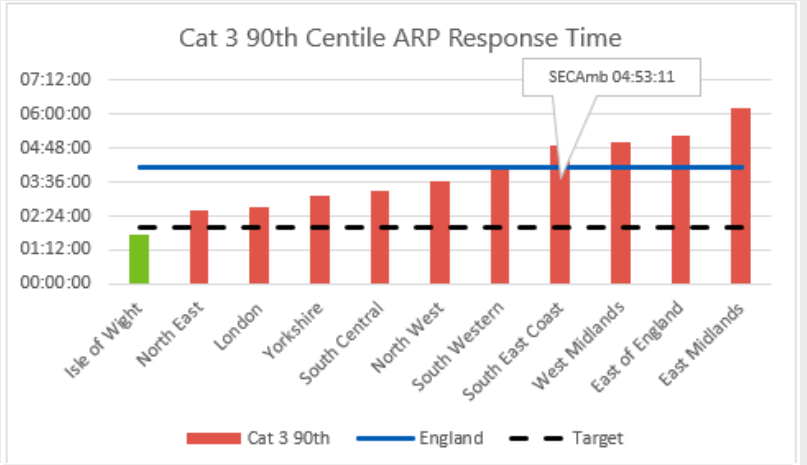
What actions are we taking?

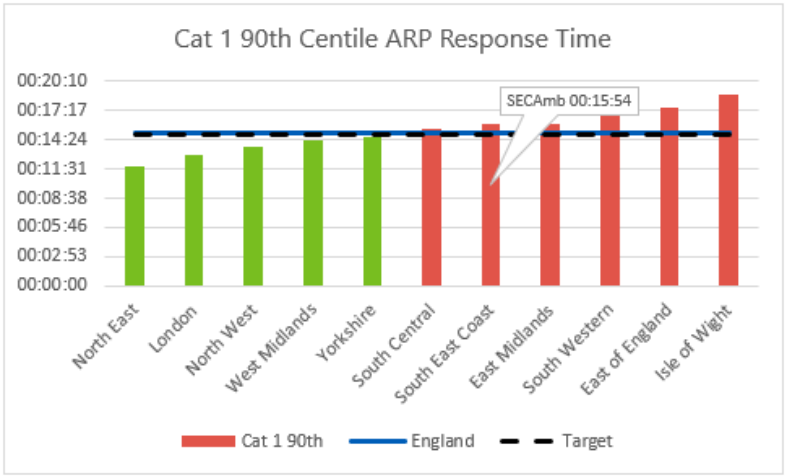
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (95.2% for March).
- Introduction of C3 & C4 Clinical Validation in EOC in January, with increased clinical staffing in EOC to maintain patient safety and support apposite ambulance dispatch
- Focus on optimising resources through appropriate use of overtime in field operations and abstraction management (sickness is on an improving trajectory but remains high).
- Continued engagement on a local and strategic level regarding hospital handover process to minimise lost hours where possible; this has been supported by local commissioning/ICB leads to drive improvements.
- 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 review of our clinical strategy, which has already started by the Clinical Advisory Group, to inform the vision for a sustainable care delivery model.

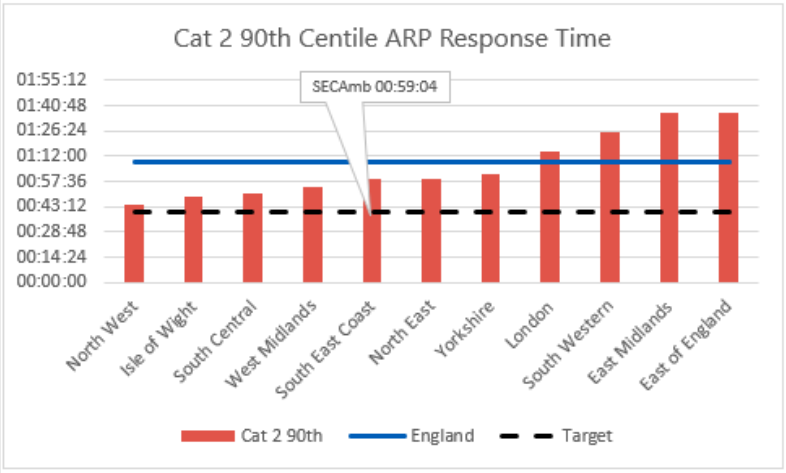
ARP Response Time Benchmarking (February 2023 Data)

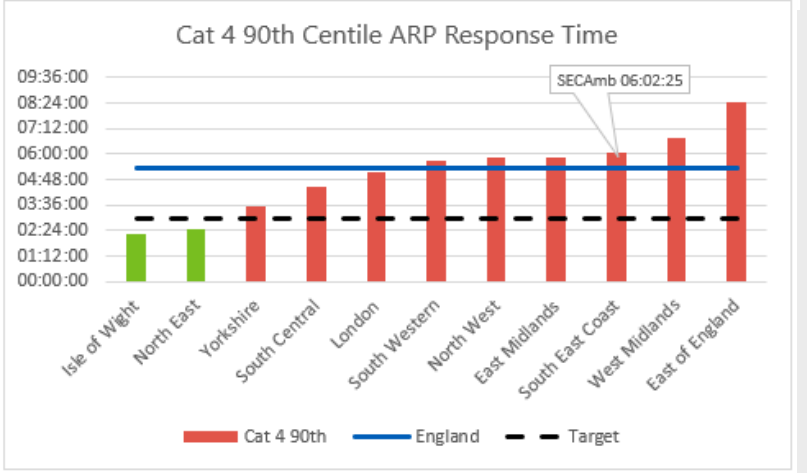












Summary

- The Trust ARP performance deteriorated in February as compared to January – both in terms of definitive performance and relative position when compared to other ambulance trusts.
- C2 mean (a focus for the UEC recovery plan) remains under the 30min target time for February

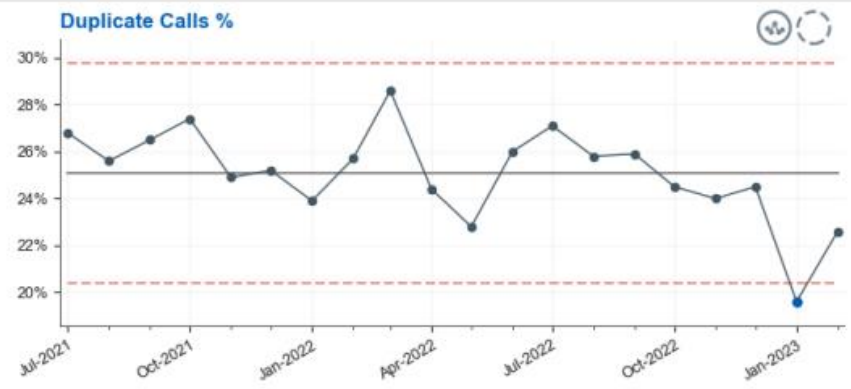
RESPONSIVE CARE

EOC Emergency Medical Advisors

999-10

Dept: Operations 999
IP: Responsive Care
Latest: 59436

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: 22.6%

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: 9.7%
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: 00:00:28
Target: 00:00:05
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

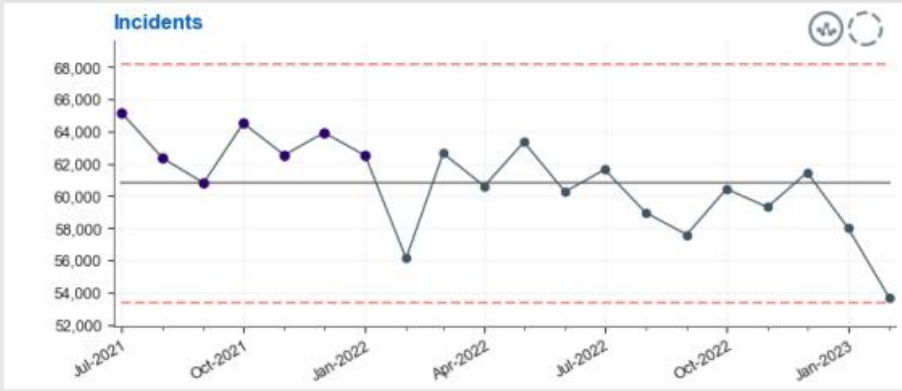
- Call answer mean time has shown marked improvement in the past two months, underpinned by better staffing and reducing call volumes – this metric is strongly aligned to the EMA resourcing levels over the same period.
- Over the duration of the past 9 months, there have been significant fluctuations in the number of ***calls answered*** whilst the levels of ***duplicate calls*** has remained relatively consistent with January showing a marked reduction related to to a reduction in call activite. 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 newly qualified call handlers 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 now stable, consistently around 9-10%, albeit below the target for H&T, the cause of this being significantly under the required clinical staffing levels in EOC.

What actions are we taking?

- EMA establishment is currently 26 WTEs below the planned levels for Feb. Of the 26 WTE gap, approximately 75% of this can be attributed to attrition being 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.
- 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 was to achieve 13% by year-end. Introducing the C3 & C4 clinical validation model in EOC in January has subsequently stabilised H&T performance in the recent months (many other ambulance trusts have seen a reduction over this same period).
- The change to the EOC operating model and actions to improve H&T, and the EMA recruitment drive and associated operational efficiencies are reviewed on a fortnightly basis by the Executive Director of Operations with the service lead, using key metrics and highlight reports.

RESPONSIVE CARE

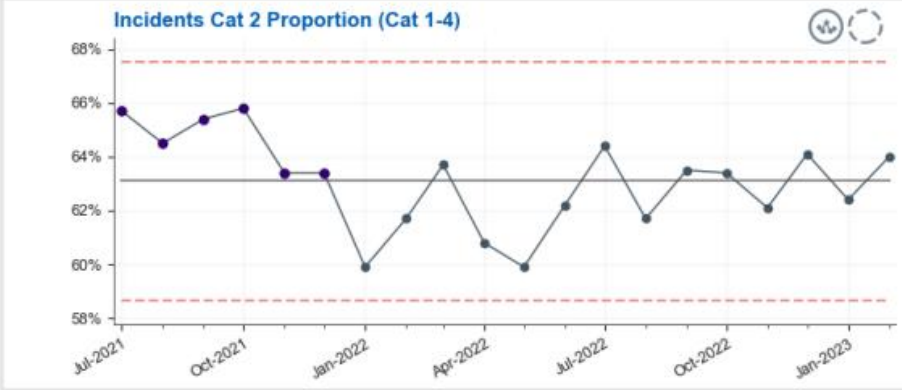
Utilisation



999-10
Dept: Operations 999
IP: Responsive Care
Latest: 53681

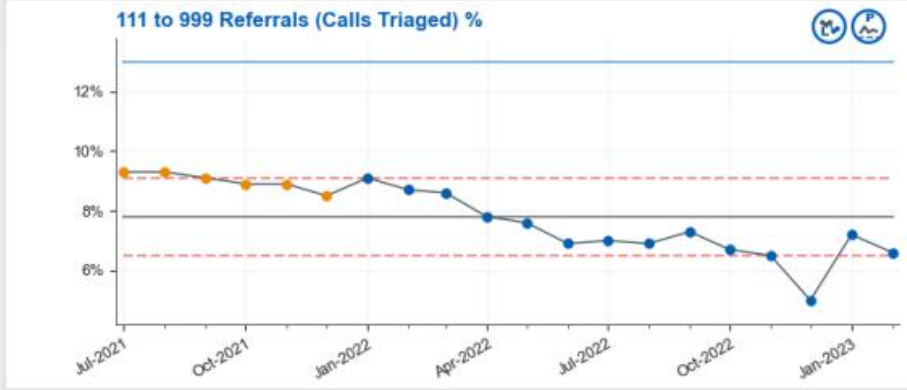
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 92.8%
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%

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



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.6%
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 ambulance referral rate from 111 in Kent and Sussex.
- 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 reduction in total number of incidents managed. The national industrial action seen in December and January's had a significant impact on the reduction of calls/incidents received.
- Frontline hours throughout the year have impacted by high abstraction levels, mainly driven through sickness plus the carry-over of additional Covid annual leave.

What actions are we taking?

- Continued effective clinical validation of non-emergency ambulance calls from Kent, Medway and Sussex's 111 service, significantly above the contractual requirements to protect 999 - (95.5% for Feb)
- Continued focus on optimising resources through abstraction management and optimisation of overtime to provide additional hours.
- Increased focus on optimising clinical validation in both 111 and EOC in real-time, coordinated by the Trust's Operations Managers Clinical (OMC) to mitigate risk and optimise clinical effectiveness across 111 and 999

RESPONSIVE CARE

999 Frontline

999-17

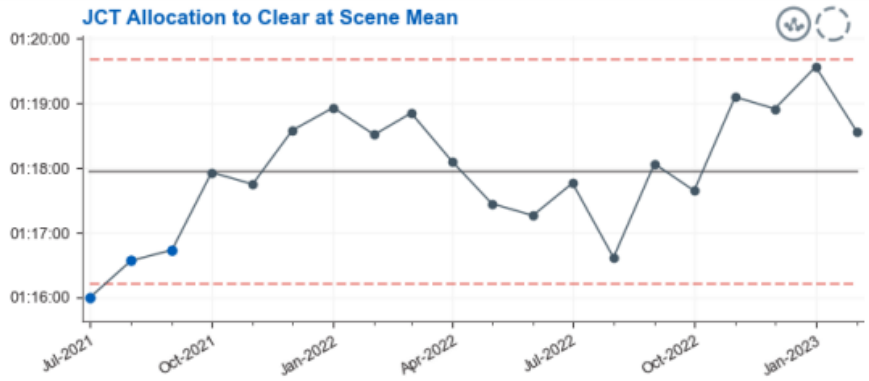
Dept: Operations 999
IP: Responsive Care
Latest: 1.1
Target: 1.09

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: 00:23:21

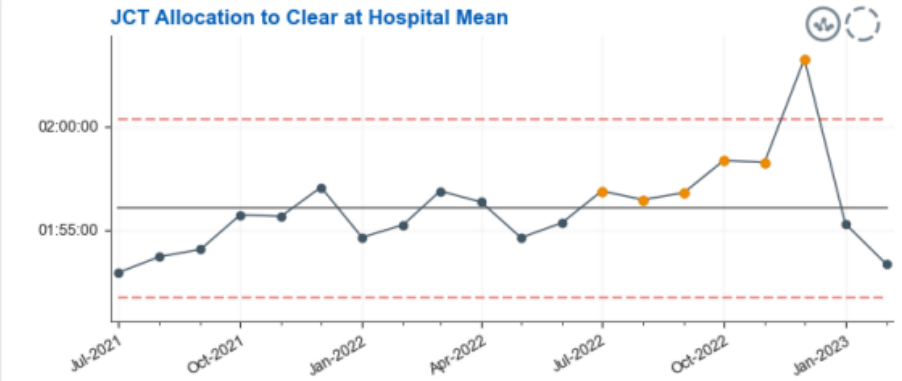
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:18:34

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: 01:53:21

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

Summary

- The number of **resources allocated per incident** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with a an improvement on the past two months.
- **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. Progress against this plan is being monitored on a monthly basis.
- 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

RESPONSIVE CARE

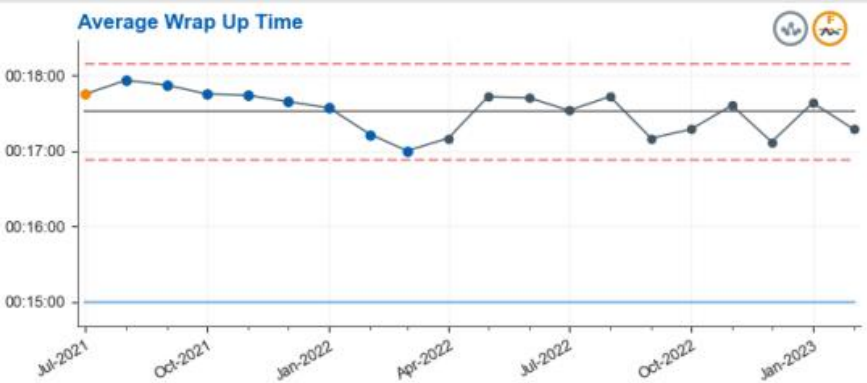
111/999 System Impacts

111-5
Dept: Operations 111
IP: Responsive Care
Latest: 9.2%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

999-9
Dept: Operations 999
IP: Responsive Care
Latest: 31.5%
Target: 35%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

999-24
Dept: Operations 999
IP: Responsive Care
Latest: 2739.15

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



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

Summary

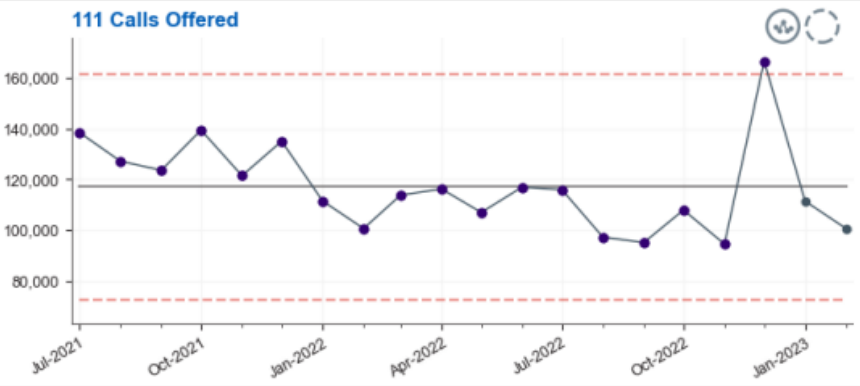
- SECAmb services (999 and 111) are key components of the emergency and urgent care health system in the SE region – this narrative provides an overview of the metrics which describe this component
- The ***111 to ED dispositions*** have been maintained at a very low level since the introduction of "111 First" and ED disposition revalidation, significantly better than the NHS E 111 national average
- The introduction of "111 First" supported by Direct Access Booking (DAB) has also resulted in the KMS 111 service facilitating smother patient pathways across the region, leading NHS E % DAB national performance
- The Trust **See and Treat** rate has remained at approx.32%, noting that there is significant variation between geographical dispatch desk areas – in Feb '22 Gatwick achieved 34.4% with Dartford at 27.2%. The usage of community care pathways as alternatives to Emergency Depts. This variation will be influenced by the availability and accessibility of the services, and the confidence of local teams to use them.
- ***Wrap-up time*** had shown some improvements but this has not been sustained resulting in a performance that is still fluctuating and in excess of the target.

What actions are we taking?

- Maintaining 111 to ED revalidation, to support improved outcomes for system partners, particularly when they are under pressure through appropriate Directory of Services (DoS) management – this is monitored within the Trust and through contract meetings with commissioners
- The Trust has embarked on a programme to lead collaboration with local teams regarding the engagement with local systems and utilisation of community pathways of care i.e., Urgent Community Response (UCR) and other services.
- 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 continues to see significantly lower handover times across all hospitals than many other English ambulance services.
- Significant improvement in handover times was seen on the first date of industrial action (21/12/22) following clear instruction from NHS England to all acute trusts, however this has not been sustained, with three hospitals in Sussex having the greatest proportion of handovers over 60mins.

RESPONSIVE CARE

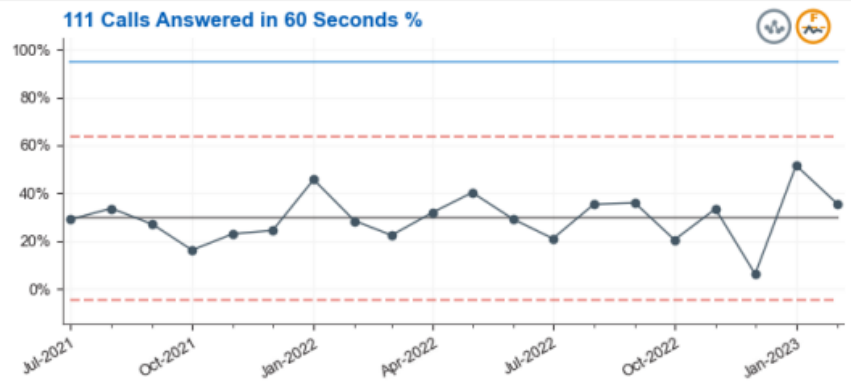
111



111-1

Dept: Operations 111
IP: Responsive Care
Latest: 100599

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

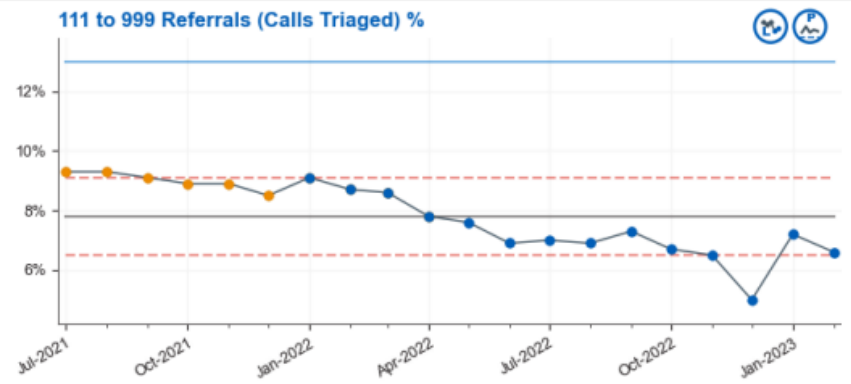


111-2

Dept: Operations 111
IP: Responsive Care
Latest: 35.7%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

111-3

Dept: Operations 111
IP: Responsive Care
Latest: 13.9%
Target: 5%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



111-4

Dept: Operations 111
IP: Responsive Care
Latest: 6.6%
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

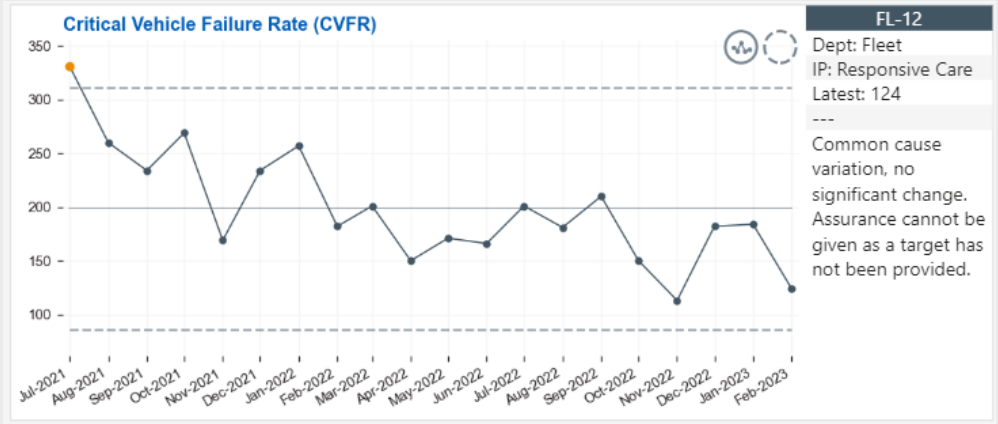
- The call activity and demand in 111 is significantly above that which SECAmb is contractually commissioned and remunerated for however, this is impacted by the % of abandoned calls and therefore potential duplicates.
- The service's operational responsiveness remains poor, as reflected in the sustained 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, this remains a challenge.
- The clinical outcomes remains strong and leads the country in terms of ED and 999 referral rates.
- The service continues to be effective in protecting the wider integrated urgent and emergency care system, as reflected in its high levels of clinical contact (50.9% in Feb) and Direct Access Booking (22,172 to ED and UTCs in Feb)

What actions are we taking?

- Trust had been successful in negotiating a new financial settlement for the 111 service during Q2 2022/23 (£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) - this is yet to be confirmed for 2023/24
- 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 successful in working with NHS E and secured additional support from an established 3rd party 111 provider, to support performance delivery across Jan and Feb 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 Q1 of 2023/24, following BC approval. This will reduce attrition and improve staff working flexibility.

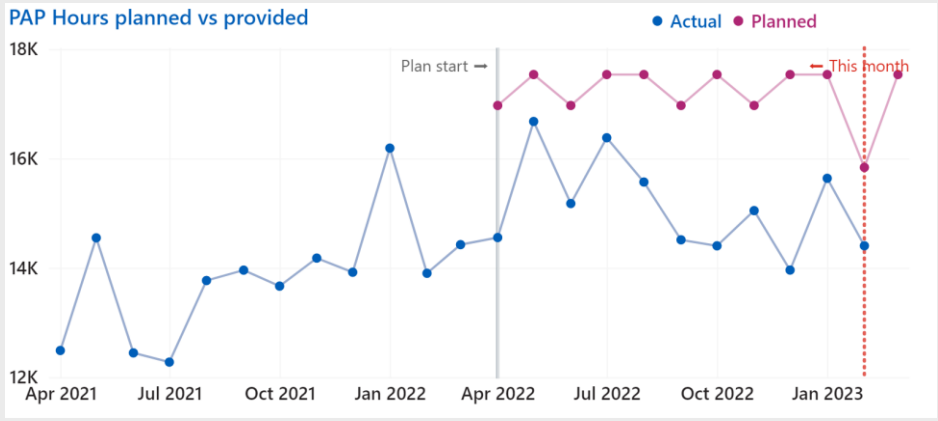
RESPONSIVE CARE

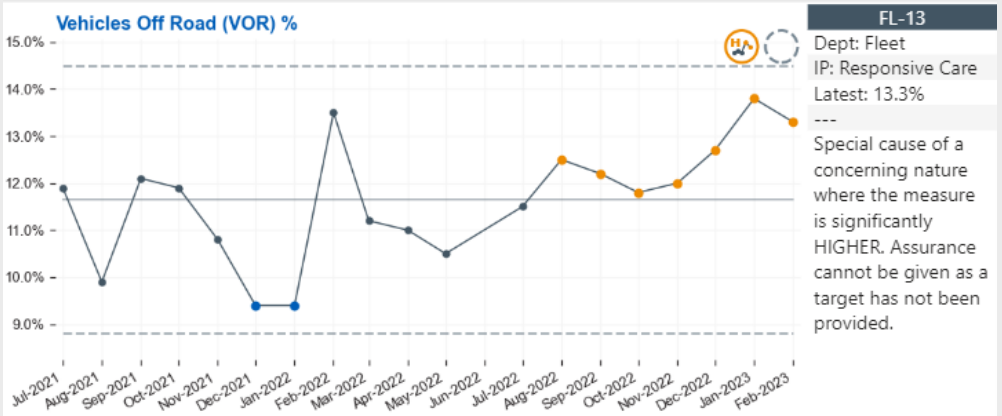
Support Services
Fleet and Private Ambulance Providers



FL-12
Dept: Fleet
IP: Responsive Care
Latest: 124

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: 13.3%

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: 67%

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

Summary and Action Plans

Critical Vehicle Failure Rate and VOR 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. Despite the reduction in CVFR, we have seen the VOR increase as reported in January to 15% for DCAs (13.3% for all fleet including SRVs and other specialist vehicles), and this is due to the new FIAT Ducato DCAs being introduced.

Planned Vehicle Services completed has seen a decline, despite being common cause variation, there are issues associated with the releasing of vehicles because of the limitations of usage of FIATs, and vacancies within the Vehicle Maintenance Team which are not being covered through overtime to protect cost. The planned services schedule and VMT workforce is being reviewed as part of the 23/24 budgeting process to ensure it's rightsized for our fleet.

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?

A full review of the fleet choice and strategy has been and will be presented to the Board as part of the Part 2 Board meeting on the 6th April 2023.

Our **PAP** hour provision has been impacted by our largest supplier of hours not filling their contract. As reported in February, 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. The reduction in contracted hours planned for 23/24 in line with the workforce plan will facilitate the contract filling it's hours.

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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

£000s	February 2023			Year to February 2023			Forecast to March 2023		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income	24,408	26,224	1,816	268,978	279,452	10,474	293,385	305,720	12,335
Operating Expenditure	23,616	24,817	(1,201)	268,209	279,117	(10,908)	293,387	305,421	(12,034)
Trust Suplus/ (Deficit)	***792***	***1,407***	***615***	***769***	***334***	***(435)***	***(2)***	***299***	***301***
System 'Control' Adjustments	*0*	*1*	*1*	*2*	*(299)*	*(301)*	*2*	*(299)*	*(301)*
Reported Suplus/(Deficit)	**792**	**1,408**	**616**	**771**	**35**	**(736)**	**0**	**0**	**0**
Cash	43,587	35,129	(8,458)	43,587	35,129	(8,458)	40,886	36,738	(4,148)
Capital Expenditure	4,345	3,798	547	32,762	26,322	6,440	36,116	31,812	4,304
Effciency Target	727	1,815	1,088	4,823	3,446	(1,377)	5,598	3,948	(1,650)

Summary

The Trust's financial performance for the 11 months to 28 February 2023 was £0.7m 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 11, specific areas of concern that will impact the Trust financial forecast position have been mitigated, the Trust is focused on delivering its target for the year, and the current outstanding risks are:

1. Risk of not meeting the requirement of the 111 SVCC to secure required funding.
2. Delivery of its financial recovery plan, risk of unknown and unmitigated costs.

What actions are we taking?

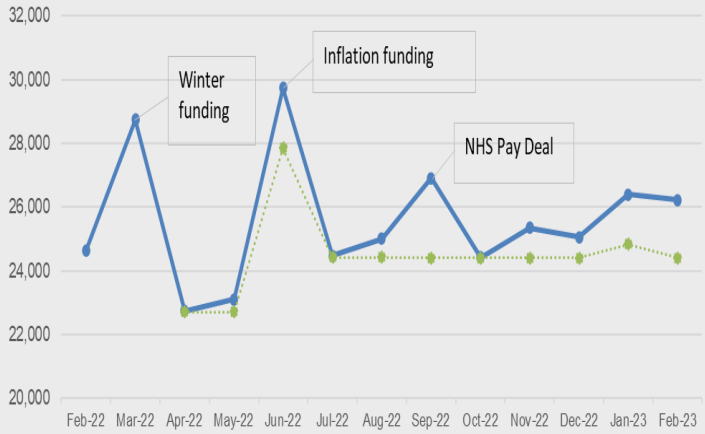
1. The Trust identified a £8.9m savings target in October 2022 to achieve a break-even position with the Trust engaging in a financial recovery plan to achieve these savings, as at February 2023, the Trust is confident in achieving this saving and meeting its financial target of break-even.
2. The financial recovery plan, and ongoing cost control includes:
    a) Executive Director challenge review meetings 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 continues:
    a) Draft plan submitted on 23 February 2023
    b) Final plan due 30 March 2023

SUSTAINABILITY & PARTNERSHIPS

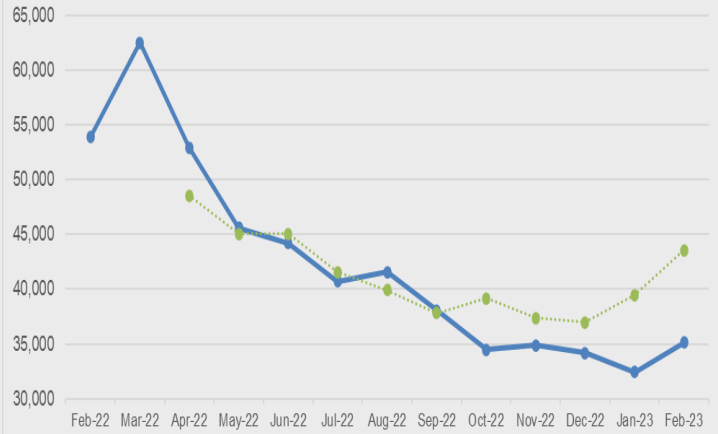
Delivered Against Plan

Actual Plan

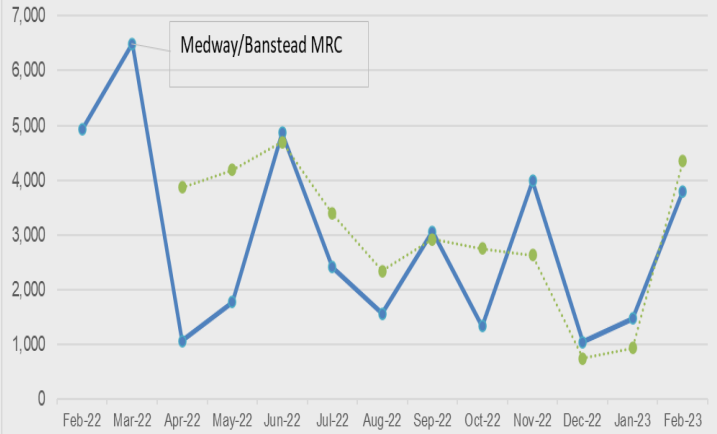
Income £000s



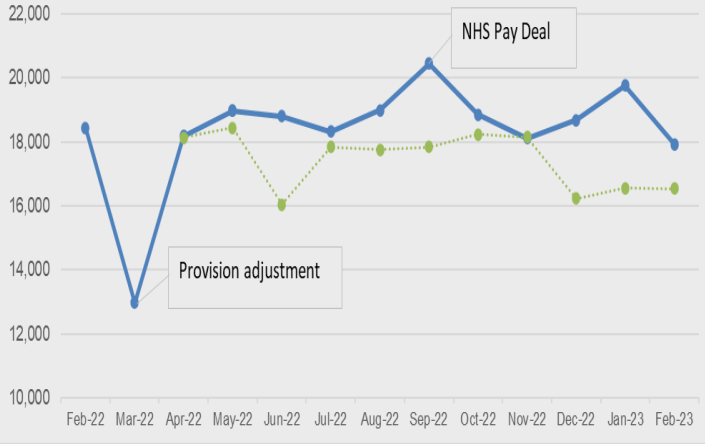
Cash £000s



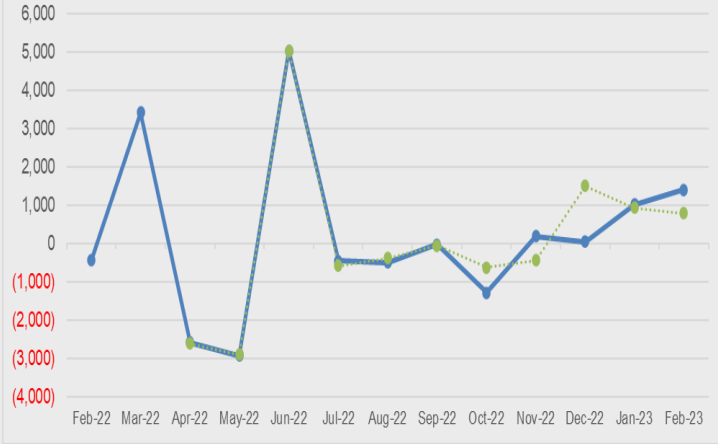
Capital Expenditure £000s



Pay £000s



Reported Surplus / (Deficit) £000s



Summary

The Trust's financial performance (surplus/deficit) for the 11 months to 28 February 2023 was £0.7m 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 £8.5m from the delay of receipts from commissioners as part of their contract commitments, This was confirmed as received in March 2023.
- Capital is below plan by £6.4m from the delays in the Medway MRC build and processing 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

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	09-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Improvement Journey - Executive Summary to the Board
Strategic Goal	**All**
Lead Director	David Ruiz-Celada, Executive Director for Planning and Business Development
Author(s)	Matt Webb, Associate Director of Strategic Partnerships & System Engagement David Ruiz-Celada, Executive Director for Planning and Business Development
Primary Board Papers	BAF Risk 257

This report covers updates to the Board Assurance Framework (BAF) risk and compliance requirements at the Trust during the period of February and March 2023. The BAF risk (ID: 257) remains scored as 12, but the factors impacting the score have changed since the last report in February.

It was agreed during March's System Assurance Meeting (SAM) that the BAF would be updated to ensure the Board's cycle of business aligns with the Trust's 2023/24 annual plan and Improvement Journey deliverables. The Trust has 61 requirements to demonstrate compliance against a combination of CQC must-do (15), should-do (27) and Recovery Support Programme (RSP) exit (19) requirements. Throughout the next quarter (Q1 2023/24), the objective is to evidence significant progress and compliance against the 15 must-do requirements.

The Improvement Journey registry has been reviewed and updated in full to ensure alignment with the Improvement Journey Framework and 2023/24 priorities. Deep dives have been completed for all four Improvement Journey programmes, with each reviewing their respective programme's CQC must-do and RSP exit requirements. Attended by each programme's executive and delivery leads, Improvement Journey Portfolio Team, and members of the Senior Management Group (SMG), impact metrics, supporting evidence requirements, and quarterly milestones up to Q3 (2023/24) were agreed on. The People & Culture and Quality Improvement programmes remain the greatest areas of focus.

As part of the transition of the Improvement Journey delivery into existing governance, day-to-day oversight of key improvement work has now transferred to existing Trust governance groups, with strategic oversight of overall progress remaining with the Improvement Journey Steering Group (IJSG). The IJSG scope and terms of reference were updated during March 2023, and this is now attended weekly by all lead executives. A forward schedule of topics aligned with the Improvement Journey Regulatory Requirement registry has been outlined, which will offer executive and delivery leads an opportunity to update and report on the progress of quarterly plans, highlight concerns, and review timelines and areas of focus for the approaching quarter, ensuring these are accurate and achievable.

The Board has received the draft Trust annual objectives, which are aligned with the Improvement Journey regulatory requirements and supported by KPIs and targets. Following the Leadership Team workshop on the 21st of March to consider the approach to developing a new long-term strategy, the recommendation from the group was to progress from April 2023 with a procurement process to identify a strategic partner to support the Trust in managing the engagement, consultation with our people, patients and partners, and structuring of a new strategy that will bring together our long-term ambitions to address our quality of care, performance, cultural and sustainability challenges.

The greatest risk remains the approach taken to monitor and evaluate the impact of the Improvement Journey action plans on our staff and patients, and how the Trust will ensure effective surveillance of regulatory requirements through the Quality Compliance and Quality & Performance Management frameworks moving forward.

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

Improvement Journey – April (2023) Board Report

Portfolio overview

Portfolio name: Improvement Journey	**Overall portfolio status:**	
	Forecast status with actions completed by the next reporting period:	
Accountable executive: Executive Director of Planning & Business Development	**Oversight:** Trust Board	
Start date: 30th June 2022 (Approval at Board)	**Projected completion date:** N/A	
Update date: 6th April 2023	**Next update due:** 1st June 2023	
Author/s: David Ruiz-Celada, Executive Director for Planning & Business Development Matt Webb, Associate Director of Strategic Partnerships		

1. Background and portfolio aim and objectives

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

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

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

1.3. The objectives for each programme were initially defined by the immediate need to address Section 29A warning notices issued to the Trust by the CQC, and the associated "must-do" (MD) and "should-do" (SD) actions outlined within the inspection reports in June and October 2022. The Section 29A warning notices expired in November 2022, with the CQC confirming satisfaction with the Trust's progress against these during their recent visit in February 2023.

1.4. In addition to this, on 14 June 2022, the Trust formally entered the national NHS England Recovery Support Programme (RSP), provided to all trusts and integrated care boards (ICBs) in segment 4 of the NHS Oversight Framework (2022). As a result of this, the Trust has been allocated an Improvement Director and is required to meet a set of "RSP Exit Criteria" (Appendix 1).

1.5. Lastly, the Board commissioned RSM UK (provider of audit, tax and consulting services) to conduct a review of the governance arrangements put in place by the Trust to assure

progress against the Improvement Journey. As a result of this review, 11 "RSM considerations" were made (Appendix 2).

1.6. As part of the transition of the Improvement Journey delivery into existing governance, day-to-day oversight of key improvement works has now transferred to existing Trust governance groups, with strategic oversight of overall progress remaining with the Improvement Journey Steering Group. The Improvement Journey Steering Group scope and terms of reference were updated during March 2023, and this is now attended weekly by all lead executives, the Company Secretary, the Head of Communications and the NHSE Improvement Director.

1.7. Co-chaired by the Director of Quality & Nursing and Director of Planning, a forward schedule of topics aligned with the *Improvement Journey Regulatory Requirement registry* milestone plan has been outlined. This forum is not a substitute for the individual Improvement Journey programme and working group meetings but an opportunity for the executive and delivery leads to provide an update and report against the progress of the quarterly plans within the registry, highlight concerns and review timelines and areas of focus for the approaching quarter, ensuring these are accurate and achievable.

1.8. As the Trust-wide approach to continuous improvement and strategic priorities is finalised for 2023/24, Trust recovery initiatives will continue to be facilitated through this framework. It is expected that this will be superseded by the Quality Assurance and Continuous Improvement frameworks during 2023/24, with clear alignment to corporate and BAF risks.

1.9. The Trust has now commenced the transitional period focused on implementing and developing a "Patient-to-Board" approach to continuous improvement, ensuring anybody across SECAmb can be a part of our Improvement Journey. Notably, this will start in Q1 (2022/23) with the implementation of the Quality & Performance Management Framework, which will provide a more effective and direct route for the escalation of risks and issues impacting the quality of care from the dispatch desk level to ICS and trust-wide.

2. Summary since the last report (Board Report – February 2023 (reporting on 20.03.23))

2.1. People & Culture

2.1.1. The Trust is progressing with the development of a new People and Culture Strategy, supported by Caroline Haynes, Chief People Officer for Sussex Community Foundation Trust, with a final draft due to be shared with the Board in April 2023. Caroline will be hosting seven engagement sessions throughout March 2023 for staff to contribute to and inform this strategy. The first strategy workshop was undertaken with the Leadership Team on the 15th of March.

2.1.2. As agreed with CQC and the Board in February 2023, the purpose of the People Strategy is to outline the Trust's strategic ambition and priorities to deliver high quality, continuously improving, compassionate care, improving the health and wellbeing of staff and leading to better health outcomes for patients.

2.1.3. Concerns have been raised regarding the Trust's ability to adequately describe the intention, objectives, and outcomes to be achieved through the NHSE Culture & Leadership Programme. Consequently, whilst the People and Culture Strategy is developed, the focus on the culture improvement programme has been EOC where the indicators for poor culture are highest due to the proportion of ER cases, speak-up concerns and higher attrition and sickness.

2.1.4. A deep-dive into the CQC must-do and RSP exit requirements allocated to the People & Culture programme was also undertaken on 1st March, attended by the programme's executive and delivery leads, Improvement Journey Portfolio Team, and members of SMG where impact metrics, supporting evidence requirements and quarterly milestones up to Q3 (2023/24) were agreed on.

2.1.5. The Trust has received the detailed 2022/23 NHS Staff Survey results and discussions are ongoing amongst the Executive Management Board to agree on a subsequent approach to results engagement and dissemination, and the development of organisational and local action plans, which will inform the People and Culture Strategy and People & Culture objectives for 2023/24.

2.1.6. The recently appointed Programme Director (Culture Transformation), Dr. Tina Ivanov, started with the Trust on 8th March 2023 and will be leading a full review of ongoing culture activities, the NHS Staff Survey results, and prioritising delivery of the People and Culture Strategy throughout 2023/24 once ratified by the Board in June 2023.

2.1.7. A new Cultural Dashboard has been developed to support oversight of the People Strategy and associated priorities. This dashboard has received initial good feedback, however further changes are anticipated as it gets aligned to the culture programme and the inclusion of the NHS Staff Survey results and agreement on the regular reporting schema.

2.1.8. Over 472 managers have now completed the Sexual Safety workshops. There have been 7 cohorts of 12-14 people each on the first-line managers' Fundamentals leadership development programme, with a total of 101 managers having attended this programme.

2.1.9. Looking ahead to Q1 (2023/24), the Trust will be agreeing on the final workforce plan for 2023/24 with commissioners, briefing local leadership teams on their respective workforce establishment and escalating workforce concerns through the newly developed Quality & Performance Management Framework. Additionally, the 2023/24 training plan is scheduled to be developed and approved by the EMB, following recommendation by the Education & Training Delivery Group.

2.1.10. In terms of key risks, the Trust continues to operate at a sustained level of high operational pressure, leading to challenged recruitment with increased staff turnover and sickness, further impacted by ongoing industrial action. (Risk ID 348 – Culture & Leadership and Risk ID 14 – Operating Model). Additionally, Employee Relations (ER) case numbers continue to rise, with a business case outlining additional capacity requirements scheduled for EMB review on the 29th of March 2023.

2.1.11. The Board will receive a draft Communications and Engagement Strategy following the work done in conjunction with Hood and Woolf during Q4 of 22/23. The adoption of the 23/24 communications plan will be aligned with the key strategic themes arising from the Trust Priorities and 5 proactive campaigns will be identified to support the strategic narrative of the Improvement Journey. This will include the development of a new Trust-wide strategy following expiry of the 2017-2022 strategy and will be used as a primary mechanism for engagement with our people, partners, and patients in 23/24.

2.1.12. Further assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) Completion of a People and Culture Strategy. (+) Draft Culture and HR Performance Dashboards presented at Leadership and SMG groups. (+) Programme Director in place for this workstream, which has been a gap up to now. (+) Year-on-year sickness has improved by 3% from 11% to 8% trust wide.	(-) Mean case length and case volume for ER has continued to worsen due to demand and capacity issues. (-) Staff survey results have shown a deterioration vs 21/22 results.	A29 – Board to seek further assurance on how the People and Culture Strategy will be disseminated and shared with staff, in particular the plans for 23/24, alignment with the Staff Survey results, and how staff will be involved in implementation of the strategy and improvement plans. A30 – Board to seek assurance on the mitigation plans to address the higher ER case length and associated improvement trajectories.

2.2. Quality Improvement

2.2.1. The Quality Improvement Group (QIG) last met on 21st February 2023; however, this meeting was not quorate due to the impacts of industrial action. Meetings planned for the 7th and 10th of March were deferred to April 2023 due to quoracy and engagement limitations, which remains a programme risk and has been reported to the Executive Director of Quality & Nursing. However, a deep-dive into the CQC must-do and RSP exit requirements allocated to the Quality Improvement programme was

undertaken on the 9th of March, attended by the programme's executive and delivery leads, Improvement Journey Portfolio Team, and members of SMG where impact metrics, supporting evidence requirements and quarterly milestones up to Q3 (2023/24) were agreed on.

2.2.2. Work is underway, led by the Associate Director of Strategic Partnerships, Deputy Director of Quality & Nursing and Deputy Director of Operations, to align the existing quality governance structure with the external integrated care board governance and reporting mechanisms. The Leadership Team has supported this approach, with the Quality & Performance Management Framework to be used to report on performance and quality minimum datasets by integrated care system footprints. We are working closely with our lead ICB colleagues on this as part of the overall partnerships' governance review, including a forward plan to 23/24 to align external scrutiny cycle of business with the Board's internal approved priorities (following Board on the 6th of April).

2.2.3. A working group has been established to determine mechanisms which provide assurance that staff had read and understood any changes to policies and national guidance. The next working group meeting is scheduled for the 3rd of April 2023, with scoping continuing around compliance, monitoring processes and agreement on reportable progress metrics. An assessment of existing policies is underway and is due to be completed by the 31st of March 2023.

2.2.4. Work is continuing to develop an internal Quality Compliance Framework that will monitor and provide Board assurance on the effectiveness of systems, processes, and quality governance in accordance with the fundamental standards of care. The mapping of existing and anticipated future Trust compliance and regulatory requirements is underway, with a proposed model for supportive announced and unannounced quality assurance (QA) visits to assess and monitor local progress being socialised with leadership teams across service delivery functions. The first announced internal QA visits have been scheduled for April 2023, with post-event review clinics currently being arranged with key stakeholders. This will be aligned to the CQC 5 Domains and future "We" statements anticipated as part of the new inspection framework the regulator will adopt later in the year.

2.2.5. The Trust has commenced the *Introduction to QI* training sessions, with three of these being delivered for all grades of staff from different areas of the organisation throughout February and March 2023. This training is designed for all colleagues to collectively learn about QI methodology, the importance of measurement in improvement, adopting a data-driven and customer-focused approach, and how QI can be applied within everyday roles. These initial sessions, each attended by circa 30 volunteers, have received positive feedback, with colleagues acknowledging the proposed approach as 'more proactive', 'empowering' and 'less restrictive'.

2.2.6. To support and enable the Trust's overarching approach to sustainable continuous improvement, the Quality & Nursing directorate is currently recruiting four QI-focused roles, supported by a questionnaire disseminated to all staff to benchmark the organisational understanding of QI and areas for development.

2.2.7. Metrics concerning End of Life Care (EoLC) calls have been defined, with targets proposed by the EoLC team. The ability to report on these is subject to data collation changes within the ePCR, which will enable more accurate reporting on unanticipated EoLC activity.

2.2.8. Formal planning to ensure readiness for the introduction of the Patient Safety Incident Response Framework (PSIRF) in September 2023 is ongoing, which will be supported by a newly appointed PSIRF Implementation Lead.

2.2.9. In terms of key risks, the programme has highlighted that the timely review of risks in accordance with Trust policy may become challenged once the high-level director input stops post-CQC improvement. The Improvement Journey Portfolio Team, Risk & Incident Lead and Head of Quality & CQC Compliance, supported by the Trust's NHSE Improvement Director, are currently mapping corporate and BAF risks against the updated *Improvement Journey Regulatory Requirements registry*.

2.2.10. Further assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) Training sessions for QI underway. (+) SI and incidents trajectory for breaches and actions as reported on the IQR.	(-) Lack of a written process for the internal Quality Assurance framework and how it will work in conjunction with the Quality and Performance Management Framework to provide effective evaluation of impact of the improvement plan on patient safety, patient experience, and staff experience.	A31 – Board to receive assurances through QPSC on the new Quality Assurance Framework and Quality and Performance Management Framework on the progress for implementation and expectations for assurance reports from both initiatives to Board.

2.3. Responsive Care

2.3.1. In light of current operational pressures, industrial action and implementation of the new joint operational site within Medway, a prioritisation exercise was undertaken by the Responsible Care executive and delivery leads in February (2023) and as a result, the programme is currently concentrating on its CQC must-do requirements, centred around vehicle and blood glucose monitoring equipment.

2.3.2. An EPRR Support Coordinator role has been recruited to ensure specialist operations vehicles are well-maintained and will also support the Fleet Operations & Logistics function in developing a resilient mechanism and associated standard operating procedure to manage all vehicle equipment through effective asset management. This will include a comprehensive review of existing asset management systems trust-wide, i.e., D4H and Key2, currently utilised for NARU and SECAmb field operations respectively, considering compatibility, usability, effectiveness, and opportunities for financial efficiencies.

2.3.3. Key impact metrics are currently under development to ensure effective monitoring of vehicle and equipment effectiveness, together with a series of assurance activities presently being scheduled for the Trust's Resilience & Specialist Operations function throughout 2023/24. These include NARU and NHSE assurance visits in April and June (2023) respectively, supported by internal quality compliance visits as determined by the Quality Compliance Framework (see Quality Improvement programme update above).

2.3.4. With regards to the requirement for all blood glucose monitors to be calibrated in line with manufacturer's guidelines, 400 devices, from an estimated 900 devices, have now been standardised and registered on the Key2 asset management system and subsequently redistributed to patient-facing vehicles trust-wide. Additionally, an associated standard operating procedure outlining the process for the registering, testing and distribution of blood glucose devices has been developed and is currently being consulted on with Make Ready Centre operatives prior to ratification; this includes devices being rotated and checked on a 12-weekly basis.

2.3.5. Key impact metrics to monitor blood glucose devices, including calibration effectiveness and defects, have been proposed by the Fleet Operations & Logistics team, with data being obtained directly from Key2. Additionally, added assurance will be sought from local managers reporting through the Operations directorate governance mechanisms together with the Quality Compliance Framework.

Positive assurance	Gaps	Recommended Board Actions
	(-) Route for assurance of progress against actions due to responsive care group focussed on efficiency and delivery of Medway, which is not aligned to MD and RSP priorities,	A32 – Board to receive assurance on the improvements made aligned to MD12 and MD13 through FIC at the end of Q1.

2.4. Sustainability & Partnerships

2.4.1. The Board has received its draft annual objectives supported by KPIs and targets at the meeting on the 6th of April 2023.

2.4.2. The Leadership team meeting held a workshop on the 21st of March to discuss the approach to developing a new long-term strategy. The recommendation from the group was to progress from April with a procurement process to identify a strategic partner to help us manage the engagement, consultation internally and externally, and structuring of a new strategy that will bring together our long-term ambitions to address our quality of care, performance, cultural and sustainability challenges. The process will start in April to coincide with the arrival of the new substantive CEO.

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

2.4.4. The Leadership Team reviewed the recently published NHSE *Delivery plan for recovering urgent and emergency care services* during February and March (2023) as part of the strategic priority setting for 2023/24. This two-year plan aims to stabilise services to meet the NHS's two major recovery ambitions - to help achieve A&E four-hour performance of 76% by March 2024 and to improve category two ambulance response times to an average of 30 minutes over the next year, with further improvement in 2024/25 towards pre-pandemic levels.

2.4.5. Priority UEC recovery focus areas are being led by members of the Strategic Partnerships, Senior Operations Leadership, Consultant Paramedic, and wider Leadership teams. These include increasing capacity through greater utilisation of appropriate non-ED pathways (i.e., Urgent Community Response services) and a subsequent reduction in unnecessary conveyance, increasing the clinical assessment of calls (including category two segmentation), reducing sickness and other staff absence, considering additional workforce gap mitigations, and enhancing clinician access to mental health expertise. Key impact metrics to demonstrate how the Trust is working collaboratively to address these areas with system partners and to ensure effectual monitoring are currently under development and will be reported on during the next Board meeting.

Positive assurance	Gaps	Recommended Board Actions
(+) Board internal well-led review and associated Development Plan (+) Annual priorities and plan for the Trust for 23/24	(-) BAF is still not reflective of the risks in a specific enough way that focusses on staff experience, and patient safety against the strategic aims of the organisation.	A33 – BAF to be refreshed to align to the annual priorities developed by the Board and approved at the April Board A34 – Board to agree approach and initial framing of the development of a new long-term Strategy for SECAmb

3. Progress report against target evidence

3.1. Progress against each must-do and RSP can be found in the section 4 below.

3.2. Following the Deep Dives, each requirement has either a final or draft set of KPIs and deliverables with quarterly milestones through 23/24 that we will use to report against as a baseline and highlight areas of risk.

Positive assurance	Gaps	Recommended Board Actions
(+) Improvement Journey plan aligns to Annual Plan for 23/24 with clear deliverables, KPIs and quarterly targets	(-) Programme resourcing to oversee delivery remains challenged due to not being substantive. (-) Evaluation of impact of the actions has not been evident thus far within the programme.	A35 – Board committees to be aligned as part of the cycle of business for 23/24 to the quarterly plans, and utilise the agreed KPIs to evaluate impact of actions taken. A36 – Model for delivery and oversight of change needs to be agreed to support long-term transformation aspirations.

4. Progress against must-do requirements

Overall progress against MD	

MD ref.	Requirement description - The trust must:	Programme	Progress statement	KPI target status	Progress against current quarter's milestone
MD1	Ensure all staff complete mandatory, safeguarding and any additional role-specific training in line with the trust target.	PCG	[MD1] The proposed training and development programme for the Operations Directorate presented to and supported by the Leadership Team in March 2023.	All improving / maintaining	Amber
MD2	Improve the culture and ensure all staff are actively encouraged to raise concerns and improve the quality of care.	PCG	[MD2] The People & Culture Strategy is under development, including a series of stakeholder engagment sessions held though March to contribute to the strategy. The final strategy draft is to be presented to the Board in early April 2023.	Metric under development (overdue)	Green
MD3	Ensure it takes staff concerns seriously and takes demonstrable action to address their concerns.	PCG	[MD3] The monthly People & Culture report to SMG has commenced, providing updates against key metrics and highlighting the top 3 areas of concern together with remedial actions being taken. The ER additional capacity business case is progressing through Trust governance process.	No improvement / >½ declining	Green
MD4	Ensure that all incident investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly to improve safety and quality of the service.	QIG	[MD4] Monthly risk and incident reporting to EMB is in place, with papers and management responses reviewed at QPSC and regular risk & incident reporting reviewed at the Audit Committee. Weekly directorate breach reporting is in place, with regular follow-up and reviews at incident working groups.	All improving / maintaining	Green
MD5	Ensure it works collaboratively with system partners to improve category 2, 3, and 4 response times.	SPG	[MD5] Priority UEC recovery focus areas have been identified, including increasing capacity through greater utilisation of appropriate non-ED pathways and a subsequent reduction in unnecessary conveyance, the clinical assessment of calls and reducing sickness and other staff absence. Key impact metrics are currently under development with system partners and will be reported on during June's Board meeting.	Metric under development (not due)	Green
MD6	Ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided.	QIG	[MD6] Work is underway to align the Trust quality governnace with its four ICBs, considering minimum datasets, representation, reporting requirements and escalation routes.	Metric under development (overdue)	Green
MD7	Ensure it seeks and acts on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving services.	QIG	[MD7] QI training is continuing with all planned sessions fully booked. Recruitment to the QI Team is in progress (comprising the QI facilitator, Project Support Officer and Head of QI roles).	Not applicable	Green
MD8	Collect and analyse the End of Life (EoL) calls and share the analysis with ICS stakeholders, with the objective of reducing the needs for unanticipated EoL care by emergency and urgent care services.	QIG	[MD8] End of Life Care metrics have been defined and are in development with the BI team. Stakeholder and forum mapping is currently being scheduled.	All improving / maintaining	Amber

MD9	Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform their role.	PCG	[MD9] Seven cohorts (101 managers) of first line managers have completed the Fundementals Development programme. The proposed training and development programme for the Operations Directorate presented to and supported by the Leadership Team in March 2023.	All improving / maintaining	Amber
MD10	Ensure there is a mechanism to provide assurance that staff had read and understood any changes to policies and national guidance.	QIG	[MD10] Working group meeting scheduled for 3rd April 2023. Metrics to be defined by the working group and added to IQR. An assessment of current policies is underway to establish monitoring for assurance purposes.	Metric under development (not due)	Green
MD11	Ensure that staff administering medicines under a patient group directive have the required training and competency.	QIG	[MD11] A PGD training bulletin was issued trust wide at the end of February 2023, with uptake monitoring ongoing.	Metric under development (not due)	Green
MD12	Ensure that blood glucose monitors are calibrated in line with manufacturer's guidelines.	RCG	[MD12] Blood glucose devices are being recalled in batches for testing and added to the electronic asset management system. A standard operating process is under development and planned for approval through internal governance.	Metric under development (not due)	Amber
MD13	Ensure that vehicle equipment used by the service provider is fit for use and accurately accounted for through an up-to-date asset register for the service.	RCG	[MD13] An EPRR Support Coordinator has been recruited to ensure specialist operations vehicles are well-maintained. A comprehensive review of existing asset management systems is ongoing with recommendations to be returned to the Operations Support Group.	Metric under development (not due)	Green
MD14	Ensure that effective systems and processes to ensure good governance in accordance with the fundamental standards of care.	QIG	[MD14] Mapping of the Trust compliance/regulatory requirements is underway, including alignment to relevant governance groups. The proposed CQC QA model is currently being socialised with Operations, with two day announced visits sceduled from April 2023.	Metric under development (not due)	Green
MD15	Ensure that enough numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.	PCG	[MD15] A clear 2023/24 workforce plan has been developed, with key principles identified, and funding discussions are in progress with commissioners. A single report has been developed to monitor progress agsinst the plan through weekly compliance meetings. The aim is to embed the workforce report within the Quality & Performance Management Framework.	No improvement / >½ declining	Amber

5. Progress against RSP Exit criteria - see appendix 1 for descriptions.

5.1. The Improvement Journey Portfolio Team reviewed all outstanding RSP exit criteria during February and March (2023), determining and examining how these will be progressed by the September 2023 deadline.

5.2. Whilst the current Improvement Journey priority is the achievement of and demonstrating significant process against the CQC must-do requirements, considerable progress has been noted in relation to the leadership and governance, communications, and engagement RSP Exit criteria.

5.3. Of the 19 RSP Exit criteria, twelve actions are on-track and five are delayed with outstanding milestones considered achievable prior to the deadline.

Overall progress against RSP	

RSP ref.	Requirement description - The trust must:	Programme	Progress statement	KPI target status	Progress against current quarter's milestone
RSP-L1	Interim CEO appointed and the Trust's Board-level leadership seen as stable.	SPG	[RSP-L1] Substantive Chief Executive appointed and commencing with the Trust on 24th April 2023.	Not applicable	Green
RSP-L2	Clear lines of responsibility and accountability for individual executives.	SPG	[RSP-L2] A review of executive accountabilities is on-going with recommendations scheduled for EMB approval.	Not applicable	Green
RSP-L3	Trust Board sighted on all key risks through an effective Board Assurance Framework and improved quality reporting aligned to the BAF and the comprehensive improvement plans.	QIG	[RSP-L3] Following a series of workshops to develop the 2023/24 strategic priorties, the Board have received the final draft annual objectives, including supporting KPI's and targets, planned for review on 6th April 2023.	Not applicable	Green
RSP-L4	Trust F2SU policy/process has received board assurance and oversight and has been appropriately resourced.	PCG	[RSP-L4] A new cultural dashboard is in development that will support the EMB and Board in regularly reviewing FTSU themes, trends and escalations.	Not applicable	Green
RSP-L5	Improved communication and engagement channels between the frontline and the Board, inclusive of routes of escalation for risks and concerns.	PCG	[RSP-L5] Monthly leadership visit (thematic analysis) reports have commenced and are shared with the Leadership Team.	Metric under development (not due)	Green
RSP-L7	External Well-Led review co-commissioned and all key recommendations acted on effectively.	QIG	[RSP-L7] The Board conducted its first review of the internal well-led self-assessment and gaps identified will be used to shape the 2023/24 Board Development programme.	Not applicable	Green
RSP-L8	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	SPG	[RSP-L8] The 2023/24 Board Development programme has been developed and is to be considered by the Board on 6th April 2023.	Not applicable	Green

RSP-L9	CQC reinspection has taken place and significant improvement found against all Warning Notice and Must Do findings/recommendations.	QIG	[RSP-L9] Scoping of the Quality Compliance Framework has commenced, with an overview provided to the Improvement Journey Steering Group. The proposal is scheduled for formal presentation to EMB in April 2023.	Not applicable	Green
RSP-F1	Comprehensive financial sustainability plan in place supported by diagnostic of deficit drivers, Quality Impact Assessment, robust efficiency plans and agreed levels of ICS investment.	SPG	[RSP-F1] TBC. MS to provide verbal update.	Metric under development (not due)	Amber
RSP-F2	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.	SPG	[RSP-F2] TBC. MS to provide verbal update.	Not applicable	Amber
RSP-F3	Trust can evidence delivery of financial trajectories for at least two most recent quarters.	SPG	[RSP-F3] TBC. MS to provide verbal update.	Not applicable	Amber
RSP-P1	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	PCG	[RSP-P1] The detailed 2022/23 NHS Staff Survey results have been received. EMB discussions are ongoing to agree on a subsequent approach to results engagement and the development of organisational and local action plans.	Metric under development (not due)	Green
RSP-P2	Workforce plan developed to address capacity gaps in 111 and 999 services with evidence of delivery against agreed recruitment trajectories. Subject to funding and signed contracts to support required levels of resources.	PCG	[RSP-P2] See MD15 for progress.	Metric under development (overdue)	Amber
RSP-P3	Trust career development and career pathways strengthened in line with the Board-approved clinical education strategy.	PCG	[RSP-P3] See MD1 for progress.	Not applicable	Green
RSP-P4	Trust not an outlier with ambulance service peers for staff retention or sickness absence.	PCG	[RSP-P4] A new cultural dashboard is in development that will support the EMB and Board in regularly reviewing sickness and retention metrics/trends against trajectories.	All improving / maintaining	Green
RSP-P5	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	PCG	[RSP-P5] A new cultural dashboard is in development that will support the EMB and Board in regularly reviewing themes, trends and escalations concerning grievances, whistleblowing/FTSU and exit interviews.	Not applicable	Green
RSP-Q2	Improved Board oversight and clarity on safety and quality metrics, ensuring there is good triangulation between demand and capacity issues driving ARP challenges, and the impact on patients and staff.	QIG	[RSP-Q2] The Quality & Performance (patient-to-board reporting) Framework is underdevelopment, with a formal proposal scheduled for EMB approval.	Not applicable	Green

6. Improvement Journey Risks, Issues, and Interdependencies

						Pre mitigated (Gross Score)						Post mitigated (Target Score)		
Risk ID	Domain	Risk Impact Category	Risk Title (short title)	Risk Cause and Effect (What might happen? What is the expected impact?)	Risk Owner	Impact (1-5)	Likelihood (1-5)	Overall Severity (1-25)	Risk response	Mitigations Action (risk manager and due date for each action)	Next Review Due Date	Impact (1-5)	Likelihood (1-5)	Overall Severity (1-25)
R7	Portfolio	Quality People Reputation	Communications & Engagement	There is no formalised mechanism to penetrate messages through the organisation which could impact the IJ's effectiveness in reaching all staff members. This is directly linked to the BAF risk in that the Trust will not be able to demonstrate significant improvement against the areas highlighted by the CQC in the warning notices and must-dos, which could lead to further reputational damage and/or regulatory action.	Janine Compton	5	4	20	Treat	Implementation of an adapted engagement approach and digital community platform. Following Hood & Woolf initial findings report the consultancy have also been supported the Trust in developing an internal Communication & Engagment strategy and delivery plan which is due for Board approval Q4 (2022/23).	20/04/2023	5	3	15
R2	Portfolio	Schedule Quality	Demand	Due to operational demand or unforeseen service pressures, including the continuing industrial action, some portfolio delivery timeframes could be impacted.	All SROs	4	4	16	Tolerate	Weekly Improvement Steering Group meetings are in place to gain assurance of delivery of the MD/RSP criteria. Programme Delivery Leads ensure ongoing assessment of unforeseen risks or issues and identification of appropriate controls and mitigations, with direct escalation to IJSG and subsequently onto EMB as required. A fortnightly review of operational pressures is incorporated within the Joint Leadership Team meetings, considering any impact on the Trust's Improvement Journey.	20/04/2023	4	2	8
R3	Portfolio	Schedule Quality	Timeframes	Due to tight timeframes for delivery and lack of project resource continuity, some milestones could be delayed.	All SROs	4	4	16	Tolerate	Weekly Improvement Steering Group meetings are in place to gain assurance of delivery of the MD/RSP criteria. Programme Delivery Leads ensure ongoing assessment of deadlines and progress. A monthly Trust Board report provides level 1 and 2 summaries and programme progress against must do's. There are identified delivery leads for each programme currently in palce.	20/04/2023	4	2	8

R9	Portfolio	Schedule Quality	Delivery	Current mechanisms to delivery the Improvement Journey are working against the programme, which could impact the success of the longer term aim.	David Ruiz-Celeda	5	4	20	Treat	The transition from the regulatory-driven warning notice phase to addressing the must-do and RSP criteria to a more strategically driven approach is being embedded. For the longer-term phase of delivering sustainable continuous improvement the approach has been defined and the requirements registry has been developed, mapping the remaining regulatory requirements across the programmes and the associated BAU structures . The terms of reference for the Improvement Journey Steering Group have been amended to the governance and assurance requirements of the new approach. Executive agreement to the new approach was received 15 March and the first Steering Group meeting held 22 March, monitoring the impact of this approach as it embeds will be undertaken by the IJ Portfolio team.	20/04/2023	3	3	9
R10	Portfolio	Finance	Funding	There is uncertainty regarding continuation of external (NHSE) funding to support the Improvement Journey beyond March 2023.	David Ruiz-Celeda	4	4	16	Treat	Identification of the funding requirements for 2023/24 has been undertaken, revieiwed by Finance and submitted to the NHSE Improvement Director for onward submission and approval by the NHSE regional team.	20/04/2023	4	3	12
R11	Portfolio	People	Delivery Resource	Resourcing and skills gaps are foreseen and identified as the Improvement Journey transitions beyond the initial compliance-driven phase to a continuous improvement approach, which could impact progress and delivery.	David Ruiz-Celeda	4	4	16	Treat	Outcomes of Programme mapping undertaken against Must-Do and RSP exit criteria,are informing development of continuous improvement framework. Improvement Journey delivery leads, Deputy Director of QI and Associate Director of Strategic Partnerships are progressing plans to ensure continuity of the Improvement Journey. Delivery leads are supporting portfolio progress.	20/04/2023	4	3	12

Appendices (updated 30.03.2023)

Appendix 1 - Improvement Journey

Appendix 2 - RSM internal audit recomm

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	10-23

Name of meeting	Trust Board
Date	06 April 2023
Name of paper	Keeping Patients Safe - Executive Summary to the Board
Trust Priority Area	**Delivering Quality / Keeping Patients Safe**
Author / Lead Director	Robert Nicholls, Executive Director of Quality & Nursing Dr Rachel Oaten, Chief Medical Officer
Primary Board Papers	BAF Risks 14, 255 & 256 Improvement Journey Integrated Quality Report slides 7-20 inclusive.

Risk:

Overview of the Governance around Risk Monitoring

The governance and reporting structures around risk management and monitoring across the organisation has been strengthened over the past year, recognising that the next phase is to embed this culture further down the ranks of the organisation. These structures are outlined below:

- Board committees receive a regular update on material changes to the Corporate Risk Register and draw to the attention of the board committees of significant risks on the register. The frequency is clearly set out within the annual board committee schedule.

- The Audit and Risk Committee receive this regular assurance report on the effectiveness of risk management systems and the frequency is determined within the annual board committee schedule.

- The Risk Assurance Group (RAG) meets monthly and is chaired by the Deputy Director of Quality and Nursing. Members of RAG include Senior leaders from each Directorate as well as the Directorate Risk Leads who are in Business Support Manager roles. The purpose of RAG is to review and moderate the effective risk management of corporate risks and associated controls and mitigations in support of the SMG.

- Both Senior Management Group (SMG) and the Executive Management Board (EMB) receive a monthly risk report to draw to their attention significant risks and risk movement on the corporate risk register. The corporate risk register includes risks rated high (12+) and extreme risks (15+).

The Trust is progressing the risk journey to the point where Risk owners routinely review their risks within the frequency set out in policy, the frequency being determined by the risk score. Out of 203 risks currently in the risk register, 133 have been reviewed as required with 70 falling out of the timescales. This is a priority for the Trust and is addressed at RAG with Directorates and monitored holding Directorates to account to fulfil this requirement as set out in policy.

There are 13 risks that are rated extreme risks on the corporate risk register and referenced in Section E of BAF. Seven of the 13 risks are new risks to this register and since the last report risk 82 HART capacity was downgraded to a 12 rating and risk 36 Trend of poor identification of STEMIs by SECAmb clinicians was downgraded to a 9 rating

. The extreme risks are listed as follows:

ID	Risk Title	Current Risk Garding
17 (new)	Integration of 111 and EOC	**16**
28	Drug Seeking Behaviour via 111 Electronic Prescribing Service (EPS)	**15**
29	EPRR Incident Response	**16**
34	Sustainability in the Medicines Governance Team	**16**
136	Process of tagging medicines pouches is not working effectively	**15**
273	Industrial Action	**25**
304	SECAmb's Ability to reach the Net Zero Target set by NHS England	**15**
346 (new)	Handover Delays - Trust wide	**16**
348 (new)	Culture and Leadership	**16**
357 (new)	Delivery of the Clinical Education Strategy	**15**
361 (new)	Capacity of HR to resolve employee relations (ER) cases within timescales	**16**
364 (new)	HR Data Subject Access Requests	**16**
369 (new)	Guildford OU Estate	**15**

The Board is asked to note the following summary of Medicines Risks register review meeting held on 28th March 2023.

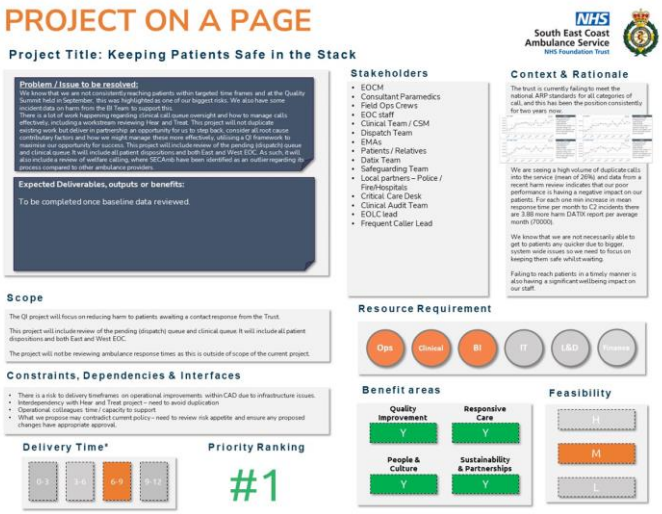
- **Medicines Distribution Centre (MDC)** – the medicines distribution unit at Paddock Wood MRC is insufficient in size to support the volume of activity now being processed through the unit. There is insufficient space to allow at times of high demand segregation between receipt and dispatch areas and processes to maintain control inbound/outbound goods are unmanageable. The risk is rated as 12 on the corporate risk register. A business case was developed that incorporate different options to resolve of mitigate the risks. The ambition is to resolve the risk completely by a move to a suitable premises to deliver full function of this service. This is a longer-term plan and further mitigations are in place. This includes moving the MDC to the ground floor at Paddock Wood. Due to the layout of the ground floor the Trust has employed contractors to develop a design for the area working closely with the Chief Pharmacist and Health and Safety Manager. It is estimated that a final design will be available in 6 to 8 weeks.

- **Drug Seeking Behaviour via 111 Electronic Prescribing Service (EPS)** - this is rated 15 on the corporate risk register. It refers to the lack of governance around identifying or flagging patients on Clinical Assessment Service (CAS) that seek out medications. The system relies solely on clinical staff recognising such patients or concerns identified through triaging the patient. The Chief Pharmacist is liaising with Cleric Computer services the company responsible for updating CAS. A review group of key stakeholders from across 111, Medical and Quality and nursing will meet in April 2023 to review this risk in more detail.

- **Sustainability in the Medicines Governance Team** – this is rated 15 on the corporate risk register. A business case was approved to increase the establishment in the pharmacy and MDC teams. Recruitment has been initiated and several staff in the MRC (the greatest increase in WTE) has been recruited. There is one specialist role (Medicines Safety Officer's role) that has not been successful, but recruitment continues. The Chief Pharmacist is working with system partners on opportunities around staff rotations programmes. It is envisaged that once staff are in post from June the risk rating will be reduced.

<u>Keeping Patients Safe in the Stack QI Project</u>

Following the Quality Summit (September 2022) and a thematic harm review of 3 years of patient safety incidents, a QI project commenced in January 2023 focused on the priority area identified as one of highest organisational risks, that of keeping patients safe in the clinical stack within EOC. The QI project utilises the DMAIC framework, Define, Measure, Analyse, Improve and Control, with a 'project on a page' dashboard to monitor progress and articulate risks to the project.



The high-level timelines being adhered to are:

- Define: Jan – Feb 2023
- Measure: Jan – April 2023
- Analyse (with benefits realisation inc financial): April – June 2023
- Improve: June (testing with PDSA cycles): June 2023 onwards
- Control: Sept – Oct 2023

<u>The IQR for Quality & Nursing highlights the following areas:</u>

- **Serious Incidents**

Improvement in the status of Serious incidents has been both maintained and progressed, currently only 4 SI investigations have breached their target date (a target no longer followed by ICB but maintained internally as a good standard measure), with a further 11 SI investigations underway and within timescale. There are 47 open SI actions, the backlog of SI actions being ONE (from 2021) with a robust monitoring process now in place to ensure further breaches do not occur.

- **Patient Safety Incident Response Framework (PSIRF)**

The process and culture around the incident management process will shift significantly over the next 2 years as we implement PSIRF**.** The Patient Safety Incident Response Plan (PSIRP) is developed with two approaches in mind, the identification of larger, themed investigations (the proactive approach) and the review and learning taken from regularly occurring incidents (reactive approach). Though the programme of work for this and to incorporate the launch of LFPSE (Learning from Patient Safety Events) are significant, their desired outcome and primary purpose relate specifically to positive engagement and partnerships with all staff and patients and their families, and the increased ability to extract learning leading to improved quality and patient safety.

- **Datix Incidents**

Overall, the number of Datix incidents reported month on month remains within a range of 300-350/week, circa 97.8% of these graded as no- or low-harm. At any one time there are on average 900 open incidents live on Datix (excluding L3 & L4 investigations).

Currently 23.8% (247) of all open incidents have breached the 45-day cycle. This is above the tolerance level of 20% as set by the Quality Improvement Group as an initial target for improvement. Of these 29 are graded as Low (minimal) harm, the remaining 218 graded as No Known Harm having incurred.

There are several corrective measures in place to reduce the number of breached datix incidents to below the current target of 20%.

- **Safeguarding**

Update on level 3 training for 2022/23:

In early 2022 the Trust's Executive Management Board agreed to suspend face to face Level 3 Safeguarding training because of the unprecedented operational demand caused by the Covid-19 pandemic. Outlined in the 2022 CQC report was the requirement to improve safeguarding training and to ensure that all staff complete mandatory safeguarding training in line with the trust target. During June 2022 agreement was reached with senior operational leaders to reintroduce the training across the Trust from September 22nd, 2022.

Commissioning requirements for Safeguarding expect a minimum 85% compliance across provider services. L3 training compliance at the beginning of September 2022 was at 55%. As such, the safeguarding team implemented several training days and worked closely with the operating unit managers to ensure that there was attendance. Monitoring of compliance was through the Quality Governance Group and Quality and Patient Safety Committee. As of 1st March 2023, a total of 1,878 clinicians out of a total of approximately 2,220 (85%) are in date with their L3 Safeguarding training.

- **Patient Experience**

The IQR for complaints response within the stipulated timeframe showed that the Trust was consistently not achieving the 95% target. In December 2022, the Board asked for further assurance in understanding the reasons for non-compliance and for corrective measures to be implemented. A report was presented to the Executive Management Board on the 29th of March 2023 and is on the agenda for QPSC scheduled for 13th April 2023. The following key actions are included in the report:

The Deputy Director for Quality Improvement led a mapping exercise that was completed in February 2023. The outcome of the exercise showed areas of inefficiencies in how the complaint

team were managing all complaints and concerns raised. Some areas have been addressed such as reorganising the capacity within the complaint team. There is now a substantive Complaint Manager leading the complaint process.

With some interventions already implemented and further actions planned, complaints as of the 22nd March 2023 was 93%. It is envisaged that the target of 95% of complaints being responded to in time will be achieved by May 2023.

Also, for noting, we have been recording **Compliments** on Datix since March 2017 and processed the highest monthly totals in January, 233 and February, 214 of this year.

- **Duty of Candour (DoC)**

The IQR shows variations in meeting the 100% DoC target in responding to patients or next of kin within the 10 day timeframe. The contributing factors linked to the variation include lack of information about the next of kin and delay in the Trust receiving information held by another organisation.

A review of the process around DoC will occur in Q1 of 2023/24 involving the ICB.

- **Violence and Aggression against staff**

Violence and aggression against our staff are high on the Trust's agenda and focus work is continuing to encourage staff to report incidents particularly in 111 and 999. The Trust is working towards developing a Violence and Aggression strategy to ensure it support our compliance with the NHS Violence Reduction Standards. A total of 134 and 115 incidents were reported in January and February 2023 respectively with verbal abuse, antisocial behaviour and staff assaults being the top 3 trends.

The Trust established a Violence Reduction working group that meets monthly to review the V&A data and progress made against several actions. Our Health & Safety group receives regular reports and Workforce and Wellbeing Committee receives assurances that progress is being made against the national standards.

- **Health & Safety Incidents**

RIDDOR

RIDDOR incidents reported in January 2023 were 13 with 10 reported within the statutory time frame to the Health and Safety Executive. The Trust reported 3 RIDDOR incidents late to the HSE which were due to staff not completing an incident report on time.

RIDDOR incidents reported in February 2023 were 8 with 6 reported within the statutory time frame to the Health and Safety Executive. The Trust reported 2 RIDDOR incidents late to the HSE which were due to staff not completing an incident report on time.

The Health and Safety Group requested further analysis of all reported incidents to identify themes and trends.

Improvement Journey:

QIG 1: All subgroup ToRs for groups that report to Quality Governance Group (QGG) have been reviewed and rewritten in line with the QIG. This was undertaken in Autumn 2022 for all groups.

QIG 5: The CQC medicines Must Do is relating to staff administering medicines under a patient group directive have the required training and competency. Thye Chief Pharmacist has implemented a number of actions to reduce the risks.

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

QIG2: Serious Incidents backlog is progressing well and have not shown an increase in backlog over quarter 2 to 4 2022/23. A review of the way in which investigations have been conducted and OUM's are now taking responsibility for appointing an investigation manager. We have also implemented a "buddy system" where investigators are aligned to a subject matter expert. This will improve the quality and timeliness of the investigation reports.

QIG 3: Risk management continues to progress. A new risk report was presented to the Audit Committee in March 2023. This report received positive feedback. A further iteration of the risk report to the Executive Management Board is underway and will be presented in April 2023. We have successfully recruited an experienced candidate to the Head of Risk position.

Recommendations, decisions or actions sought	1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area. 2. That the Board note the quality metrics and performance against this Trust Priority Area. 3. That the Board note progress made against the first QI programme on 'Keeping Patients Safe in the Stack'. 4. That the Board note the actions being undertaken to strengthen the risk management process. 5. That the Board is asked to note the sustained improvement in the SI actions and backlog. In addition, the improvement made in complaints responses and the plan to reach 95% compliance by May 2023

Agenda No	

Name of meeting	Trust Board
Date	6th April 2023
Name of paper	Patient Safety Incident Response Framework briefing and situation report
Responsible Executive	Rob Nicholls, Executive Director of Quality & Nursing
Author	Tam Moorcroft, Head of Patient Safety
Synopsis	This paper provides the Trust Board with an overview of the key differences between the outgoing Serious Incident Framework and the incoming Patient Safety Incident Response Framework (PSIRF). Also included is a status report on the inter-related workstreams; the Learning from Patient Safety Events (LPSE) and the Datix Cloud (DCIQ) development and.
Recommendations, decisions, or actions sought.	The Trust Board is asked to note the contents of the paper and appendices

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

Patient Safety Incident Response Framework (PSIRF)
briefing and situation report

1. Introduction

This paper provides the Trust Board with an introduction to the Patient Safety Incident Response Framework (PSIRF), including a situation report for its development and implementation.

The outgoing Serious Incident Framework (SIF) (NHS England, 2015) is an investigation framework with a strict criterion to determine what must be investigated and how they are to be investigated, under the categorisation of 'Serious Incidents (SIs)'. The PSIRF is a different way of working, by which it does not differentiate between the impact of patient safety incidents that have previously been deemed to be more serious than others but allows Trusts to decide different approaches in investigating patient safety harm events and themes to ensure the best use of resources, to engender learning and improvement.

The PSIRF (NHS England, 2022) was published in August 2022 and is expected to be approximately one year in the development of full implementation, though early pilots commenced 2-3 years ago and still refining and developing this shift in patient safety incident culture. Whilst there is an expectation that Trusts will actively commence implementation during Autumn (Q3) 2023, it has been shared by NHS England that a 'go live' must be carried out only when Trusts feel ready to do so, within reason.

The Learning from Patient Safety Events (LFPSE) is expected to launch simultaneously with the PSIRF.

Whilst these programmes of work are significant, and the workstreams major, their desired outcome and primary purpose relate specifically to positive engagement and partnerships with all staff and patients and their families, and the increased ability to extract learning leading to improved quality and patient safety.

2. Patient Safety Incident Response Framework

Currently, Trusts typically identify their serious incidents from individual cases recorded where the level of harm is indicated to be moderate or higher, with the addition of some high-level complaints and coronial cases. Thus a reactive, after-the-event response.

In contrast, the PSIRF requires an annual plan to be developed based on the top 9-10 concerns identified from a wide range of patient safety events (including incidents, SIs, clinical audit, complaints, litigation and learning from death reviews), that are agreed and signed off by the Integrated Care Board (ICB). The Patient Safety Incident Response Plan (PSIRP) is developed with two approaches in mind, the identification of larger, themed investigations (the proactive approach) and the review and learning taken from regularly occurring incidents (reactive approach).

1 Themed investigation – the PSIRP will determine what themed investigations will be undertaken across the year. These may be significant issues, or even complex, wicked problems where lessons are struggling to be learned and improvements made. Ideally, the plan would be completed in-year, but it is acceptable for investigations to be carried over to the following year's plan to encourage regular review and / or continuous learning.

2 Regular incidents – the PSIRP will define the approach to be taken with Patient Safety Incident Investigations (PSIIs). The analysis of the patient safety events will

also provide the Trust with the insight into what are the recurring incidents, and what the most appropriate and meaningful way learning can be captured and taken forward for improvement. The PSIRF does not dictate a Trust's approach to these incidents, however, it does expect the agreed PSIRP to predetermine the method to review and learn.

There are multiple methodologies that can be adopted and applied which will aid maximisation of systematic learning for continuous improvement from incidents, and the PSIRF allows the Trust to choose which methods are the most appropriate for the different PSIIs. As a brief example (and this has not yet been discussed or considered), if the Trust decided to routinely review PSIIs where patients have fallen and had a long lie[1] or suffered major trauma, the method to review and learn from them would have been predetermined, allowing local managers to automatically know they must carry out an after-action review or a swarm huddle for instance. The PSIRP, so in turn the policy, will inform what approach is taken with PSIIs, enabling staff to respond quickly to extract learning without waiting for the outcome of the Serious Incident Group discussion.

The external governance arrangements for investigations will also be significantly different to the SIF. Currently the Trust's Commissioners review SI reports and approve them for closure. Under the PSIRF, commissioners will not have approval rights, however, it is expected they will be involved throughout the process to agree the PSIRP and engage with the overall reviews for assurance purposes, and to ensure a holistic system-wide approach. The governance structure will be developed in collaboration with commissioners.

3. Learning From Patient Safety Events (LFPSE)

In addition to the implementation of the PSIRF the Patient Safety Team are also developing the new Learning from Patient Safety Events (LFPSE) function. The LFPSE works to replace two external systems – the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS).

The NRLS is the national system that collates all NHS Trust's reportable patient safety incidents. This information is analysed, lessons and actions are identified and shared across all Trusts for implementation to reduce risk. The intelligence gleaned from the NRLS is fundamental in the development of safety alerts. The function also works as a benchmarking tool for Trusts by measuring incident reporting facts and figures i.e., levels of harm and reporting rates. The StEIS is the national system for declaring and monitoring SIs and is accessible by Integrated Care Boards and NHS England.

Both the above systems are recognised to be primarily acute Trust focused, particularly the NRLS, which has made it challenging for other NHS Trusts to effectively use them and benefit from their intended output. The LFPSE is being developed with all Trusts in mind and promises to ensure better access, usability and learning outputs.

4. Datix Cloud

The Patient Safety Team has also been developing the Datix Cloud (DCIQ) software system which will replace the current DatixWeb system. The functions managed via Datix are incidents and SIs, complaints, compliments and PALs, risk management, litigation claims and inquests and safety alerts. All these functions will be transferred over to the DCIQ platform with the new addition of learning from deaths and structured judgement

[1] A long lie is a term used for those patients that have fallen and remain on the floor for a prolonged period, whilst awaiting assistance. As a rule of thumb, the patient would have been on the floor / ground for two hours or more, particularly if elderly.

reviews; risk management has already transitioned, and the safety alerts module will move on 1st May 2023. The remaining modules are in the development stages of their build but are intended to be transitioned within the coming financial year.

The timing of the DCIQ incident module development is timely as it can be progressed with the PSIRF and LFPSE structures at the forefront of the build. However, recognising that the incident module has become unwieldy and is reportedly no longer user friendly it is also vital that colleagues from across the Trust are fully engaged with the module development to ensure the forms are as succinct as possible whilst providing the information required for both internal and external reporting, and good quality analysis to enable the identification of issues and the planning for and measurement of improvements. A stakeholder engagement group is to be created to ensure the co-design of the module.

5. Situation report

The recommended timescale provided within the PSIRF guidance for implementation and steps to progress is shown at appendix A. Whilst this timescale has slipped, each stage of progression remains important to reduce any temptation to rush and skip vital steps which could have a negative long-term impact on the success of the framework.

The appointment of the PSIRF Implementation Lead (band 8b) has been successful. The Lead commences a 12-month fixed term contract late April / early May and will work in partnership with the Head of Patient Safety and the new steering group, to gain better traction with these developing patient safety functions.

Work is underway to collate three years' worth of patient safety event data, from the broadest reach possible, as described above. Once all this data is received the task to analyse will commence to enable both elements of the PSIRP to start to be developed. The BI Lead for Patient Safety will support this analysis with steer from the new group.

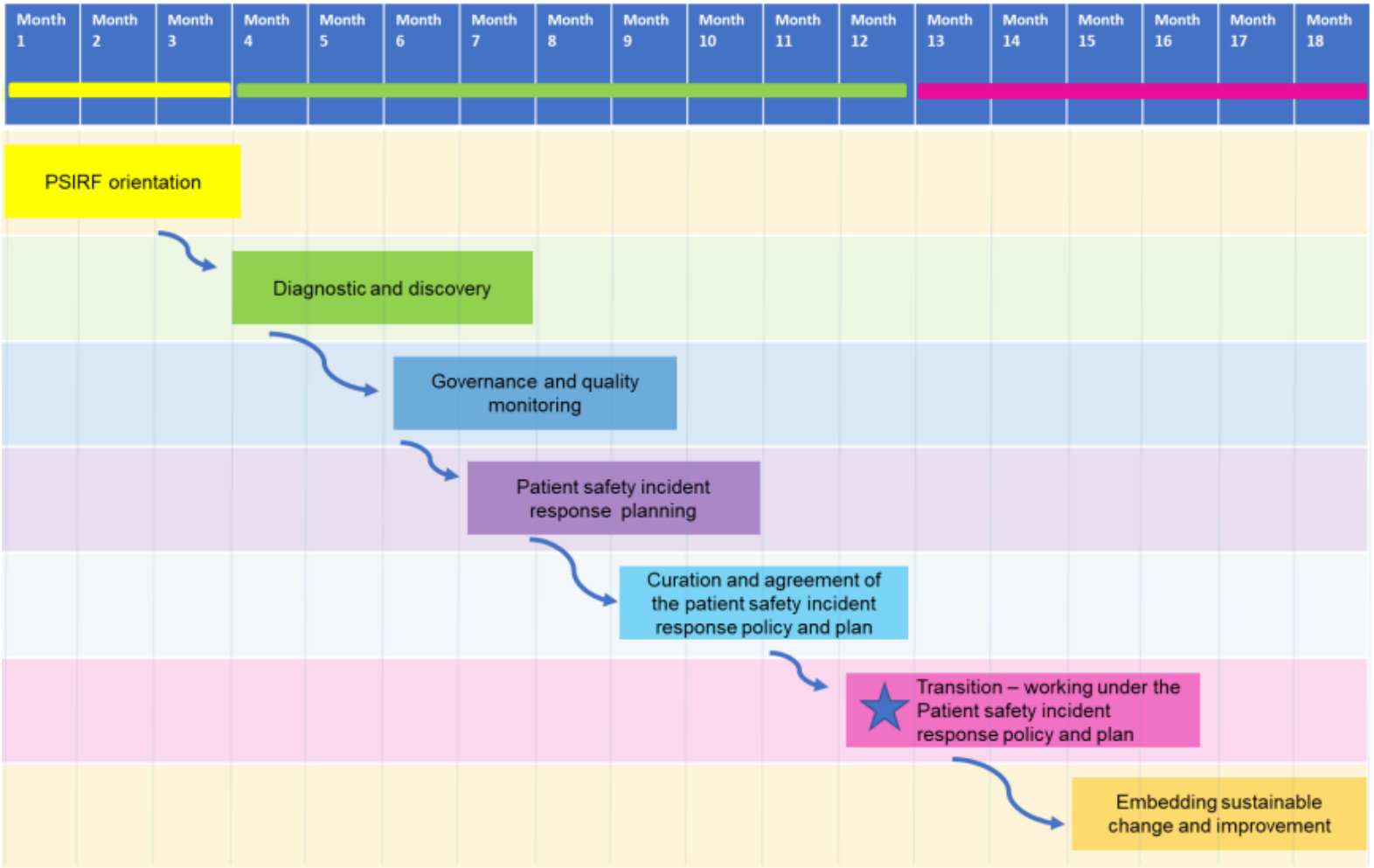
Simultaneously, various methods of review and investigation will be explored and tested to assess whether they are deemed appropriate to form part of the PSIRP.

As previously referred to, a steering group has been set up to oversee all the related workstreams, and specifically:

- Establish the Patient Safety Incident Response Framework (PSIRF) within the Trust
- Embed Learning from patient safety events (LFPSE) into the Trusts Incident management systems.
- Review and update incident and investigation management arrangements
- Update applicable policies in respect of incident and investigations.
- Develop DCIQ Incident and Investigations modules to meet the needs of PSIRF, LFPSE and any agreed changes to the wider incident and investigation arrangements for the Trust.

The steering group will report into the Quality Improvement Group, and thereby into Quality Governance Group, with ToR having been drawn up to go to QGG in April 2023 for sign-off. For information the full draft terms of reference are shown at appendix B.

Appendix A - Guidance for implementation plan and preparation stages provided within PSIRF guidance



Phase	Duration	Purpose
PSIRF orientation	Months 1 – 3	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements. This phase establishes important foundations for PSIRF preparation and subsequent implementation.
Diagnostic and discovery	Months 4 – 7	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.
Governance and quality monitoring	Months 6 – 9	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF.
Patient safety incident response planning	Months 7 – 10	For organisations to understand their patient safety incident profile, improvement profile and available resources. This information is used to develop a patient safety incident response plan that forms part of a patient safety incident response policy.
Curation and agreement of the policy and plan	Months 9 – 12	To draft and agree a patient safety incident response policy and plan based on the findings from work undertaken in the preceding preparation phases.
Transition	Months 12+	Organisations continue to adapt and learn as the designed systems and processes are put in place.

APPENDIX B

SOUTH EAST COAST AMBULANCE SERVICE NHS TRUST

Steering Group
(Incident and Investigation Management)

Terms of Reference (ToR)

1. Constitution

1.1. This Steering Group (the Group) is a formally constituted subgroup of the Quality Governance Group (QGG) and will function until the delivery of the workstreams set out in section 2 is complete.

2. Purpose

2.1. The purpose of the Group is to coordinate and deliver the following workstreams:

- Establish the Patient Safety Incident Response Framework (PSIRF) within the Trust
- Embed Learning from patient safety events (LFPSE) into the Trusts Incident management systems
- Review and update incident and investigation management arrangements
- Update applicable policies in respect of incident and investigations
- Develop DCIQ Incident and Investigations modules to meet the needs of PSIRF, LFPSE and any agreed changes to the wider incident and investigation arrangements for the Trust.

3. Membership

3.1. The membership of the Group comprises of:

- Head of Patient Safety (Chair)
- PSIRF Implementation Lead
- Head of Risk and Incidents
- Serious Incident Lead
- Datix Manager
- BI Patient Safety Lead / representative
- Executive Assistant Quality and Nursing (Minutes)
- N.B. Other Directorate stakeholder representation to be discussed.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the group shall be at least three members and shall include:

- Head of Patient Safety (Chair) or PSIRF Implementation Lead
- Head of Risk and Incidents or Datix Manager
- Serious Incident Lead

4.2 The Chair of the Group will be the Head of Patient Safety. In the absence of the Chair the PSIRF Implementation Lead will Chair the meeting.

5. Attendance

5.1. Directorate stakeholders will be invited to attend meetings, where this would benefit the development and rollout of the workstreams identified in section of this TOR.

5.2. The Executive Assistant for Nursing and Quality shall attend to take minutes of the meeting or will secure suitable cover when they are unable to attend.

5.3. Members unable to attend a meeting are required to send a fully briefed named deputy. Members are required to attend 75% of these group meetings.

5.4. The Chair of the Group will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the group, the Chair will discuss the matter with the members and if necessary, seek a substitute or replacement.

5.5. Attendance at group meetings will be disclosed to QGG.

6. Frequency

6.1. Meetings of the Group will be held fortnightly. Meeting dates will be diarised on a quarterly basis and extraordinary meetings may be called between regular meetings to discuss and resolve any critical issues arising. The venue for the meetings will rotate around Trust sites and where the need requires meetings will be online.

7. Authority

7.1. The Group has no executive powers other than those specified in these Terms of Reference or by the Trust Board in its Scheme of Delegation.

7.2. The Group is authorised by the QGG to investigate any action within its TOR. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Group.

7.3. The Group is authorised to develop and deliver the workstreams as identified in section 2 of this TOR with the full support of key stakeholders across the Trust.

8. Duties

8.1. The subject matter for meetings will be specific to the delivery of the workstreams as detailed in section 2 of this TOR.

8.2. At all scheduled Group meetings, Workstream Leads will provide members written and verbal progression update on their respective workstreams to include:

- Review of workstream project plans
- Update actions and issues log for each workstream

- Raise project risks against workstreams as applicable.
- Identify milestone project points for each workstream.
- Update on engagement with stakeholders across the Trust for each workstream.
- Escalate risk and milestone barriers to the group for reporting up to QGG.

9. Reporting

9.1. The Group shall be directly accountable to the QGG. The Administrator of the Group shall provide minutes of each meeting to QGG and draw to the attention of QGG any significant issues that require disclosure or escalation.

10. Support

10.1. The Group shall be supported by the Executive Assistant Quality and Nursing and duties shall include:

10.1.1. Agreement of the meeting agendas with the Chair of the Group.

10.1.2. Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings.

10.1.3. At least five working days prior to each meeting, papers will be issued to all Group members and any invited stakeholders.

10.1.4. Circulating approved draft minutes within ten working days from the date of the last meeting.

10.1.5. Advising the Chair and the Group about fulfilment of the Groups TOR and related governance matters.

11. Reports

11.1. For each meeting the Group will be provided with the following information and papers 7 days in advance of scheduled Group meetings:

- Administrator: Agenda
- Administrator: Workstream project plans, issue, and action logs
- Administrator: Risk register

12. Review

12.1. The Group will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these TOR's.

12.2. The Group shall review its own performance and Terms of Reference at least quarterly to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to QGG for approval.

12.3. These Terms of Reference shall be approved by the QGG.

Review Date: on a monthly basis

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	10-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Learning from Deaths Q2 Report 2022-23
Responsible Executive	Dr Rachel Oaten, Chief Medical Officer
Author	Dr Richard Quirk, Deputy Medical Director
Synopsis	The independent random reviews of the care of patients who have died in our care has continued to demonstrate compassionate care in the majority of cases. The main reason for the panel to judge care as 'adequate' or 'poor' is once again related to delays in getting to the patient.
Recommendations, decisions or actions sought	The committee is asked to note the report and the actions that the Trust is taking.

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

Learning from Deaths Report – Quarter 2 – 2022/23

1. Introduction

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

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

1.3. There are additional statutory requirements to provide information to the Child Death Overview Panel for all children who die, a requirement to report deaths of people with Learning Disabilities to LeDeR (Learning Disabilities Mortality Reviews), a requirement to

report all deaths of people with serious mental health conditions to their mental health trust and a requirement to report all obstetric incidents (which meet their criteria) must be reported to the Healthcare Safety Investigations Branch (HSIB).

2. Overview of Quarter 2 (22/23) mortality data

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

Table 1

	2020				2021				2022			
Month	**F**	**M**	**U**	**Total Deaths**	**F**	**M**	**U**	**Total Deaths**	**F**	**M**	**U**	**Total Deaths**
Jan	277	377	7	661	406	543	0	949	312	425	1	739
Feb	265	369	4	638	286	378	1	665	254	355	1	610
March	285	413	9	707	248	383	0	631	288	429	0	717
April	341	466	11	818	254	366	0	620	275	389	1	665
May	265	347	5	617	207	335	1	543	244	389	0	633
June	214	325	13	552	204	323	1	528	240	357	1	598
July	223	367	2	592	229	403	0	632	294	413	2	709
Aug	266	370	3	639	208	336	0	544	263	374	3	640
Sept	204	333	3	540	238	346	0	584	262	345	0	607
Oct	240	354	0	594	305	406	0	711				
Nov	225	380	1	606	254	426	2	682				
Dec	334	464	0	798	341	432	1	774				

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

Table 2

Age Range (Yrs)	No. of patients who died – July 2022	No. of patients who died – August 2022	No. of patients who died – September 2022
Under 1 year	6	2	2
1-18	3	5	3
18 – 29	13	15	8
30 – 39	23	18	14
40 – 49	42	23	31
50 – 59	76	73	62
60 – 69	111	111	84
70 – 79	174	144	131
80 – 89	164	168	175
90 – 99	89	77	89
100+	6	3	3
Age unknown	2	0	5

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

Table 3

	No. of patients who died – July 2022	**No. of patients who died – August 2022**	**No. of patients who died – September 2022**
Dead on arrival	294	253	255
Resuscitation attempted	234	215	187
Advance Care Plan/Do not attempt resus (DNACPR)	155	144	140
Professional Decision not to Resuscitate	21	24	21
End of Life	5	3	3

3. Review process

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

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

3.3. Table 4 shows the outcomes of the Structured Judgemental Reviews of the 60 randomly selected deaths in Quarter 2 22/23.

Table 4

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	40 (67%)	11 (18%)	7 (12%)	2 (3%)	0	0
On scene handling (Care)	59 (98%)	1 (2%)	0	0	0	0
Transfer and Handover (Including discharge and worsening care advice)	25 (42%)	2 (3%)	0	0	0	33 (55%)
Other Aspects of Care (quality and legibility of records)	57 (95%)	1 (2%)	1 (2%)	1 (2%)	0	0
Overall Assessment of Care	54 (90%)	6 (10%)	0	0	0	0

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

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

3.4.1. Initial Management

In the 9 cases where care was seen to be 'adequate' or 'poor', the reason for the majority of these ratings was a delay in reaching the scene. The majority of calls are classed as Category 1 and should receive a response within 7 minutes (on average). For most of those incidents where the Trust has taken longer than 7 minutes to arrive on scene, the reviewers have not identified any significant harm caused to those patients as they were either already dead, were receiving adequate bystander CPR/defibrillation or getting there sooner was unlikely to make a difference to the outcome.

The specific delays are as follows:-
8 minutes response to a C1
8 minutes response to a C1
8 minutes response to a C1

12 minutes response to a C1
16 minutes response to a C1
17 minutes response to a C1
22 minutes response to a C1
31 minute response to a C2
39 minute response to a C2

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

It is worth noting that there were 18 patients where initial care was judged to be 'adequate' or 'poor' in the last quarter and this has fallen to 9 patients in this quarter. This mirrors a reduction in response times during Q2 2022/23.

3.4.2. On Scene Handling

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

The panel did not identify any 'adequate' or 'poor' care on scene during this quarter.

3.4.3. Transfer and Hand over

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

The panel did not identify any 'adequate' or 'poor' care during transfer, in this quarter.

3.4.4. Other aspects of care (including documentation)

There was one patient where the care was described as 'adequate'. This was related to the panel's view that the notes created by the clinician in the electronic patient record (ePCR) were substandard and more detail was required. This is being fed back to the crew by their manager.

There was one patient where the care was described as 'poor'. This was related to the panel not being able to retrieve an electronic patient record (ePCR) for this patient. The Trust is obliged to hold and store a record of the care provided for every patient and on this occasion an ePCR has not been able to be retrieved. We continue to look into how this could have happened.

3.4.5. Overall Care

This quarter there were no patients where the overall care was judged to be 'adequate' or 'poor'. This is an improvement on last quarter where two patient's overall care was judged to be 'adequate'.

4. Referrals to the Learning from Deaths panel

4.1. During this reporting period, no cases were referred to the Serious Incident Group for assessment.

5. Peer reviews and assurance

5.1. The Trust lead for Learning from Deaths (Deputy medical director) has been working with the National Lead for Learning from Deaths at NHS England to assess the effectiveness of the national policy within the ambulance sector. As a result, NHS England have sent out a self assessment survey to all ambulance Trusts in partnership with the Association of Ambulance Chief Executives. The feedback of which will inform future policy changes.

5.2. The Trust lead for Learning from Deaths is also arranging a peer review of our internal processes by the equivalent panel in East Midlands Ambulance Service. The findings from this review will be reported in the next quarterly report.

6. Learning from the random review of 60 deaths

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

6.2. In a small number of reviews there was a delay in attending the patient. The reviewers have not found evidence that these delays significantly impacted on the outcome for these patients.

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

6.4. Support from Operational Team Leaders (OTLs) and Critical Care Paramedics (CCPs) in the management of complex arrests is clearly documented and it is evident that everything that could be done to save life is being attempted.

6.5. Consistent with other ambulance trusts, we do not have a system to identify patients who have died within 24-48 hours of admission to hospital to be able to review their pre-hospital care. NHS Improvement are looking into ways of identifying these patients.

7. Conclusion

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

8. Actions resulting from the review of deaths from Quarter 2 22/23

Action	Who?	Update/Date	
Finalise the Trust's approach to calls for 'verification of death'	EOLC Steering Group/Quality Governance Group	December 2022	**Awaiting Police Chief Officer sign off**
Peer Review with East Midlands Ambulance Service	Deputy Medical Director	May 2023	**In progress**

Dr Richard Quirk
Deputy Medical Director
March 2023

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	11-23

Name of meeting	Trust Board
Date	6 April 2023
Name of paper	People and Culture - Executive Summary to the Board
Strategic Goal	Focus on People
Lead Director	Ali Mohammed, Executive Director of HR and OD
Primary Board Papers	BAF Risks i. Recruitment (255) ii. Retention (13) iii. Culture and Leadership (348) Integrated Quality Report (slides 20-32) Improvement Journey (People and Culture)
Executive Summary	**Risk Overview** The Trust saw a dip in operational pressures in the period since the last Board, but we are experiencing an increase in demand with higher than planned staff turnover and sickness. The previous combined risk of retention, culture and leadership has been split into two risks with one now specifically focusing on retention and the other now confirmed as Culture and Leadership (risk 348). Industrial action has been paused while members are balloted on a national pay offer. However, there is a risk that the offer could be turned down and strike action restarted. All unions with a mandate have sought a six-month extension to that mandate while they ballot. The IQR is reflective of the current risks (except for industrial action) through the key metrics set out in the Overview (slide 21). **Recruitment** The time to hire has increased since the last Board report, however, the chart shows both 'volume' or cohort and 'ad hoc' recruitment. The former are to fill spaces on both contact centre and field operations planned courses, while the latter are to fill vacancies in other positions that arise throughout the year. This will be split for the next IQR and may not have been immediately apparent on the previous IQR. A Quality Improvement project will be undertaken commencing in Q1 23/24 to look at recruitment through to onboarding to reduce the workload on the team, improve efficiencies, and improve candidate experience. International recruitment for Paramedics funded by Health Education England has been a success with 81 either started or due to start this year. There are a further 41 in stages of compliance or offer. The funding for this recruitment source ends in September, and the current team are unable to absorb this back into the team as it stands. Recruitment of international paramedics has different requirements and will require continue dedicated resource within the team to ensure continued success of the programme.

Retention

The Retention Plan agreed at EMB and SMG in late 2022 has been incorporated into the People and Culture Strategic Priorities 23/24. Rather than a separate Retention Plan, it will be a workstream of the 23/24 priorities. The Trust is also exploring system working opportunities on retention issues with the Sussex ICS workforce retention lead in Sussex.

Staff retention remains a high concern and the 151 FTE gap between planned and actual FTE will place an additional demand and strain to meet the increased 23/24 workforce plans.

Sickness absence is reducing but, at 7.9% is still above our target of 5%. Monthly scrutiny of action plans at Operations Senior Leadership meetings are now in place with support from HR Business Partners and Advisors. Slide 31 of the IQR shows a declining trajectory of Wellbeing Hub referrals, however, individuals could be self-referring to one of the three ICB Resilience Hubbs. However, a long-term program of promoting the Wellbeing Hub and services is to be developed, so that staff are more aware of the avenues to seek assistance and help. This should see an increase in the referral rate. A very well received month long *Your Mind Matters* campaign has run and will be evaluated to assess its impact; for example, clicks on information on the micro-site.

The focus on achieving the statutory and mandatory training target of 85% by the end of March 2023 is on course with February at 80%. However, it is apparent that the Trust will not meet its rolling appraisal target by the end of March 23. Immediate corrective actions plans are being developed by a Task and Finish group to build a supporting solution to facilitate rapid improvement in the trajectory. This is likely to be outside of ESR in the short-term with a long-term plan to build a co-designed user-friendly solution that works with ESR.

Culture and Leadership

The new Programme Director (Culture) commenced in role on 8 March 2023 and is currently onboarding and scoping the programme of cultural transformation work that sits within the People and Culture strategic objectives for 2023/24.

Nearly 500 managers have now attended the Sexual Safety Training workshops, however, DNAs remain an issue with the reasons now recorded on ESR OLM so that they can be reported to EMB.

In terms of updated progress with sanctions applied to alleged sexual misconduct cases, we now have our first full year's data from April 22 to March 23. This shows that we are applying appropriate sanctions in respect of cases. A total of 14 disciplinary processes have been commenced with six resulting in intermediate or serious sanctions (including dismissal). Five complex cases are due to be resolved during April and May 23 and therefore remain active currently.

As updated at the last Board, the next steps on the work with ACAS proceeds, with a proposal from ACAS now received. This requires the assent of each party before it can proceed.

	The 2022 Staff Survey report has been received as have the free text comments. A separate paper sets out the findings from the results, and the actions to engage locally and across the organisation. This includes the Trust's first use of AI to synthesise the free text comments into themes for ease of analysis and action. Concerns raised through the FTSU team remain high with continuing concerns about detriment. The themes appear to be similar to previous months including bullying and harassment, inappropriate behaviours and safety/wellbeing.
Recommendations, decisions or actions sought	We continue to face a number of operational and workforce challenges. These are reflected with the BAF and Trust Risk Register and by the scale of the work set out in the Improvement Journey. The work set out in the Improvement Journey People and Culture workstream focused initially on those areas within the CQC warning notices but importantly also starts to address the deeper issues in respect of culture, leadership and staff experience. It is recommended that the Board continue to endorse the actions taken to date and individually and collectively own and support the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience.

South East Coast Ambulance Service
NHS Foundation Trust

Culture (Board Development)

Board 6 April 2023

1. Purpose

1.1. This paper summarises the work on culture already completed at Board level and acts as a single reference point. It outlines the agreed actions (as of March 2023) and identifies the next steps for the Board.

2. Introduction and association with risk

2.1. The Board understands that a transformation of the organisation's culture is the keystone to future success. This is recognised in risk 348 on the Board Assurance Framework where the risk is described as "*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*".

2.2. This BAF risk was initially scored as a 16 via the risk assessment matrix and remains at 16. This position is unlikely to change quickly but it is anticipated that the actions identified in this paper will help to lay the necessary foundations for later improvement in this area.

2.3. The Board recognises that it needs to lead the shape the culture and assist the executive in embedding this within the organisation.

2.4. Following the Francis Inquiry in 2013, NHS Boards were asked to ensure safety and quality were at the heart of board discussions. SECAmb has placed safety and quality at the forefront of the Board agenda for a number of years. However, this is not enough. Francis also drew attention to the importance of staff needing to feel valued and listened to. Staff need to be supported in raising concerns and encouraged to advocate for patients. Equally, staff need to feel safe at work and know that when they raise difficult issues they will be treated with courtesy and respect from everyone. It is through these processes and values that the Board can ensure a safe positive culture becomes a lived reality. This is the hardest part. At the recent well-led self-assessment, the Board acknowledged it found these conversations difficult.

2.5. Nevertheless, after acknowledging the difficulty, the Board recognised the importance of starting to hold these conversations. This paper is the new start of this journey.

2.6. To help support a strategic direction, the Executive has proposed to develop a rapid People Strategy that will include an outline of high-level goals for the culture transformation journey. This will help give some strategic direction to the transformation ahead but will also permit future staff engagement work to flesh out some of the detail.

2.7. As part of the well-led self-assessment, the Board also identified the need to place culture within the Board development plan so that it could rapidly develop a way of having

meaningful Board discussions and identify the necessary Board behaviours that will help prepare and support the culture transformation.

2.8. This paper summarises the progress of the Board Development Plan to date.

2.9. In-between the development days and the drafting of this paper the annual Staff Survey results have been published and many of the comments dovetail with the Board's own discussions. The Exec team will explore the themes arising out of the survey and these will help inform the operational plans for transformation.

3. The Board Development Plan

3.1. A number of aims were identified for the culture component of the Board Development Plan.

3.2. The aims were,

- To feel more able to discuss culture and have identified the mechanisms to facilitate discussion
- To have some unified understanding as to what a good culture experience feels like at SECAmb
- To have a suite of suggested metrics to monitor the impact of the culture transformation programme
- Identify the necessary collective actions/behaviours of the Board to help facilitate the transformation
- To identify if any further support is necessary (added after well-led work)
- To identify the individual contributions each member of the Board can make to help support the transformation programme (this is being undertaken individually)

3.3. To help structure the work (at the Board meeting on 15 December 2022) the Board agreed the proposal to use the Leadership Way as the framework for the culture component of the Board development plan.

3.4. This framework sets out the compassionate and inclusive behaviours all leaders need to have at every level. The proposal was to discuss these behaviours through five bespoke sessions. These sessions would also include a reflective exercise that would permit the Board to identify a number of areas or themes that would facilitate Board level discussions on culture.

3.5. These five sessions were;

1. Introduction: Collective and Individual Responsibilities
2. Our Personal Experiences (all Board Members talking about their experience of good and bad culture)
3. Becoming more compassionate
4. Becoming more curious
5. Becoming more collaborative

3.6. Sessions 1 & 2 looked at the Board conversations and aims 1, 2, 3, and sessions 3,4 & 5 considered the Board behaviours and aims 4 and 5.

4. Sessions 1 & 2 – Board Conversations

4.1. The sessions were a mixed mode of workshops and instruction and included a number of case studies from industry and NHS Trusts and this included 2 external speakers sharing their experiences of other Trust Boards undertaking this journey. The following sections summarises the key points and decisions.

4.2. It was recognised the Board needs to become as comfortable discussing culture as it is with quality.

4.3. It was agreed that a suite of metrics will help give some oversight and will need to be added to the current Quality dashboard and this will be worked up by the Executive over the coming months.

Action: The Executive to work up a draft culture dashboard

4.4. Once the People Strategy is approved then the Board will also receive regular progress reports. However, a formulaic Board update on the progress on the implementation of a strategy and oversight of culture metrics is not going to be enough to facilitate the necessary change.

4.5. The following areas were identified as additional areas where the Board could have meaningful discussions on culture.

Trust Values

4.6. It was agreed that the values need more visibility at Board. Both within papers, in behaviour, and also as a distinct piece of work. The discussion also suggested there would be a benefit in refreshing the current values to ensure they were streamlined and easy to reference.

Action: The Executive to undertake a refresh of the Trust values and ensure they have visibility at Trust Board.

Addressing Staff Concerns

4.7. The Board is trying to ensure greater alignment with staff as part of its general improvement plan. However, the Board membership recognised the benefits to the culture transformation by having the Board visibly address a number of top priorities each year. These can be relatively simple, but they need to be issues that are important to the majority of the staff. The Board agreed to undertake an exercise that would help the Trust identify these priorities.

Action: The Executive to lead the identification of which staff identified priorities the Board is going to address in 2023/24

Staff Networks

4.8. There is good visibility of the staff networks at the Workforce and Wellbeing Committee. But it was agreed that the Executive and the Board could do more (such as executive sponsorship of the networks). The Board would like to receive updates on the work of the Networks and see the Networks as a platform for engagement.

Action: To consider how the Board and Executive is going to raise the profile of the Staff Networks (potential Executive sponsorship)

Quality Improvement

4.9. Quality Improvement is happening. The Trust has recently employed a lead. However, this has not been framed within the context of culture. Learning and improvement are key drivers for a positive culture and the Board agreed to present the Quality Improvement information to Board through the lens of culture transformation.

Action: Quality Improvement to be presented at Board as part of cultural transformation and for any associated papers to be written from that perspective.

Leadership

4.10. Well-Led at every level is key. The Board recognised the need to do more on leadership development and have greater visibility of the impact of this work. In addition, the Board needs to consider how it can also help support leadership development through its routine work.

Action: To hold a further Board level discussion on leadership and especially clinical leadership and as part of the culture work to receive dedicated papers on leadership development.

Every Voice Counts

4.11. More work needs to be undertaken to work up this concept. But, the Board recognised it needed to champion equity. Initially this can be undertaken with improved visibility of Equality, Diversity and Inclusion work but over time this can be widened to ensure all Trust staff are equally empowered to contribute. The Board agreed to increase the visibility of EDI work.

Action: The Board to understand the experience of minority group staff working at SECAmb by actively champion EDI data against relevant metrics and ensuring EDI experiences are discussed at Board.

A Focus on People

4.12. The Trust currently describes two groups of people: staff and patients. Yet, the behaviours need to be extended to everyone. It was agreed to maximise the opportunity to talk about people and become a people focussed organisation.

Action: Purposely move towards being people focussed (rather than split patients and staff into two groups).

4.13. These initiatives will only make an impact if the forward planner and the agenda frames these items within the context of culture. Board members also need to be prepared for some areas, such as staff networks, to develop more depth of information over time but to continue to champion these contributions as important. Additionally, the Board can seek different ways of receiving the information. For example, by inviting a Network chair to present, or several network members to dial into the meeting, or increasing the attention given to the non-executive insights.

5. Sessions 3, 4 & 5 – Board Behaviours

5.1. The second Board development day consisted of sessions 3, 4 and 5. The purpose was to consider how the Board could become (and encourage) more compassion, more curiosity and more collaboration.

5.2. The day took the format of small group discussions against a number of key questions. Following feedback, the membership agreed a number of actions to help improve the three focussed areas. These are detailed below.

Becoming More Compassionate

5.3. The discussion recognised that creating a safe space for discussion and feedback can be a challenge, particularly in groups and there may be a need to create space for individual conversations. There was also recognition that there were behaviour differences between part 1 and part 2 of the Board meetings. Following discussion, the following action was agreed.

Action: At the start of part 2 of the Board meetings, have an agenda item to review and reflect on how part 1 went and what the Board could have done differently/should do differently next time.

5.4. Diversity was recognised as essential and there was acknowledgement that it was important to demonstrate compassion for all. It was agreed that the Board needed to discuss diversity more.

Action: To hold a more detailed Board discussion on diversity and to also include personal commitments/actions.

5.5. The Board acknowledged the importance of language and recognised the following,

- The Board doesn't always talk with compassion when talking to/about each other
- The Board members needs to be conscious about how they talk about people and remember that discussions can also be overheard
- Identify consequences for board behaviours both positive and negative
- Become people focused – not just staff and/or patients
- We all need to be brave and call out others when language/behaviours aren't what they need to be

5.6. The Board concluded that the systems and processes need to reinforce the right behaviours (for example, through the appraisal system).

5.7. The Board doesn't always respect the diversity of views and other experiences that individuals bring to the discussion. The respect for the board and sub-committees isn't where it needs to be as demonstrated by the late provision of papers.

Action: A commitment to ensure papers are delivered on time.

5.8. There was recognition that overall board preparation had improved and that more Board members were contributing to the discussions. However, there is an opportunity to be more open about vulnerability and challenge and for everyone to own the difficulties.

5.9. There was recognition that the natural tension between the role of the non-executive and executive can be constructive if viewed correctly. This needs to be recognised and maximised.

5.10. The question “are we a compassionate organisation?” was challenging and thoughtful. The Board needs to reflect on this as part of the culture change programme.

Becoming More Curious

5.11. It was agreed that the Board is clinically curious but less so in the managerial space

5.12. It was identified that curiosity should come from taking a longer-term view and it was agreed to give this further consideration.

Action: Challenge to look towards more long-term considerations

5.13. The Board doesn’t have built into the business cycle an opportunity to reflect on what the Board could do better.

5.14. The Board does not routinely use all the data or collect all the necessary data to include in considerations (for example, patient experience).

5.15. Consideration was given as to how the Board could use the opinions of new recruits and how the organisation can learn from their early insights.

Action: Consider options to hear from the wider workforce, particularly those who are our future.

5.16. The Board recognised it needs to hear more directly from leaders and may need to flex the approach so that more staff feel able to present or attend the Board.

Action: Schedule more opportunities for the Board to hear from leaders from across the Trust.

5.17. The Board recognised that asking for granularity of data does encourage curiosity but there were concerns that inappropriate curiosity can lead to over-promising which results in under-delivery?

5.18. It was widely recognised that there has been better challenge between Execs & NEDs at the Board

5.19. The Board does not always define the expected standards and terms such as ‘High standards’ are used.

Action: We need to consider and quantify what the ‘high/highest standards’ mean.

5.20. It was agreed that answers do not need to be immediate. It is acceptable for the answer to follow.

5.21. Curiosity can be a preventative measure as opposed to/as well as being reactive to issues

5.22. It was decided that a Board meeting that solely focussed on curiosity could be helpful. This could be a forum where the membership could have a wider and more open discussion on a particular topic, e.g. the new operational delivery model.

Action: Plan a curiosity board meeting during Q1 2023-24

Becoming More Collaborative

5.23. A number of principles were discussed,

- The current strategies under development need to dovetail with the corporate strategies
- Board members need to do work on relations with unions and SMG etc
- Strategies need to be clear on what they need from collaborations/partnerships

- There is a difference between collaboration, delegation, and abrogation of responsibilities and partnerships
- We need to create space and manage time more effectively to support discussions and improve paper delivery to committees

Action: At a future forum the Board needs to consider how the SECAmb Exec and non Exec team can strengthen their partnership presence across the footprint of the Integrated Care Boards

5.24. There was acknowledgement that the Board could collaborate more and this needs to build from investments in relationships.

5.25. There needs to be wider system insights at the Board. This needs further consideration, but a start could be to review the Integrated Care Board's papers to identify lessons and issues.

Action: The Partnership team to undertake regular review of ICB papers and consider if and how this can be brought to Board.

6. Summary of Actions and next steps

6.1. These two development days are the start of the journey and the Board recognises there is further work and some of the identified actions need further description. The actions, with suggested leads, are summarised below.

Table 1. Actions arising from workshops

Actions to Support Conversations at Board *The following actions will facilitate the Board to start having conversations around organisational culture*	Lead	Proposed Due Date
The Executive to work up a draft culture dashboard	Director of Business Planning	End of April 2023
The Executive to undertake a refresh of the Trust values	Director of HR	End of April 2023
Ensure the values have visibility at trust Board	Company Secretary & Finance Director & Head of Communications	To commence June 2023
The Executive to lead the identification of which staff identified priorities the Board is going to address in 2023/24	Director of Strategy & Director of Business Planning	End of April 2023
To consider how the Board and Executive is going to raise the profile of the Staff Networks (potential Executive sponsorship)	Director of HR	End of April 2023
Quality Improvement to be presented at Board as part of cultural transformation and for any associated papers to be written from that perspective.	Director of Nursing & Quality & Chief Medical Officer	To commence June 2023
To hold a further Board level discussion on leadership and especially clinical leadership and as part of the culture work to receive dedicated papers on leadership development.	All Directors & Company Secretary	End of August 2023
The Board to understand the experience of minority group staff working at SECAmb by actively champion EDI data against relevant metrics and	Director of HR	To commence June 2023

ensuring EDI experiences are discussed at Board.		
Purposely move towards being people focussed (rather than split patients and staff into two groups).	Director of Business Planning & Director of Operations	End of April 2023
Actions to Support Board Behaviours *The following actions will help the board to lead some of the required behaviour changes*	Lead	Proposed Due Date
At the start of part 2 of the Board meetings, have an agenda item to review and reflect on how part 1 went and what the Board could have done differently/should do differently next time.	Chair & Company Secretary	To commence June 2023
To hold a more detailed Board discussion on diversity and to also include personal commitments/actions.	Company Secretary & Director of HR	End of August 2023
A commitment to ensure papers are delivered on time.	All. Non-Executives to challenge late papers to committees	From April 5 2023
Challenge to look more towards long-term considerations	Chair & Company Secretary	To commence June 2023
Consider options to hear from the wider workforce, particularly those who are our future.	Director of HR	End of August 2023
Schedule more opportunities for the Board to hear from leaders from across the Trust.	Chair & Company Secretary	To commence June 2023
The Board needs to consider and quantify what the 'high/highest standards' mean.	Director of Nursing & Quality & Chief Medical Officer	End of June 2023
Plan a curiosity board meeting during Q1 2023-24	Director of Operations & Chief Financial Officer	End of April 2023
At a future forum the Board needs to consider how the SECAmb Exec and non Exec team can strengthen their partnership presence across the footprint of the Integrated Care Boards	Director of Business Planning & Chief Financial Officer	End of April 2023
The Partnership team to undertake regular review of ICB papers and consider if and how this can be brought to Board.	Director of Business Planning	End of April 2023

6.2. A number of the above actions will be followed up in subsequent development sessions. In the meantime, it is recommended that the Board have an update on how these actions are embedding within the work of the Board at each Part 2 meeting.

7. Recommendation

7.1. The Board is invited to reapprove the actions in Table 1 and support a reflective review on progress at each Part 2 meeting.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	11-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Comms and Engagement Strategy
Strategic Goal	All

In Q3 we engaged external support in the development of a new comms and engagement strategy, acknowledging the need to take a more strategic approach to communications and engagement at SECAmb, using it as a key leadership tool.

This strategy has been developed in collaboration with key internal stakeholders. It describes how we will focus our communications activity so it is aligned with organisational priorities and values, develop a core organisational narrative, and ensure both our reactive and proactive activity is informed by stakeholder insights, situational awareness, and continuous evaluation.

The benefits of this strategic approach will be a clear and consistent focus on what matters to SECAmb and our people, better understanding of our internal and external stakeholders and therefore, communications activity that we know resonates with them and better meets their needs. This in turn will build greater understanding of and support for SECAmb among our staff, patients, partners, regulators and the communities we serve.

The strategy provides a framework for the delivery of communications and engagement activity and it sets out our communications aims and objectives, our key audiences and stakeholders and our communications and engagement channels. It will allow us to focus our resources for the greatest benefit to the organisation and our stakeholders.

Our Communications and Engagement Strategy

Version 1.0: April 2023

Our Communications and Engagement Strategy

Version 1.0 – April 2023

Contents

About this document

This document sets out our corporate communications and engagement strategy for both internal and external audiences. The strategy sets out our communications and engagement aims and objectives, audiences and stakeholders and communications channels.

In essence, the strategy describes the purpose of the communications function and our overarching approach to communications and engagement at SECAmb. It provides the framework for detailed communications plans that will be developed to support the delivery of specific priorities.

Executive summary

What is strategic communications and engagement?

Strategic communications and engagement is where:

- an organisation understands the environment in which it operates, the needs of key audiences and stakeholders, and routinely evaluates past communications activity to inform future activity

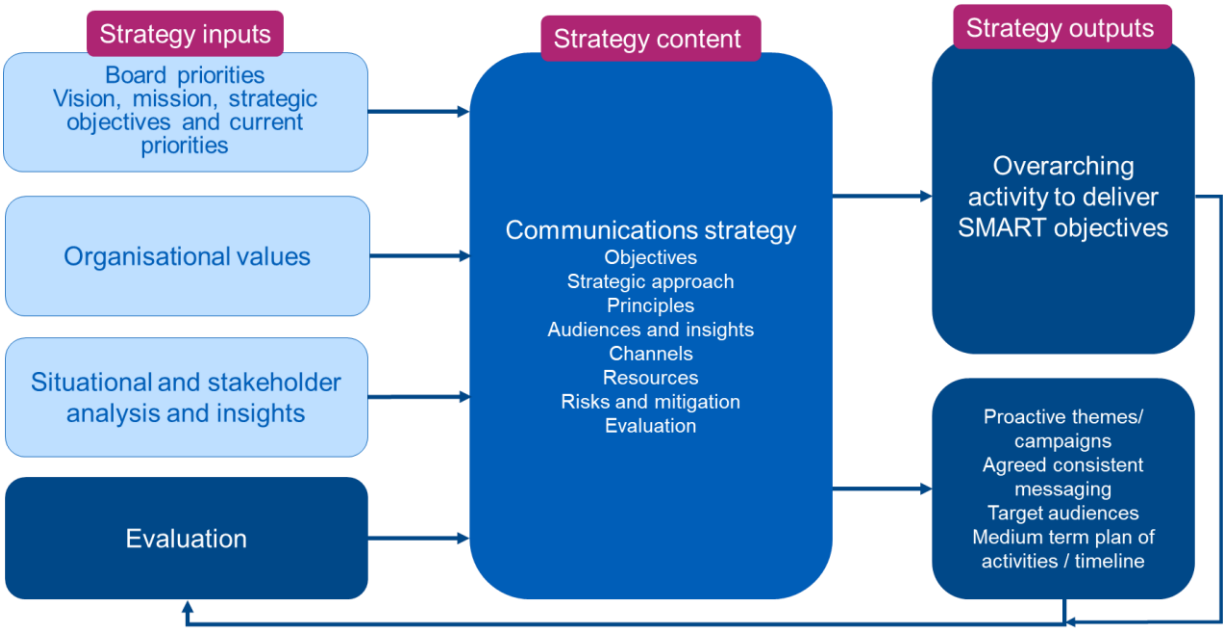
and

- communications and engagement activity is aligned to organisational strategy/priorities

so that

- communications and engagement activity is designed and delivered to both meet audience/stakeholder needs and support the delivery of organisational priorities.

Strategy inputs, content and outputs



Our communications and engagement strategy on a page

Our overarching aim	**EXAMPLE*:** To be a safe organisation for our patients and our people and to define our role as an urgent and emergency care provider for the next five years.				
Our specific communications and engagement aims	**Our staff** • Build trust and relationships by demonstrating our values in everything we do • Regularly demonstrate our improvement progress • Engage and involve our people in what matters to them • Celebrate excellence • Build a shared future vision	**Our patients and carers** • Build trust and confidence in our services by demonstrating our values and improvement progress • Engage and involve our patients in what matters to them • Demonstrate excellence • Build a shared future vision	**Our partners and stakeholders** • Build trusted relationships by demonstrating our values • Engage and involve our stakeholders, working in partnership for the benefit of our patients • Build support and a shared future vision	**Our local communities** • Build trust and confidence in our services by demonstrating our values • Engage and involve local communities in what matters to them • Demonstrate excellence • Build support and understanding for a future vision	
Our communications and engagement strategy	Our strategy is to support SECAmb to deliver its overarching aim using effective communications and engagement through which we can: engage and build relationships with key audiences; demonstrate we live by our values; support the delivery of organisational priorities; and build awareness, understanding, pride in and support for what we do amongst the people who matter to us most.				
Our principles	• Communicate with openness and transparency to build trust with our staff, system partners, stakeholders, patients and local communities • Support the cascade of messaging across the organisation and to external audiences, and bring back audience insights and reactions • Provide genuine and authentic engagement opportunities for our staff, stakeholders, system partners, patients, and local communities • Demonstrate how we listen to and act on feedback • Develop content based on a deep understanding of staff, system partner, stakeholder and patient and public motivations, needs, concerns, and perspectives • Demonstrate how we are living our values through our everyday work • Provide information in a timely manner, in a range of formats and via a range of channels, appropriate to the needs of different audiences • Make sure our content is consistent and clear; written and spoken in 'plain English' avoiding jargon • Regularly seek feedback and review, evaluate and adapt as needed, our approach to communicating and engaging to ensure we meet our audiences' needs.				
Implementation	Proactive campaigns/activity – integrated and coordinated packages of communication and engagement on specific themes that are delivered through all channels (internal communications, social media, web, media, stakeholder relations etc)				
Underpinned by	Internal communications & engagement	Public engagement	Stakeholder relations	Social media and digital/web	Planning & evaluation	Consistent branding / visual identity
	Advice & guidance	Media relations	Marketing	Team development	Publishing	Insight & research

* We recognise SECAmb is in the process of revising and developing its corporate strategy, but this aim resonates with current priorities and purpose. It can be updated as required.

Communications and engagement benefits

The benefits of achieving our aims and objectives will be:

- We will have a clearer understanding of the views of our staff, system partners, stakeholders and the people who use our services, and what is important to them. This will help inform the further development and delivery of our corporate strategy and other enabling strategies (e.g. People and Culture, Clinical), and inform our ongoing communications and engagement content and approach
- Key stakeholders will be aware of the improvements SECAmb has made and will have more confidence in the organisation and its leadership to sustain improvements
- Staff across the organisation, system partners, stakeholders, patients, and local communities will have a better understanding of SECAmb's role, values, and priorities and how they relate to them, including any action these audiences need to take to support delivery of SECAmb's operational and strategic goals
- Support to delivering higher levels of employee engagement and experience
- Support to delivering higher levels of stakeholder engagement and experience
- Support to delivering the priorities within the corporate five-year strategy
- Support to enhancing SECAmb's reputation as an organisation (externally) and SECAmb's leadership's reputation (internally) – giving 'license to operate' and headroom to focus on the delivery of operational and strategic goals.

1 Background and context

1.1 About us

South East Coast Ambulance Service is an NHS Foundation Trust. We respond to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region.

We cover a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire) which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country.

We have over 4,000 staff working across 110 sites in Kent, Surrey and Sussex. Almost 90 per cent of our workforce is made up of operational staff – those caring for patients either face to face, or over the phone at our emergency dispatch centre where we receive 999 calls.

Our patients range from the critically ill and injured who need specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.

As well as a 999 service, we also provide the NHS 111 service across the region.

We are part of four Integrated Care Boards across Kent, Surrey and Sussex:

- NHS Kent and Medway
- NHS Surrey Heartlands
- NHS Sussex
- NHS Frimley.

1.1.1 Recent challenges

Following inspections by the CQC during the Spring and Summer of 2021 and taking on board the results of the NHS Staff Survey, we recognised we need to make sustainable improvements. Most recently we have been focused on delivering short-term targeted actions to address CQC warning notices, must-do and should-do actions, as well as developing a plan to deliver ongoing improvement beyond the initial period of recovery.

In addition, we have faced a number of changes in our organisation's leadership team over recent years, which has understandably been destabilising.

We have heard and acknowledge that the culture in our organisation is not as good as it could be. Our staff have told us that there are problems with bullying and harassment, and sexualised behaviour in the workplace. They have told us they don't feel valued and that SECAmb is not always a good place to work.

In response to this context, we developed our *Improvement Journey* which has four pillars around which our improvement work is structured:

- Quality Improvement
- Responsive Care
- People and Culture

- Sustainability and Partnerships

In February 2023 the CQC lifted its warning notices, in recognition of the improvement work we have delivered. However, we know there is still work to do to get to where we want to be as an organisation.

In particular we are facing an' identity crisis', as a result of changes and growth in demand over recent years. The time is right to carefully consider what our core purpose should be so we can clearly define SECAmb's role and focus. We need to consider the balance between providing emergency (999) and urgent care (111), and between conveyance to hospital and providing care to patients on scene to avoid attendance at hospital.

In addition we acknowledge we still have a way to go to improve our organisational culture so that SECAmb is a good place to work, offering a positive experience for our staff.

1.2 What is strategic communications and engagement?

Strategic communications and engagement is where:

- an organisation understands the environment in which it operates, the needs of key audiences and stakeholders, and routinely evaluates past communications activity to inform future activity

and

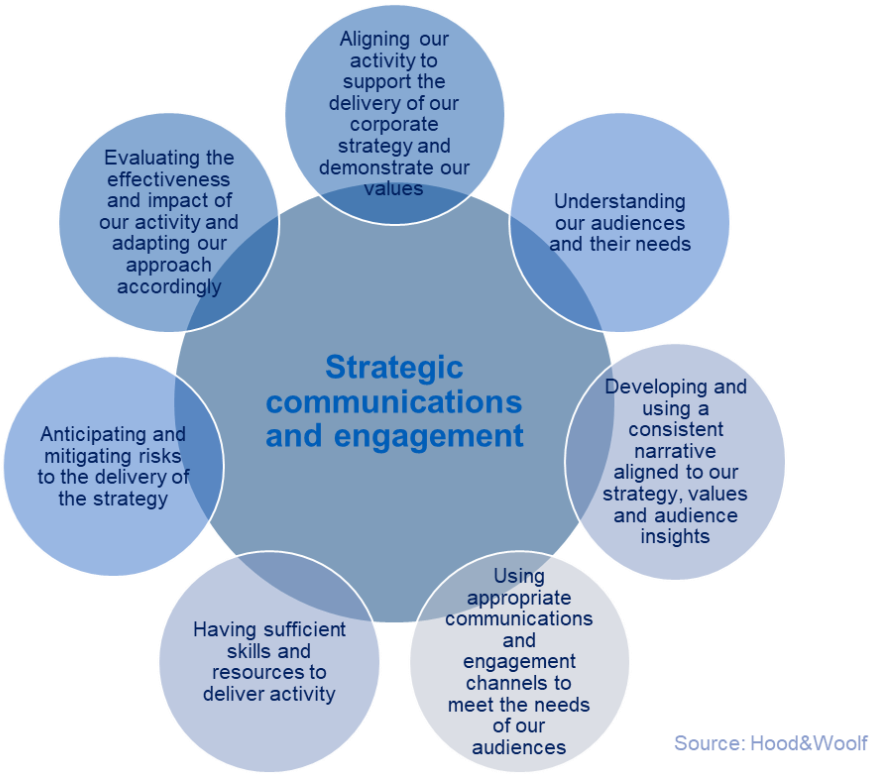
- communications and engagement activity is aligned to organisational strategy/priorities

so that

- communications and engagement activity is designed and delivered to both meet audience/stakeholder needs and support the delivery of organisational priorities.

1.3 How we will deliver strategic communications and engagement at SECAmb

Our communications and engagement activity and resource will be focused on supporting the organisation to deliver its goals and priorities, in a way that reflects and aligns with our organisational values. Our work will be steered by the strategic approach and elements of the process outlined below.



1.4 A note about staff engagement

This strategy covers our approach to communicating and engaging with our internal and external audiences, including our staff.

The term ‘staff engagement’ can mean different things depending on the context. At SECAmb, ‘staff engagement’ has traditionally been referred to in two main ways:

The first is focused on staff experience of the organisation – what it is like to be an employee at SECAmb. In this context, staff engagement refers to how staff feel about our organisation, how ‘engaged’ they feel with SECAmb. It is measured in three key ways:

- Motivation: Staff enthusiasm for and psychological attachment to the activities of the job
- Advocacy: Staff belief that the organisation is a good employer as well as service provider and is worthy of recommendation to others
- Involvement: Staff feeling that they have opportunities to suggest and make improvements to their own job as well as to the wider workgroup or organisation.

The second meaning covers the mechanisms and activity for communicating, talking with and exchanging information, ideas and views with staff, i.e. how we engage with staff. Examples of mechanisms for engaging with staff include:

- Communications channels such as the intranet, e-bulletin, team briefing bulletins, Chief's message/video messages, Yammer etc
- Meetings such as Town Hall, Teams A/B/C, team meetings, 1-2-1s

- Staff networks and staff engagement representatives, unions
- Trust webinars, listening days, site visits
- Staff surveys.

At SECAmb, we will use the term '***employee engagement and experience'*** to refer to our work to improve staff motivation, advocacy and involvement. We will use the term ***'engaging with staff'*** to refer to the mechanisms of engaging staff.

Responsibility for employee engagement and experience and engaging with staff falls to a wide number of teams and individuals across SECAmb. For example, including the executive team, communications team, directors, operational leads and line managers.

This communications and engagement strategy is focused on the mechanisms of ***engaging with staff.*** *H*owever, through effective, open and honest and two-way communications and engagement we will help to deliver improved employee engagement and experience.

We are also developing a People and Culture Strategy that will describe our approach to delivering improved employee engagement and experience at SECAmb. As described above, the communications and engagement activity will play a role in supporting the delivery of that strategy.

2 Our communications and engagement aims and objectives

2.1 Our communications and engagement aims

As an organisation, our overarching and ongoing communications and engagement aims are to:

- Use and focus our communications and engagement activity to support SECAmb to deliver its operational and strategic goals
- Engage our staff on our organisational values so they understand and support them, understand how to put them into practise, and recognise when they are being demonstrated by colleagues across the organisation
- Continue to build and develop constructive relationships, dialogue, understanding and support for SECAmb, its priorities and goals, among our key audiences, internally and externally
- Provide genuine opportunities for staff and stakeholders to share their views and feedback, and develop mechanisms for feedback to be regularly considered and responded to.

Our specific aims by key audience groups are shown in the table below.

Our staff	Our patients and carers	Our partners and stakeholders	Our local communities
• Build trust and relationships by demonstrating our values in everything we do	• Build trust and confidence in our services by demonstrating our values and	• Build trusted relationships by demonstrating our values	• Build trust and confidence in our services by demonstrating our values and

• Regularly demonstrate our improvement progress • Engage and involve our people in what matters to them • Celebrate excellence • Build a shared future vision	improvement progress • Engage and involve our patients in what matters to them • Demonstrate excellence • Build a shared future vision	• Regularly demonstrate our improvement progress • Engage and involve our stakeholders, working in partnership for the benefit of our patients • Build support and a shared future vision	improvement progress • Engage and involve local communities in what matters to them • Demonstrate excellence • Build support and understanding for a future vision

2.2 SMART objectives – how we will achieve our aims

We have developed the following SMART (SMART = specific, measurable, achievable, relevant and time-bound) objectives to help us achieve the aims of this strategy.

Type of objective	SMART objective
Inputs	• Design and deliver a stakeholder relations workshop with the executive team to map and agree priority stakeholder audiences for SECAmb, reflecting the most recent changes to the health and care systems in Kent, Surrey, Sussex and North East Hampshire, to inform a comprehensive stakeholder engagement approach, by end of May 2023 • Undertake desk research to identify a) existing research on stakeholder communication and engagement needs and preferences across the SECAmb geography and b) any gaps in intelligence that would benefit from further research/engagement with stakeholders by end of April 2023 • Design and deliver a stakeholder perceptions audit with circa top 10-15 stakeholders identified from workshop, to establish a baseline to measure improvement, by end of May 2023 • Deliver an initial review of the communications function, specifically to identify any skills gaps and to ensure best use of current resources by September 2023
Outputs	• Develop and deliver an updated core narrative and communications content for internal and external audiences about current organisational priorities and focus by end of April 2023 • Update/establish communications and engagement channels/mechanisms using the findings from engagement with staff and stakeholders, and the stakeholder mapping exercise,

Type of objective	SMART objective
	to identify any additional channels and/or identify any changes to existing channels to ensure they are meeting the needs of their audience by end of May 2023 • Each year, identify up to 5 key priority workstreams for focused, targeted and proactive communications and engagement activity and develop communications plans to support their delivery and review quarterly • Develop and deliver content at least once per week that demonstrates and brings to life SECAmb's organisational values for internal and external audiences • Work with colleagues across the organisation to develop and deliver up to 3 opportunities over the course of each year for stakeholders, patients and our communities to engage with us about what matters to them and to help us shape our future priorities • Produce 10 'You said, we did' examples each year for internal and external audiences to demonstrate listening and responsiveness • Deliver 12 opportunities to celebrate and share excellence with internal and external audiences each year • Evaluate the detailed communications and engagement plans (up to 5 per year) to measure their reach and impact • Undertake internal engagement with staff on communications and listening channels to check on the impact of the new communications and engagement strategy by end of March 2024
Outcomes	• Demonstrate an improvement in stakeholder perceptions of SECAmb and improved understanding of its priorities and focus, measured annually again the baseline audit • Demonstrate evidence to support improved staff survey and staff engagement scores measured annually [NB: – delivering this strategy should support improvements but improved staff survey scores will also be dependent on factors outside of the control of the communications team and outwith the activity described in this strategy] • Demonstrate evidence to show patient and community input into SECAmb's strategic priorities on an annual basis

2.3 Communications and engagement benefits

The benefits of achieving our aims and objectives will be:

- We will have a clearer understanding of the views of our staff, system partners, stakeholders and the people who use our services, and what is important to them. This will help inform the

further development and delivery of our corporate strategy and other enabling strategies (e.g., People and Culture, Clinical), and inform our ongoing communications and engagement content and approach

- Key stakeholders will be aware of the improvements SECAmb has made and will have more confidence in the organisation and its leadership to sustain improvements
- Staff across the organisation, system partners, stakeholders, patients, and local communities will have a better understanding of SECAmb's role, values, and priorities and how they relate to them, including any action these audiences need to take to support delivery of SECAmb's operational and strategic goals
- Support to delivering higher levels of employee engagement and experience
- Support to delivering higher levels of stakeholder engagement and experience
- Support to delivering the priorities within the corporate five-year strategy
- Support to enhancing SECAmb's reputation as an organisation (externally) and SECAmb's leadership's reputation (internally) – giving 'license to operate' and headroom to focus on the delivery of operational and strategic goals.

3 Our communications and engagement approach

3.1 Communications and engagement principles

Our communications and engagement activity will be based on the following principles, helping to deliver our overarching aims and objectives. We will:

- communicate with openness and transparency to build trust with our staff, system partners, stakeholders, patients, and local communities
- support the cascade of messaging across the organisation and to external audiences, and bring back audience insights and reactions
- provide genuine and authentic engagement opportunities for our staff, stakeholders, system partners, patients, and local communities to influence, inform and co-design our organisational strategy, direction, and ways of working
- focus on demonstrating the feedback loop so that our key audiences are clear their voices have been heard and they understand how their views have been considered and acted upon
- develop content based on insights, through developing a deep understanding of staff, system partner, stakeholder and patient and public motivations, needs, concerns, and perspectives
- communicate and engage in a way that protects and enhances the reputation of South East Coast Ambulance Service, looking for opportunities to demonstrate how we are living our values through our everyday work

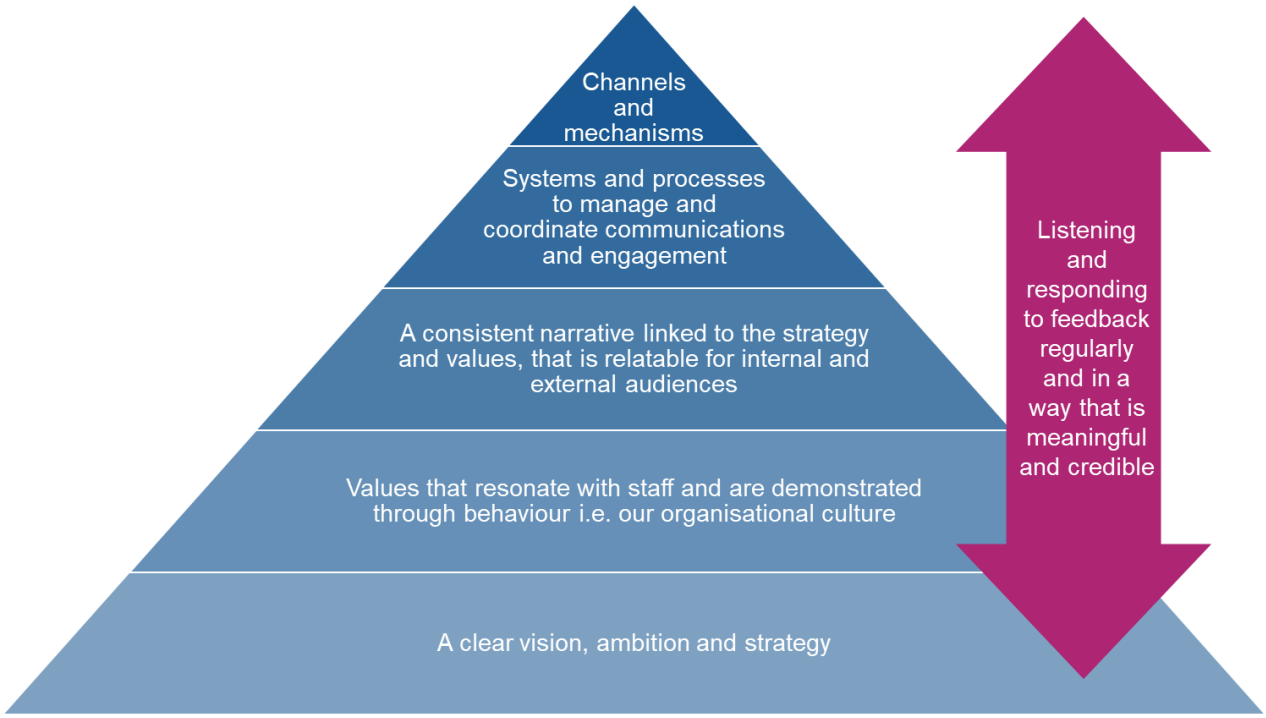
- seek opportunities to demonstrate a ‘servant’ leadership approach that seeks to support and facilitate front-line staff to do their jobs to the best of their abilities
- provide information in a timely manner, in a range of formats and via a range of channels, appropriate to the needs of different audiences and particularly reflecting the diverse ways in which our audiences operate and a range of communications preferences
- make sure our communications and engagement materials are available in accessible formats for those that need them
- make sure our content is consistent and clear; written and spoken in ‘plain English’ avoiding jargon and technical information, particularly with regards to public and patient information
- regularly seek feedback from our key audiences and review, evaluate and adapt as needed, our approach to communicating and engaging to ensure we meet their needs.

3.2 Communications and engagement linked to organisational strategy and values

Our approach to communications and engagement will be built on and informed by our organisational strategy that will set out a vision, priorities, and delivery plan for the organisation, as well as our organisational values.

We will use the corporate strategy and values to develop a clear and consistent narrative that will be the ‘golden thread’ in all our communications activity. We will ensure we have the right systems and processes in place to allow us to deliver high quality strategic communications activity that supports the delivery of the corporate strategy and demonstrates our organisational values. We will use a range of communications and engagement channels and mechanisms to deliver this activity, aligned to the needs of our audiences.

We will build in listening and feedback mechanisms at every level so that we can ensure the views of our internal and external stakeholders inform how our organisation works and that their communications and engagement needs are being met.



3.3 Developing a core narrative

An updated, organisational core narrative, messaging and associated communications products will be developed to reflect our new corporate strategy, recognising the narrative and messaging will iterate over time. It will be based on insight, understanding the starting points of our audiences and will be relevant and tailored for different audiences as needed – within an overarching consistent message framework.

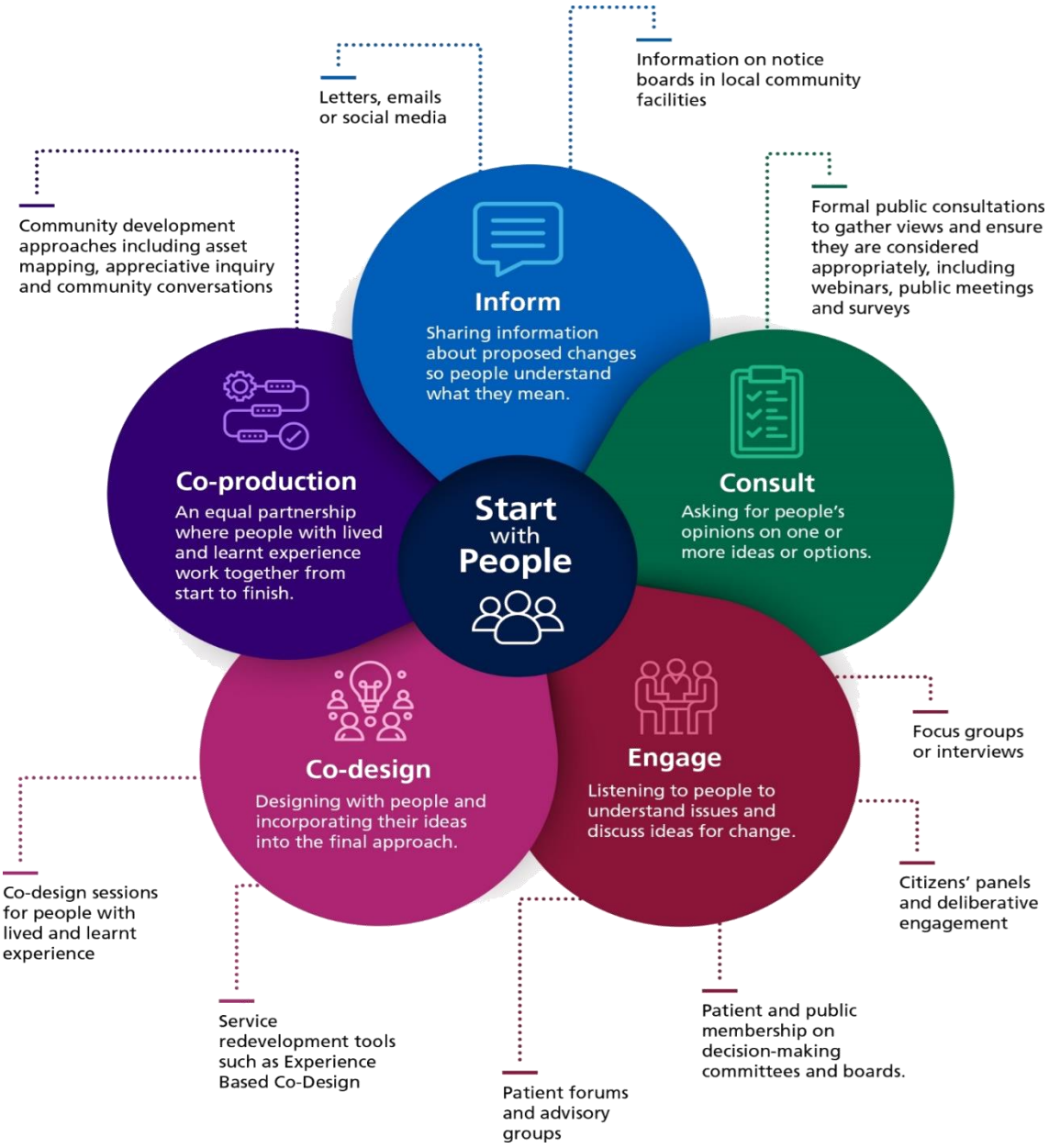
The narrative will acknowledge recent challenges and set out the need for a new organisational strategy, what we want it to achieve, our approach to developing it and how staff, system partners, stakeholders and those who use our services can be involved.

Narratives developed to support individual communications and engagement activity will draw on and reflect the core narrative.

3.4 Our communications and engagement methodologies

Our approach recognises that we will need to use different levels of communications and engagement for different audiences. As shown in the diagram[1] below, communications and engagement can range from one-way information sharing through to the co-production of services.

[1] Source: https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/. NHS England, July 2022



Much of what is described in this strategy will fall under informing, engaging and co-design. While this diagram is focused on patient and public involvement it is equally relevant for describing the range of methodologies for communicating and engaging with all audiences and stakeholder groups within this strategy.

4 Our target audiences

4.1 Our stakeholders and key audiences

We have identified the range and type of stakeholders we will engage and communicate with.

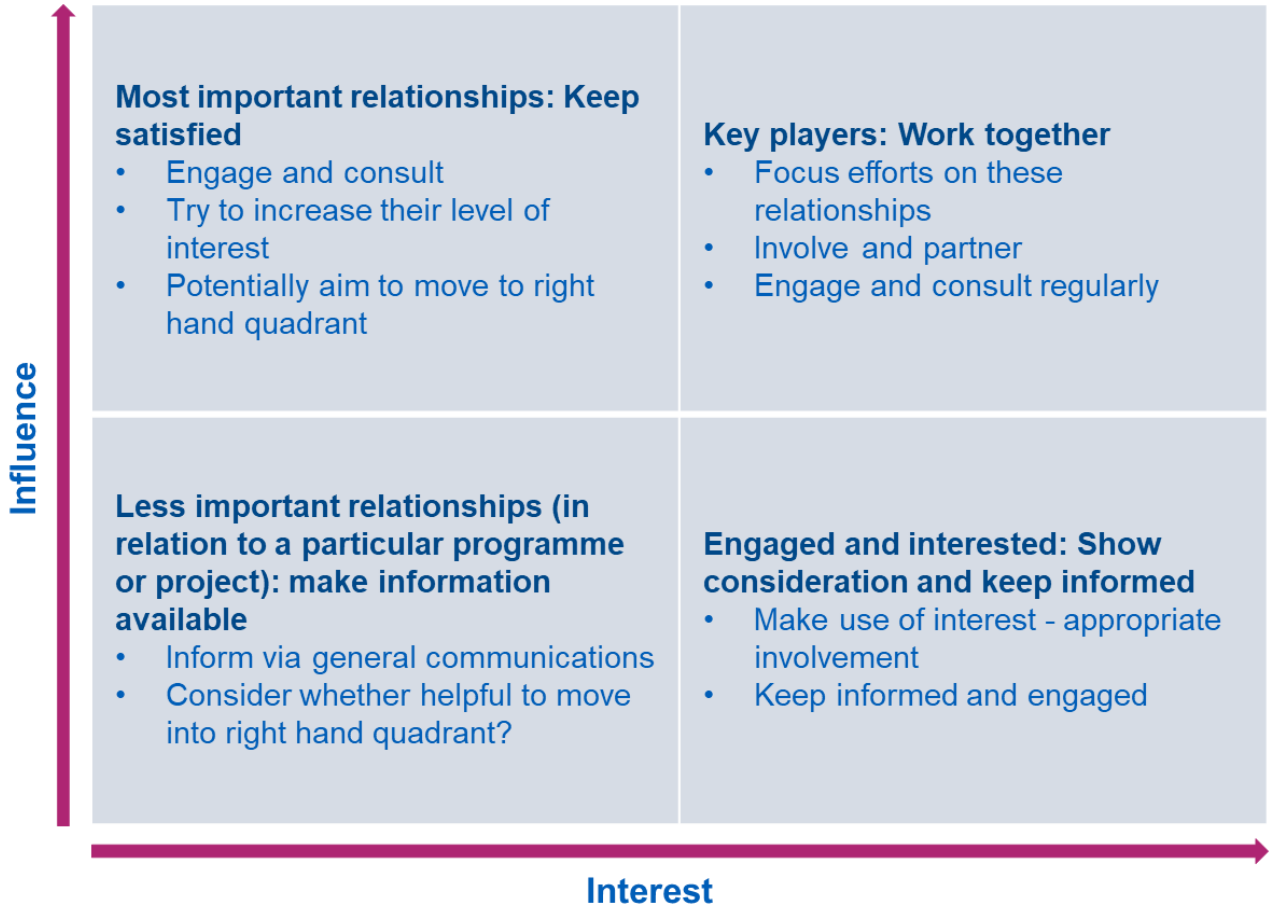
Audience group	Details
Patients and public	• Residents of Kent, Surrey, Sussex and NE Hampshire • Patients, carers and their families • Seldom heard groups • Groups with protected characteristics • Healthwatch • Patient and carers groups • Campaign groups • Voluntary, community and faith groups • Significant local employers and anchor institutions in Kent, Surrey, Sussex and NE Hampshire • Local business organisations and chamber of commerce
Staff	• Trades unions, staffside groups and professional organisations • Senior and middle managers • All SECAmb staff and volunteers
System partners	• ICBs: Kent and Medway, Surrey Heartlands, Sussex, Frimley, HIOW • Acute, community and mental health providers across Kent, Surrey and Sussex and NE Hampshire – boards and some frontline staff (e.g.: in ED, psychiatric liaison, urgent care services) • Upper tier local authorities – Kent County Council, Medway Council, East Sussex County Council, West Sussex County Council, Brighton & Hove Council, Surrey County Council, Hampshire County Council • Care home providers • GPs and practice staff • Pharmacists, dentists, opticians • VCSE organisations providing health and care services • Deaneries, universities, and medical schools
Healthcare regulators and scrutiny	• CQC • NHS England (South East; and national, especially Urgent and Emergency Care policy team, Health Education England team etc) • Professional bodies • South East Clinical Senate • HOSCs and HASCs in upper tier local authorities
Political	• MPs • Health Oversight and Scrutiny Committee members • Health and Wellbeing Boards • Councillors
Media	• Local traditional and online print and broadcast channels across Kent, Surrey, Sussex and NE Hampshire • Social media

Audience group	Details
	• National print and broadcast • Trade press (professional media outlets such as nursing or medical journals and publications, as well as online and social media counterparts, are often useful channels for raising awareness of proposals to staff and professional groups) • Partner organisation news channels such as council papers, local directories, parish bulletins and leaflets and voluntary sector organisation newsletters

4.2 Stakeholder mapping

As described in section 1.2, to ensure our communications and engagement activity is effective we need to have a good understanding of our stakeholders – what they think, know and feel about SECAmb, and what their communications and engagement needs and preferences are. The insights we gather will be used to inform our message and content development.

We will use the grid below to map the stakeholders and audience groups set out in section 4.1 above to gain a better understanding of how we can most effectively communicate and engage with them.



When we refer to **influence,** we are asking 'how much impact can this group or individual have on our organisation?' – this impact can be measured in different ways. For example, the actions of care home staff can have significant impact on call outs, impacting the availability of crews.

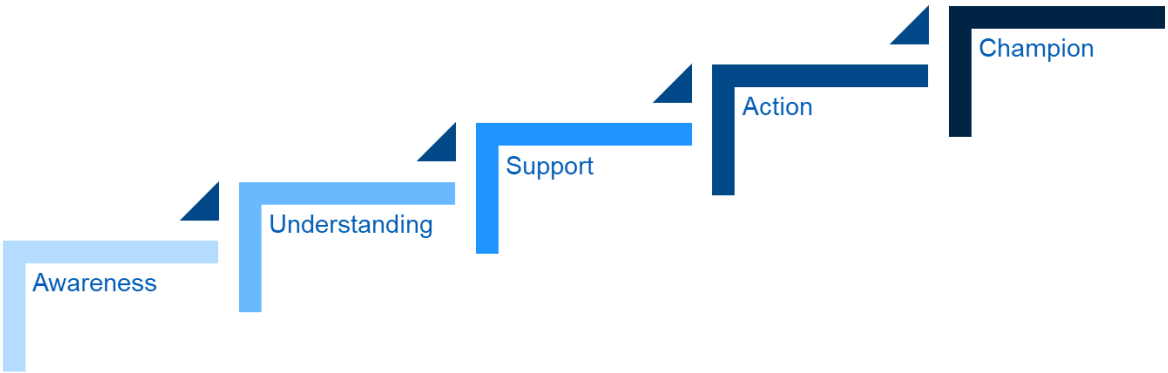
When we refer to **interest**, we mean how relevant are we to a stakeholder group. Care home staff are likely to have a relatively low interest in SECAmb beyond the need to call for an ambulance.

We recognise there is a wide range and number of partners and stakeholders we may want to involve and engage with as an organisation. This will also change over time and according to particular projects, programmes and areas of focus. As per best practice, we recognise our stakeholder audiences will have different needs and interests. We will shape our communications and engagement activity accordingly.

4.3 Engagement spectrum

Our audiences and stakeholders will sit somewhere on this engagement spectrum from 'awareness' of SECAmb through to being a champion of the organisation.

We will be mindful in the development of messaging and content for key programmes and projects as to where stakeholder audiences may be on this spectrum at any particular point in time. This will guide our work; we can't expect a particular individual or audience group to take action around or champion an issue if they are not even aware of it or don't have an understanding of it.



4.4 Stakeholder mapping to inform our communications and engagement activity

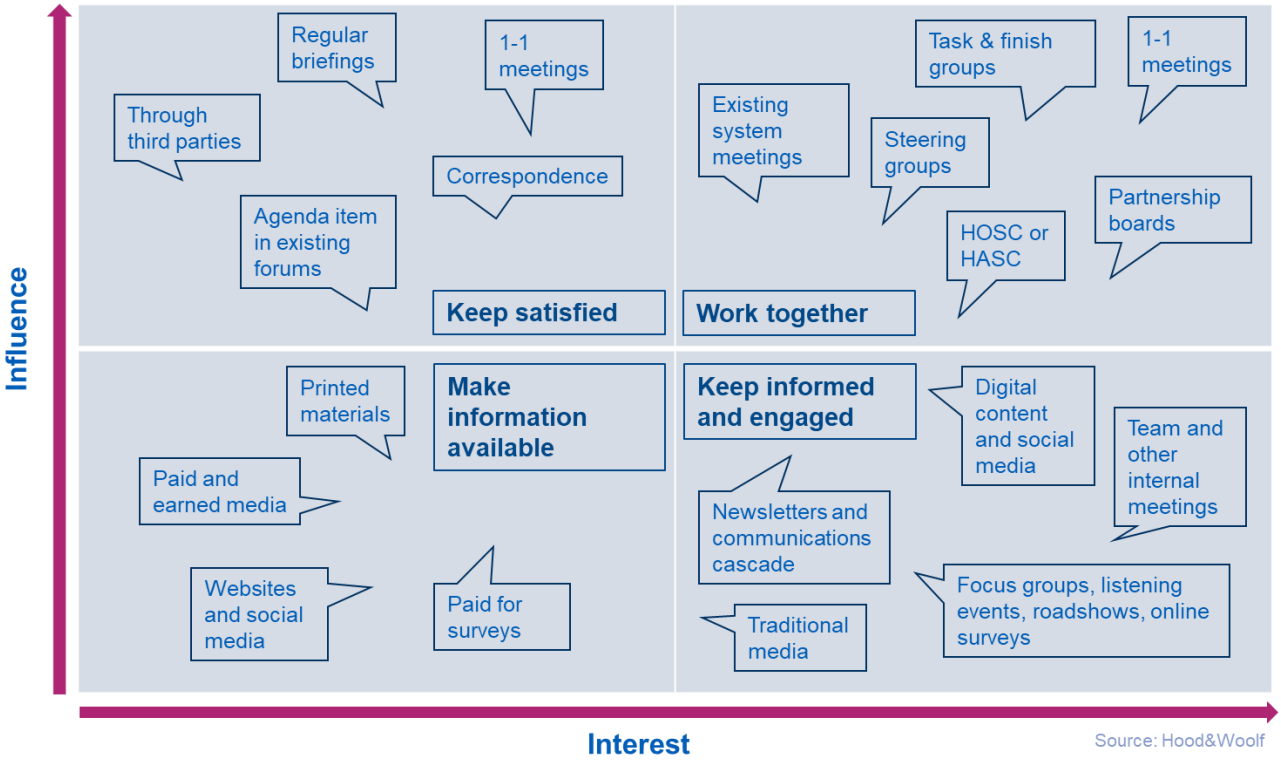
As we develop the new organisational strategy, and plan other communications and engagement activity, our stakeholder and engagement mapping work will help us to identify the key groups we need to target to ensure we have involved stakeholders effectively. It will also help inform our message and content development.

5 Our communication and engagement channels

5.1 Mapping our channels and planning our approach

As shown below, mapping our communications and engagement channels against the stakeholder map allows us to identify which communications and engagement approaches are likely to be most

appropriate and effective for different groups (NB: this is not intended as an exhaustive list of channels/engagement methodologies).



We recognise that each stakeholder group is not homogonous, and that different, tailored approaches may be needed for certain organisations or individuals within a stakeholder group. Our communications activity will be flexible enough to take this into account and we will take a targeted and nuanced approach to our stakeholder relations. One size doesn't fit all.

5.2 Our internal and external communications channels and mechanisms

We have a wide range of internal and external communications and engagement channels in place, and where appropriate we will develop or commission new and/or one-off channels as needed to support the delivery of specific pieces of work.

5.2.1 Existing internal communications and engagement channels

Channel	Content	Audience	Frequency
Intranet	Provides resources for staff. Has a dynamic news section which is used to create weekly e-bulletin. Also hosts podcasts for the clinical and education departments with quick and useful practice reminders. Has interactive/comment function	All staff	Daily

Channel	Content	Audience	Frequency
e-bulletin	Created weekly - provides an update on news which has been uploaded to intranet over the course of the week	All staff	Weekly
Team briefing bulletins	Must know operational and clinical briefings which go out weekly with urgent ones that go out as and when needed	All staff and external providers	Weekly/ as required
Chief's message	Fortnightly (alternates with written message) update from the Chief on recent activities and highlighting significant or important Trust issues	All staff	Fortnightly
Chief's video message	As above but as a short video	All staff	Fortnightly
Trust webinars	MS Teams sessions on various topics. Staff are able to create their own and post to the Trust's Stream platform and is used widely across the organisation. Also corporate-led events on issues of importance that allow staff to ask questions which are posted via the Q&A. Recordings and FAQs are then posted on the intranet and promoted via the bulletin	All staff	As required
Two-minute films	Aligned currently to Improvement Journey, these are on subjects relating to developments across the Trust. Delivered by any relevant member of staff. Feature in the weekly e-bulletin	All staff	Weekly
Yammer	Interactive platform for staff to create interest groups and engage with each other	All staff and volunteers	Daily
Staff twitter account	Share significant Trust news which may be of interest to staff such as CQC report etc. The account doesn't allow for interactions so is a one-way comms mechanism	All staff	As required
MS stream channels	Various channels to post video content which can be surfaced on our intranet. Videos can be liked and commented on	All staff	As required
Emails	All staff emails are sent as and when required but are reserved for the most important need-to-know information.	All staff	As required

Channel	Content	Audience	Frequency
Toilet door frames (for posters)	All new Make Ready Centres have picture frames on the back of toilet doors to share information on campaigns such as the flu vaccinations, wearing seat belts etc	Make Ready Centre staff	As required - normally part of a targeted campaign
Notice Boards	Notice boards at all Trust locations which are managed by local admin teams (with varying degrees of success in usage).	All staff	As required
Video screens	Located in control centres and Make Ready Centres - large information digital screens which can post need-to-know information which is normally used for targeted campaigns such as vaccinations programmes, improvement journey updates etc	All operational staff	As required
Weekly organisational briefing event	An open forum for staff and managers to come together and where managers may brief staff on matters coming up and allow staff to ask questions	Staff and managers	Weekly
Teams A	A meeting for all the senior operational leadership to discuss operational requirements	Senior ops managers	Weekly
Teams B	A meeting for senior ops colleagues to meet with the operating unit managers (and sometimes other managers) to brief on issues and service developments	Operating unit managers	weekly
Teams C	Meetings for operating unit managers to engage with their local teams on key operational and Trust business	Operational managers and team leaders	Varies
Staff networks	There are a number of staff networks representative of our diverse workforce, and these offer an opportunity to engage and work with them on campaigns etc	Interested staff	Varies

5.2.2 Existing external communications and engagement channels

Channel	Content	Audience	Frequency
Your service your call magazine	Newsletter style magazine providing latest developments in the Trust for FT members	FT membership	Quarterly
Website	This provides information on the Trust business and legally required information. Press releases etc are also shared via our website	The public	Regularly as required
Linked-in	This social media platform is used primarily for our recruitment drives	The public /potential employees	Regularly as required
Instagram	Used to share good news and to show support for the work of colleagues and other partner organisations as well as important national and local awareness days and campaigns	The public	Regularly
Facebook	Used to share good news and to show support for the work of colleagues and other partner organisations as well as important national and local awareness days and campaigns	The public	Regularly as required
Twitter	Used to share good news stories and respond to public interest and questions on our service	The public	Regularly
YouTube	Used to share public interested videos such as patient stories, board meeting recordings, recruitment videos and award citation films	The public	Regularly

5.2.3 Potential new or one-off communications and engagement channels

In addition to our existing communications and engagement channels we are likely to need to develop new channels of communication or use some short term/one-off approaches to ensure a wider and/or more targeted dissemination of our messages and create opportunities to engage with stakeholders, local people, and staff in more detail. The most common channels are set out below, although we may use other types of communications channels depending on the requirements of the programmes we are working on.

Channel	Description
Printed materials	While printed materials such as booklets, flyers, posters etc are resource intensive, and can date quickly, they can be a helpful way of raising awareness and provide an important channel for people who don't typically access information digitally. We may need to produce a range of printed materials to support specific communications and engagement activities, for example booklets, posters, flyers etc.
Paid for advertising	Where resources permit, and the need for widespread or very targeted awareness dictates, we will make use of paid for advertising in local media, and via social media channels.
Events, meetings and roadshows	Meetings, events and roadshows can be a helpful way to share information with and gather views from staff, stakeholders, patients and the public.
Research and surveys	On occasions, and where it is considered a good use of resources, it may be effective to use paid for research with key audiences in the form of surveys (online, telephone and street-based) and focus groups. This can help us to ensure that, when necessary, we get feedback and responses from a broad and representative range of people from our target demographic, who by default are not self-selecting.

6 Resourcing

The delivery of communications and engagement activity within SECAmb falls to a wide range of people across the organisation. The primary responsibility for delivering this strategy sits with the communications team, but the Board, Chief Executive and executive team, operational leaders and line managers across SECAmb will all play a vital role. Where the communications team is not directly leading the delivery of communications and engagement activity they will help support and facilitate others to do it so there is consistent messaging, tone, style, and 'look and feel' to the organisation's communications and engagement activity.

The delivery of the strategy will require a range of communications and engagement skills. There will need to be dedicated resource that can provide the following knowledge, skills, and experience:

- Strategic communications planning
- Internal communications and engagement
- Stakeholder relations and public affairs
- Horizon scanning, risk and reputational management
- Political awareness and system knowledge
- Message and narrative development
- Campaign planning and delivery
- Proactive and reactive media and social media management/handling
- Copywriting and content development
- Producing reports, correspondence, and briefing documents
- Publicity, advertising and marketing
- Public/patient engagement and involvement
- Digital and social media content creation
- Event and meeting management

- Design and print production
- Project management

In addition to staffing resource, a programme budget will be scoped against the delivery plan for this strategy. This is to deliver planned activity in the form of:

- Communications and engagement campaigns
- Design and print production
- Photography, digital and video content
- Advertising
- Marketing materials/products
- Display materials (e.g., banner stands, posters etc)
- Media monitoring
- Events and meetings
- Research/surveys etc
- Media training

7 Risks and mitigations

We have identified potential risks that could impact on the delivery of this strategy and mitigations against these.

Risk	Mitigation	Status (RAG)	Owner
Lack of resource/capacity to deliver the communications and engagement strategy means the aims and SMART objectives are not met leading to lower levels of confidence in SECAmb/SECAmb's leadership to deliver sustainable improvements and to have a clear vision and focus for the future	• Communications and engagement plan tested with Communications and Engagement Steering Group • Resourcing requirements clearly mapped and identified • Resourcing request to cover any gaps discussed at exec/board level • Scope and/or resource adjusted accordingly – acknowledging any trade-offs that reduction of scope would bring		XX
Unexpected, unplanned or new priorities arise and refocus resource away from delivering agreed communications and engagement priorities leading to a lower confidence in the organisation/Communications Team	• Acceptance of risk and likelihood of occurrence due to nature of work • Regular horizon scanning undertaken to anticipate potential new priorities • Quarterly review of annual delivery plan carried out to check progress and re-prioritise as required • Resourcing request to cover any gaps discussed at exec/board level • Scope and/or resource adjusted accordingly – acknowledging any trade-offs that reduction of scope would bring		

Risk	Mitigation	Status (RAG)	Owner
	• Rationale for changes to planned activity clearly communicated across organisation and externally as appropriate		
Factors beyond the control of the Communications Team (e.g., industrial action not resolved, significant rise in demand for services due to pandemic resurgence, People Plan not implemented etc.) impact on staffs' perception of communications and engagement at SECAmb	• Executive and Senior Leadership Team recognition of the importance of good operational leadership and line management throughout the organisation, as well as valuing staff and other culture and external factors, that will impact on perceptions of SECAmb's 'communications' • Regular horizon scanning undertaken to anticipate potential limiting factors • Close working with colleagues across the organisation to understand impact and resolve potential issues • Where limiting factors are identified, reports provided to Board/Exec highlighting likely impact and potential mitigations		
Insufficient time and capacity to understand and engage with key audiences could lead to disenfranchised stakeholders	• Dedicated time and resource to undertaking stakeholder mapping and agreeing ownership of stakeholder relationships at a senior level • Development and delivery of detailed ongoing stakeholder engagement plan • Sufficient resource allocated to supporting senior leaders to deliver effective engagement with key stakeholders (e.g., sufficient time and focus to meet and talk with external stakeholders, core narrative, key messages etc) • Regular review of activity and impact		XX
Lack of political buy-in and support for the next phase of SECAmb's Improvement Journey and the development of the five-year strategy means the leadership team has to spend time defending and explaining	• Early engagement with regulator (NHSE SE, CQC) and key political stakeholders across the region (MPs, HOSC and HWB chairs, local authority leaders and chief executives, other key councillors etc) • Identification of genuine opportunities for staff and stakeholders to co-design and feed into the development of the strategy		XX

Risk	Mitigation	Status (RAG)	Owner
	• Regular briefings and updates with consistent messaging		

8 Evaluation

This communication and engagement strategy will be measured and evaluated against the SMART objectives set out in Section 2.2. SMART objectives will also be set and evaluated for individual communications plans in support of the overarching strategy.

The majority of the SMART objectives can be internally assessed and assured against delivery. We will use existing mechanisms and methodologies (e.g., Staff Survey/Pulse Survey), and as appropriate, bespoke no-cost/low-cost means such as a targeted Survey Monkey (or similar) to gather feedback from internal and external audiences about the impact of our communications and engagement activity and to assess its impact on perceptions and opinions of SECAmb.

We will make sure the outputs and outcomes from our communications and engagement activity continue to feed into the ongoing improvement work taking place across SECAmb.

9 Review date

As set out in the SMART objectives in Section 2.2, an annual communications and engagement delivery plan will be developed each year, to coincide with the wider organisational business planning cycle. The annual delivery plan and associated key priority area communications plans will be reviewed quarterly and updated as necessary based on feedback and evaluation insights.

A full review of this strategy will be carried out in April 2026.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

NHS Staff Survey 2022

Trust Board

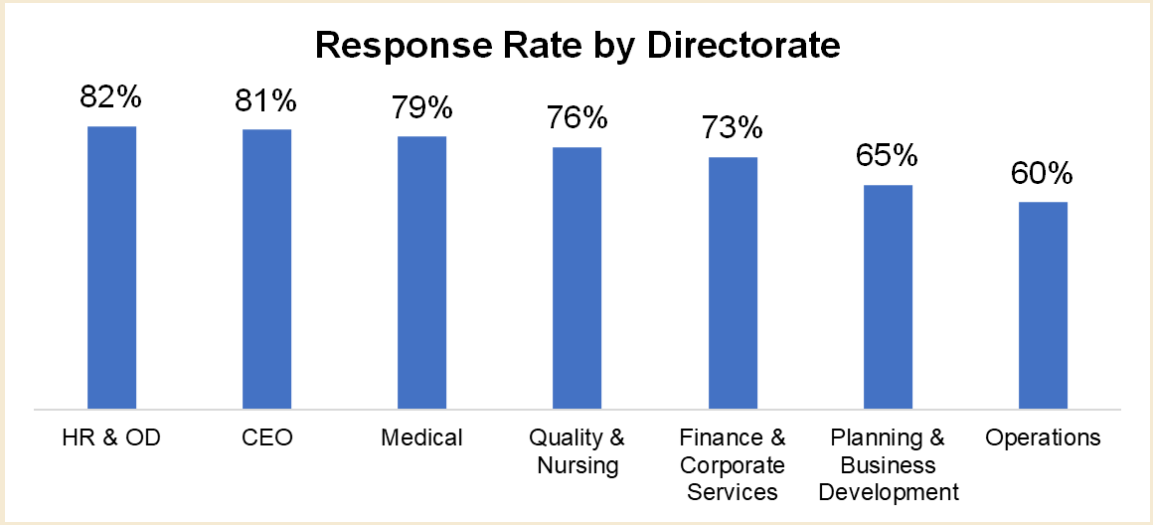
6 April 2023

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

NHS Staff Survey – Fieldwork & Response

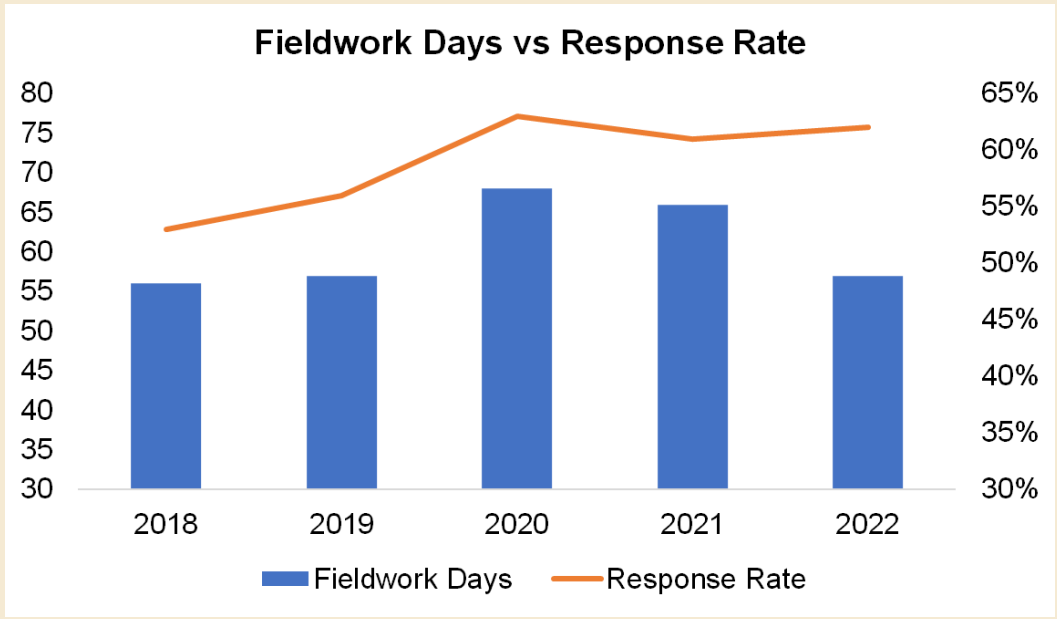
South East Coast Ambulance Service NHS Foundation Trust

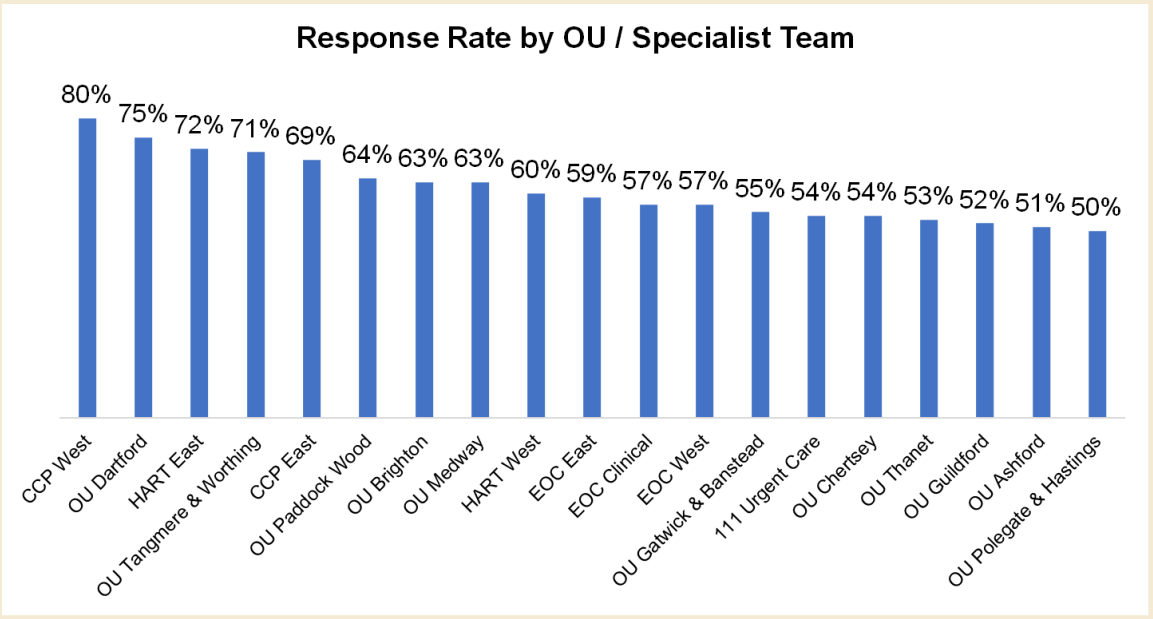
- Final response rates – **62%** (core) & **31%** (bank) – both higher than the national average.
- Achieved our 60% minimum target for the third time, despite a shorter fieldwork period.
- Our interactive NSS promo pack for managers shared as good practice by NHSE nationally.
- View the full fieldwork and response rate report here.



2609 responses

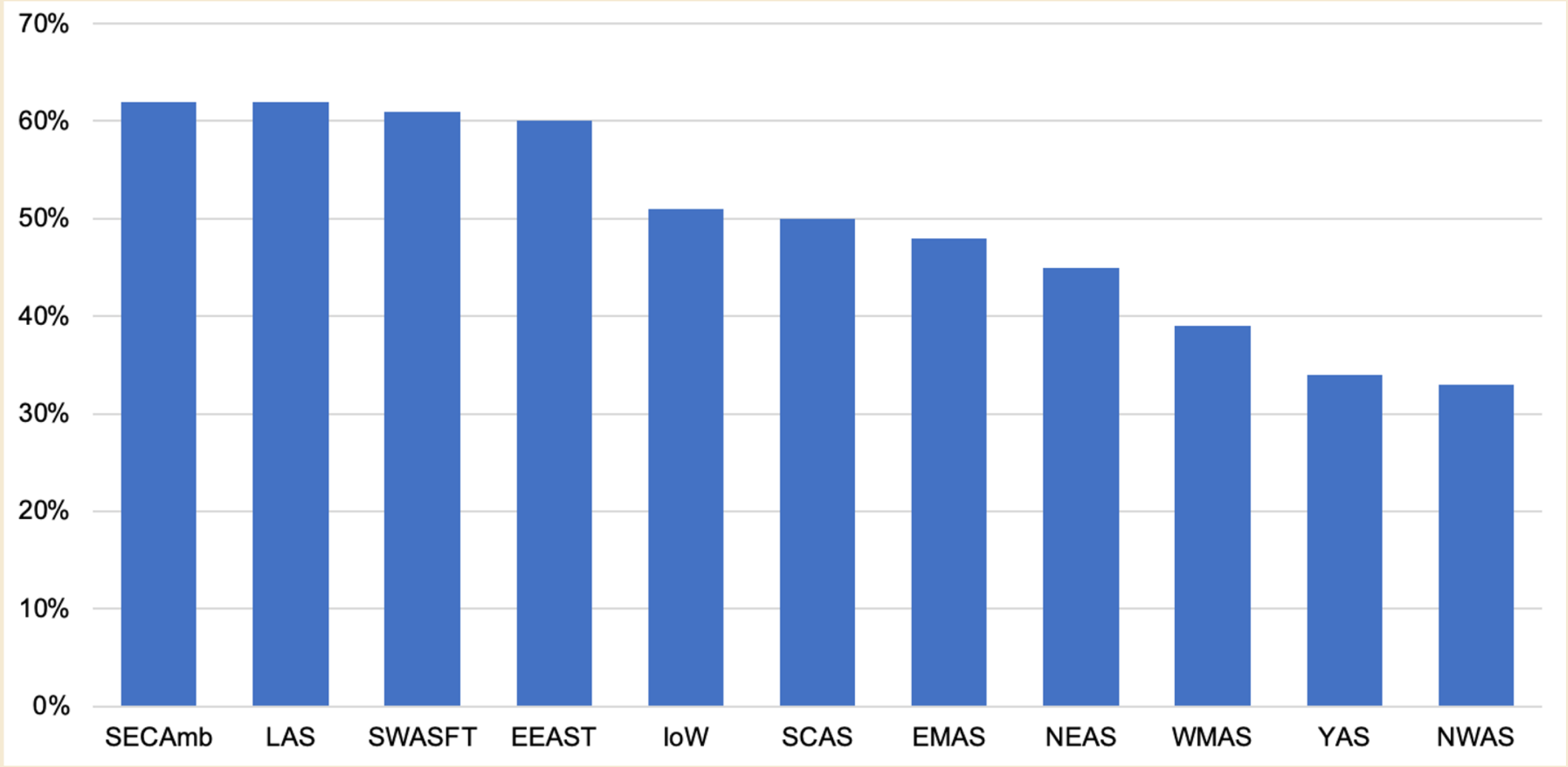
Our highest to date!





NHS Staff Survey – Amb Trust Response Rates

NHS
South East Coast Ambulance Service
NHS Foundation Trust

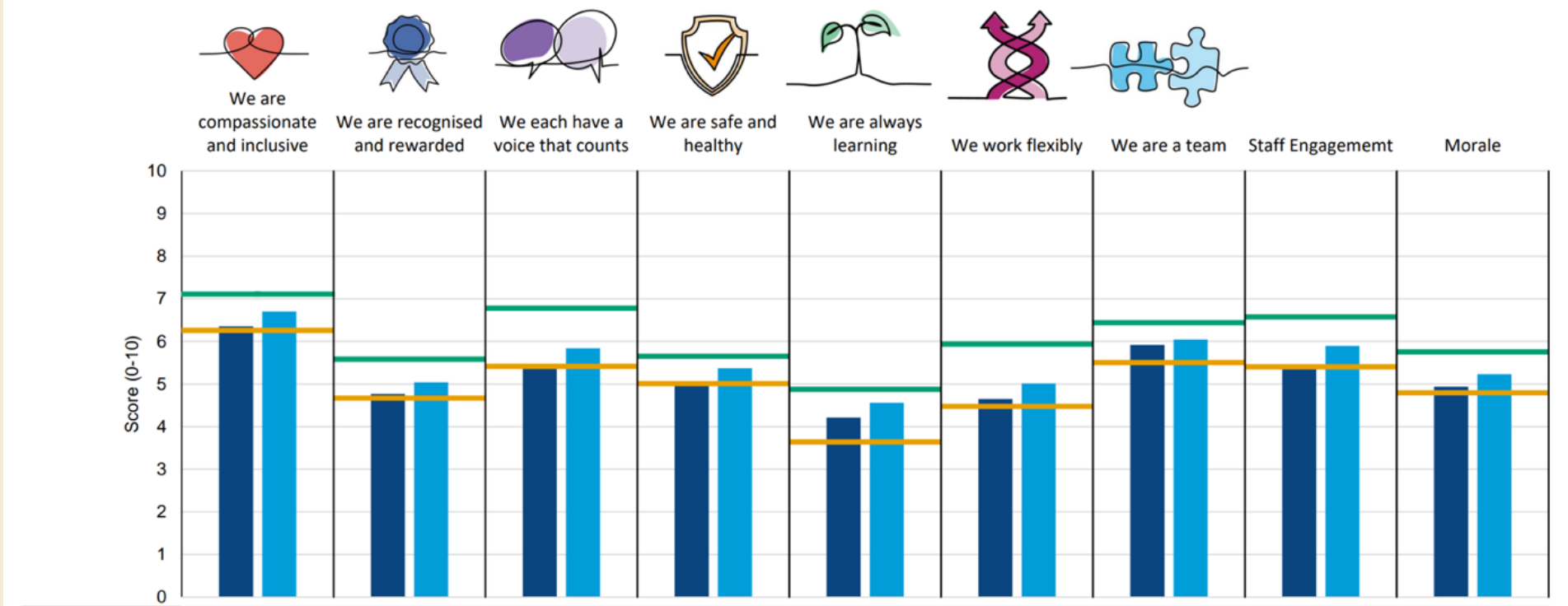


NHS Staff Survey – Theme Results

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Our scores are below average in every People Promise element and Theme in 2022.

Our scores for ‘We each have a voice that counts’, ‘We are safe and healthy’, and Staff Engagement are or are equal to that of the worst performing ambulance trust.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.4	4.8	5.4	5.0	4.2	4.7	5.9	5.4	4.9
Best	7.1	5.6	6.8	5.7	4.9	5.9	6.4	6.6	5.8
Average	6.7	5.0	5.8	5.4	4.6	5.0	6.0	5.9	5.2
Worst	6.3	4.7	5.4	5.0	3.6	4.5	5.5	5.4	4.8
Responses	2607	2604	2587	2605	2438	2596	2603	2607	2608

Theme Results – Amb Trust Comparison

NHS
South East Coast Ambulance Service
NHS Foundation Trust

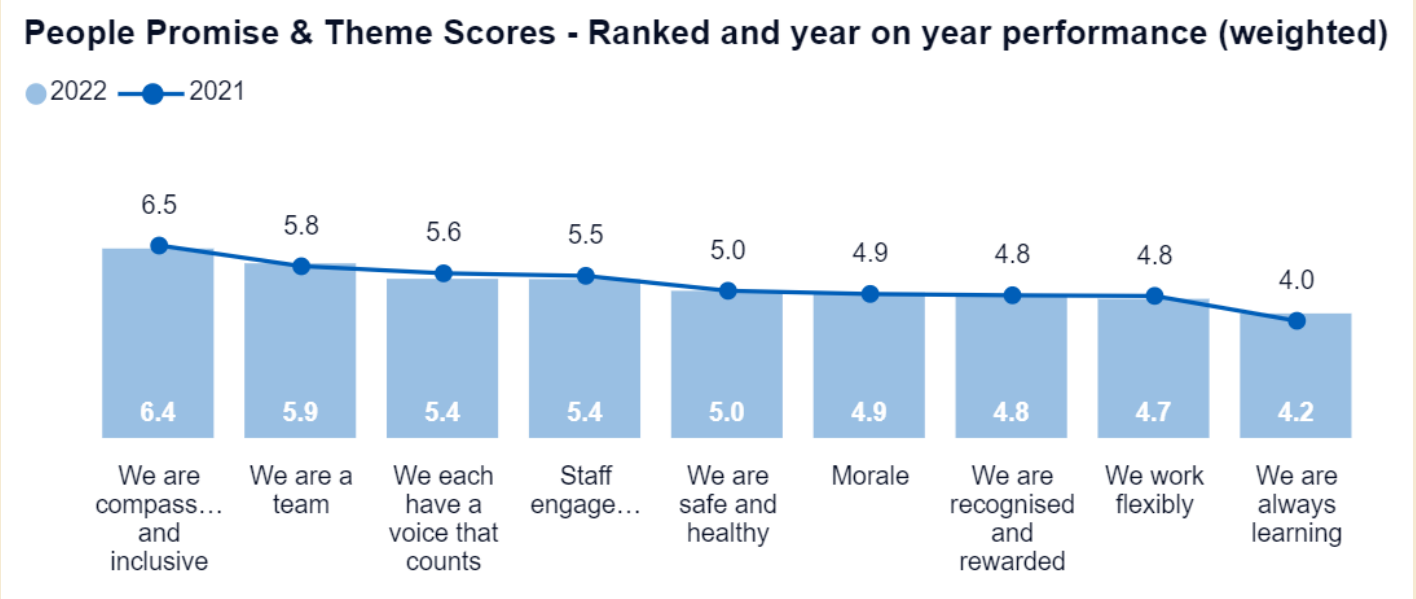
We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
IoW 7.1	IoW 5.6	IoW 6.8	IoW 5.7	SCAS 4.9	IoW 5.9	IoW 6.4	IoW 6.6	IoW 5.8
SCAS 6.9	EMAS 5.2	EMAS 6.0	EMAS 5.5	IoW 4.8	EMAS 5.4	SCAS 6.4	EMAS 6.0	EMAS 5.4
EMAS 6.8	SCAS 5.2	SWASFT 6.0	SWASFT 5.5	SWASFT 4.8	YAS 5.3	EMAS 6.1	YAS 6.0	WMAS 5.4
SWASFT 6.8	SWASFT 5.1	YAS 6.0	NEAS 5.4	YAS 4.7	LAS 5.2	SWASFT 6.1	NWAS 5.9	YAS 5.4
YAS 6.8	LAS 5.0	SCAS 5.9	NWAS 5.4	NWAS 4.6	EEAST 5.1	YAS 6.1	SCAS 5.9	SWASFT 5.3
NWAS 6.7	NWAS 5.0	LAS 5.8	WMAS 5.4	WMAS 4.6	SCAS 5.0	LAS 6.0	SWASFT 5.9	NWAS 5.2
LAS 6.6	YAS 5.0	NWAS 5.8	YAS 5.4	EMAS 4.5	SWASFT 5.0	NWAS 6.0	LAS 5.8	SCAS 5.2
NEAS 6.5	SECAmb 4.8	WMAS 5.8	SCAS 5.3	LAS 4.5	NWAS 4.9	SECAmb 5.9	NEAS 5.7	LAS 5.1
SECAmb 6.4	WMAS 4.8	NEAS 5.6	LAS 5.2	NEAS 4.4	SECAmb 4.7	WMAS 5.7	WMAS 5.6	NEAS 5.1
WMAS 6.4	EEAST 4.7	EEAST 5.5	EEAST 5.1	SECAmb 4.2	WMAS 4.7	NEAS 5.6	SECAmb 5.4	SECAmb 4.9
EEAST 6.3	NEAS 4.7	SECAmb 5.4	SECAmb 5.0	EEAST 3.6	NEAS 4.5	EEAST 5.5	EEAST 5.4	EEAST 4.8

NHS Staff Survey – Theme Results YoY

South East Coast Ambulance Service NHS Foundation Trust

- Year-on-year, there was a 0.1-point improvement in the ‘We are a team’ element, and a 0.2-point improvement in ‘We are always learning’, the latter of which is deemed to be statistically significant by the Survey Coordination Centre.

- Our scores in ‘We are compassionate and inclusive’, ‘We work flexibly’ and ‘Staff Engagement’ declined by 0.1. The score for ‘We each have a voice that counts’ declined by 0.2.



- The declines in ‘Staff Engagement’ & ‘We each have a voice that counts’ were also deemed statistically significant. (Staff Engagement measures advocacy, motivation and involvement in improvement and decisions that affect us. ‘We each have a voice that counts’ measures autonomy, control, and raising concerns.)

NHS Staff Survey - Question Results

NHS
South East Coast Ambulance Service
NHS Foundation Trust

- 43 questions improved YoY.
- Improvements ranged from 0.1% to 10.5%.

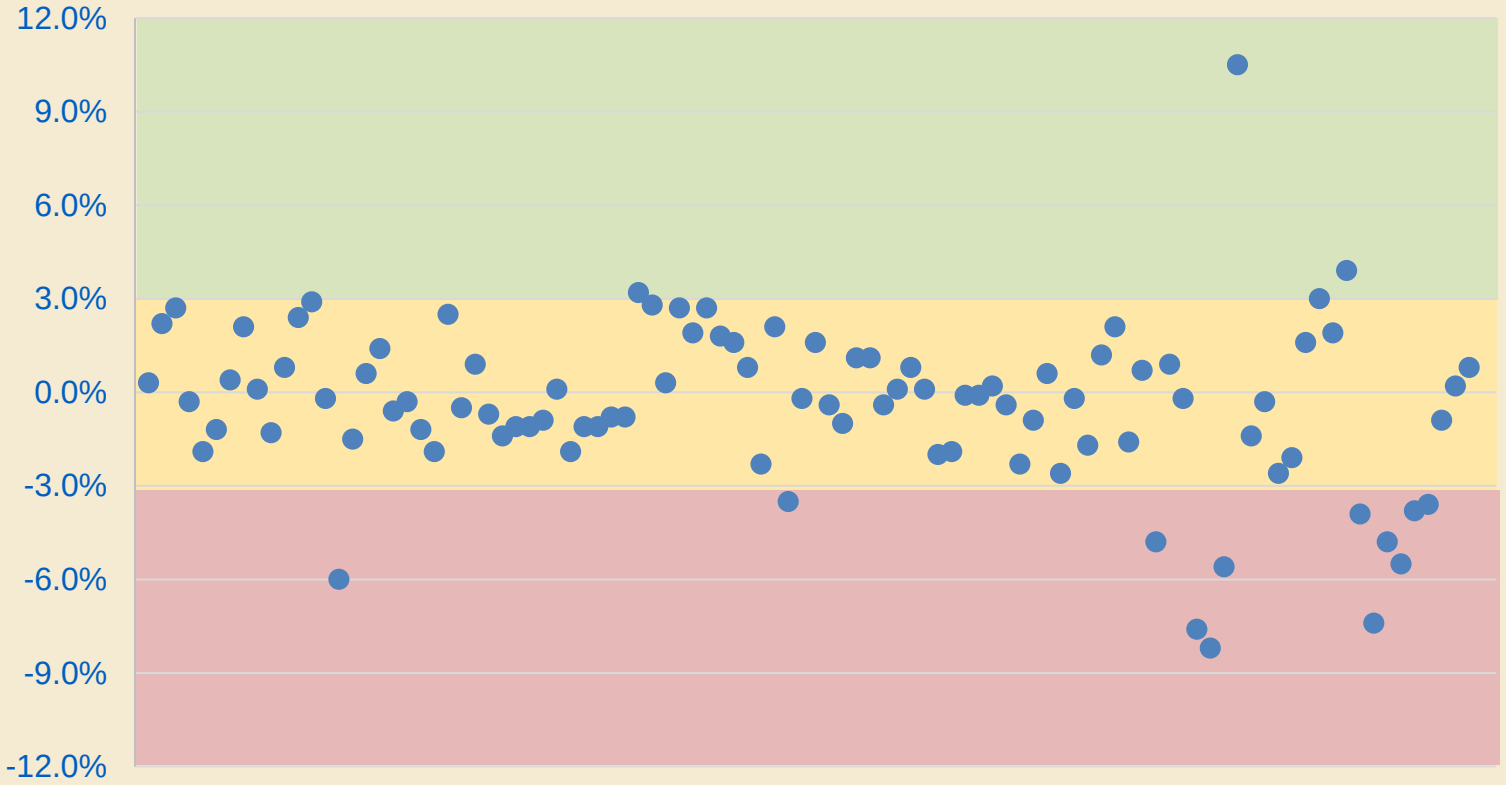
- 55 questions worsened YoY.
- Declines ranged from 0.1% to 8.2%.

Theme/Measure	Ques. Improved	Ques. Worsened
Staff Engagement	5	4
Morale	8	5
We are compassionate & inclusive	5	12
We are recognised & rewarded	2	3
We each have a voice that counts	4	7
We are safe & healthy	11	12
We are always learning	5	4
We work flexibly	1	3
We are a team	5	7

NHS Staff Survey - Question Results

South East Coast Ambulance Service NHS Foundation Trust

Difference for each question YoY



This graph shows the increase or decrease in positive scores for each question year on year (2021 - 2022). The positive score indicates a favourable result - the higher the positive score, and the greater the increase, the better.

The majority of scores fall within a 3% margin either side of 0 in terms of difference year on year. Scores outside of this margin indicate a more significant swing in either direction.

NHS Staff Survey - Question Results

South East Coast Ambulance Service NHS Foundation Trust

These questions fall outside of the -3% to +3% window, suggesting that the scores may indicate a more significant change in these areas.

To access a heatmap and see the results for all questions, click here (please open in the desktop app rather than online to enable all features).

Question	% Change
In the last 12 months, have you had an appraisal? (Yes).	10.5%
I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	3.9%
My immediate manager encourages me at work (Agree/Strongly agree).	3.2%
I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	3.0%

Question	% Change
I am confident that my organisation would address my concern (about unsafe clinical practice) (Agree/Strongly agree).	- 8.2%
I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	- 7.6%
My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	- 7.4%
My level of pay (Satisfied/Very satisfied).	- 6.0%
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	- 5.6%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	- 5.5%
I would recommend my organisation as a place to work (Agree/Strongly agree).	- 4.8%
On what grounds have you experienced discrimination? Disability (No).	- 4.8%
Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	- 3.9%
I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	- 3.8%
If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	- 3.6%
My organisation takes positive action on health and well-being (Agree/Strongly agree).	- 3.5%

NHS Staff Survey – Highest Performance

South East Coast Ambulance Service NHS Foundation Trust

In the last 12 months how many times have you personally experienced physical violence at work from managers (Never).	99%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (Never).	98%
On what grounds have you experienced discrimination? Religion (No).	96%
On what grounds have you experienced discrimination? Sexual orientation (No).	87%
In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (No).	85%
On what grounds have you experienced discrimination? Ethnic background (No).	85%
On what grounds have you experienced discrimination? Disability (No).	84%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (No).	83%
My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).	81%
I always know what my work responsibilities are (Agree/Strongly agree).	81%
On what grounds have you experienced discrimination?Other (No).	79%
I feel that my role makes a difference to patients / service users (Agree/Strongly agree).	79%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (Never).	78%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (Never).	78%
I enjoy working with the colleagues in my team (Agree/Strongly agree).	77%
I am trusted to do my job (Agree/Strongly agree).	77%
The last time you experienced physical violence at work, did you or a colleague report it (Yes).	72%
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review (Yes).	70%

This table shows the questions for which we achieved the highest positive scores.

Positive scores indicate the proportion of survey respondents answering favourably.

If a question is shaded green, this means that question also showed a potentially significant improvement year-on-year.

If a question is shaded red, this means that question showed a potentially significant decline year-on-year.

For all questions, the higher the score, the better the result.

NHS Staff Survey – Lowest Performance

South East Coast Ambulance Service NHS Foundation Trust

I often think about leaving this organisation (Strongly disagree/Disagree).	30%
The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).	28%
I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	26%
If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	26%
I am able to make improvements happen in my area of work (Agree/Strongly agree).	26%
I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	25%
My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	23%
How often, if at all, do you not have enough energy for family and friends during leisure time (Never/Rarely).	22%
The extent to which my organisation values my work (Satisfied/Very satisfied).	21%
It (the appraisal) helped me agree clear objectives for my work (Yes, definitely).	21%
How often, if at all, are you exhausted at the thought of another day/shift at work (Never/Rarely).	20%
I have unrealistic time pressures (Never/Rarely).	19%
My level of pay (Satisfied/Very satisfied).	18%
How often, if at all, do you feel burnt out because of your work (Never/Rarely).	18%
It (the appraisal) left me feeling that my work is valued by my organisation (Yes, definitely).	16%
There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	15%
It (the appraisal) helped me to improve how I do my job (Yes, definitely).	13%
How often, if at all, do you find your work emotionally exhausting (Never/Rarely).	12%
How often, if at all, does your work frustrate you (Never/Rarely).	9%
How often, if at all, do you feel worn out at the end of your working day/shift (Never/Rarely).	7%

This table shows the questions for which we achieved the lowest positive scores.

Positive scores indicate the proportion of survey respondents answering favourably.

If a question is shaded green, this means that question showed a potentially significant improvement year-on-year.

If a question is shaded red, this means that question showed a potentially significant decline year-on-year.

For all questions, the higher the score, the better the result.

NHS Staff Survey – Free Text Synthesis

South East Coast Ambulance Service NHS Foundation Trust

All Staff
• Lack of support for new employees • Inadequate pay compared to responsibilities and experiences • Poor management, including favoritism, nepotism, and a lack of communication • Bullying and poor work/life balance • Need for development time built into rotas and funded by the NHS • More transparency in decision-making and better communication from senior management • Constant demand for ambulance services, leading to high call volumes, long waiting times, and verbal abuse • Lack of support services directed towards operational/patient-facing staff • Discrimination against those with additional needs and favoritism within the trust • Staff exhaustion, low morale, and retention problems

Bank Responses
• Dissatisfaction with the pay structure and feeling undervalued and unappreciated for work and experience • Discrimination against non-qualified staff in terms of promotional opportunities • Increasing workload and pressure leading to compromises in the quality of patient care • Treatment of bank staff, including lack of development opportunities and support • Outdated equipment and vehicles • Lack of communication and engagement • Poor quality of management • Lack of support for mental health and wellbeing of staff • Poor dispatch resulting in staff attending unnecessary incidents and becoming demotivated and unhappy.

These tables show a synthesis of the free text comments and have been produced using AI capability (courtesy of Mercury Analytics AI Open-End Analysis) to analyse the 185 pages of commentary.

They are **not** intended to replace the comments but merely to summarise the key themes.

Draft Recommendations

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Considering all aspects of our results, including our theme scores and the comparison with our benchmarking group, our lowest performing questions, as well as potentially significant declines year-on-year, we would make the following recommendations:

- **Recommendation 1**: Consider what further work is required to improve psychological safety in teams, with the aim of improving confidence and feelings of safety around speaking up or raising concerns. In addition, review our processes in relation to how we act on concerns when they are raised by employees or patients/service users, and how we share learning and outcomes with employees.

- **Recommendation 2**: Continue to review our processes and principles in relation to the involvement of employees in decisions and changes that affect them through a focus on Employee Engagement and Quality Improvement. Consider how we can ensure employees feel able to make improvements happen in their area of work, and how we can ensure managers and leaders actively seek input on decisions and changes, turning insights into action at local and Trust level.

- **Recommendation 3**: Consider any further supportive measures or policy/process changes that could be introduced to address work/life balance, burnout, overwork and general wellbeing, with a focus on our approach to flexible working, our promotion of pre-existing wellbeing offers, and any other arrangements that may be adversely impacting employees.

Our survey contractor's recommendations support our assessment, with their own recommendations suggesting a **focus on raising concerns** and **wellbeing**. IQVIA also suggested looking at the reasons why **some staff feel that the care of patients is not the organisation's top priority**.

The OD Team are supporting managers across the Trust to review their own results and develop local plans to address local issues in collaboration with staff. This is especially important given the somewhat large variance in employee experience across areas, as shown in local survey results.

*Draft recommendations to be reviewed and agreed at EMB in April

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	11-23

Name of meeting	Trust Board
Date	06.04.20023
Name of paper	Draft Action Plan regarding the Trust's response to 'Listening to Workers: A speak up review of ambulance trusts in England.' National Guardian February 2023
Responsible Executive	Rob Nicholls
Author	Kim Blakeburn FTSUG
Synopsis	On 17th March 2023 the Trust received notification from the Chief Workforce Officer NHSE and the Director for Integrated Urgent and Emergency Care NHSE to complete and return actions regarding recommendations 2 and 4 of the Nation Guardian's report. Submission is via a template that was used in the attached draft response and is required to be submitted by 28th April 2023. The following is a summary of the recommendations: 1. Review broader cultural matters in ambulance trusts • Responsible organisation(s). Department of Health and Social Care and NHS England Recommendation 2. Make speaking up in ambulance trusts business as usual. For all Ambulance Trust 3. Effectively regulate, inspect, and support the improvement of speaking up culture in ambulance trusts. Care Quality Commission. 4. Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers. All Ambulance Trust. SECAmb's FTSUG will provide the Trust Board in June 2023, with a more detailed analysis of the Trust's position against the National Guardian's report.
Recommendations, decisions or actions sought	For information

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**

Recommendations	Key Actions	Expected outcome/Measure of progress	Progress Implementation Timescale	Accountable Lead
Make speaking up in Ambulance Trusts business as usual - Trust Board accountability	From Sept 2022, FTSU training was mandated for all staff.	The target training compliance in a rolling year is to achieve a minimum of 85%.	685 staff completed have completed speak-up training to date.	FTSUG
	Include FTSU in Trust induction and onboarding documents.	There is a standard agenda item on the induction programme with the FTSU team being involved in delivering these sessions. An on-boarding document will further inform staff about speaking up and how to escalate concerns.	FTSU is incorporated in induction however, further improvement is required to provide information through a wider variety of formats. A video is being developed with support from Brighton University and an on-boarding PageTiger (online learning tool) is in development.	FTSUG
	Deliver a programme of staff engagement events across all service lines and at a range of locations to raise speaking up awareness.	A programme of awareness events delivered across the rolling year using case studies to increase understanding and confidence in speaking up. There will also be virtual clinics accessible via the Trust intranet site.	FTSUG engaging with operating management teams via existing meeting structures at multiple levels - programme to be available from 1st June 2023.	FTSUG
	To provide a wider range/diversity of avenues for staff to receive information regarding speaking up.	Production of a range of information types/sources with bitesize information with the aim of staff reporting greater confidence and understanding of FTSU.	The Trust interal website ('The Zone') has been updated and will be regularlly reviewed. Information has been shared with staff via social media (Yammer and Twitter).	FTSUG working with the Communications Manager
	FTSU data and trend analysis reported to the Trust Board via bi-annual reports and the Integrated Quality Report (IQR).	Board is regularly informed of FTSU activities, trends and outcomes.	The Board currently receives bi-annual reports presented by the FTSUG. The new FTSU dashboard will provides greater granularity and comprehension of the data published - this also supports integration with the IQR.	Director Q & N
	Delivery of a board development session specifically focussing on FTSU - supported by the National Guardian.	Board accountability and assurance of FTSU.	Board development days in place. A session in the Autumn of 2022 was supported by the National FTSU Guardian. Further sessions delivered to Executive team by the FTSUG. Planned session for the Board in Spring 2023 regarding the National Guardian's Office report.	Company Secretary
	Delivery of a FTSU data dashboard (via PowerBI) which enables leadership teams to triangulate FTSU data alongside other people-focussed metrics.	FTSU dashboard in place and being well used to support staff and the wider Trust.	The dashboard is in place with access by all relevant staff/managers.	FTSUG
	To develop a model of FTSUG champions across all operational teams.	FTSU champions in place in all teams, with appropriate support in place, raising awareness and signposting.	Job descriptor has been developed. Currently developing the governance around the roles that will take into consideration protected time, reporting and escalation routes.	FTSUG
	To review and revise the Trust's current FTSU policy ensuring that it encompasses the minimum standards set out in the FTSU policy of June 2022. All Boards are expected to evidence this by January 2024.	An updated FTSU policy reflecting the national template. The Trust to conduct an analysis of current position against the revised guidance. Develop an improvement plan that will be monitored via the Trust's governance process.	A draft policy is in development and will be ratified by June 2023. A gap analysis and improvement plan will be developed thereafter and monitored via the Executive Management Board and reported to Trust Board in the bi-annual FTSUG report.	FTSUG
Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers	Review of capacity and capabilities within the Trust's FTSU service.	FTSU team is accessible to more staff, covering a wider geographical area. Opportunity for FTSU to work proactively with managers to support delivering a speak up culture as BAU.	In August 2022, the Trust increased the FTSU establishment by 2.0 WTE staff to support the FTSUG. 2.0 WTE was recruited in October 2022. The appoinment of the deputy FTSUG roles was through a fair and transparent recruitment process. A review of the impact of these additional posts will be conducted in September 2023.	FTSUG
	FTSUG and Deputies are supported through supervision: peer support, mentoring and coaching.	Support the roles to work extensively across the Trust with other leaders to help embed a speak up culture. Work in partnershipwith but at the same time challenge senior leaders. Support the triangulation of data that enables the Trust to improve the quality of our services and our peoples experience.	January 2023, regular funded external supervision is provided to the entire team. The FTSUG attends network meetings and has support from the National Guardian's office. FTSUG attends Teams A & B alongside the T&F group.	FTSUG
	There is an Executive and Non-Executive lead for FTSU on the Trust Board.	Ensure that FTSUG is supprted and that there is a clear escalation route for concerns. The Board and Committees are apprised on FTSU development, concerns and national priorities.	From May 2022, the Director for Quality and Nursing is the Executive Lead for FTSU and there is a Non-Executive Lead. Both have scheduled regular fortnightly meetings with the FTSUG. Ad hoc meetings are provided as required.	Director Q&N
	The Chief Executive to have regular scheduled meetings with the FTSUG.	Provides the CEO with overarching FTSU themes and trends that informs triangulation of information.	From September 2022, the CEO meets monthly with the FTSUG.	CEO
	The Director for Quality and Nursing to meet with the CQC to have FTSU as a standard item of the engagement meeting where FTSUG will be in attendance.	This will enable more open and transparent conversation on FTSU issues and align to future CQC inspections.	In March 2023 the Director of Q&N discussed this with the CQC Inspector, and there was agreement that this will prove beneficial. FTSU will be a standing agenda item on the Trust's CQC engagement meetings. The next scheduled meeting is in June 2023.	Director Q&N
	A manager toolkit developed to support managers responding to concerns.	The toolkit has several key information on FTSU that supports managers in managing their response to concerns raised.	All managers receive their toolkit form the FTSUG.	FTSUG

Southeast Coast Ambulance Service NHS Foundation Trust

WWC Escalation Report to the Board

Overview of issues covered at the meeting 16.02.2023

Item	Purpose	Link to BAF Risk
Before the main agenda began the following issues were raised under Executive Escalation: 1. Crawley College – Marking Update. The CMO updated that while there are still some gaps in assurance related to the backlog, improvement has been demonstrated. This is supported by a decrease in the number of complaints. 2. Medway Move – Impact on our People. The HR Director updated that the EOC 111 moves are more complex (than Medway Ambulance Station) and is impacted by the delay in the move to September-time. This is unsettling for staff and the executive is ensuring a individualised approach to the staff affected; the policy has been amended to provide relocation costs to help avoid redundancies and support welfare. The next three agenda items related to specific gaps in assurance identified by the Board in December.		
EOC Staff Retention	Following the Board's concern in December related to the 40% annual turnover, to seek assurance that there are robust solutions being put in place to achieve the stated 10% improvement by May 2023. And to ensure clarity on the timeframe for the culture action plan.	Risk 13 – Retention Risk 348 – Culture
The committee welcomed the executive's acceptance that the steps to-date have not worked. This has led to seeking external support to ensure the right level of capacity and capability and a paper was provided setting this out. The committee sought assurance that this new approach will be different and therefore produce better outcomes and is assured with the methodology being used which has been tested elsewhere. The is realisation however that there is no silver bullet and while the external support will help, it will require continued ownership of management. Measuring the impact will be difficult as there are so many different factors, but metrics such as call answer performance, retention and sickness will help the committee determine impact. In light of this the committee is assured with the commitment from the executive but not yet assured it will deliver the change needed, including the 10% improvement in turnover reported in the IQR.		
East Kent Maternity Review	To seek assurance that there is a process in place to ensure we use the lessons from the various	Risk 348 – Culture

	culture-related issues arising from this review.	
Following up from the Board discussion in December, the committee explored how we are using the lessons from this external review to inform our approach to people and culture. It is pleased by the good cross-directorate working, reinforcing that culture is a matter for us all, not just the HR dept. The recommendations will be used to inform the People and Culture Strategy and the committee asked that there is specific mapping so it is clear how this is being embedded.		
International Recruitment	To seek assurance that we are using the learning from previous international recruitment that resulted in high turnover.	Risk 255 – Recruitment Risk – Retention
The Board asked the committee to seek assurance that we are ensuring robust induction, training and support to the international recruits to ensure they are welcomed and supported in the transition to the UK and to SECAmb. Using the learning from when we did this 4-5 years ago when a high number of recruits left within the first 12 months. The executive set out a much more personalised approach being applied this time, where we are involving each individual and their families. The committee is assured by this and in particular how the Trust values are being demonstrated. In 6-12 months the committee will know what impact this has had from the data related to attrition.		
Health & Wellbeing: Sickness Management	To seek assurance the plan to better manage sickness is robust and is being implemented effectively.	Risk 13 – Retention
The approach to sickness management was explored with some assurance about more in person support. The executive is seeking to establish benchmarking of ambulance sickness data and is setting up a session to learn from West Midlands Ambulance Service who have managed to achieve low levels of sickness absence. In addition, there are targeted action plans being developed by HR and OUMs at the seven OUs with the highest persistent sickness. The committee is not fully assured but supports the steps being taken. It has asked for clearer timescales so it can hold the executive to account for delivery. The committee explored how this data triangulates, e.g. does highest sickness correlate with grievances etc. Currently there is no robust quality and performance management framework that ensures this type of systemic triangulation. However, the executive are prioritising this and aim to implement a new framework in Q1.		
Health & Wellbeing: Shift Over Runs	To seek assurance enough is being done to mitigate the high number of shift overruns, acknowledging	Risk 13 – Retention

	the link to staff wellbeing and high sickness.	
The committee received a paper setting out some of the measures in place to manage overruns and asked the executive to ensure it better communicates this so staff understand the steps being taken to address this difficult and longstanding issue. The IQR currently shows a target of 5% and the committee challenged whether this realistic when it has been significantly higher than this for several years. A workshop is being held which will include a review of the target, and the outputs of this will be considered by the committee in April.		
Workforce Plan	To seek assurance that the plan is robust and how we are ensuring the adequate capacity to support delivery, e.g. the clinical education business case.	Risk 255 – Recruitment
There was a detailed review of the workforce plan, with the gap in field ops of circa 100 WTE being rolled into next year. The funding issues for next year were explored with a range between an increase of 371 WTE (assurance was sought that clinical education could support this) to allowing recruitment to shrink if there is insufficient funding. The discussions with commissioners are ongoing and the committee discussed in this context the need to take a strategic view on skill mix and adapting our operating model, for example to provide more remote support; this links to the operating model BAF risk. The committee is clear that whatever direction the Board takes in thinking through the implications of any changes to our operating model on our workforce, linked to funding and the UEC Recovery Plan, we must continue to ensure all groups of staff are valued and are supported to contribute most efficiently and effectively to service provision.		
Culture & Leadership Programme	To seek assurance the plan is being delivered in accordance with the agreed timeframe.	Risk 348 – Culture & Leadership
The committee noted that this programme has been paused, to focus on the development of the People & Culture Strategy. It will then return to this to ensure it closely aligns with the strategy. The committee supported this on the basis that what is important is that we agree the right priorities and actions, to allow a more simplified narrative and approach.		
External HR Review Actions – ER / WB Cases	To seek assurance that there is clarity about each of the open cases and effective plans to conclude each one, including assurance on the business case to increase capacity given the high number of cases.	Risk 348 – Culture & Leadership

The committee will have the HR review as a standing item, with focus on a subset of the actions. The focus of this meeting was ER cases and a paper was received confirming the progress to date. There is still a high number of cases which needs continued attention and focus to ensure a more normalised position is eventually achieved. An external HR Director supported a review of the most complex cases and there is now a clear plan to resolve each one over the next 4-6 weeks. The committee acknowledged the issues with capacity to manage the high number of cases; there are 172 open cases with resource to manage at any one time about 15 and so a business case is being developed to increase capacity temporarily. On a positive note the average time to resolve cases is reducing and the average suspension is now 60 days from 200. The committee reinforced the importance of ensuring local managers are supported to deal with issues more effectively to reduce the numbers escalating. The committee will be seeking additional assurance to demonstrate this is improving.		
Staff Networks	To receive updates from the Chairs of the Pride and Enable Staff Networks	N/A
Informative updates were provided from the Chairs of both the Pride and Enable Networks. Both doing really good work although re-building from the impacts of the pandemic. The committee challenged the executive to help provide more support to staff networks, and ensure they are better integrated.		

Specific Escalation(s) for Board Action	There are no specific escalations for the Board to take action on. However, the Board is asked to note two things: 1. Acknowledging the pressures everyone is under, and concern expressed by the executive about the time they have to prepare paper, the committee reinforced the need for timely paper; several papers for this meeting were late. 2. While the committee reflected that the curiosity and challenge was good, holding to account is hampered due to inconsistent articulation of timeframes / trajectories. There is too much emphasis on planning and so as we move in to more delivery in the next period, the committee will be expecting greater clarity on trajectories for improvement and how the impact will be measured.

Southeast Coast Ambulance Service NHS Foundation Trust

People Committee Escalation Report to the Board

Overview of issues covered at the meeting 27.03.2023

This was an extraordinary meeting and as part of the review of its TOR, the committee proposes to the Board that it is renamed the People Committee.

Item	Purpose	Link to BAF Risk
People & Culture Strategy	To review the progress with the development of the People & Culture Strategy	Risk 348 – Culture & Leadership

An update was received setting out how the strategy was being developed with the support of the HR Director from Sussex Community NHS FT. A number of engagement sessions were held throughout March across each directorate and touching all the levels of the organisation. At the same time, a values 'check in' has been undertaken and it will be supported by a new Comms and Engagement Strategy that will be coming to Board in April.

One of the main drivers for the People & Culture Strategy is to have a clear framework that sets out what we need to prioritise to improve staff experience and how the various initiatives will align. The committee really supports this aim so all the work is more coordinated and it reinforced the need for a clear, focussed and realistic delivery plan, so there is clear accountability for the delivery of the change that is needed.

Training Priorities	To provide the oversight and delivery plan of the proposed programme for the training & development programme for the Operations Directorate for 2023/24	Risk 15 - ETD

The Training Plan helped to demonstrate good cross-directorate working. It is the first time we have developed a training plan across operations and corporate services that is costed. The committee will oversee delivery as a standing agenda item.

The committee explored one of the main aspects of the related BAF risk re abstraction and some of the feedback from the staff survey about time given to access training. Assurance was sought that provision has been made for abstraction; five days that is included in the budget.

There are however aspects of training that is not in the plan, such as conflict resolution and restraint; MH first aid; and neurodiversity awareness training. The executive is picking this up and how it might be funded with commissioners to see if it can be added to the plan in the future, if not this year.

The committee feels that this is really positive as we have taken a risk-based approach and listened to staff feedback about the importance of training. Including from corporate staff who have fed back that their

training is not always prioritised; there is some work ongoing in corporate services to help establish what additional professional training might be needed, e.g. CPD. Taken together with the training plan for operational staff, this will constitute a training needs analysis for all staff.

Inclusion Annual Reports ▪ Gender Pay Gap ▪ Annual Diversity Report ▪ EDS 2022 verbal	To seek assurance that the Trust is taking positive action to ensure equality.	N/A

Gender Pay Gap / Diversity Report

These reports were considered together. This first provides a comparison on the pay of male and female employees and shows the difference in the average earnings (mean and median). The gender pay audit is different to equal pay, which looks at the pay differences between men and women carrying out the same jobs, similar jobs or work of equal value. Any potential equal pay issues are addressed by adherence to Agenda for Change terms and conditions and pay framework, and a robust and objective job evaluation process.

The main findings included the following:

- Our female workforce grew by 1.47% from previous year.
- There are still more males than females in all bands from Band 7 upwards.
- Our Mean Pay Gap increased from 9.98% to 10.92%
- Our Median Pay Gap decreased from 11.09% to 10.89%
- There is an over-representation of females by 30.14% in lower pay quartiles.

The committee asked for further assurance on promotion opportunities for women and BAME staff as this is going in the right direction. It feels that more targeted intervention is needed to be included in the equalities action plan. It will ensure regular review of the plan to ensure progress is made.

SECAmb currently has one equality objective, which was published in 2017, and is currently being reviewed: *'The Trust will improve the diversity of the workforce to make it more representative of the population we serve'.* When the new CEO starts an equality objective will be set for each executive director.

EDS

A verbal update was provided outlining a new approach this year with a soft launch. The full report will then be published in 2024. The executive is gathering evidence internally which is showing us 'under-developed' across most of the domains. Despite this we remain compliant and the integrated equality action plan will be reviewed by the committee at its meeting in May.

Specific Escalation(s) for Board Action	There are no specific escalations from this meeting. However, the Board is asked to a agree the change to People Committee.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	12-23

Name of meeting	Trust Board
Date	6 April 2023
Trust Priority Area	**Delivering Modern Healthcare**
Author / Lead Director	Emma Williams, Executive Director of Operations
Primary Board Papers	Summary of Operational Performance & Efficiency

This paper builds on that provided to the previous Trust Board considering the areas of greatest risk, performance issues and the Improvement Journey actions and workstreams.

1. BAF & extreme risks
   - BAF Risk 13 – Operating model (including performance against the Ambulance Response Programme (ARP) standards).
   - BAF Risk 14 – Workforce retention.
   - BAF Risk 15 – Education, Training & Development.
   - BAF Risk 17 – Integration of 111 & EOC including service delivery plan for 2023-24. and the Single Virtual Contact Centre national model.
   - BAF Risk 257 – Improvement Journey including operational efficiency programmes for 2023-24.
   - Risk 29 – EPRR Incident response.
   - Risk 82 – HART Capacity.

2. Additional considerations
   - Industrial action – Service delivery and lessons learned to date.
   - Urgent & Emergency Care Recovery Plan – key metrics for ambulance services:
     - C2 mean performance trajectory.
     - Hospital handover times
   - Development and implementation of a new performance and quality framework.

Recommendations, decisions, or actions sought	1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area. 2. That the Board note the associated metrics within the Integrated Quality Report – their performance levels against targets and/or trends over time including the SPC assessments. 3. That the Board note the actions being undertaken to address/mitigate the risks and improve performance within these areas.

Update for Trust Board

1. BAF & extreme risks

BAF risk description	BAF Risk 13 – Operating model
Additional considerations	Performance against the Ambulance Response Programme (ARP) standards.
IQR metrics	Slides 35 & 39-45, with most ARP metrics showing common cause variation with either failing or 'hit & miss' processes.
Progress since last Trust Board meeting	• Significant progress in the co-design and implementation of new rotas for field operations to better match resource provision to demand. This was paused to allow a review of grievances submitted – recommendations have now ben implemented and rota development & consultation is underway. Rotas are due to go live towards the end of Q1. • Call answering remains a significant challenge – weekly reviews are in place with the senior team. The focus remains on robust recruitment, with improvements in timely compliance checks, scoping of a form of psychometric testing to review individual personal resilience and exploring potential for short-term support by other services whilst staffing numbers increase. • A focus on 'Hear and Treat' (H&T) continues – February saw SECAmb maintaining performance at approx. 10% whilst several other trusts saw a decrease over this period. February saw the training of a cohort of Paramedics within Field Operations to be able to undertake H&T on their local operating units, particularly focused at managing the lower acuity calls, assisting local patients associated within their geographical area, supported by Paramedic Practitioners. In addition, the Trust is reviewing the learnings from other ambulance services relating to C2 segmentation to consider if/to what level this could be implemented to provide additional clinical assessment/support for a defined cohort of C2 calls. • Throughout February into March, negotiations with the lead ICB have been ongoing to confirm the budget envelope and therefore the staffing levels across the 999 service for 2023-24. The delivery of the service against this budget will result in a small increase in staffing numbers, but will also require additional efficiencies, both for the Trust and system partners. • The Kent, Medway & Sussex 111 service is undergoing an operational delivery plan review considering budgetary changes for 2023-24 (see later). However, priority will continue to be given to ensure best-in-class revalidations for both 999 and Emergency Department outcomes remain – these benefit patients in 111 and 999 as well as the wider health system. • The impact of the continuing industrial action during January and February saw the call & incident number remain at a lower level, although higher than that seen at the end of December. Through strong, positive negotiations with the GMB union a good set of derogations were agreed which, in collaboration with the additional staffing support received as part of the MACA (Military Aid to the Civil Authorities) request, saw continued good care delivered to patients across SECAmb on the days of industrial action.

	• It continues to be recognised that a fundamental review of the service operating model is required – a session is being planned for the board during April/May to commence a discussion, supported by the development of the Clinical and People strategies, and Trust priorities for 2023-24.

BAF risk description	BAF Risk 14 – Workforce retention
Additional considerations	Significant turnover rates within the EOCs, with recognition that the move to Medway will have an additional retention implication over the forthcoming 6+ months.
IQR metrics	Slide 26
Progress since last Trust Board meeting	• Moorhouse Consulting commenced a 10-week programme of work within the East & West EOCs engaging and listening to staff about the culture within those locations and its implication on staff well-being (including retention). A small co-design group has commenced identifying both potential quick wins as well as medium/longer term ideas for consideration. • The Ashford 111 service is planned to move to the new Medway/Gillingham centre at the end of Q1 2023-24 with Coxheath EOC joining them in the early autumn (dependent on completion of several IT upgrades/changes). The continued un-certainty of the exact dates of move in and the impact on a proportion of staff cannot be under-estimated.

BAF risk description	BAF Risk 15 – Education, Training & Development
Additional considerations	Staff feedback via the NHS staff survey and operational engagement workshops run in Dec/Jan with first-line managers and above.
IQR metrics	Slide 33
Progress since last Trust Board meeting	• Continued focus on completion of Statutory & Mandatory, Clinical Key Skills and Safeguarding training, recognising that the Operations Directorate is on track to achieve the target 85%, but that within that are specific teams/areas which are under trajectory. • During February a comprehensive training plan for all operational areas has been worked up to deliver 6 key components for 2023-24 (listed below). This paper was presented to WWC for approval on 27/03/23 with all in attendance confirming the commitment for the Trust to deliver the programme in full – abstractions for this training have been factored in the resource planning for the next financial year. 1. Statutory & Mandatory/Core Skills Training Framework 2. Clinical Key skills (content approved at QPSC) 3. NHS Pathway updates (EOC/111 staff) 4. Safeguarding level 3 training for registrants (3-yearly cycle) 5. Values, behaviours, and organisational culture 6. Resilience, Major incidents, JESIP etc • Three additional areas of training are being considered – the associated risks, requirements and potential impacts/outcomes are being worked up at present and will be presented to the Education, Training and Delivery Group in May. These additional areas are not currently factored into the Operations Directorate training plan.

BAF risk description	BAF Risk 17 – Integration of 111 & EOC
Additional considerations	111/Integrated Urgent Care Clinical Assessment Service (IUC CAS) delivery plan for 2023-24. and the Single Virtual Contact Centre national model
IQR metrics	Slide 45
Progress since last Trust Board meeting	• The budget negotiation for the 111/IUC CAS has now completed with monies identified as initially being recurrent no longer being so. The implication is that the review of the model of delivery agreed between SECAmb and the Kent and Sussex teams in the autumn is being revisited. The current proposed model will primarily see the service prioritising 111 call handling with a reduction in the IUC CAS – this is supported by the commissioners who have stated that 'down-stream' clinical services are in place to support patients calling the service. • The change in the budget for 2023-24 means that the service will be unable to recruit sufficient call handlers to meet the required number to enable SECAmb to join the Southeast region Single Virtual Contact Centre model. Discussions with service commissioners and NHS England regional leads are on-going. • Discussions were held at the Finance & Investment Committee on 30/03/23 confirming that the 111 service must be delivered within the budget, and that whilst the Trust must continue to optimise efficiencies within the 111 and EOC services, consideration should now be given to the level of integration/separation now required.

BAF risk description	BAF Risk 257 – Improvement Journey including
Additional considerations	Operational efficiency programmes for 2023-24
IQR metrics	Slides 43 & 44
Progress since last Trust Board meeting	• The key workstreams that were developed under the Responsive Care Group (RCG) continue, particularly focusing on rota. implementation, H&T and dispatch improvements etc continue. • Operational directorate priorities have been shared for consideration in line with those from other directorates.

Risk description	Risk 29 – EPRR Incident response
Additional considerations	Manchester arena inquiry recommendations for ambulance and emergency services.
IQR metrics	Nil
Progress since last Trust Board meeting	• Training programme for 2023-24 confirmed with WWC as stated previously including training on a range of resilience areas. • The Resilience Forum continues to strengthen with engagement from all directorates and lead commissioner ICB. Recent key actions include: ✓ The approval of the Incident Response Plan which now goes forward for sign-off at EMB. ✓ Continuing review and refresh of business continuity plans. ✓ Focus on reinvigorating CPD opportunities for all commanders as exercises at local and regional level recommence/scale up.

	• The Manchester arena inquiry recommendations are under review through a programme of work with SE region fire and police services – initial workshop in January with a follow up in April.

Risk description	Risk 82 – HART Capacity
Additional considerations	Nil
IQR metrics	Nil
Progress since last Trust Board meeting	• HART staffing levels (the compliance with the requirement to have 2 teams of 6 operatives on duty 24/7/365) are part of the annual EPRR assurance cycle. This has always been a challenge within the current funding envelope that has not changed in since the implementation of the HART programme. • During 2022-23, a national review was undertaken with the recommendation that commissioners increase the funding to support an uplift in staffing numbers. A letter instructing ICB teams to comply with this budget increase has been sent out from NHS England and is under consideration at present.

2. Additional considerations

Industrial action	Currently, industrial action is on hold whilst Trade Unions ballot their members on the proposed offer from HM Government – these are due to finish in mid-April.
Urgent & Emergency Care Recovery Plan	In January, the Dept of Health & Social Care published the 'Delivery Plan for recovering urgent & emergency care services'. Clearly defined within the document were a range of ambitions and five areas of focus that require sustained focus: 1. Increasing capacity 2. Growing the workforce 3. Improving discharge 4. Expanding & joining up health & care outside hospital 5. Making it easier to access the right care From this document amongst a range of activities ambulance services are required to engage with, two key metrics have been identified: • C2 mean performance trajectory. • Hospital handover times The C2 mean performance of 30mins has been set as an expected target for all ambulance services – the Trust is working up plans based on the provisional budget and confirmed list of areas of efficiencies to be delivered.

Performance & Quality framework	Building on the development and learning from the IQR, a new performance & quality framework is being worked up with the intention to provide: ✓ A reporting/delivery structure from Team to Board to Team ✓ A framework providing integrated metrics to provide a holistic overview of service delivery. ✓ A suite of metrics against which local actions can be taken to drive improvements for staff and patients – with metrics linked to the 4 Trust priority areas (RC, PC, QI & SP), with data at team level as a minimum that can be collated at ICB level as required. ✓ A structure which enables improved coherence in reporting through to Trust groups and committees using metrics aligned to the IQR ✓ A timeline to implement the framework in full across all operational service line areas by the end of Q1 2023-24 The Performance Team are developing the dashboards following feedback from the senior leadership team and local managers as to which metrics are most relevant for the initial roll-out.
UK Covid-19 Inquiry	The Trust has now formally received a 'Request for Evidence under Rule 9 of the Inquiry Rules 2006' which it must respond to in early May.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	13-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Sustainability and Partnerships – Executive Cover Page
Strategic Goal	**Sustainability and Partnerships**
Lead Director	Martin Sheldon, Interim CEO
Author(s)	David Ruiz-Celada, Executive Strategic Planning and Transformation
Primary Board Papers	BAF Risk 16 (Financial Sustainability) BAF Risk 17 (Integration of 111 & EOC) IQR Sustainability and Partnerships Section (slide 47 onwards) Improvement Journey Report (Must Do 5 and Partnership Report)

Financial Performance 22/23 (BAF Risk 16 - Financial Sustainability)

Trust reports a year-to-date break-even position as of 28th of February 2023, £0.7m worse than planned. Efforts to close the £8.9m in-year deficit include a financial recovery program targeting overspends and savings across all directorates, and non-recurrent opportunities, such as the release of £1.0m from provisions due to an interest rate increase and £0.3m gains from the sale of assets. Despite a high initial cash position, the current balance of £35.1m remains £8.5m below plan, highlighting the need to generate cash surpluses, rebuild reserves, and review long-term capital plans.

Operating Plan 23/24 (BAF Risk 16 - Financial Sustainability)

The Trust's financial and operating plans for 2023/24 project a £4.5m deficit, a 34-minute C2 mean response time, and restricted capital investment due to eroding cash reserves.

Funding challenges include withheld system funding, no growth in any ICB, an allocation shortfall for additional ambulance capacity, and non-recurrent 111 SVCC funding.

Operational assumptions include internal and external efficiencies through improved rotas, specialist resourcing, increased UCR referrals, and reduced handovers. The financial plan assumes a 2% pay award, 3%-6% inflation, and a focus on sustainable transformation schemes to release cash.

The Trust aims to achieve a 34-minute C2 mean response time and identify an additional £2m in efficiencies to meet a 3% efficiency target (£9m).

Risks involve challenges in increasing core staff, the potential impact of reduced 111 funding on the 999 service, ICB expectations for delivering a break-even plan without additional funding, and the impact of continued deficits on the cash position.

Underachievement of the £9.0m efficiency target and unfunded cost pressures could further worsen the underlying financial position.

Partnerships update

The Urgent & Emergency Care (UEC) Recovery Plan aims to stabilize NHS services by March 2024. The Trust's Leadership Team are focusing on priority areas such as increasing capacity, improving clinical assessments in EOC, reducing staff absence, and enhancing mental health expertise access, as well as increasing UCR referrals.

This report provides updates on the activities on the alignment of the NHSE UEC Recovery Plan priorities with existing ICS UEC workstreams, ICB Joint Forward Plans (JFP) developments, Regional Ageing Well (Urgent Community Response) program, and the Regional UEC Mental Health Response.

The Trust's is committed to working with system partners on improving regional UEC services, including mental health responses and UCR referrals, as a key enabler to deliver our joint objectives for 23/24.

The Trust has also been involved in Sussex and Kent's Joint Forward Plans development, which are the 5-year forward plans across our systems. We will be mapping the overlaps and gaps along our lead commissioners as part of the development of our refreshed long-term strategy for SECAmb.

Strategy Development

In Q4 of 22/23 there has been significant work done to develop some of our strategies and plans that required it most urgently:

- People and Culture Strategy
- Communications and Engagement Strategy
- Development of the 23/24 Priorities to support the Improvement Journey for the next 12 months
- In addition – the Clinical Advisory Group presented a need case for change in our approach to delivering patient care to Leadership in December

The Leadership Team held a workshop on the 15th of March to discuss our approach to developing a new strategy for SECAmb. There is need to renew our strategic approach in the context of:

- Ensuring our current operating not meet the long term needs of our people or our patients
- A changing NHS with ICBs developing their 5-year Joint Forward Plans
- Having a strategic direction that takes us beyond our initial Improvement Journey plans in response to poor CQC and Staff Survey results
- Poor colleague engagement and disconnect from the purpose, vision, mission for SECAmb in the space of UEC in the healthcare system
- We currently are not delivering services in a financially sustainable way for the long term

We will begin the process to appoint a strategic partner to provide us with additional capacity to engage, collate and develop our new strategy, whilst maintaining internal ownership of the direction based on the feedback from our people, patients and partners.

This is now an objective for 23/24, and the aim will be to sign if off by December 2023 to feed into our planning for 24/25. This will be the focus of the Joint Board / COG meeting on 27 April.

Medway Make Ready, 111 and EOC Building (Capital Programme)

The Trust took partial occupation of the new Medway Make Ready Centre in Medway on the 31st of March 2023.

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

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	13-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Strategic Partnerships update - Executive Summary to the Board
Strategic Goal	**All**
Lead Director	David Ruiz-Celada, Executive Director for Planning and Business Development
Author(s)	Matt Webb, Associate Director of Strategic Partnerships & System Engagement
Primary Board Papers	BAF Risk 257

The Urgent & Emergency Care (UEC) Recovery Plan aims to stabilise NHS services and meet the two major recovery ambitions by March 2024. The Leadership Team reviewed the plan during February and March 2023 as part of the strategic priority setting for 2023/24, and the Trust's Strategic Partnerships, Senior Operations Leadership, Consultant Paramedic, and wider leadership teams are leading priority UEC recovery focus areas. These include increasing capacity through non-emergency department pathways, improving the clinical assessment of calls, reducing staff absence, and enhancing clinician access to mental health expertise.

This report updates the Board on the four ongoing regional UEC priority areas, as reported to the Executive Management Board throughout Q4 (2022/23).

Alignment with ICS UEC workstreams

The Trust's four integrated care boards are aligning the NHSE UEC Recovery Plan priorities to existing ICS UEC workstreams with continued oversight through each Integrated Care System (ICS) UEC Board.

ICB Joint Forward Plans (JFP)

The Trust's Strategic Partnership Team is engaged with each ICB on their Joint Forward Plan developments (JFP), with the first JFP (NHS Kent & Medway) having been shared with the Trust for Executive Management Board review in April 2023.

Regional Ageing Well (UCR) Programme

The Trust is fully engaged with the Regional Ageing Well (Urgent Community Response) programme, which aligns with the NHSE Going Further for Winter and NHSE UEC Recovery Plan aims.

Regional UEC Mental Health Response

The Trust is working with NHSE and mental health commissioners to determine the regional response to the *Mental Health Commissioning Guidance for Ambulance Services* (2022). The Trust was represented at an NHSE-led regional UEC Mental Health workshop on the 27th of March to consider several areas proposed by NHSE.

The Trust is committed to working collaboratively with system partners and enhancing the quality of care for patients in the UEC sector. The development of the JFP and the focus on improving regional UEC services, including mental health responses, highlights the Trust's commitment to meeting the NHS's recovery ambitions.

Recommendations, decisions or actions sought	The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in June (2023).

Introduction

This report updates the Board on the four ongoing regional Urgent & Emergency Care (UEC) priority areas, as reported to the Executive Management Board throughout Q4 (2022/23).

1) Urgent & Emergency Care (UEC) Recovery Plan
2) ICB Joint Forward Plans (JFP)
3) Regional Ageing Well (UCR) programme
4) Regional UEC Mental Health response

Urgent & Emergency Care (UEC) Recovery Plan

The Leadership Team reviewed the recently published NHSE Urgent & Emergency Care (UEC) Recovery Plan (*Delivery plan for recovering urgent and emergency care services)* during February and March (2023) as part of the strategic priority setting for 2023/24. This two-year plan aims to stabilise services to meet the NHS's two major recovery ambitions - to help achieve A&E four-hour performance of 76% by March 2024 and to improve category two ambulance response times to an average of 30 minutes over the next year, with further improvement in 2024/25 towards pre-pandemic levels.

Priority UEC recovery focus areas applicable to the Trust are being led by members of the Strategic Partnerships, Senior Operations Leadership, Consultant Paramedic, and wider Leadership teams. These include increasing capacity through greater utilisation of appropriate non-emergency department pathways (i.e., Urgent Community Response services) and a subsequent reduction in unnecessary conveyance, increasing the clinical assessment of calls (including category two segmentation), reducing sickness and other staff absence, considering additional workforce gap mitigations, and enhancing clinician access to mental health expertise. Key impact metrics to demonstrate how the Trust is working collaboratively to address these areas with system partners and to ensure effectual monitoring are currently under development and will be reported on during the next Board meeting.

The Trust's four integrated care boards are currently aligning the NHSE UEC Recovery Plan priorities to existing ICS UEC workstreams with continued oversight through each Integrated Care System (ICS) UEC Board. Attended monthly by the Trust's Strategic Partnerships team, the ICS UEC boards have concentrated on winter preparedness and resilience, reducing falls conveyances to emergency departments, maximising the use of appropriate non-emergency department pathways (i.e., community services), improving call answer and ambulance response times (i.e., category two incidents) and optimising Hear & Treat processes, including enhancing 999/111 referrals into Urgent Community Response (UCR) services.

ICB Joint Forward Plans (JFP)

The Health and Care Act (2022) requires integrated care partnerships to produce an integrated care strategy and Joint Forward Plan (JFP) to set out how each assessed population's physical and mental health needs can be met through the exercise of the functions of the Integrated Care Board (ICB), partner local authorities and NHS England (NHSE).

The National Health Service Act (2006) (as amended by the Health & Care Act (2022)) requires integrated care boards and their partner NHS and foundation trusts to prepare and publish their JFP before the start of each financial year. For the first year, however, the date for publishing the final plan is 30 June 2023.

Each ICB is currently developing its JFP in consultation with its partner provider and foundation trusts. The Trust's Strategic Partnership Team, on behalf of the Trust, is engaged

with each ICB (i.e., through the ICS UEC boards) on the JFP development, with the first JFP (NHS Kent & Medway) having been shared with the Trust for Executive Management Board review in April 2023.

Regional Ageing Well (UCR) Programme

The Trust is fully engaged with the Regional Ageing Well (Urgent Community Response) programme, which aligns with the NHSE Going Further for Winter and NHSE UEC Recovery Plan aims to improve category two ambulance response times and reduce subsequent conveyance and avoidable admissions.

This programme recognises that not all falls result in serious injury, and a proportion of these can be responded to by community-based response services (as described by the Association of Ambulance Chief Executives (AACE) Falls Response Governance Framework), supporting NHS statutory services, such as ambulance services, to prioritise higher acuity patients. The programme's key principles are therefore to improve the coverage of community-based falls response services across the regional footprint with a view to enhancing outcomes and experience for those who fall by improving initial response times and reducing the risk of long-lies, and improving system efficiency, focusing ambulance capacity where it is needed most and building on existing community-based provider models.

The Trust is currently working with its four ICBs and NHSE to ensure existing Urgent Community Response (UCR) provision is being utilised to its full potential by ensuring UCR services are accepting falls referrals as set out in the national 2-hour guidance and are easily accessible through ICS single points of access and direct electronic referrals from the ambulance service. This includes the development of a regional dashboard using ambulance and community services data to validate and monitor activity, which follows a comprehensive mapping exercise undertaken during Q3 and Q4 (2022/23), examining the existing provision of community-based falls response services and identifying gaps in provision across the Trust's footprint.

Regional UEC Mental Health Response

The Trust is continuing to work with NHSE and mental health commissioners to determine the regional response to the *Mental Health Commissioning Guidance for Ambulance Services* (2022), having adopted several of the options outlined, including 'Mental Health First Aid' training, enhancing mental health clinician coverage within 999/111 and exploring alternative models for ambulance and mental health practitioners to converge at the scene (where appropriate).

The Trust was represented at an NHSE-led regional UEC Mental Health workshop on the 27th of March to consider several areas proposed by NHSE, including closer partnership working with police forces and third sector organisations to avoid unwarranted variation, enhanced on-scene responses as alternatives to emergency department or S136 detention, regionally/ICS co-ordinated real-time response plans to frequent callers with complex or dual diagnosis and options for mental health act transport, reviewing dedicated ICS resourcing and support.

During the regional event, members of the Trust jointly presented with colleagues from the Sussex Partnership NHS Foundation Trust on the recently tested Blue Light Triage (BLT) model, endorsed by partners as an effective pathway, which promotes the right support first-time, improves service-user experience, reduces crew on-scene time and avoidable conveyance to emergency departments.

The Trust will be meeting with colleagues from NHSE in April to consider the event's outputs, shared learning and recommended next steps.

Conclusion

The Trust is committed to working collaboratively with system partners and enhancing the quality of care for patients in the UEC sector. The development of the JFP and the focus on improving regional UEC services, including mental health responses, highlights the Trust's commitment to meeting the NHS's recovery ambitions.

The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in June (2023).

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	13-23

Name of meeting	Trust Board
Date	06.04.2023
Name of paper	Finance Report
Executive sponsor	Martin Sheldon Interim Chief Financial Officer
Authors names and roles	Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Kevin Steer (Head of Financial Accounting & Compliance), Rachel Murphy (Financial Manager - Projects, Business, and Investments)
Synopsis	This report provides an update on the Trust's Financial Position for Month 11 as at 28 February 2023. The Trust is reporting a year-to-date break-even position, £0.7m worse than plan. The forecast breakeven position for the year to 31 March is based on two current workstreams: 1. We have made considerable progress to reduce overspends and identify savings via the financial recovery programme we have rolled out and continue with all the Directorates. We are confident the work to date has identified the level of savings required to close the gap of £8.9m deficit identified as the year end reforecast risk to plan. We will have to achieve the anticipated March projection but are certain we will be able to reduce the deficit to the break-even forecast position required by the SE Region. On the upside, it is possible we can make a small surplus. 2. Although the review work has focused on maximising recurrent savings, other non-recurrent opportunities have contributed to reducing the overall deficit to breakeven. £1.0m has been released from provisions because of the change in the discount rate from the increase in interest rates. We also recognised £0.3m from the gains of sale of assets (sales of Sittingbourne ambulance station). Whilst our cash position at the start of the financial year was high predominantly due to the timings of receipts and payments, we have been eroding our Cash Reserves. Our current Cash Balance improved by £2.7m to £35.1m in the month but remains £8.5m (19.5 per cent) below plan despite the delay in Capital expenditure. This is driven by the timing of £7.5m receipts relating to both the 111 and 999 contract income that was settled by the commissioners in March. This emphasises the need to return to generating cash surpluses to rebuild our cash reserves and review and constrain our current Long Term Capital Plan during the current planning process.
Recommendations, decisions, or actions sought	The Board are asked to note the financial performance against plan, the steady improvement to recover this year's outturn position and the medium-term impact on Cash Reserves. The detailed work on the financial recovery continues and the revised assessment will be reported next month.

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**N/A**

2022/23

Finance Report to the Board of Directors

11 Months to 28 February 2023

Contents

Executive Summary

Values are shown in millions and are subject to rounding.

	Year to February 2023				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Income	£272.3m	£279.5m	£7.1m	✓	£297.0m	£305.7m	£8.7m	✓
Underlying Expenditure	£276.3m	£280.1m	(£3.8m)	✗	£304.9m	£306.9m	(£2.0m)	✗
Surplus / (Deficit)	**(£4.0m)**	**(£0.7m)**	**£3.3m**	✓	**(£7.9m)**	**(£1.2m)**	**£6.7m**	✓
Further Trust Savings Required[1]	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Non-Recurrent Adjustments^	£4.7m	£1.0m	(£3.7m)	✗	£7.9m	£1.5m	(£6.4m)	✗
Trust Surplus / (Deficit)	**£0.7m**	**£0.3m**	**(£0.4m)**	✗	**£0.0m**	**£0.3m**	**£0.3m**	✓
System 'Control' Adjustments	£0.0m	(£0.3m)	(£0.3m)	✗	£0.0m	(£0.3m)	(£0.3m)	✗
Reported Surplus / (Deficit)*	**£0.8m**	**£0.0m**	**(£0.7m)**	✗	**£0.0m**	**£0.0m**	**£0.0m**	✓
Efficiency Programme	£4.8m	£3.4m	(£1.4m)	✗	£5.6m	£3.9m	(£1.7m)	✗
Cash	£43.6m	£35.1m	(£8.5m)	✗	£40.9m	£36.7m	(£4.1m)	✗
Capital Expenditure	£32.8m	£26.3m	£6.4m	✓	£36.1m	£31.8m	£4.3m	✓

[1] Trust savings required to meet break-even financial plan, being delivered through Directorate financial recovery reviews.
^Planned non-recurrent adjustments were expected from balance sheet flexibilities; the majority of these are unlikely to materialise.
*Reported Surplus / (Deficit) represents the system (Control total) position, reconciliation provided separately

Year to date

- The Trust is reporting a break-even position for the year to February 2023, £0.7m adverse to plan. This is driven by the reduction in the 999 contact funding and lower than planned efficiency savings.

- As directed by NHSE in January, we have released £1.0m provision relating to ill health, early retirement, and injury benefit because of the change in discount rate from the increase in interest rates. Gains on disposal also ceased to become an adjusting item when reporting the system position. This change has therefore improved our ability to report a system reported break-even position by £0.3m. These partly mitigate the impact of the reduction in the 999-contract funding.

- Significant progress has been made with the Directorate Financial Recovery reviews in identifying productivity improvement. We have delivered £1.8m efficiency savings in the month. This means the year-to-date achievement of £3.4m is £1.4m adverse to plan, an improvement of 42 per cent compared to last month. We remain confidence that the existing financial position scrutiny and the new structured efficiency approach will enable us to address the under delivery in efficiency to achieve the overall breakeven position.

- The cash position recovered by £2.7m this month to £35.1m. Although this is £8.5m below plan; the Trust has received the further £7.5m of receipts relating to both the 111 and 999 contract income in March 2023 and an additional £2.9m was received by NHS Sussex ICB in the month as catch-up.

- Capital expenditure of £26.3m is £6.4m lower than plan due to slippage on Medway Make Ready centre and delays in fleet spend. Mitigations are currently being progressed to accelerate IT infrastructures to deliver the target.

Forecast Outturn

- The Trust is confident that it will now meet its overall forecast breakeven position as planned and required by SE Region.

- The Directorate financial position scrutiny and challenge reviews have made substantial improvement into identifying cash releasing savings in year. We are on track to recover the initial reforecast year end deficit of £8.9m and potentially report a small surplus based on the upside forecast position.

- This is however dependent on all business areas meeting their agreed savings targets and projected spend in March.

- The Executive challenge review meetings continue to take place with further meetings in March (21st – 27th) focussing on business areas achieving financial plan and the further agreed improvement of financial forecasts together with efficiency delivery.

2023/24 Financial Planning

- Planning for 2023/24 continues and the draft financial plan was submitted on 23 February.

- A final plan will be submitted on 30 March 2023 after Board approval.

- All business area budgets are expected to be signed off by 31 March 2023.

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

1. Income

	Year to February 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
999 Income	£243.8m	£242.2m	(£1.6m)	✗	£265.9m	£264.1m	(£1.8m)	✗
111 Income	£18.2m	£25.9m	£7.7m	✓	£19.8m	£29.2m	£9.3m	✓
HEE Income	£1.3m	£1.8m	£0.5m	✓	£1.4m	£2.0m	£0.6m	✓
Grant Income	£0.0m	£0.3m	£0.3m	✓	£0.0m	£0.3m	£0.3m	✓
Covid Income	£6.8m	£6.8m	£0.0m	✓	£7.4m	£7.4m	£0.0m	✓
Other Income	£2.6m	£2.4m	(£0.2m)	✗	£2.9m	£2.7m	(£0.2m)	✗
Total Income	**£272.7m**	**£279.5m**	**£6.7m**	✓	**£297.4m**	**£305.7m**	**£8.3m**	✓

- 999 income is less than plan because of the Integrated Care Board (ICBs) proposed block contract value, which is likely to be approximately £1.8m less than planned (£1.6m year to date).

- 111 income is greater than plan due to the agreement reached with commissioners in funding additional resources and SVCC (Single Virtual Contact Centre). This supports the additional expenditure currently seen in 111.
  - SVCC (Single Virtual Contact Centre) funding is £3.3m and is subject to us meeting the recruitment of the required call handling staff to join the South-East SVCC in January.
  - Agreement has been reached where Vocare will take circa 3,000-3,500 calls per week (c.15%) between 6.00am to 10.00pm to help support our call answering performance whilst we plan for the SVCC, this has been agreed until 31 March 2023.

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

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

- Other income variance dominantly relates to SORT (specialist operational response team), this is forecast to be £0.6m below plan (£0.6m year-to-date). This is linked to being able to train staff, and the corresponding expenditure, such training has been impeded due to the delays in recruiting trainers and the lower than hoped applicants to the role. Mitigating this is additional £0.2m in relation to International Paramedic Recruitment and £0.3m for the improvement journey. These three sources of income are reflective of relevant expenditure. An additional £0.2m was received in respect of the work undertaken for the implementation of the 999 Intelligent Routing Platform (IRP).

2. Expenditure

By Directorate	Year to February 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Chief Executive Office	£3.0m	£3.4m	(£0.4m)	✗	£3.3m	£3.7m	(£0.5m)	✗
Finance	£25.7m	£25.3m	£0.4m	✓	£28.1m	£27.7m	£0.3m	✓
Quality and Safety	£2.7m	£2.6m	£0.0m	✓	£2.9m	£2.9m	£0.0m	✓
Medical	£11.5m	£9.6m	£1.9m	✓	£12.7m	£10.6m	£2.1m	✓
Operations	£166.7m	£161.6m	£5.1m	✓	£181.9m	£176.9m	£5.0m	✓
Operations - 111	£18.2m	£26.7m	(£8.4m)	✗	£19.9m	£29.1m	(£9.2m)	✗
Planning & Business Development	£26.5m	£25.7m	£0.8m	✓	£29.0m	£28.0m	£1.0m	✓
Human Resources	£4.5m	£4.5m	£0.0m	✓	£4.9m	£4.9m	£0.0m	✓
Total Directorate Expenditure	**£258.8m**	**£259.6m**	**(£0.7m)**	✗	**£282.6m**	**£283.9m**	**(£1.3m)**	✗
Covid	£4.4m	£4.7m	(£0.3m)	✗	£4.8m	£5.0m	(£0.2m)	✗
Depreciation^	£9.4m	£8.4m	£1.0m	✓	£10.2m	£9.2m	£1.0m	✓
Financing Costs	£2.1m	£1.1m	£1.1m	✓	£2.3m	£1.3m	£1.1m	✓
Total Underlying Expenditure	**£276.3m**	**£280.1m**	**(£3.8m)**	✗	**£304.9m**	**£306.9m**	**(£2.0m)**	✗
Further Trust Savings Required	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Non-Recurrent Adjustments	(£4.3m)	(£1.0m)	(£3.3m)	✗	(£7.5m)	(£1.5m)	(£6.0m)	✗
Total Expenditure	**£272.0m**	**£279.1m**	**(£7.2m)**	✗	**£297.4m**	**£305.4m**	**(£8.0m)**	✗

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

Year to date performance against plan

- Total year to date expenditure of £279.1m is £7.2m higher than plan. The full year forecast of £305.4m is expected to exceed plan by £8.0m.

- This continues to be driven by the overspends in NHS 111 of £8.4m because of the additional resource requirement above plan in line with the increased demand. This is largely mitigated by the further income mentioned above (see page 6). The extra spend of £0.7m is due to the reliance on agency clinicians and overtime to compensate for the higher abstraction levels of 34.0 per cent, including sickness of 14.7 per cent, and the increasing resourcing challenges to facilitate safe service delivery.

- Further mitigation is realised from the lower than planned year to date provision of frontline hours of 13.5 per cent which is generating total Operating Unit pay savings of £2.6m compared to plan.

- This is because planned provision of substantive staff hours was 12.7 per cent below plan year to date, while the recruitment challenges persist, and attrition rates remains higher than planned. High sickness abstraction levels including Covid of 10.7 per cent is also leading to a year to date abstraction level of 35.5 per cent compared to the plan of 33.0 per cent.

- The overall timing in planned recruitment is driving the corresponding underspends across other expenditure categories notably, education and training costs of £1.3m and related reduction in travel spend.

- The other favourable variances in the various spend categories, notably finance costs and establishment (predominately telephony & radio communication) are largely due to timing.

- Depreciation and Rights of Use are also below plan by £2.3m due to delays in both capital projects and new (ambulance) leased assets.

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

NHSEI Categories	Year to February 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Pay/Staff Costs	£190.5m	£201.7m	(£11.2m)	✗	£211.1m	£220.3m	(£9.2m)	✗
Depreciation (including Rights of Use Assets)	£17.8m	£15.5m	£2.3m	✓	£19.5m	£17.0m	£2.5m	✓
Premises Costs	£15.3m	£15.3m	£0.0m	✓	£16.6m	£16.7m	(£0.1m)	✗
Transport Costs	£16.0m	£15.2m	£0.8m	✓	£17.5m	£16.7m	£0.8m	✓
Purchase of Healthcare (PAPs;IC24;HEMS)	£13.3m	£12.9m	£0.4m	✓	£14.6m	£14.0m	£0.6m	✓
Supplies and Services	£8.2m	£8.1m	£0.1m	✓	£8.8m	£8.8m	£0.0m	✓
Establishment	£4.9m	£4.5m	£0.4m	✓	£5.4m	£4.8m	£0.6m	✓
Education Costs	£2.3m	£1.0m	£1.3m	✓	£2.6m	£1.2m	£1.4m	✓
Operating Lease Expenditure	£2.2m	£1.6m	£0.6m	✓	£2.4m	£1.7m	£0.7m	✓
Finance Costs	£1.8m	£1.1m	£0.7m	✓	£2.0m	£1.3m	£0.7m	✓
Clinical Negligence (CNST)	£1.6m	£1.5m	£0.1m	✓	£1.6m	£1.5m	£0.1m	✓
Gains / Losses on Asset Disposal	£0.0m	(£0.3m)	£0.3m	✓	£0.0m	(£0.3m)	£0.3m	✓
Other	£2.0m	£2.0m	£0.0m	✓	£2.8m	£3.2m	(£0.4m)	✗
Total Underlying Expenditure	**£275.9m**	**£280.1m**	**(£4.2m)**	✗	**£304.9m**	**£306.9m**	**(£2.0m)**	✗
Further Trust Savings Required	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Non-Recurrent Adjustments	(£3.9m)	(£1.0m)	(£2.9m)	✗	(£7.5m)	(£1.5m)	(£6.0m)	✗
Total Expenditure	**£272.0m**	**£279.1m**	**(£7.2m)**	✗	**£297.4m**	**£305.4m**	**(£8.0m)**	✗

Full year performance against plan

- The full year adverse staff cost variance of £9.2m has occurred from the additional resources agreed for 111 after budget setting corresponding with income as detailed in page 6.

- Depreciation and Rights of Use are forecast to be £2.5m lower than planned due to delays in both capital projects and new (ambulance) leased assets.

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

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

3. System 'Control' Adjustments

- In January 2023 NHS England announced that gains on disposal of assets will no longer be adjusted when reporting the system position, this change has therefore improved our ability to reach the system requirement to break-even.

Reconciliation to system reported position	Year to February 2023	Forecast to March 2023
Trust Surplus / (Deficit)	£0.3m	£0.3m
System 'Control' Adjustments:		
Grant Income	(£0.3m)	(£0.3m)
Remove Impact of Donated Assets	£0.0m	£0.0m
Reported Surplus / (Deficit)	**£0.0m**	**£0.0m**

4. Efficiency Programme

	Year-to-Date				Annual	Delivery Gap - to Mar 2023	
	Plan	Actual	Variance		Plan	Actual	
	£000	£000	£000		£000	£000	
Directorates							
Medical	384	518	134	✓	402	116	✓
Operations	2,843	2,219	(624)	✗	3,412	(1,193)	✗
Planning and Business Development	385	23	(362)	✗	452	(429)	✗
Finance & Corporate Services	894	628	(266)	✗	985	(357)	✗
Trust Board & Exec Directors	97	46	(50)	✗	105	(59)	✗
Quality and Nursing	79	0	(79)	✗	87	(87)	✗
HR	141	11	(130)	✗	155	(144)	✗
Total	**4,823**	**3,446**	**(1,377)**	✗	**5,598**	**(2,152)**	✗

- The delivery of the 2022/23 efficiency target of £5.6m, which represents 1.9 per cent of operating expenses has been extremely challenging. However, we are focussing effort on the Financial Recovery reviews to identify saving plans to mitigate the risk.

- Significant improvement has been made, with 62 per cent of the efficiency target of £5.6m now fully validated (Exec Sign off and QIA approved). A further £0.6m schemes are presently validated or scoped awaiting sign off whilst £1.6m are proposed and under development. Recurrent schemes represent 70 percent of the £3.4m fully validated schemes.

- We delivered £1.8m savings against a plan of £0.7m in the month. This leads to a year-to-date achievement of £3.4m, which is 28.5 per cent below plan. The main driver for the £1.3m shortfall remains the non-delivery of planned operational efficiencies.

- The gap to year end is currently £2.2m, but work continues through the ongoing Executive challenge reviews and the scrutiny of financial position to identify further efficiency schemes to close it. We are anticipating achieving a full year forecast of £4.0m whilst mitigating the remaining balance through non recurrent savings.

- Engagement with stakeholders continues as part of the planning process to ensure focus remains on developing a pipeline of sustainable schemes for 2023/24 and beyond. Two efficiency workshops have been held to establish the new efficiency process, while cross departmental workstreams are presently under development to facilitate the delivery of productivity improvements across the Trust.

5. Covid

	Year to February 2023				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Covid Income	£6.8m	£6.8m	£0.0m	✓	£7.4m	£7.4m	£0.0m	✓
Covid Expenditure	£4.4m	£4.7m	(£0.3m)	✗	£4.8m	£5.0m	(£0.2m)	✗
Surplus / (Deficit)	**£2.4m**	**£2.2m**	**(£0.3m)**	✗	**£2.7m**	**£2.4m**	**(£0.2m)**	✗

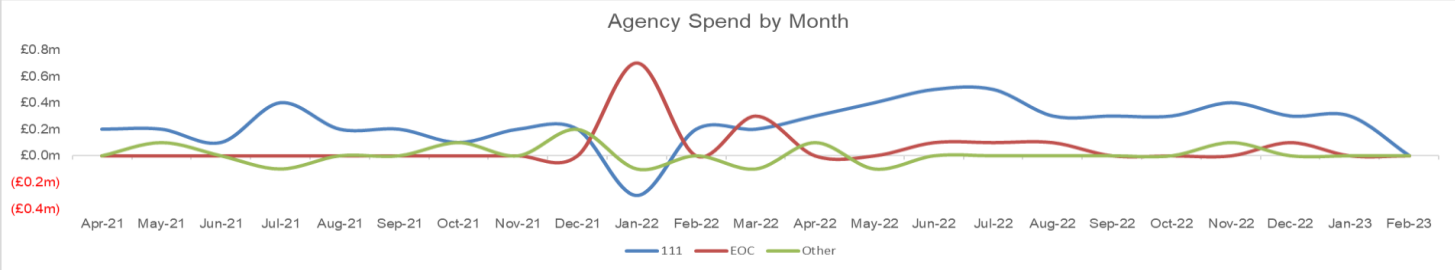
- Covid spend is £0.3m worse than plan and expected to be £0.2m adverse to plan by the year end. Covid related sickness has decreased in recent months, enabling the year to date and forecast expenditure to be reduced.

6. Agency

	Year to February 2023				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Agency Expenditure	**£4.9m**	**£4.1m**	**£0.8m**	✓	**£5.5m**	**£4.7m**	**£0.8m**	✓

- Overall spend with agencies was significantly reduced in February, with 111 successfully converting agency staff to permanently employed. Most of the agency spend was in NHS 111 (£3.6m of total). Agency expenditure is currently 2.0% of the Trusts total pay costs.

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

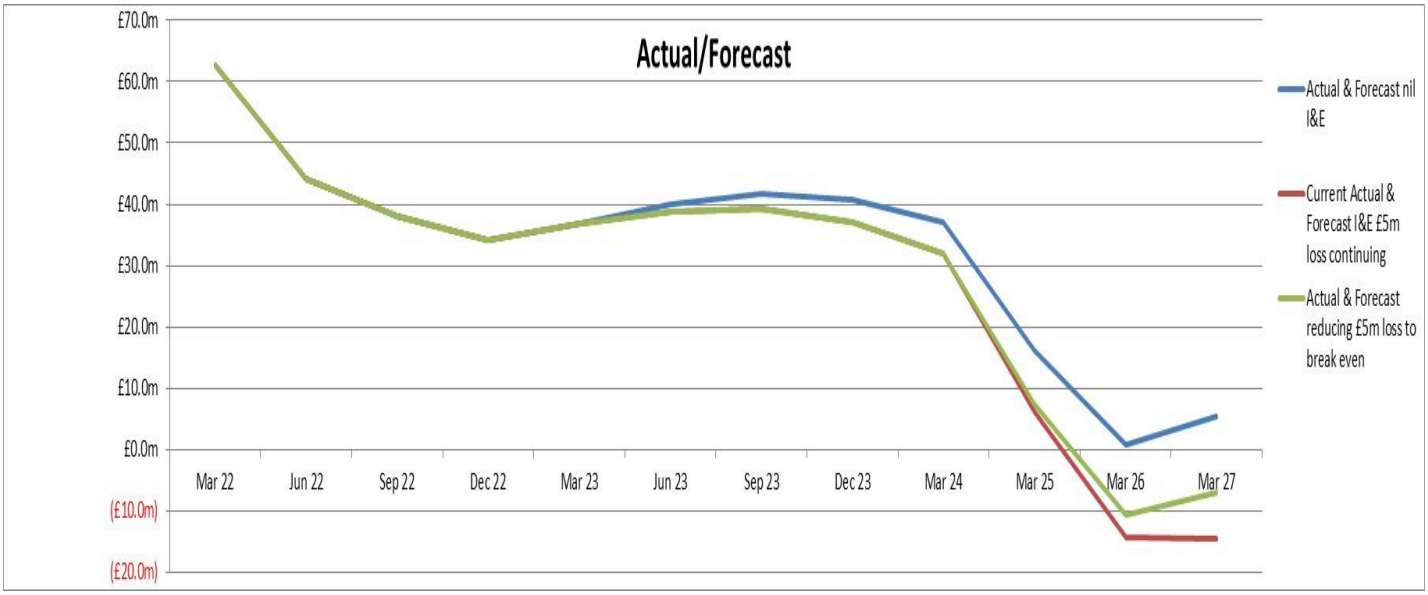


7. Cash and Balance Sheet

	£000 Previous Month	£000 Change	£000 Current Month	£000 31 March 2023
NON-CURRENT ASSETS				
Property, Plant and Equipment	112,647	2,562	115,209	119,285
Intangible Assets	2,390	(157)	2,233	2,089
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**115,037**	**2,405**	**117,442**	**121,374**
CURRENT ASSETS				
Inventories	2,423	(18)	2,405	2,571
Trade and Other Receivables	17,761	(1,590)	16,171	9,121
Asset Held for Sale	657	0	657	657
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	32,403	2,726	35,129	36,738
Total Current Assets	**53,244**	**1,118**	**54,362**	**49,087**
CURRENT LIABILITIES				
Trade and Other Payables	(36,899)	(2,409)	(39,308)	(37,508)
Provisions for Liabilities and Charges	(6,070)	(61)	(6,131)	(6,131)
Borrowings	(7,721)	86	(7,635)	(7,722)
Total Current Liabilities	**(50,690)**	**(2,384)**	**(53,074)**	**(51,361)**
Total Assets Less Current Liabilities	**117,591**	**1,139**	**118,730**	**119,100**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(12,459)	0	(12,459)	(12,459)
Borrowings	(24,135)	268	(23,867)	(23,936)
Total Non-Current Liabilities	**(36,594)**	**268**	**(36,326)**	**(36,395)**
TOTAL ASSETS EMPLOYED	**80,997**	**1,407**	**82,404**	**82,705**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	108,908	0	108,908	109,244
Revaluation reserve	5,810	0	5,810	5,810
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(32,648)	0	(32,648)	(32,648)
Income and expenditure reserve - current year	(1,073)	1,407	334	299
TOTAL TAX PAYERS' EQUITY	**80,997**	**1,407**	**82,404**	**82,705**

- Non-Current Assets are up by £2.4m in the month represented by new assets under construction of £3.8m net of monthly depreciation of £1.4m.
- Trade and other receivables are down by £1.6m mainly because of the £1.7m decrease in accrued income where the Trust was in receipt of Sussex ICB catch-up funds. Trade receivables increased to £2.1m with invoices raised to West Midlands AS totalling £0.7m.
- Cash was down £1.8m and whilst income was static payments for pay including PAPs and general non pay were up £0.5m each with capital cash expenditure increasing by £0.2m above the shortfall from last month.
- Trade and other creditors were up by £2.4m which was made up of an increase in accruals of £3.0m partially offset by a reduction in trade creditors of £0.3m and tax and other pay creditors being down by £0.3m.
- After the provision adjustment last month, the remainder of the balances will be reviewed at year end otherwise there is only a refund in the month.
- Borrowings are down by £0.3m in total with a correction being booked in the split of short and long-term liabilities. This is a result of payments made on DCA leases in the month.
- The movement on the I&E reserve represents the Trust's reported surplus for the month and year to date.

8. Cash Forecast



- Forecast cash for the remainder of 2022/23 and then forecast or future years 2023/24 through to 2026/27 based upon the total capital expenditure plans (CDEL and ROU), expected disposals and the Income & Expenditure (I&E) cash requirement for the Trust to operate from day to day following the draft 23/24 plan submission.
- The upside case is indicated by the top blue line above, where a break-even I&E position has been assumed for all future years. This means our cash position will be around £5m due to significant planned capital investment in 2024/25 and 2025/26.
- The middle green line predicts the eroding cash position if the Trust reports a £5m loss in 2023/24 per the draft plan and reduces the losses to zero over the forecast years whilst the red line shows the trend when the forecast losses for next year continues.
- Overall, though the block income arrangement has been assumed to continue in the new financial year, our cash position will continue to decline if the Trust persist to make deficits and will eventually run out within the next two years.

9. Working Capital

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	19	
Debtors % > 90 Days	5.0%	9.0%	
Trade Creditor Days	30	37	
BPPC - Value of inv's pd within target (ytd)	95.0%	90.5%	
Cash (£m)	39.5	35.1	

- Debtor days at month end are 11 ahead of target despite accrued income for block income not received.
- Debtors % over 90 days are below target due to historic overdue invoices of £104k from NHS Horsham and Mid Sussex CCG for divert charges and £64k from NHS Lewes High Weald Havens CCG for disputed A&E charges. Both CCGs are no longer operating, and both have been absorbed into the new NHS Sussex ICB.
- Creditor days are off target by 7 days for the month. This includes purchase order receipts not yet matched to invoices of which the main balances are Crawley HQ rent under investigation, and balances with utility companies Frimley Health FT for drug supplies and Churchill Contract Services awaiting invoices.
- The BPPC for value of invoices paid is improved in the month but remains behind the YTD target largely because of issues with last year end invoices for IC24. Year to date 18 invoices totalling £5.3m failed the BPPC test causing this shortfall and if we adjust for these failures the % would have been 95.3%. Invoices are now processing on time and meeting BPPC targets.
- Cash is below plan at month end but up on last month end after receipt of Sussex ICB catch up income of £2.9m. Further payment is anticipated from Kent ICB in March that should ensure the cash balance ends nearer to the planned £40.9m for year end. The Kent ICB amount of anticipated block income is currently accounted for under accrued income within trade debtors.

10. Capital

	Year to February 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Estates	£0.8m	£1.1m	(£0.3m)	✗	£0.8m	£1.3m	(£0.4m)	✗
Strategic Estates	£13.0m	£10.8m	£2.2m	✓	£13.1m	£12.8m	£0.3m	✓
IT	£0.6m	£0.4m	£0.2m	✓	£0.7m	£0.6m	£0.2m	✓
Fleet	£2.3m	£3.9m	(£1.6m)	✗	£2.5m	£6.2m	(£3.8m)	✗
Clinical Operations	£1.0m	£0.7m	£0.3m	✓	£1.1m	£0.9m	£0.3m	✓
Total 'System' Capital (CDEL*)	**£17.5m**	**£16.9m**	**£0.6m**	✓	**£18.3m**	**£21.8m**	**(£3.4m)**	✗
Right of Use Assets (Leases)	£14.8m	£9.3m	£5.5m	✓	£17.5m	£9.7m	£7.7m	✓
Total Capital	**£32.8m**	**£26.3m**	**£6.4m**	✓	**£36.1m**	**£31.8m**	**£4.3m**	✓

- Capital expenditure for the year to date was 19 per cent below plan. The further delay to Medway MRC and anticipated leased vehicles.

- The full year forecast capital spend is £31.8m compared to the plan of £36.1m. The underspend of £4.3m is caused by the items listed in the table below.

	ICB Capital allocation	National Funding (PDC)	Right of Use Capital (Leases)	Total
Original Plan	£18.3m	£0.3m	£17.5m	£36.1m
Changes to CDEL:				
Reduction in ROU as per NHSEI	£0.0m	£0.0m	(£3.9m)	(£3.9m)
Increase for DCAs	£3.0m	£0.0m	£0.0m	£3.0m
Grants	£0.3m	£0.0m	£0.0m	£0.3m
Disposals	£1.1m	£0.0m	£0.0m	£1.1m
Reduction for overplanning	(£0.9m)	£0.0m	£0.0m	(£0.9m)
New CDEL	**£21.8m**	**£0.3m**	**£13.6m**	**£35.7m**
Underspend				£0.0m
Move DCAs from ROU to purchase			(£3.9m)	(£3.9m)
Capital forecast	**£21.8m**	**£0.3m**	**£9.7m**	**£31.8m**

- The main risks to meeting the year end capital expenditure forecast is the delivery of the remainder of the spend on Medway MRC of £2.0m and on the 57 DCA due to start conversion of £3.9m before the end of March 2023. Mitigations for these two risks are currently being progressed. A Business Case is being progressed through approvals for some yearend IT spend to mitigate these issues.

- The Trust applied for national funding for the purchase (not lease) of additional DCAs. This 'funding' will just be an increase in CDEL without any cash.

11. Underlying Position

- The following table adjusts the reported position and removes identified non-recurrent income and expenditure, to show an indicative underlying financial position.

Underlying Position	Year to February 2023	Plan to March 2023	Forecast to March 2023
Reported Surplus / (Deficit)	**£0.0m**	**£0.0m**	**£0.0m**
Covid Funding	(£6.8m)	(£7.4m)	(£7.4m)
999 Support Funding		(£1.8m)	
Unidentified Savings			£0.0m
Non Recurrent Adjustments	(£1.0m)	(£7.9m)	(£1.5m)
Gains on Sale of Assets	(£0.3m)		(£0.3m)
Underlying Surplus / (Deficit)	**(£8.1m)**	**(£17.1m)**	**(£9.2m)**

- This shows that for the year to date, the Trusts underlying position is a deficit of £8.1m with a forecast out-turn deficit of £9.2m; This represents the financial gap to the funding we receive from our core contracts.

- This gap is being addressed through the financial recovery program as part of the financial planning for 2023/24

12. Risks

Risk	Impact	Likelihoo	Scor
Risk of not achieving recruitment necessary to meet the requirement to join the Single Virtual Contact Centre (SVCC)	>£1.0m <=£1.5m	Unlikely >20% <=50%	6
Forecast reflects the expected costs; This risk reflects any further deterioration to the forecast for any unforeseen and unexpected costs.	>£0.5m <=£1.0m	Unlikely >20% <=50%	4

- The table above shows those risks to achieving this year's financial target. As we are now only one month until the close of the year-end, the risks have mainly been mitigated. The severest risk is linked to the unforeseen events in March 2023.

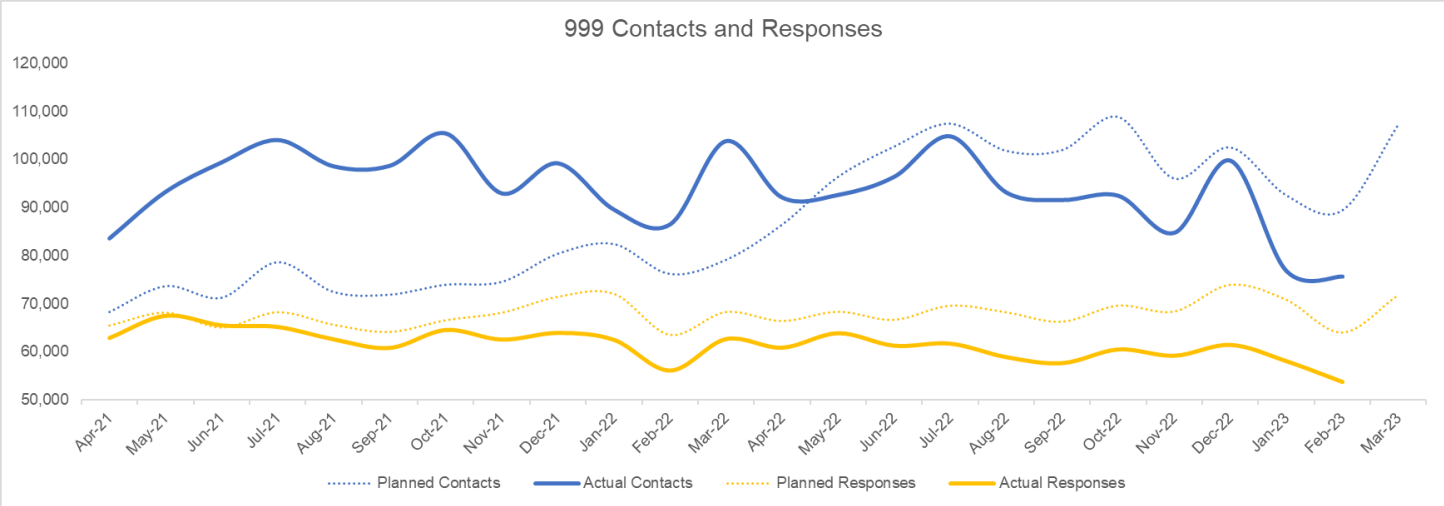
Appendices

A. Finance Pack

SECAmb Finance Pack M11.pdf

B. Activity

999 Activity:



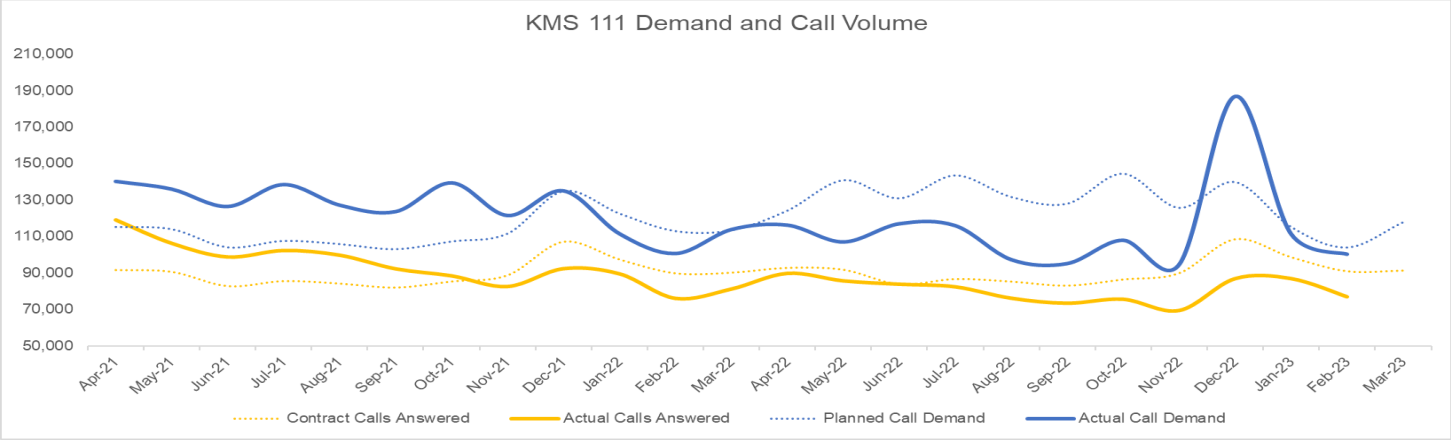
Year to February 2023, 999 contacts (demand) is 8.0 percent down against plan with response activity 12.7 percent lower than planned.

Both demand and activity are also down compared to the same period last year with demand 4.8 percent lower and activity 7.1 percent down year to date.

Category 2 mean response times continue to be of concern with the average for the year at 35.0 minutes versus 29.3 minutes compared to last year. In February we slipped to fifth best performing Trust in this category nationally at 28.9 minutes, this is still less than the national C2 mean at 32.3 minutes.

Handover delays have had a severe impact on the availability of crews to reach patients in time, an additional 7,532 hours were lost in the year to February 2023 compared to last year, this is equivalent to around 2 ambulances per day, despite transporting 6.9 percent (27,545) less patients to hospital.

111 Activity:



February 2023 saw demand continue to remain static with demand (calls offered) on the service (including Vocare) being 3.7 percent lower than planned.

Year to February 2023 (including Vocare), 111 calls offered (demand) is 12.5 percent down against NHSEs plan with call answer activity 11.0 percent lower than contracted for the year to date, although this is 34.6 below the expected NHSE volumes.

Both demand and activity are down versus the same period last year with demand 10.8 percent lower and activity 15.2 percent down. This trend would indicate the Trust requires less staff to meet future demand.

Calls answered in 60 seconds performance has improved to 31.2 percent for the year to date against 32.4 percent for the same period last year.

SECAMB Board

Finance and Investment Committee (FIC) Escalation Report

Overview of issues covered at the meeting on 30.03.2023.

Item	Purpose	Link to BAF Risk
Operating Plan 2023/24	To review and approve the final submission of the 2023/2024 plan, due to be submitted to NHSE on 30 March 2023.	Risk 16 – Financial Sustainability
The committee reviewed the plan, which followed the draft that was considered at the extraordinary meeting of the Trust Board earlier in the month. The main headline is that with a planned £4.5m deficit, the funding will ensure a 34-minute C2 mean. The Board is aware that, recognising the challenges in the sector post COVID where no ambulance service is achieving ARP, there is an interim national target of 30-minutes C2 mean. The committee supports the plan, which includes significant internal efficiencies, and agrees that it is the best that can be reasonably achieved within the funding from commissioners. The discussions with commissioners will be ongoing to ensure clarity on funding from next year, as the executive is clear that to ensure ARP standards are met beyond 2024/25 additional funding will be required. The committee also reviewed the constrained capital investment plan and while it is satisfied that we appear to be prioritising the right areas, it has asked for further detail on the unconstrained capital plan to test the implications of not investing in the other areas. In summary, the committee supported the submission of the plan. It acknowledges this effectively means we are not being commissioned to achieve ARP, but against the background of recent years (of non-achievement) it is a plan that aims to ensure a trajectory of improvement over time. There are two specific areas for the Board's consideration, set out in the escalation section below.		
Financial Performance- M11	To seek assurance that there is robust budget management to ensure we meet our financial plan.	Risk 16 – Financial Sustainability
At Month 11 the committee is confident the Trust will achieve a year-end breakeven position. It reflected that despite the various challenges, the Trust has met its financial plan every year since 2017. Noting the planned deficit this year to further improve the performance trajectory / patient quality, the Trust Board will in due course need to take a view on the likely medium to long term financial position in the context of quality. This will need to explore the strategic solutions in probable event that sufficient funding is not available.		
In-Year Savings – Quality Impact	to seek assurance that the financial savings have not had a	N/A

	detrimental impact on quality/patient safety.	
As requested previously the committee received an assurance paper setting out the impact on quality, from the savings made to close the £8.9m gap identified in Q3. The committee is assured that there has been no significant adverse impact on quality and by the governance that underpinned the recovery plan; the paper set out how the savings were made which the committee reflected were more efficiencies, than savings.		
Acquisitions and Disposals	To seek assurance on the governance and oversight related to how property is valued, and marketed and is aligned to the Estates Strategy.	N/A
A helpful paper was considered providing the status of our current property disposals. The total anticipated sales income is circa £11.2m and the committee sought assurance with the process for ensuring the right people are involved in deciding what can be sold. Noting that this aligns with the Board approved estates strategy, the committee reinforced the need to ensure we dispose of properties we no longer need, to help our cash position and what is available to invest in capital projects.		
Green Plan	to seek assurance that all elements of sustainability are being captured as part of the plan.	N/A
A detailed presentation was provided by the consultants we have procured to support the development of our Green Plan, which is essentially our strategy to reduce emissions to net zero. There is still much to consider, including how we ensure alignment with our ICBs and how it will be funded.		
111 Single Virtual Contact Centre (SVCC)	to seek assurance that SECAmb is appropriately funded to ensure compliance with the expectations of NHS England regarding operational implementation of SVCC.	Risk 17 – Integration of 111 / EOC
The committee is assured that the executive has properly engaged with this initiative. However, we do not have the funding to enable us to meet the threshold for SVCC. An options paper is being developed to set out the implications and next steps. A discussion is needed by the Board to determine how 111 CAS aligns with the Trust's strategic direction. In the meantime, a part 2 discussion is needed to ensure clarity on what we are communicating externally about SVCC.		
DCA Replacement Programme 2023/24	For approval / recommendation to Board.	N/A
An options paper and related business case were considered together. This is on the Part 2 agenda and the committee recommends the Board approves the 57 new DCAs, which ensures compliance with the national specification and aligns with our own Fleet Strategy. This will give the headroom to then work up a new strategy from 2024/25.		
Specific Escalation(s) for Board Action	In the context of the operating plan for 2023/24 and the constrained finances / need to be more efficient, the Board needs time to explore the strategic approach to skill mix and implications for our operating model. The committee suggests this is included in the Board development plan for 2023/24.	

	The Board needs to determine how 111 CAS aligns with the Trust's strategic direction, especially as we are nearing the end of the current contract. The committee suggests this is included in the Board Development Plan for 2023/24.

In Q3 2022/23 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. It will be reviewed and updated in March, ahead of the Board annual review in April.
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 was discussed at the March leadership team meeting, with a plan to start implementation in Q1.
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 FIC meeting in January and Board meeting in February, related to the clarity of the report.
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. At its meeting in March it was told that discussions with commissioners are ongoing. The Trust and commissioners are reaching out to our peers to check how others contract (we are aware of similar arrangements) to make it more comparable. The expectation is that this will be resolved by June 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 Q1.