South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

01 June 2023
10.00-13.15

Trust HQ
Nexus House, Crawley

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
16/23	10.00	Welcome and Apologies for absence		-	DA
17/23	10.01	Declarations of interest		To Note	DA
18/23	10.02	Minutes of the previous meeting: 06 April 2023		Decision	DA
19/23	10.03	Matters arising (Action log)		Decision	PL
20/23	10.05	Chair's Report		Information	DA
		Board Committee TOR and Annual Plan		Decision	PL
21/23	10.15	Audit & Risk Committee Report		Information	MW
22/23	10.25	Chief Executive's Report		Information	MS
Strategy					
23/23	Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report**		
Quality Improvement – *We listen, we learn and improve*					
24/23	10.45	**Keeping patients safe**	Board Story		RO
			Quality Assurance Visits / Framework		MD
			Quality & Patient Safety Committee Report		TQ
	11.20	**Break**			
People & Culture – *Everyone is listened to, respected and well supported*					
25/23	11.30	**Improving Culture**	People & Culture Strategy and Delivery Plan		AM
			FTSU Guardian's Board Report		FTSUG
			People Committee Report		SS
Responsive Care – *Delivering modern healthcare for our patients*					
26/23	12.20	**Operational Performance & Efficiency**			EW
Sustainability & Partnerships – *Developing partnerships to collectively design and develop innovative and sustainable models of care*					
27/23	12.45	**Achieving Sustainability / Working with Partners**	Strategy Development		DR
			Partnerships Report		DR
			Finance Report		CP

Board Effectiveness				
28/23	13.10	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
29/23	13.15	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, 06 April 2023

Trust HQ, Nexus House

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Martin Sheldon	(MS)	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
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Rachel Oaten	(RO)	Chief Medical Officer
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Steve Lennox	(SL)	Improvement Director
Margaret Dalziel	(MD)	Deputy Director of Quality & Nursing
Siobhan Melia	(SM)	Guest

Chairman's introductions

DA welcomed members, those in attendance and those observing this meeting in person or via MS Teams. He thanked MS for covering as Interim CEO, until Simon Weldon joins later in the month and welcomed SM who has joined to assist with the handover.

01/23 Apologies for absence

Christopher Gonde	(CG)	Associate NED
Robert Nicholls	(RN)	Executive Director of Quality & Nursing.

02/23 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.

03/23 Minutes of the meeting held in public 02.02.2023

Save for an amendment to page 6 related to STEMI, which TQ will provide the correct words for, the minutes were approved as a true and accurate record.

04/23 Action Log [10.03-10.05]

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

05/23 Chair's Report [10.05–10.17]
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 and showing the Board is becoming more curious. DA reflected on the development as a Board over the last year, which is important as we accept responsibility for ensuring delivery.

In his report DA sets out the issues raised by the Council of Governors which will be issues picked up during this meeting.

On Board appointments, DA thanked SM for her efforts in the past nine months. He presented SM with a SECAmb shield as thanks. SM thanked the Board for its support. DA confirmed that MS is the interim CEO until 14 April when Simon Weldon joins. His induction programme is in place and we look forward to welcoming him to the Trust.

Lastly, DA noted that there is much to get through and so asked members to be focussed and succinct, with the focus on culture particularly important today.

Well Led Self-Assessment
DA summarised the output, which is an honest assessment of where we are as a Board and where further work is needed; it helps to indicate introspection, honesty and challenge. The Board acknowledged that it is content that the report accurately reflects the sessions, noting the plan to undertake a further re-assessment later in the year.

Board Development Plan
PL explained that the paper first reminds the Board of the development sessions completed in the year just ended. One session was omitted, the training on Cyber Security in February 2023. The paper then outlines the proposed priorities for Board Development this year. PL reinforced that the plan is informed by the outputs of the Board's self-assessment against the Well-Led Framework. On behalf of the Chair PL will support the planning, but each session will include the input also from at least one executive and one non-executive director to help ensure full Board buy-in and ownership. For example, the development of the Board's role in risk management, the first of two sessions is later today, has been devised with input of both RN and MW. Each session will include clear outcomes / measures of success, to help our assessment of the impact in improving the effectiveness of the Board.

Board supported the plan, as reflective of its development needs.

06/23 Audit & Risk Committee Report [10.17–10.33]
MW explained that when we formally recommend the final report and accounts approved within this will be the annual governance statement which sets out how resources are managed and controlled. We have been faced with the challenge of having three CEOs in the past 12 months and so the incoming CEO will need to sign this off and so the role of the committee is help provide assurance to him.

In terms of the meeting, MW reflected the progress that has been made. For example, risk management is starting to show positive signs related to process but still some way to go to ensure this is embedded throughout. It is important when we undertake leadership visits that we ask the right questions about risk and the level of understanding.

The second point relates to the control environment. As the report confirms, there have been some internal audit reviews with limited assurance. This is worrying but also in some ways a good sign as it demonstrates greater transparently on the control weaknesses that exist. This will allow us to address them sustainably.

What this means is that the Head of Internal Audit Opinion may be less positive, but it will be an accurate reflection of the year.

MW then describes the concerns related to digital capability following the major Incident in November. He paid tribute to work to address this but escalated to the Board that several months on we seem no clearer on why it happened and so has implications for having an appropriate digital strategy and robust digital functionality. An external review is being commissioned which the committee supports.

The committee considers fraud at each meeting and the related risks. There is nothing to escalate other than to raise the emerging issue related to declaring secondary employment; time sheet recording and fuel cards, as set out in the report. These are emerging issues just for awareness but goes to the culture we are seeking to address.

PB added that there was concern also about policies. PL updated the progress made with this in recent weeks.

DR challenged what we are doing in response to the limited assurance reviews. MW responded that there are action plans in place agreed by the lead director. PL reinforced too the role of other committees to ensure delivery and impact. The outputs of these reviews will be reflected in the annual governance statement.

07/23 Chief Executive's Report [10.33–10.58]
MS took the Board through some of the key points from his report, highlighting the following:

- EMB is increasingly becoming a more challenging environment, there has been much attention on staff survey results to help rebuild confidence among our people.
- People and Culture – MS welcomed Tina Ivanov, our new programme director who is helping accelerate the work we are doing.
- He thanked SM for her help and reflected her input has been good for the trust, Board and EMB.
- Leadership visits are ongoing; they need more structure aligned to our comms and engagement strategy.
- Values check in – really good piece of work. JC updated that it closed yesterday with feedback heavily in favour of revised values (80% - 350 individual responses, plus from staff networks in addition to one of the questions in the diagnostic phase of culture work in EOC) and some really good feedback from staff networks too.
- Medway – on the 31 March we took on partial possession. Some building work still to complete in the next few days. We are working through the people plan, noting some will not be moving across due to things like distance to travel.
- Staff survey results were not good and we must do better; this is an item later on the agenda.
- Lastly, on performance, MS reinforced our aim to get to 30minute C2 mean as a prelude to getting back to ARP soon after.

DA thanked SM for this update and before opening to questions reflected concern about the impact of the junior doctor strike on handover times and acuity of patients we need to covey. We will continue to work with our partners to get message to government that this needs to be resolved. In the meantime, the Board noted the significant risk, as set out in the BAF.

HG asked about UEC recovery plan and how we reconcile this with our plan for the year. MS responded that we are one part of the system of UEC. The intention is to return to normality post COVID with a clear statement over this two-year period that operational delivery returns to normal way of working. HG asked if we have submitted a one-year plan. MS confirmed that we have but we have an internal plan that bridges

the gap to ARP, although this relies on funding and our discussions on changes to our operating model (see BAF risk).

LS referred to the coordination of our four ICBs and asked if Surrey Heartlands is still to be our lead. MS confirmed that they will be for the foreseeable future. We need to ensure we feed in to each ICB discussion to ensure continuity of messaging, linked to our comms and engagement strategy and partnerships report later on the agenda.

SM added that she caught up with Surrey Heartlands last week and the plan is to set out a MOU to ensure partnership working. We were told to move to Sussex but this has been paused. DA expressed come frustration and asked that we all work to ensure good partnership working,

DA summarised that related to national ARP standards, we should always aim to get to patients as quickly as reasonably possible. He asked RO and MD to ensure we continue to track patient impact. MD confirmed we do this via harm reviews and the cluster Sis. We are also setting up a collaboration forum for the system to look at the wider impacts on the system of delays. RO added that she engages the regional clinical leads and this data is being fed in to help reduce system harm. DA thanked both for this update and reflected that staff need assurance from the Board that we are using all endeavours to meet patient need within the resources we have. And are escalating to commissioners as required.

08/23 Strategic Priorities [[11.00-11.-09]
DR explained that we started last year without a clear plan which led to the development of the Improvement Journey and related priorities and objectives; this was a plan that dealt with the findings from the staff survey and CQC inspection. This new plan uses the learning from the past year and it will be aligned with agendas of Board / committees to ensure delivery and holding to account. It is based on our four strategic themes, as set out in the document. There are some gaps in KPIs because further consultation is needed. This will be updated in the coming weeks.

DA thanked DR for his leadership in getting the plan to this point, which has had much engagement, including with our Council of Governors.

PB asked about the timeline for agreeing the new strategy. DR confirmed that the plan is to agree this at the December Board meeting. We have started the process of engaging stakeholders and are working through how to get external support to provide the capacity in the development of the strategy taking account of the ICB forward plans.

SS referred to the People & Culture priorities and asked if we could include a diversity metric specifically related to a more diverse workforce at senior level. AM agreed and explained we do have an objective by 2026 that we will have gender balance in management roles >Band 7. This needs to be included in personal objectives.

The Board agreed the strategic goals and in-year corporate objectives, noting some will be subject to slight revision in the coming weeks.

09/23 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.

10/23 Keeping Patients Safe [11.09-11.46]

Board Story

This is a positive story demonstrating the work to deliver better patient outcomes, with early CPR and use of defibs critical to survival rates. This is timely as we publish our annual cardiac report, which demonstrates that we perform well as discussed at Board last time. The video was then played.

DA felt that it was a great story and well produced; very powerful and reinforces why we are here.

TQ linked it to the trust values, with the staff in the video clearly very proud.

MD then turned to her paper drawing the link to the IQR and key areas such as work to further improve risk management and culture of raising risks. On the medicines risk, RO updated that the Architect is currently working up plans to reduce the health and safety risks at Paddock Wood. It is progressing but not as quickly as we would like. We do however have more capacity in the medicines team with new recruitment to support distribution and the risks related to packing medicines. A review was undertaken of all the risks to ensure robust mitigation is in place, in the meantime. DA clarified that the Chief Pharmacist and her team are engaged with architect. This was confirmed by RO; the H&S team are too.

The Board noted that the QI project related to keeping pts safe in the stack, which started in January, is going well and includes staff across directorates. The aim is to conclude this project by October 2023.

In relation to Serious Incidents, significant progress has been made with just three now in the backlog with the oldest one breaching just 6 weeks ago. Systems are in place to reduce breaches. DA welcomed this progress and thanked MD and her team.

MD confirmed that Datix Incidents continue to be in the normal range. The backlog of incidents is still too high, but we do have a clear picture and are working with commissioners on this as significant number relate to issues for commissioners, rather than SECAmb.

The Board noted from the IQR the improvement in complaints response timeliness, which is a good example of use of the assurance cycle at Board; with the Board asking for action following the process issue highlighted by the IQR in December.

MD acknowledged that duty of candour compliance is variable and there is QI focus on this to ensure improvement.

DA thanked MD for this helpful summary and the improvements noted.

LS asked about SIs and specifically where we are with the process review and cascade on lesson learned. MD responded that the reviews of SI process has led to an action plan including adherence more closely to policy and better learning. Also greater focus on training helped by reduction in backlog e.g. capacity to do the training. CQC asked for a number of SIs which they are reviewing. No further action has been requested.

PSIRF

TQ asked about PSIRF and what we need to change. MD explained that this is a shift in culture, based on 'just culture'. We have taken steps already related to harm reviews and different methodologies. A steering group is in place to draw on the main elements of both the transactional and transformational culture change to embed this, e.g. align SIG with the ICS footprint. So there are some infrastructure changes needed. Our PSIRF implementation lead is joining soon to support this. Regular updates are scheduled at QPSC.

SS referred to the medicines management estates issue and asked for a timescale. RO responded that it will be a minimum of 6-8 weeks for the Architect to drawn up plans. The Board noted that the lease on Paddock Wood will be extended and so this a medium to long term plan. QPSC will continue to retain close oversight of this.

DR referred to the IQR and the NHSP audit which is showing special cause variation. He asked if we have an issue with compliance of audit completion also with compliance of the audits completed. EW responded that this is linked to capacity and staff having regular audits. NSHP is aware. EW explained that as we have several new staff this will typically lead to higher non-compliance.

Action
The Board has noted the special cause variation in the IQR related to NHSP audits. It has asked QPSC to follow this up, to understand the reasons and what corrective action is necessary. There is also a cultural issue here related to the support we provide staff who are audited, e.g. ensuring it is a learning tool, not punitive.

Learning from Deaths Report
RO highlighted that the panel who do reviews have identified staff delivering good and compassionate care. Compared to Q1 there are no cases this quarter where cases are judged as adequate or below. Delay continues to be a theme. We are still marking our own homework, and this is a national issue that we haven't yet agreed a resolution to. NHSE is working on guidance and in the interim we are aiming to establish agreement with another ambulance service to review each others' deaths, to ensure the judgments are fair and appropriate. We are aiming to start this from Q1 this year.

DA thanked RO for this update.

TQ asked how we measure compassionate care. RO responded that it is subjective to the senior clinicians which is why the external view will help.

TQ then asked how we work with system partners on this, noting that the early discussion on the ICB collaborative forum aims to address this, to share data across the system. DA encouraged escalation if these discussions get stuck. DR added that the Hewitt review recommends sharing of data across ICSs.

[Break 11.46 – 11.58]

11/23 Improving Culture [11.58-13.21]
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:

- Recruitment – the plan is to change the way we present the data on time to hire as this currently includes both large recruitment and other recruitment, so can be misleading. It will show both in the future.
- Sickness absence – while above the 5% target we have monthly scrutiny of plans.
- On target for stat man training
- Appraisals – there is an issue related to the use of the new system so looking to make changes to make it easier for people to use.
- Culture and Leadership BAF risk – we spoke earlier about the sexual safety workshops. Undertaking evaluation and will come to the People Committee. It is a source of much distress in terms of those experiencing poor behaviour and the IQR shows improving timelines for dealing with these cases. But numbers of incidents is still a concern. By end of May we expect all complex cases to be resolved.

- Staff survey – we have used AI to synthesise free text comments.

MD added we have a good dashboard for FTSU cases and referred to the separate paper that sets out our response to the specific recommendations for the ambulance sector, following the NGO review. The Board noted that we still see many concerns and the themes and patterns are consistent. The focus must be on how we deal with these issues so people are listened to and action taken.

TQ expressed concern about the impact on staff from their experiences and asked about how we ensure no detriment is perceived. MD outlined the work to reinforce process that is for us all to raise issues safely.

Action
AUC to explore the reasons why staff are perceiving detriment as a result of speaking up and seek assurance that the processes in place will mitigate this.

DA asked for SM's view. She reinforced the need for ongoing meetings between the CEO and FTSU Guardian. Secondly, there is a misunderstanding among operational leadership about the role of FTSU Guardian, and so EW has taken positive action with her leadership team to remedy this – some of the perceived detriment arose from this misunderstanding.

SS feels this is about how some people respond to criticism and if it is defensive, it is something about how we support people to receive feedback better to ensure action / learning. More needs to be done as it affects whole organisation. EW added that we have committed to a day on culture values and behaviour training this year. The aim is to cover all these issues.

DR explained that the FTSU action plan is action focussed but doesn't include measures of success. MD will ensure these are added.

LS attended the sexual safety workshop recently and noted that 50% scheduled to attend did not. Also there appeared a gap in awareness about the dignity at work advocates and so asked if the profile is high enough.

SM confirmed that directors are following up on those managers not yet attending the workshops.

MW asked of the sexual safety training will be rolled out to all staff. EW confirmed this is in the training day she mentioned. MW then asked if we could have team-based training to reinforce what is learned. EW did not think this was practical in phase 1 as this is about re setting the baseline. These workshops are deliberately cross directorate, rather than team based.

DR referred to the IQR and the concern highlighted by the SPC chart for mean length of grievance cases and reference to a business case to ensure more capacity; he asked when we expect this. AM explained that the business case is due to come to EMB this month.

DA felt that much of these issues get stopped at source with effective line management. Important part of our culture therefore so that we prevent the need for grievances, which should be by exception not the rule.

HG also referred to the IQR and the SPC charts for stat man training and appraisals; both highlight a failing process and yet AM appears to reflect a better picture. AM responded that the run rate of stat man training is such that we should meet the target. HG ask therefore why the SPC is showing this as a fail. DR added that these are rolling targets and so SPC charts don't work as well for rolling targets so something we can do to show in more helpful way.

Action

As part of the development of the IQR, SPC charts don't work well for rolling targets and so need to present this data in a more helpful way for the Board. Stat Man Training and Appraisals, two examples identified by the Board in April.

Board Development – Culture

DA summarised the outputs of the Board session on culture, reinforcing the role of the Board collectively to set clear expectations. These sessions helped us to understand how we discharge this. The paper sets out the outputs of the work in recent months and it will be ongoing as part of the board development plan.

SS referred to section 4.3 and the action for the executive to work up a draft culture dashboard. She asked therefore whether this will show a level of granularity by OU / Directorate. DA asked for assurance that we look across our operational and corporate teams to assess metrics for culture. MS responded that the new operational quality and performance framework is to be implemented in Q1. The culture dashboard is in development. DR added that we are at risk of having a HR performance report rather than a culture dashboard. We therefore need to go through a process linked to the people and culture strategy to establish how we measure delivery of the strategy.

The Board reflected on the risk of having too many actions and felt we need a smaller number of priorities that really matter to people to change the culture. With regards the actions arising from the Board culture sessions, the Board agreed these in principle, subject to a review to make them more succinct.

Action
As part of the development of the People and Culture Delivery Plan, clear metrics / dashboard to be established that demonstrates impact on culture.

Comms & Engagement Strategy

PL outlined the working on the development of this new comms and engagement strategy. In Q3 we engaged Hood & Woolf to support the development of the strategy, acknowledging the need to take a more strategic approach to communications and engagement at SECAmb. Hood & Woolf are a specialist communications and engagement organisation with significant public sector and health experience. The strategy has been developed in collaboration with key internal stakeholders and it was instigated by the CEO who set up a small working group; PL DR and JC.

To set the baseline for this Hood & Woolf first undertook an assessment of our internal communications to test what we currently have in place. This concluded that we have a good range of communications channels and well delivered content. However, they identified a gap between that and an overarching approach where communications activity is more specifically focused on supporting delivery of strategic goals. The strategy therefore describes how we will focus our communications activity to develop a core narrative that is aligned with the Trust's strategic priorities and values. And how we intend both our reactive and proactive activity to be informed by stakeholder insights and situational awareness.

The intended benefits of this strategic approach will be a clear and consistent focus on what matters to our people with a clearer understanding of our internal and external stakeholders. The strategy includes a framework for delivery.

Lastly, PL summarised this strategy as a framework that will help ensure we align our comms and engagement activities to help deliver our strategic priorities, therefore improving patient and staff experience. It is a lengthy document and we will be producing a much shorter summary for our people. It is here as an enabling strategy for Board approval.

SM added that the genesis of this was frustration from people about our comms. We did some initial changes e.g. video messages / Yama etc. but as set out the frustration was actually less about comms and more about our culture.

DA thanked PL and SM for the helpful context to this important area that needs to be coordinated.

MP agreed it is a good strategy and will evolve as we develop a new overarching trust strategy. His slight concern was about how we operationalise and deliver it. We need to be optimistic about our ambition but resourcing might be a limiting factor, as flagged as one of the key risks. MP added that this is so important as an enabler as if done right it will engage our workforce and improve networks and engagement with system partners.

DA agreed, adding this is fundamentally about how we all work and engage and communicate with each other.

JC added that it has been a really useful exercise and provides a really solid framework to deliver our priorities, acknowledging what has been said about resources.

SS is supportive and challenged the list of all comms channels as we have feedback that staff don't have team meetings /conversations to deliver the channels listed. DA suggested we try not to answer this now but is one of the challenges in delivery. MP felt that managers need to be held to account too. JC agreed and we can do more to support them closer to the front line.

The Board agreed that this a really good strategy and it was approved.

Action
Update to Board each quarter on the delivery of the comms and engagement strategy and the impact it is having.

<u>Annual Staff Survey – Findings / Response</u>

AM stated by confirming the really good response rate is positive. Some findings were more positive as set out in slide 9 – so encouraging signs to have some green shoots. However, the rest makes very difficult reading and AM suggested we should all be very concerned about this, as we have discussed earlier. AM drew the Board's attention to specific aspects from the slides reflecting a need to get to the core of some of these issues which are recurring and longstanding.

The draft recommendations are for information and will be agreed in the coming days.

DA noted that we can't say we haven't been told; the feedback is very clear. We need to focus this conversation on what we are going to focus on. In light of this steer the Board explored how we are learning from others and what the key priorities should be linked to the People & Culture Strategy.

MW felt that we need to convey in a more meaningful way that we intend to make a step change in terms of our response, aligned to the People & Culture strategy. And hold to account for delivery.

SM reminded the Board that we are six months from the next survey. On reflection, we haven't talked about the staff survey enough with sufficient focus. We need direct oversight of delivery against actions filtered through the organisation to aggregate local plans. The Board needs a greater role in oversight and assurance. This will come via the delivery plan for the People and Culture Strategy.

DA expressed shame from reading some of the free text. He reinforced that this is a board matter and challenged every director to raise their game; the executive need to be clearer on delivery and the NEDs can no longer accept reassurance. DA noted that every Board member shares the values of the organisation and we know from this feedback, FTSU etc. where hotspots are. So his expectation is that we now tackle this head on to ensure improvement and how we hold each other to account to the right standards. At the very least we can expect is to be treated with respect and it is the responsibility on all staff to make these improvements, led by the Board.

Freedom to Speak Up – National Review
As above.

People Committee Report
SS confirmed most of issues have been picked up on the agenda today. The Board therefore noted the report, agreeing to the change in name to People Committee.

12/23 Operational Performance & Efficiency [13.21-13.40]
EW summarised the key aspects from her report linking to the IQR and BAF risks.

On the HART funding issue and potential impact, DA asked that we escalate this via the CEO with urgency. It is not a risk the Board is prepared to accept. EW will follow this up with MS.

DR referred to the special cause variation related to Fleet and set out the actions being taken. He also described the issue with unforms. This will be added to the IQR for visibility given it is an emerging issue.

HG asked about H&T and expressed frustration that we haven't made significant progress with this despite being a priority for several years. He does not have confidence we have actions to deliver what is a substantial change. EW responded that we recognise from the learning from the strike days the need for more clinicians in EOC, but the challenge is recruitment. We need to use our workforce differently therefore, as mentioned last time related to working within local OUs. EW is confident this will help.

TQ added, this is about case mix / acuity and whether patients suitable for H&T are suitable if acuity is increasing. EW explained that C2 segmentation will inform this review.

The Board requires more assurance with the steps in place to improve H&T rates. It has not allocated a specific action on the basis that this is one of the objectives within the improvement plan for the year.

13/23 Achieving Sustainability / Working with Partners [13.40-13.59]
Partnerships Report
The Board noted this new report, which will be a regular report and will develop over time. DR highlighted that we have since received the Hewitt report which includes the review of role of ICSs and this will impact how we interact with the systems in the future, including the need increase data sharing as referred to earlier.

DR also highlighted the work on the EUC recovery plan and focus on urgent community response. We need to hold the system to account for their role in helping us delivery C2 mean of 30 minutes.

DA reflected the feedback he has received about how we are engaged in the system, building our relationships with our ICS partners. The comms and engagement strategy links to our role in the system, in terms of leadership and engagement.

Finance Report

MS took the Board through the finance report confirming the year to-date is breakeven. MS expressed much confidence we will achieve breakeven for the year end, although a small element of this is non-recurring. He commended executive colleagues for their approach to help ensure efficiencies were delivered, and confirmed there has been no negative impact on quality, given the approach taken. The related BAF risk is therefore reduced on the basis of the improvements in recent months.

In terms of the current year, the plan is for a £4.5m deficit, and we will aim to bridge this to zero, non-recurrently. Disposal of properties will help this and it will also help our cash balance. MS felt that we are now on the road to financial sustainability.

DA opened to questions.

SS referred to the HEE income increase and asked what impact this has for the clinical education business case. MS responded that this is not meant to mitigate the ask for the business case and confirmed we have already funded the clinical education business case.

EW reflected that the positive way we have interacted with the finance team in the past six months has been noted by her team. The fact we are planning in a triangulated way with better data is really good. DA felt that this is a significant step and linked it to our culture.

FIC report

Board noted report.

14/23 Review of Board Effectiveness [13.59-14.01]

Our Leadership Way:

- Compassion
  The Board felt this was demonstrated through the discussion about the staff survey and need to get comms and engagement right, through the delivery of the strategy.
- Curiosity
  There was good challenge, including from the executive.
- Collaboration
  Good collaboration around the Board table and discussion about system collaboration. Also, our approach to culture has different directors leading; it is not just seen as a matter for the HR Director.

15/23 AOB

None

There being no further business, the Chair closed the meeting at 14.04

DA then asked if there were any questions from the public in attendance, related to today's agenda.

One question was asked about the comms and engagement strategy and reference to volunteers. JC confirmed that there mention of volunteers.

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	C	Final Draft to be reviewed at AUC prior to inclusion in the Annual Report which the Board will receive. See AGS in part 2
15.12.2022	70 22a	QPSC to seek assurance on the implementation and effectiveness of the Falls Programme.	PL	29.06.2023	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	01.06.2023	Board	C	06.04.2023: 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. 01.07.2023: See QPSC Escalation Report on the Agenda
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.	SW	Q2 2023/24	Board	IP	
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	C	Added to COB - see Escalation Report on the Agenda.
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	03.08.2023	Board	IP	06.04.2023: This is deferred to the meeting on 1 June 01.06.2023: Deferred to 3 August 2023.
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	29.06.2023	People Committee	IP	06.04.2023: On agenda for 20 April - will be included in the Board report on 1 June. 01.06.2023: The paper was deferred to June; it is on the agenda for the meeting on 29 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	C	06.04.2023: Verbal update to be provided - AM confirmed 15% as at last week and we hope to clear the remaining in the coming weeks. We are following up with the individuals.
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	C	06.04.2023: On agenda for 13 April. Will be included in the Board report on 1 June. 01.06.2023: See 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	People Committee	C	06.04.2023: On the agenda for WWC on 20.04.2023 01.06.2023: See Escalation Report
06.04.2023	10 23	The Board has noted the special cause variation in the IQR related to NHSP audits. It has asked QPSC to follow this up, to understand the reasons and what corrective action is necessary. There is also a cultural issue here related to the support we provide staff who are audited, e.g. ensuring it is a learning tool, not punitive.	EW	24.08.2023	QPSC	IP	Added to COB
06.04.2023	11 23a	AUC to explore the reasons why staff are perceiving detriment as a result of speaking up and seek assurance that the processes in place will mitigate this.	MD	13.07.2023	AUC	IP	Added to COB
06.04.2023	11 23b	As part of the development of the IQR, SPC charts don't work well for rolling targets and so need to present this data in a more helpful way for the Board. Stat Man Training and Appraisals, two examples identified by the Board in April.	DR	TBC	Board	IP	
06.04.2023	11 23c	As part of the development of the People and Culture Delivery Plan, clear metrics / dashboard to be established that demonstrates impact on culture.	AM	03.08.2023	Board	IP	
06.04.2023	11 23d	Update to Board each quarter on the delivery of the comms and engagement strategy and the impact it is having.	JC	03.08.2023	Board	IP	First update scheduled for August.

Key

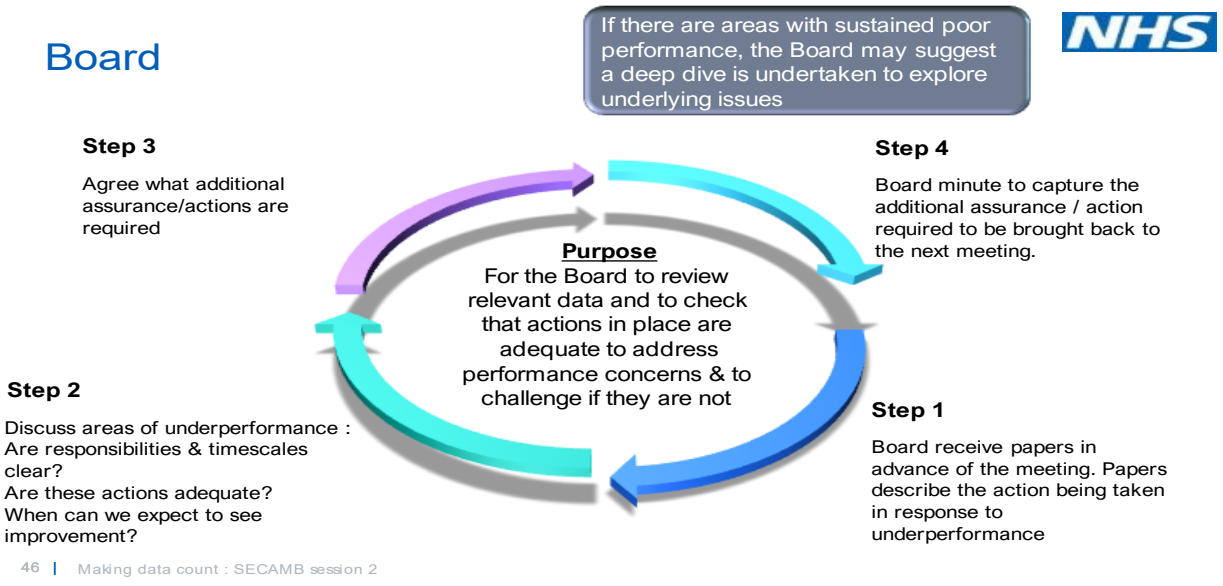
- Not yet due
- Due
- Overdue
- Closed

		Item No	20-23
Name of meeting	Trust Board		
Date	01.06.2023		
Name of paper	Chair Board Report		
Report Author	David Astley, Chairman		

Board Meeting / Effectiveness

At the meeting in April, the Board set the strategic goals and in-year corporate objectives. The Board Assurance Framework has been updated to help provide the Board with greater clarity on progress against the organisational objectives and the main risks to their achievement. It is now a much more detailed document although it has effectively subsumed the Improvement Journey and so there are now just two primary documents for the Board, along with the Integrated Quality Report (IQR). The Board committees have updated their annual plans in line with the BAF (Appendix 1).

Like the BAF, the IQR continues to evolve and I am pleased with the way the Board is making use of the Assurance Cycle. Since it was introduced in September 2022 the Board has improved the way it directs its committees and/or the executive, when it has identified a gap in assurance. This meeting will include such follow up, as captured in the Action Log and set out in the relevant Committee Escalation Report.



One of the Board's priorities is to improve the experience of our staff and volunteers. On the agenda is the new People and Culture Strategy, and the delivery priorities for the year. It is essential that progress is made in this area. Freedom to Speak Up is important source of

assurance and our local FTSU Guardian is attending this meeting to provide her bi-annual report to the Board.

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 is outlined below.

Recommendation	Progress
Consider Terms of Reference for the Trust Board. Clearly identifying the aims of the Board and referencing them as appropriate in the operation of the Board.	New Terms of Reference will be reviewed first by the Audit & Risk Committee, prior to approval at the next meeting on 3 August 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 April covered the previous COG meeting and aligned closely to the issues within the Board's focus. This Report includes the outputs of the joint Board COG meeting in April.
Individual authors, the Chair and the Secretary to ensure papers adequately address the need to assess, monitor and drives 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, as set out in the paper received in April.
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 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

Our Governors have a key role in our governance structure, holding the Board to account for the performance of the Trust. They do so on behalf of the Trust's members, who include our staff and our public. Jodie Simper, Corporate Governance and Membership Manager, supports our Governors to organise membership events aimed at promoting the work of the Trust and attracting new members. A number of events are scheduled over the summer across the Southeast. In recent weeks there were events at the English Festival in Gillingham; Spring Live at Ardingly; the Brighton Marathon; and the Godalming Festival, where over a 100 of new public members enrolled. We also now have rolling posts on a number of social media channels.

The Board and Council of Governors came together on 27 April to hold a workshop on strategic planning, exploring why the Trust needs a new strategy; how it should be co-designed; and the questions the strategy should seek to address. The feedback included:

- Ensuring stakeholders across the organisation are engaged in the development and implementation of the strategy, reflecting the desire for inclusivity and diverse perspectives.
- Establishing strong partnerships with system stakeholders, emphasising the importance of collaboration.
- Maintaining transparency and clear communication throughout the process, including regular updates and opportunities for input.
- Continuously focussing on meaningful engagement and consultation, staying true to the co-design principles expressed during the workshop.

- Ensuring we listen to all voices and set appropriate boundaries as this will be an exercise that gives us a realistic way forward to ensure SECAmb meets patient needs and becomes sustainable.

The outputs of this workshop have informed the specification to engage an external partner to help us with the development of the new strategy. The aim, as set out in one of our corporate objectives for this year, is for the new strategy to be agreed by the Board in December 2023.

Leadership Visits

I continue to undertake leadership visits, to hear from staff about what is working well and where there are challenges. Some of the feedback has included the following:

- Poor staff engagement was again evidenced. Some staff feeling more "talked at" by their line managers / senior leaders.
- Some concern was also expressed about a lack of clear vision of what our strategy for the future is. This reinforces the importance of engaging in the development of our new strategy over the coming weeks and months.
- Positive feedback about the continued instruction that training must not be cancelled.
- In terms of people development, this is still inconsistent as demonstrated by a visit to Brighton when I spoke with two colleagues, one who had benefited greatly from the Aneurin Bevan Leadership programme and the other who had not received any leadership training in his 18 years with SECAmb.

I am confident that we are making some good progress but there is a long way to go to ensure this is experienced throughout the Trust. The development of the Trust strategy during 2023 will be a significant opportunity to ensure our people are engaged in the future of SECAmb.

Board Appointments

I very much welcome Simon, for whom this will be his first formal meeting of the Board, following his arrival as Chief Executive on 14 April. Simon has already made a positive impact and will help us make the improvements needed.

I would like to also welcome Margaret Dalziel, who was appointed as interim Executive Director of Quality & Nursing, following Rob Nicholls decision to take up a secondment opportunity.

Last but not least, I welcome Charles Porter who is with us for the next few weeks as interim Chief Finance Officer, until Saba Sadiq joins in early July.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	20/23

Name of meeting	Trust Board
Date	01.06.2023
Name of paper	Board Committee Annual Review
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of Board Committees' membership (Appendix 1) and the terms of reference for the Audit, Quality & Patient Safety, People, and Finance and Investment committees. The annual plan (cycle of business) for each committee is included, which have been updated to reflect the strategic goals / objectives agreed by the Board in April.
Recommendations, decisions or actions sought	The Board is asked to agree the Board Committee membership and revised Terms of Reference, and note the annual plans.

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**

Appendix 1
(Membership of Board Committees)

	Appointments and Remuneration	Audit & Risk Committee	Quality & Patient Safety	Finance & Investment	People Committee	Charitable Funds
David Astley Chairman	**√**		**√**			
Michael Whitehouse Non-Executive Director	**√**	**Chair**		**√**		**Chair**
Liz Sharp Non-Executive Director	**√**		**√**	**√**	**√**	
Subo Shanmuganathan Non-Executive Director	**√**	**√**	**√**		**Chair**	**√**
Howard Goodbourn Non-Executive Director	**Chair**	**√**		**Chair**		
Tom Quinn Non-Executive Director	**√**	**√**	**Chair**		**√**	
Paul Brocklehurst Non-Executive Director	**√**			**√**		
Max Puller Non-Executive Director	**√**				**√**	
Christopher Gonde NEXT Director	**√**				**√**	
Chief Executive	**√**	**A**				
Executive Director of Quality & Nursing		A	**√***	**√**		**√**
Chief Medical Officer			**√***		**√**	
Executive Director of Operations			**√**		**√**	
Chief Finance Officer		**A***		**√***		**√***
Executive Director of HR	**A**				**√***	**√**
Executive Director of Strategic Planning				**√**	**√**	

√ Member
A – Attends
*denotes committee Executive-Lead

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Quality and Patient Safety Committee ('QPS') referred to in this document as 'the committee'.

2. Role & Purpose

To enable the Board to obtain assurance that high standards of care is provided by and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the trust to:

- promote safety and excellence in patient care
- identify, prioritise and manage risk arising from clinical care
- ensure the effective and efficient use of resources through evidence-based clinical practice
- ensure compliance with legal, regulatory and other obligations

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three Independent Non-Executive Directors and at least three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Tom Quinn, Independent Non-Executive Director (Chair)
- Liz Sharp, Independent Non-Executive Director
- Subo Shanmuganathan, Independent Non-Executive Director
- David Astley, Chairman
- Executive Director of Nursing & Quality (Joint Executive Lead)
- Chief Medical Officer (Joint Executive Lead)
- Executive Director of Operations

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are being reviewed.

6. Frequency
The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority & Duties
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of governance and internal control in relation to the areas with its purview are designed well and operating effectively.

In particular, in respect of general governance arrangements:

- to ensure that all statutory elements of clinical governance are adhered to within the trust

- to review and approve the trust's annual clinical governance / patient safety / quality reports before submission to the board

- to consider matters referred to the committee by the Board

- to review and approve the annual clinical audit programme

- to make recommendations to the audit committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference

In respect of safety and excellence in patient care, to ensure that internal standards are set and monitored, including (without limitation):

- to ensure the registration criteria of the Care Quality Commission continue to be met

- to support the Board to promote within the trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy

- to ensure that robust arrangements are in place for the review of patient safety incidents (including near-misses, complaints, reports from HM Coroner) from within the trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning

- to ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed

- to identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey / PALS and ensure appropriate action is taken

- to ensure that risks to patients are minimised through the application of a comprehensive risk management

- to ensure the trust incorporates the recommendations from external bodies, as well as those made internally e.g. in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery

- to assure that there are processes in place that safeguard children and adults within the trust

- to escalate to the Board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the trust

- to assure that the trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the trust, so as to identify areas for improvement and ensure that these improvements are affected. In particular, in respect of efficient and effective use of resources through evidence-based clinical practice

In particular, in respect of efficient and effective use of resources through evidence-based clinical practice:

- to review and recommend for approval by the Board the annual quality plan/account and to monitor progress

- to review proposals for cost improvement programmes and other significant service changes and to monitor their impact on the trust's quality of care (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the committee) and report any concern relating to an adverse impact on quality to the board of directors

- to ensure that care is based on evidence of best practice/national guidance

- to ensure that there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance

- to monitor trends in complaints received by the trust and commission actions in response to adverse trends where appropriate

- to monitor the development of quality indicators throughout the trust

- to identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas

- to ensure the research programme is implemented and monitored

- to ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission)

- to ensure that where practice is of high quality, that practice is recognised and propagated across the trust

- to ensure the trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board: 28.07.2022

Quality & Patient Safety Committee	Executive Lead	13 April 2023	18/05/2023 Q Account	29 June 2023	24 August 2023	19 October 2023	18 January 2024
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
ESCALATION							
Executive Escalation (verbal)	Executive Director of Quality & Nursing	√	√	√	√	√	√
TRUST BOARD - GAPS IN ASSURANCE							
15.12.23 Complaints Timeliness	Executive Director of Quality & Nursing	√					
15.12.23 Effective Implementation of the Falls Programme	Executive Director of Operations	√					
02.02.23 H&T Safety	Executive Director of Operations	√					
06.04.23 NHSP Audits	Executive Director of Operations				√		
MANAGEMENT RESPONSES (As required)							
NHS Pathways Audits	Chief Medical Officer						
Incidents Backlog	Executive Director of Quality & Nursing	√					
Medicines Governanance - progress on risks and issues	Chief Medical Officer	√					
Non-Medical Prescribing & Electronic Prescribing Service	Chief Medical Officer			√			
Public Access Defibrillators and supporting communities with Out of Hospital Cardiac Arrest	Executive Director of Operations			√			
Falls programme	Executive Director of Operations			√			
SCRUTINY							
Key Skills Plan 2024	Chief Medical Officer						√
Clinical Audit including 2023/24 Clinical Audit Plan	Chief Medical Officer	√					
Research & Development	Chief Medical Officer						
Medicines Management	Chief Medical Officer	√					
Patient Records - progress of PRDS, ePCR. Reporting functions and use of PAP. Paper PCR timeline for validation	Chief Medical Officer						
National Guidance: JRCALAC / NICE etc.	Chief Medical Officer						
Clinical / Professional Scope of Practice (CCP/PP)	Chief Medical Officer						
Clinical Outcomes - impact of Telemedicine on patients showing signs of a stroke	Chief Medical Officer						
Clinical Outcomes - Stemi care bundle, the impact of the introduction of Paracetamol	Chief Medical Officer						
Maternity services (linked to Ockenden) including clinical outcomes	Chief Medical Officer						
End of Life Care	Chief Medical Officer						
Frequent Callers	Chief Medical Officer						
Management of Acute Behavioural Distrubance	Chief Medical Officer						
Operation Carp - Recommendations Action Plan	Chief Medical Officer			√			√
PAD sites/Defibs	Executive Director of Operations	√					
NHS Pathways Licence Compliance	Executive Director of Operations						
Bariatric Care	Executive Director of Operations						
PAP Quality Governance & Safety	Executive Director of Operations			√			
CFRs	Executive Director of Operations						
Medical Equipment	Executive Director of Planning and Business Development						
Serious Incidents	Executive Director of Quality & Nursing						
Harm Reviews	Executive Director of Quality & Nursing						

Integrated Patient Safety Report (complaints, incidents, claims, inquests, Learning from Deaths etc.)	Executive Director of Quality & Nursing			√	√		√
Patient Experience	Executive Director of Quality & Nursing						
QI Project - Patient Safety in the Stack	Executive Director of Quality & Nursing	√			√		
Quality Improvement	Executive Director of Quality & Nursing			√			
Quality Impact Assessment	Executive Director of Quality & Nursing						
Infection Prevention and Control	Executive Director of Quality & Nursing						
Safeguarding	Executive Director of Quality & Nursing						
Mental Health	Executive Director of Quality & Nursing						
CQUIN	Executive Director of Quality & Nursing						
Quarterly / Annual Reports							
Clinical Audit	Chief Medical Officer						√
Controlled Drugs Accountable Officer (CDAO)	Chief Medical Officer				√		
Learning from Deaths	Chief Medical Officer			Q3 22-23	Q4 22-23	Q1 23-24	
Research	Chief Medical Officer					√	
Cardiac Arrest	Chief Medical Officer					√	
Complaints (Patient Experience)	Executive Director of Quality & Nursing				√		
IPC	Executive Director of Quality & Nursing				√		
Safeguarding	Executive Director of Quality & Nursing				√		
Quality Account	Executive Director of Quality & Nursing		√				
Enabling Strategies							
Dementia Care	Chief Medical Officer						
End of Life Care	Chief Medical Officer						
Medicines Optimisation	Chief Medical Officer						
Clinical & Quality [see strategic Goal / Objectives]	Executive Director of Quality & Nursing	√					
Patient Experience	Executive Director of Quality & Nursing						
STRATEGIC GOALS / OBJECTIVES							
Quality Improvement:							
Build & Embed an approach to QI Objective 1: Quality Improvements on how we keep patients safe in the EOC stack during periods of escalation and at points of discharge Objective 2: A QI Strategy to take the organisation forward and empower those closest to patients to lead improvements Objective 3: Training and engagement in QI for our people	Executive Director of Quality & Nursing			Objective 2	Objective 1 & 3	Objective 1 & 3	Objective 1 & 3
Learning from Patients Staff & Partners Objective 4: Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF. Objective 5: Improvements in Out of hospital cardiac arrest survival rates from point of initial contact through to deployment of volunteers and specialist resources Objective 6: Building on existing pre-hospital maternity education and training in response to local and national cases/reports to enhance patient care and experience	Chief Medical Officer Executive Director of Quality & Nursing			Objective 4	Objective 5 & 6	Objective 5 & 6	Objective 5 & 6

Patient Safety & Risk Mitigation Objective 7: A Quality and Performance Management Framework that runs from our Patients to the Board Objective 8: A Quality Compliance Surveillance Framework that helps us assure the improvement we are making	Executive Director of Quality & Nursing Executive Director of Operations			Objective 7&8			Objective 8
Responsive Care:							
Safe Effective & Timely Care Objective 1: A Category 2 Mean response time that is improved and closer to National Standards Objective 2: A Call Answer Mean time of 10 seconds Objective 3: Implementation of dispatch improvement actions to improve effectiveness of resource utilisation (RPI, cross-border working)	Executive Director of Operations					Objective 3	
Smarter & Safer Approaches to our Response to Patients Objective 4: *Improvements in our Hear and Treat rate to a minimum of 14%* Objective 6: *Improved utilisation of all clinical resources from volunteers to specialist practitioners to achieve improved performance*	Executive Director of Operations Chief Medical Officer				Objective 4		Objective 6
Sustainability & Partnerships							
Vision & Strategy - Operating Model Objective 1: *A new Clinical and Quality strategy that meets the needs of our patients now and in the future*	Chief Medical Officer			Objective 1			
Partner of Choice Objective 3 - *Optimised Urgent and Community referral pathways, avoiding conveyance to EDs, and improving the use of the ICS SPOAs*	Executive Director of Strategic Partnerships & Transformation				Objective 3		
Internal Audit							
Serious Incident Management	Executive Director of Quality & Nursing				√		
Governance							
Committee Annual Self-Assessment	Company Secretary			√			√
Cycle of Business	Company Secretary	√					√
Terms of Reference	Company Secretary	√					√

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) referred to in this document as 'the Committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the workforce, encompassing resourcing, staff wellbeing and HR processes, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and at least two Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Subo Shanmuganathan, Independent Non-Executive Director (Chair)
- Tom Quinn, Independent Non-Executive Director
- Liz Sharp Independent Non-Executive Director
- Max Puller, Independent Non-Executive Director
- Chris Gonde, Associate Non-Executive Director
- Executive Director of HR & OD (Executive Lead)
- Executive Director of Operations
- Executive Medical Director
- Executive Director of Strategic Planning & Transformation

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are being reviewed.

6. Frequency

The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board: 28.07.2022

People Committee	Executive Lead	11 May 2023	20 June 2023	17 August 2023	09 Nov 2023	15 Feb 2024
ADMINISTRATION						
Apologies	Chair	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√
Minutes	Chair	√	√	√	√	√
Action Log	Chair	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√
ESCALATION						
Executive Escalation (verbal)	Executive Director of HR & OD	√	√	√	√	√
BOARD - GAPS IN ASSURANCE						
15.12.23 Process for Evaluating Training	Executive Director of HR & OD			√		
02.02.23 RIDDOR - root causes / benchmarking	Executive Director of Quality & Nursing		√			
02.02.23 EOC Culture Improvement	Executive Director of Operations	√	√	√	√	√
MANAGEMENT RESPONSES (As required)						
Progress of Ops Trust Learning & Development Plan 2022-25	Executive Director of HR & OD					
Incidents of Violence and Aggression Action Plan	Executive Director of Quality & Nursing		√			
Retention Plan	Executive Director of HR & OD		√			
SCRUTINY						
Wellbeing / Welfare						
Appraisals [PC 5]	Executive Director of HR & OD					
Staff Survey / Improving Staff Experience [PC 1]	Executive Director of HR & OD					
Pulse Surveys	Executive Director of HR & OD			√	√	√
Health & Safety						
Health & Safety Management	Executive Director of Quality & Nursing		√			
Management of violence and aggression	Executive Director of Quality & Nursing		√			
ETD						
External Compliance (Ofsted; Fquals; ESFA)	Executive Medical Director					
Stat Man Training	Executive Director of HR & OD	√				
Annual Training Plan	Executive Director of HR & OD					√
Continuous Professional Development	Executive Director of HR & OD			√		
Driving Standards	Executive Medical Director					
Apprenticeship Governance	Executive Medical Director					
Higher Education Institution - partnerships with Universities	Executive Medical Director					
Management Training & Development - Fundamentals [PC 8]	Executive Director of HR & OD					
Staff Induction Programme [PC 3]	Executive Director of HR & OD					

Succession Planning & Talent Management	Executive Director of HR & OD					
Workforce Planning / Recruitment						
Workforce Plan 2023/24 - to include Retention	Executive Director of HR & OD	√	√	√	√	√
Student Paramedics - recruitment and support	Executive Director of HR & OD					
Recruitment	Executive Director of HR & OD	√				
Employee Relations						
Bullying & Harassment [PC Objective 4]	Executive Director of HR & OD					
Until it Stops Campaign (Sexualised Behaviours) [PC Objective 4]	Executive Director of HR & OD					
Grievances [PC Objective 9]	Executive Director of HR & OD					
Unions - Relations / Joint Working [P&C Objective 12]	Executive Director of HR & OD					
Equality, Diversity, Inclusion & Wellbeing						
Equality Delivery System - EDS2 Goals, Delivery on the WRES, DES, Equality Objectives, Gender Pay gap.	Executive Director of HR & OD				√	
Governance & Controls						
Payroll Discrepancy - effectiveness of policy	Executive Director of HR & OD					See IA
Payroll Contract	Executive Director of HR & OD					See IA
Pre-Employment Checks	Executive Director of HR & OD			√		
HR Review (Sandra Grant)	Executive Director of HR & OD	√	√			
STRATEGIC GOALS / OBJECTIVES						
People & Culture:						
Getting our Foundations Right Consistently Objectives 1-4	Executive Director of HR		**PC 2 & 3**	**PC3**	**PC1 & 4**	**All**
Internal Processes Objectives 5-8	Executive Director of HR			**PC6 & 7**	**PC5**	**All**
Improving Experience of our People Objectives 9-12	Executive Director of HR		**PC7 & 12**	**PC12**	**PC9 & 11**	**All**
Responsive Care:						
Provide exceptional support for our people delivering care Objective 7 - improvement in shift overuns	Executive Director of Operations			**RC7**		
Sustainability & Partnerships:						
Objective 5 - A joint workforce plan for our systems, strengthening development pathways for our clinicians and creating long-term sustainability in our paramedic workforce	Executve Director of HR & OD			**SP5**		
Quarterly / Annual Reports						
Staff Survey Results / Next Steps	Executive Director of HR & OD					√
Annual H&S Audits	Executive Director of Quality & Nursing		√			
Annual Wellbeing report	Executive Director of HR & OD				√	

Annual Inclusion report (including an overview of stat and legislative requirements: Equality Delivery System (EDS2), Delivery on the WRES, DES, Equality Objectives, Gender Pay gap, etc)	Executive Director of HR & OD				√	
Enabling Strategies						
People Strategy	Executive Director of HR & OD	√				
Clinical Education Strategy 2022-25	Executive Medical Director	√	√			
Inclusion Strategy 2016-21 (overdue review)	Executive Director of HR & OD					
Health and Wellbeing Strategy 2017-22 (under review)	Executive Director of HR & OD					
Internal Audit Plan 2022/23						
Wokforce Planning	Executive Director of HR & OD				√	
Payroll	Executive Director of HR & OD					√
Annual Reviews						
Committee Annual Self-Assessment [Board Effectiveness Review]	Company Secretary			√		
Cycle of Business	Company Secretary					√
Terms of Reference	Company Secretary					√

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'the Committee'.

2. Role & Purpose

The Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the board of directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions.

The Committee shall provide the board of directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the foundation trust's activities (clinical and non-clinical) both generally and in support of the annual governance statement.

In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have at least three members, to include the Chairs of the other Board committees appointed by the Board from amongst the independent Non-Executive Directors of the Trust.

3.2. The Chairman of the Trust shall not be a member.

3.3. One of the members with recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.4. Current members**:**

- Michael Whitehouse, SID and Deputy Chair (Chair)
- Howard Goodbourn, Independent Non-Executive Director – FIC/ARC
- Subo Shanmuganathan, Independent Non-Executive Director - PC
- Tom Quinn, Independent Non-Executive Director - QPSC

In addition, each Independent Non-Executive Director (save the Chairman) will be an ex-officio member of the Committee.

4. Quorum
The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance
5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Chief Finance Officer
- Executive Director of Quality & Nursing
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

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

5.4. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency
6.1. The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least four times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Authority
7.1. The Committee has no executive powers. It is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

7.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. 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 Committee.

7.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

8. Duties

8.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

8.2. Governance, Risk Management and Internal Control

8.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

8.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

8.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires

providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing/FTSU policy(s) to test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

8.3. Internal Audit

8.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

8.4. External Audit

8.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

8.5. Financial Reporting

8.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

8.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

8.6. Other Assurance Functions

8.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

8.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

8.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

9. Purview
The purview of the Committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

10. Reporting
The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

12. Review
12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board: 28.07.2022

Audit & Risk Committee	Executive Lead	25 May 2023	13 July 2023	21 Sep 2023	14 Dec 2023	21 March 2024
ADMINISTRATION						
Apologies	Chair	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√
Minutes	Chair	√	√	√	√	√
Action Log	Chair	√	√	√	√	√
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√
Committee / Meeting Effectiveness	Chair	√	√	√	√	√
BOARD - GAPS IN ASSURANCE						
06.04.2023 - FTSU (perception of detriment)	Executive Director of Quality & Nursing		√			
FINANCIAL STATEMENTS & THE ANNUAL REPORT						
Annual Report & Accounts -External Audit Report -ISA260 Report (Audit Hilights Memo) -Management Representations Letter on the financial statements -Management Representations Letter on the quality report	Chief Finance Officer KPMG	√				
Plan for the production of the Annual Report & Accounts	Chief Executive				√	
Annual Governance Statement	Company Secretary	√				√Draft
Accounting Policies	Chief Finance Officer				√	
Accounting and Reporting Systems	Chief Finance Officer					√
Financial statements - integrity / judgments	Chief Finance Officer				√	
Single Tender Waivers	Chief Finance Officer		√			
Losses and Special Payments [incl. baseline numbers / % as per action 164-19 04.03.2019]	Chief Finance Officer	√				√
INTERNAL AUDIT						
Counter Fraud Progress Report	RSM		√	√		√
Counter Fraud Work Plan	RSM					√
Counter Fraud Annual Report incl. SRT	RSM					√
Internal Audit Progress Report	RSM		√	√	√	√
Internal Audit Annual Plan	RSM					√
Annual Report to include Internal Audit Opinion	RSM	√				√Draft
EXTERNAL AUDIT						
External Audit Finding Report	KPMG	√				
Report to Governors on Quality Report	KPMG	√				
Limited Assutance opinion on Qualiry Report Indicators	KPMG	√				
Progress Report / Technical Update	KPMG					√
Audit Plan	KPMG				√	
GOVERNANCE & RISK MANAGEMENT						
Business Continiuty	Exec Director of Operations			√		
Data Quality	Exec Director of Planning				√	
Whistleblowing / FTSU	Exec Director of Quality & Nursing			√		
Decl. of Interests	Company Secretary			√		
Policy Management	Company Secretary	√				√
Assurance Map - Annual Review	Company Secretary		√			√
Board Assurance Framework Review	Company Secretary	√				
Risk Review, incl. BAF Risk Report	Executive Director of Nursing / Company Secretary		√	√	√	√
Risk Management System / effectivess of the policy and procedure	Exec Director of Quality & Nursing				√	
SO's/SFI's	Chief Finance Officer			√		
Annual Self Certification GC6/COS 7	Company Secretary	√				
Corporate Governance Statement	Company Secretary	√				√Draft
Integrated Quality Report Annual Review	Exec Director of Planning				√	
Information Governance (incl. *Annual Report)	Exec Director of Quality & Nursing			√*		√
Annual Review of Cycle of Business	Company Secretary					√
Annual Self-Assessment	Company Secretary					√
Review of Terms of Reference	Company Secretary					√
Review Purview / TOR of other Board Committees	Company Secretary					√
STRATEGIC GOALS / OBJECTIVES						
QI Objective 7 - A Quality and Performance Management Framework that runs from our Patients to the Board	Executive Director of Operations		√			
S&P Objective 4 - A new internal and external governance that aligns strongly to our ICBs, helping us strengthen relationships and ways of working	Executive Dirtector of Strategic Planning		√			
MANAGEMENT RESPONSE (delete once received)						

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the Committee'.

2. Purpose

The purpose of the Committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, investments and relevant corporate services, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:

- Howard Goodbourn, Independent Non-Executive Director (Chair)
- Michael Whitehouse, SID and Deputy Chair
- Paul Brocklehurst, Independent Non-Executive Director
- Liz Sharp, Independent Non-Executive Director
- Chief Finance Officer (Executive Lead)
- Executive Director of Quality & Nursing
- Executive Director of Strategic Planning & Transformation

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- Deputy Director of Finance

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

6. Frequency
The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least quarterly. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively.

8. Purview
The purview of the committee is set out in the accompanying cycle of business document, which is approved by the Board along with these Terms of Reference. The committee will prioritise areas of scrutiny using a risk-based approach.

9. Support
The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting.

The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. This will include an external peer review, as determined by the Committee Chair. Any proposed changes shall be submitted to the Board for approval.

Date Approved by the Board: 28.07.2022

Finance and Investment Committee	Executive Lead	15 June 2023	27 July 2023	28 Sept 2023	30 Nov 2023	25 Jan 2024	28 March 2024
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
ESCALATION							
Committee (IPR) Dashboard	Chief Finance Officer	√	√	√	√	√	√
Executive Escalation (verbal)	Chief Finance Officer	√	√	√	√	√	√
TRUST BOARD - GAPS IN ASSURANCE							
(confirms issues as directed by the Board)							
MANAGEMENT RESPONSES							
SCRUTINY							
Financial Planning - annual plan / budgets	Chief Finance Officer	√	√	√	√	√	√
Financial Long Term Plan (3 - 5 years)	Chief Finance Officer						
Financial Performance (Pack)/Forecast/Capital Plan/Cost Improvements	Chief Finance Officer	√	√	√	√	√	√
Financial Governance/Rob Cooper Report	Chief Finance Officer	√		√			
Commissioning Updates including ICS Boards/Financials	Chief Finance Officer	√		√		√	
Patient Level Costing - Submission/Feedback	Chief Finance Officer		√		√		√
Environmental Sustainability Delivery Plan	Chief Finance Officer		√		√		
Procurement Self Assessment	Chief Finance Officer			√			
Legal Costs Update	Company Secretary			√			√
IT/ Digital - Update on Activities	Chief Finance Officer		√				√
Fleet Update on Activities	Executive Director of Planning & Bus Dev		√		√		√
Estates - Maintenance / Quality	Chief Finance Officer	√		√		√	√
PAP Contract - Governance Review	Executive Directors Ops/Finance						
Disposals and Acquisitions	Chief Finance Officer			√			√
BAF Risks	Company Secretary	√	√	√	√	√	√
Improvement Cases							
Improvement Case Schedule / Tracker	Chief Finance Officer	√		√		√	
Improvement Cases for Recommendation	Responsible Exec	√	√	√	√	√	√
Benefits Realisation Post Project Review	Responsible Exec	Performance Cell	Brighton				
Enabling Strategies							
Digital Strategy/Delivery Plan	Chief Finance Officer		√				
Estates Strategy/Delivery Plan	Chief Finance Officer		√				
Fleet Strategy /Delivery Plan	Executive Director of Planning & Bus Dev		√				
Data Strategy/Delivery Plan	Executive Director of Planning & Bus Dev		√				
Procurement Strategy /Delivery Plan	Chief Finance Officer		√				
Environmental Sustainability Strategy/Delivery Plan	Chief Finance Officer		√				
Strategic Goals / Objectives							

Responsive Care							
Objective 9 A new Ambulance design and Fleet strategy that meets our needs for the future	Executive Director of Planning & Bus Dev				√		
Sustainability & Partnerships							
Objective 6 Our financial commitments as agreed with commissioners for FY 23/24	Chief Finance Officer	√	√	√	√	√	√
Objective 7 Cost efficiency improvements to ensure our resources are focussed on delivering patient care	Chief Finance Officer	√	√	√	√	√	√
Objective 8 Our de-carbonisation commitments as set out by our Green Plan	Executive Director of Planning & Bus Dev				√		
Internal Audit							
Estates Management	Chief Finance Officer			√			
Procurement and Contract Management	Chief Finance Officer					√	
Financial Management	Chief Finance Officer						√
Fleet Management	Executive Director of Planning & Bus Dev						√
Governance							
Committee Annual Self-Assessment	Company Secretary						√
Cycle of Business	Company Secretary	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
Terms of Reference	Company Secretary						√

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	21-23

Name of meeting	Trust Board
Date	1 June 2023
Name of paper	Audit & Risk Committee Escalation Report – May 2023
Author	Michael Whitehouse, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 25.05.2023. This was the year-end meeting, focussing on the Draft Annual Report & Accounts. The drafts will be considered by the Board in Part 2.

Internal Audit / Head of Internal Audit Opinion

Each year the Head of Internal Audit provides an opinion, based upon the work performed in-year, on the overall adequacy and effectiveness of organisation's risk management, control and governance processes. Four possible opinions can be given, two considered positive and two negative, with one being the best and four the worst. For the year just ended the third opinion was given. This was due to four reviews concluding either partial or minimal assurance and issues with the timeliness of some of the follow up actions agreed by management.

Concern was expressed by the committee about the lack of management grip arising from the policy management (minimal assurance) review. This related specifically to a high number of policies overdue their review date. While progress has been made since the audit, the committee needs greater assurance on the plan going forward. The Chief Executive was in attendance and committed to bringing a clear plan with a trajectory to the next meeting in July.

The committee accepted that with the risk management (partial assurance) review, while Internal Audit found that the new policy and process is sound, there wasn't enough evidence that it had yet been embedded. The committee will receive the related action plan at each of its meetings until it is satisfied that there is more systemic management of risk in place.

Annual Accounts / External Audit

The financial statements at year end are broadly in line with the reports the Board has received in-year. The committee provide challenge and suggestion on how to deal with some of the technical aspects of the accounts, such as the impairment. However, overall it is satisfied with the way the accounts have been prepared. External Audit are still progressing their work; the main risk relates to the value for money assessment (linked to the CQC inspection findings), which will likely conclude weaknesses that will be covered in the final audit opinion.

Annual Report / Annual Governance Statement	
The committee reviewed the Annual Report which includes the AGS, It is satisfied with the overall content and tone, and with the issues being drawn out in the AGS. Some suggestions were made in particular with the AGS, which will be updated ahead of the version scheduled to be considered by the Board. The Annual Report is a very long document and structured in line with the FT Annual Reporting Manual; it is therefore not very digestible for the general public. In recognition of this, the executive will produce a summary version in time for the Annual Members Meeting.	
Specific Escalation(s) for Board Action	The committee escalated to the Board in April its concern with the increase in internal audit reviews providing partial or limited assurance, indicating that the control environment is not as resilient as it needs to be. The committee believes that this is reflected appropriately in the Head of Internal Audit Opinion. It will continue to seek 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	22/23

Name of meeting	Trust Board
Date	01.06.2023
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 April and May 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 have remained operational performance and the issues most affecting our people, however other actions taken include:

- Supporting the development of the delivery plan for our People & Culture Strategy
- Close monitoring of the plans for the move to the new Medway Make Ready Centre
- Development of our Operational Plan for the year

5 EMB continues to hold a meeting each month as a joint session with the Trust's Senior Management Group to oversee the delivery of the Improvement Journey, feedback from the on-going programme of leadership visits and development of our Trust Strategy.

6 **Board changes**
I was pleased to join SECAmb as substantive Chief Executive on 24 April 2023 and have been made to feel really welcome so far. You can read more about my activities during the first few weeks in the section below.

We have also seen other changes at Board level during this period:

7	On 5 May 2023, Martin Sheldon moved to a new role at Hampshire & Isle of Wight ICB after joining SECAmb in October 2022 as Interim Chief Finance Office. I am also grateful to him for stepping up as Interim Chief Executive for a short period during April ahead of my arrival.
8	Charles Porter has now joined us as Interim Chief Finance Officer ahead of Saba Sadiq starting with us as the substantive Chief Finance Officer in July 2023.
9	In May 2023, Director of Quality & Nursing, Rob Nicholls, took up a secondment opportunity at Barts Health NHS Trust; Margaret Dalziel, the Deputy Director, has been appointed as the Interim Director until Spring 2024.
10	**Engagement** Since joining SECAmb in April 2023, I have engaged in a programme of visiting as many of our sites as possible and have thoroughly enjoyed the time I have spent hearing from colleagues about what is important to them.
11	To date, I have visited Ashford, Tangmere, Brighton and Paddock Wood Make Ready Centre, and the Clinical Education Centre at Haywards Heath and intend to continue this approach over comings, committing at least a day each week. These visits have proved incredibly informative and are helping me develop my key priority areas for action.
13	I have also spent time during my induction period meeting some of our key system partners, including colleagues from a number of other ambulance Trusts through the Association of Ambulance Chief Executives (AACE), which has provided extremely informative.
14	During April and May, our senior leaders have continued their programme of visits to sites across the Trust. A new approach has been agreed to support the programme, to ensure that the visits are as beneficial for all parties and that a framework is in place to ensure that appropriate action is taken in response to the feedback given and this is shared with those involved and back out to the organisation.
	B. Regional Issues
15	**Development of new operational centre at Medway** I was pleased to hear that we have now achieved practical 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.
16	We remain on track for field operational staff from the Medway Operational Unit to occupy the new facility from 8 June 2023 onwards. Road staff will then be joined by colleagues from the Ashford 111 contact centre during w/c 26 June. We are working towards EOC staff, currently based at the Trust's control room in Coxheath, beginning to relocate to the new centre later this year.

17	I understand that the teams are looking forward to moving to the new centre. Our current buildings, including our Coxheath site, are outdated and the new centre will provide much improved facilities for the teams who'll be based there.
18	**Completion of first Apprentice Paramedic Programme course** I am pleased that, during May 2023, the first cohort of colleagues to undertake our Level 6 Degree Apprenticeship Paramedic Programme were recognised at a special ceremony in Crawley to celebrate the completion of their journey to becoming paramedics - a fantastic achievement of which they should be very proud.
19	The programme, delivered in partnership with the University of Cumbria, sees staff complete their paramedic education over a two-year period as an apprentice while continuing to work for SECAmb and provides a great opportunity for in-house progression. The event was held locally to recognise the significant efforts made by the staff throughout the programme, ahead of a formal graduation ceremony later this summer.
20	We have close to 100 apprentices enrolled on our apprenticeship degree and will continue to run three new cohorts each year.
	C. National Issues
21	**HM The King's Coronation** It was great to see SECAmb proudly represented at the His Majesty The King's Coronation procession on 6 May 2023.
22	Thank you and well done to Richard Orme and Neil Godden who were part of the team of 20 ambulance service colleagues who performed the role of street liners on the Whitehall section of the procession route.
23	I am sure it was a day neither of them will forget and I am pleased that, as a crown badge organisation, SECAmb was able to be represented and play a part in such a historic occasion.
24	**The NHS Assembly 'NHS@75 conversation'** I am looking forward to being joined by colleagues on 26 May 2023 in a Trust-wide virtual meeting to explore views on the NHS ahead of it marking its 75th anniversary.
24	The meeting will explore colleagues' thoughts on three main areas: • How far the NHS has come in 75 years • Where it is now • What they would like from it in the future.
25	We will use the meeting to provide feedback to the NHS Assembly, who are leading on and gathering views with a national engagement exercise.
26	I hope this will provide a good opportunity for me to meet more colleagues and for all of us to share our thoughts on the future of the NHS and the ambulance service's key role within it.

27	**Industrial Action** During late April and early May 2023, we saw industrial action taken by members of the RCN and Unite in SECAmb as part of the on-going national pay dispute.
28	As the time of writing, industrial action has been paused, due to the acceptance of the national pay deal by most of the trade unions representing NHS staff, although we continue to work closely with our NHS partners to mitigate the impact of industrial action by junior doctors.
29	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
30	**Operational Performance** The performance of all ambulance services nationally remains challenged and both 999 and 111 demand remains inconsistent.
31	We continue to work hard to ensure that we provide as responsive a service as possible to our patients. 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.
32	We have seen some improvement during recent weeks in our 999-call answer times but this remains an important area of focus for us.
33	We moved to REAP Level 2 on 9 May 2023 but continue to keep this under close review.
34	**Operational Plan** Following sign-off of the Operational Plan by the Board last month, EMB have spent time working through the operational and financial implications of its delivery.
35	We have submitted a compliant plan for 2023/24 that meets the national requirement to break-even financially. This requires delivery of a significant efficiencies programme which will be overseen by the Senior Management Group with the aim of delivering cost reductions without impacting patient care.
36	Operationally, the submitted plan seeks to deliver a 30-minute Category 2 mean performance in line with national requirements. As well as improvements in how we use our operational resources and an increase in our Hear and Treat rate, delivery of this performance is also reliant on increases in appropriate alternative pathways and referrals to Urgent Community Response, Mental Health, Urgent Treatment Centres, and Primary Care and are joint targets owned by SECAmb and our system partners.
37	The plan is ambitious and will require significant focus from all teams in order to deliver.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	23-23

Name of meeting	Trust Board
Date	01.06.2023
Name of paper	Board Assurance Framework (BAF) 2023 24
Author	Peter Lee, Company Secretary

This new version of the BAF is drafted in line with the approach supported by the Audit & Risk Committee in March. It includes not just an assessment of the risks to achieving the Trust's strategic priorities, but also progress against each of the in-year corporate objectives.

It will evolve following feedback from the Board, to ensure it continues to help the Board's assessment of progress against the agreed strategic priorities of the Trust.

The strategic risks in section 2 will be specifically reviewed in July, as part of the Board development session on risk management / appetite. This session will also inform a review of section 3 (extreme risks) as we evolve from focussing on risk score, to risks that are outside the tolerance levels set by the Board.

Progress against the in-year delivery of each Strategic Goal is RAG-rated, as illustrated below.

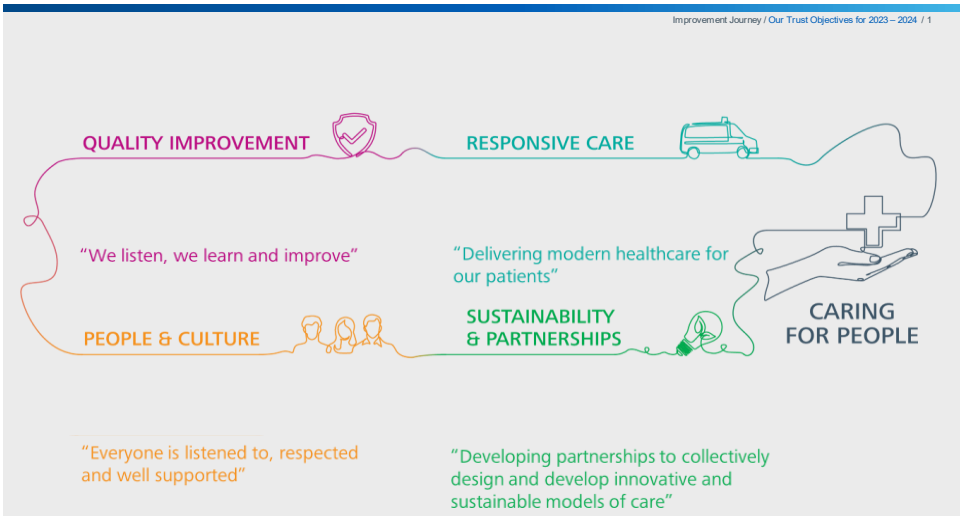
Goal 1	Build and embed an approach to Quality Improvement at all levels	
Goal 2	Become an organisation that Learns from our patients, staff, and partners	
Goal 3	Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk	
Goal 1	Getting our foundations right consistently	
Goal 2	Making internal processes effective	
Goal 3	Improving the experience of our people	
Goal 1	Deliver safe, effective, and timely response times for our patients	
Goal 2	Implement smarter and safer approaches to how we respond to patients	
Goal 3	Provide exceptional support for our people delivering patient care	
Goal 1	Develop a refreshed vision and strategy for SECAmb and our operating model	
Goal 2	Be a great system partner, establishing SECAmb as a system leaders in the UEC arena, becoming the partner of choice	
Goal 3	Become a Sustainable Urgent and Emergency healthcare provider	

Board Assurance Framework
Introduction

1. Purpose

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. 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.

The Trust's priorities are aligned with the now well-established four strategic themes, which help frame each meeting agenda of the Trust Board.



Each theme has three Strategic Goals and a number of in-year Objectives. These are set out in section 1.

The aim of the in-year objectives set by the Board at the start of this year is to help achieve the strategic goals. These are therefore considered the priority actions assessed by the Board in the context of its operating plan, feedback from staff, and the findings of last year's CQC inspection.

The BAF sets out the progress against the objectives, the main risks to achievement, in addition to the longer-term risks that could impact on the strategic goals.

2. Structure

Section 1 sets out by Strategic Theme, each of the Goals and in-year Objectives. The lead director for each objective summarises progress to-date and describes the main risk to achievement; each objective is to be achieved by a particular quarter.

Taken together with the KPIs in the Integrated Quality Report, this provides the Board with the data and information to help inform its level of assurance in meeting the agreed goals.

Section 2 gives details about the longer-term risks to achieving the strategic goals, which follow the in-year risks listed in section 1. This will support the Board's assessment on the adequacy of controls and actions that are in place to manage these risks appropriately.

Section 3 summarises for the Board's awareness, the non BAF risks that are currently rated Extreme. It includes a description of the mitigating actions being taken and the extent to which these risks have oversight of the Board, directly or via one of its committees.

Section 4 links to the National Oversight Framework and provides an assessment of progress against the Recovery Support Programme Exit Criteria, accepted by the Board in August 2022. These criteria have informed the in-year objectives and while there is therefore significant overlap with section 1, this is included to provide explicit oversight.

3. Board Oversight

The focus of each Board committee is informed by this BAF to help oversee delivery and management of the key risks, as set out in each of the committee annual plans.

The regular Committee Escalation Reports to the Trust Board summarise the levels of assurance obtained and when significant gaps in assurance are identified, confirm what intervention by the Board is needed.

As demonstrated in recent meetings of the Board, it also directs its committees focus when it identifies gaps in assurance. These are then added to the committee annual plan and reported back to ensure closure of the Assurance Cycle.

Board Assurance Framework
Section 1: Strategic Goals - Delivery

Quality Improvement

Goal 1		Build and embed an approach to Quality Improvement at all levels	
In Year Objective	**QI 1**	**Quality Improvements on how we keep patients safe in the EOC stack during periods of escalation and at points of discharge**	
	Measure	Reduce level of harm experienced by our patients vs 22/23 baseline	Q4
	QI 2	**A QI Strategy to take the organisation forward and empower those closest to patients to lead improvements**	
	Measure	Signed off Strategy at the Board	Q2
	QI 3	**Training and engagement in QI for our people**	
	Measure	For 10% of all staff to have completed 'Introduction to QI' Provide QI team support, coaching and facilitation to at least 5 local QI projects	Q4

In year progress with the achievement of the Strategic Goal is Green because all actions are on track for completion at the current time. Any risks have been identified and mitigations are either in place or being discussed.

Progress to-date:
Keeping Patients Safe in the Stack QI project team meetings are fortnightly. Stakeholder engagement has been completed alongside analysis of data. The improvement strategy agreed focuses on reducing non-value adding activity, thus reducing the cognitive burden on clinicians and allow them sufficient time to assess and identify high risk patients.

A root cause analysis session took place on 22 May 2023 and the outcome of this is currently being analysed. Once this is complete, recommendations will be made by the project team regarding improvements to be implemented and a paper presented by the end of June 2023.

A draft QI Strategy for 2023-2025 has been completed and this is now being shared with stakeholders prior to sign off by QPSC in June 2023 and the Board in August 2023.

To date, three 'Introduction to QI' training sessions have been facilitated and attended by 64 members of staff across the organisation. Participants complete a Training Evaluation Form assessing their level of QI knowledge, confidence, and motivation before and after the training. 57 responses have been received that show a significant improvement in QI capability post training.

Minor delays have been experienced in the Keeping Patients Safe in the Stack QI project due to the Director of QI being on sick leave, ongoing difficulties in releasing operational and front line staff to support and some issues accessing the required data due to individual and team work

arounds. Despite this, project timeframes are being met and work is being completed as per the project plan.

There is a risk in achieving the 10% of all having completed Introduction to QI training if we are not able to release operational colleagues to attend this. Discussions are underway with the Executive Director of Operations to discuss how this can best be facilitated. If we are not able to train 10% of staff, we will not have the traction or critical mass required to facilitate a cultural shift to deliver continuous improvement.

In Year Risks to achieving the objectives

Goal 1	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
QI 1	Lack of time / capacity for operational support of QI projects	3 x 4 = 12	3 x 4 = 12	4 x 2 = 8

Mitigation

- Project team in place. Not had consistency from those on the ground due to shift work. As such, we will ask whoever is on shift to dial in. Comms have been shared to support this.
- Give people specific tasks to complete even if not attending project meetings

	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
QI 2				

Mitigation

	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
QI 3	There is a risk that we are not able to release operational colleagues to complete introduction to QI training	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8

Mitigation

Discussions are being had with the Executive Director of Operations who will plan a 'dosing approach' to release the 426 people (15 have already been trained) who will be required to meet 10% between now and 31st March 2023. This equates to 42 people per month for the next 10 months.

Discussions are also being had as to whether QI training can be included in the Values Day being organised across the Trust.

The issue will be discussed at EDT group to identify any other opportunities to complete this training within existing training infrastructure.

Goal 2		Become an organisation that Learns from our patients, staff, and partners	
In Year Objective	**QI 4**	**Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF.**	
	Measure	PSIRF Plan agreed at Board in Q3 Central Incident review panel established by Q2 Regional Incident review groups by Q3 Training programme in place for and attended by core facilitators.	Q2
	QI 5	**Improvements in Out of hospital cardiac arrest survival rates from point of initial contact through to deployment of volunteers and specialist resources**	
	Measure	Increasing using for GoodSAM in the community Increasing numbers of CFRs in the community Improving the quality of telephone CPR and signposting to PAD sites Increasing number of resources carrying a defibrillator e.g. managers, non-operational vehicles and blue light partners. Increasing the number of Public Access Defibrillators Use CPR feedback to crews as part of debriefing to increase the quality of resuscitation Increase compliance with standard care bundle for post-resus care Reduce health inequalities by working with public health to identify communities with higher cardiac arrest rates.	Q4
	QI 6	**Building on existing pre-hospital maternity education and training in response to local and national cases/reports to enhance patient care and experience**	
	Measure	Decrease in concerns/complaints/legal cases related to maternity patients Reduction in HSIB investigations into the quality of care provided to maternity patients Decrease in number of Serious Incidents related to maternity	Q4

In year progress with the achievement of the Strategic Goal is **Amber** because

QI 4: All milestones on separate project plan met and on target.
QI 5: Milestones and project plan is being developed.
QI 6: Workstream and project plan in development

Progress to-date:

QI 4:

- ✓ PSIRF Implementation Lead commenced May 2023
- ✓ Comprehensive programme plan being finalised
- ✓ Programme plan aligned to Datix Cloud development and LIPSY developed through establishment of Incident process improvement steering group
- ✓ Collated 3-years data from all sources holding patient safety information including legal and audit
- ✓ Identified and met with all internal and key external stakeholders.

QI 5:

- Created a unified objective that management of cardiac arrests is a priority for both the medical and quality & nursing directorates.

- Explored with the Operations Directorate how the medical and quality teams could work alongside EOC leadership to improve the management of cardiac arrests on the telephones.
- Supported the review of PADs.

QI 6:

- Started delivering the Pre-hospital Practical Obstetric Multi-Professional Training (PRE-PROMPT) roll out.
- From June there will be rolling programme across the three counties every quarter.

Corrective action:

QI 4:

- Set out training plan for core facilitators – this is currently being scoped and training providers being approached.

In Year Risks to achieving the objectives

Goal 2	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
QI 4	Lack of engagement from Trust colleagues	[4X3=12]	4X2=8	4X1=4
Mitigation				
Comprehensive communication plan enacted to keep high awareness and keep colleagues updated on progress. Bespoke approaches to different stakeholders Co-design of approach to different topics on PSIRP Meet on 121 basis with all senior leaders and keep them updated				
	Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
QI 5	Lack of engagement and joint working between directorates to implement the out of hospital cardiac arrest plan 23-24	4x3=12	4x3=12	4x1=4
Mitigation				
Joint priority setting across the directorates, joint planning meetings, shared responsibility for delivery.				
	Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
QI 6	Pressure on front line operations withdrawing staff from training to focus on operational duties.	4x1=4	4x1=4	2x1=2
Mitigation				
At the moment staff are coming to training in their own time which mitigates the risk but is not sustainable.				

Goal 3		Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk	
In Year Objective	**QI 7**	**A Quality and Performance Management Framework that runs from our Patients to the Board (QAF)**	
	Measure	We will evaluate effectiveness and impact after 6 months (well led review)	Q2
	QI 8	**A Quality Compliance Surveillance Framework that helps us assure the improvement we are making**	
	Measure	We will evaluate effectiveness and impact after 6 months (well led review) Feedback plans delivered to Operating Units within 2 weeks of visit. Corporate plans delivered to MDT forum every 12 weeks and a 'live' enacted action plan available. Quarterly assurance reports to EMB	Q4

In year progress with the achievement of the Strategic Goal is **Green** because

QI 7:

- the QAF has been developed and presented to internal and external stakeholders.
- the integrated performance & quality dashboard for dispatch level reviews is underway.
- Plans in place for reformatting QGG integrating Clinical, Operations and Quality in exploring and assessing KLOE

QI 8:

- Initial co-designed model completed, and Quality Assurance & engagement visits commenced in April 2023 as planned taking a PDSA approach.
- Further development informed by first visit to Banstead incorporated into May visit to Chertsey
- Full years programme set out and distributed to all Units

Progress to-date:

QI 7:

- Conceptualise and set out the QAF, presented and discussed QAF with stakeholders and shaped the concept with feedback – model outlined in Board paper
- Agreed on metrics for the dashboard with local leaders and colleagues, now being developed.
- Worked in partnership with Operations and Partnership team to have an integrated regional model – paper to come to EMB end of May 2023
- Developed model for QGG

QI 8:

- Completed co-design of QA&EV
- Undertaken April and May visits as planned, improving methodology and approach after each visit and in full co-design with staff involved.
- Full years programme set and distributed.
- Pre-visit briefings developed and implemented with wider teams to assess weightings in KLOE. Improving model as more data made available.
- Involving wider group of staff in visits and capturing feedback from those in the Units as well as the visitors

Goal 3		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	QI 7	Dashboard not developed by end of Q2 thereby stalling the commencement of integrated Performance & Quality Reviews.	[3X3+9]	3X2=6	3X1=3
	Mitigation				
	Close working with BI to obtain a minimum data set that enables the conversation to commence, while further metrics are collated.				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	QI 8	Lack of engagement with staff who may regard this as a punitive exercise rather than an engagement and supportive tool	[4X3=12]	4X2=8	4X1=4
	Mitigation				
	Continuous co-design with operations staff at all levels of the organisation Once established set out comprehensive communication plan to keep high awareness, draw out learning and the 'so what' factor, and keep colleagues updated on progress. Bespoke approaches to different stakeholders Follow-up of actions for wider Trust with regular feedback,				

People & Culture

Goal 1		Getting our foundations right consistently	
In Year Objectives	**PC1**	**Respond to issues raised in Staff survey and recent reviews (housekeeping)**	
	Measure	>95% of housekeeping actions completed	Q3
	PC2	**Implement new leadership visit process consistent with C&E Strategy**	
	Measure	>90% compliance	Q1
	PC3	**Rapid on-boarding QI project**	
	Measure	TTH<60 days TT-WFE TBC Increased % people passing probation	Q2
	PC4	**Comprehensive package of training for managers, awareness days for our people and robust application of our policies relating to safety in the workplace, with a focus on B&H and Sexual Misconduct**	
	Measure	Engagement, safety and morale scores improved Pulse and Staff Surveys	Q4

In year progress with the achievement of the Strategic Goal is Green because all actions on track and high confidence level for delivery as planned.

Progress to-date:
Implement new leadership visit process consistent with Comms & Engagement Strategy. Leadership visits process and SOP approved.

Annual calendar of visits published and tracking of attendance and themes reported monthly to EMB – in draft awaiting confirmation from leaders for dates.

Communication package – not started

Impact measure not yet commenced as the new approach has not started. New style of leadership visits to commence in June 2023.

Due to recent approval of strategy, all risks under-review and actions yet to be identified and fully assessed for impact on target risk (for all People & Culture actions). This will be updated next report.

Goal 1		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	PC1	High number of activities planned, which will require human resource to complete. No additional resource is available.	3x3=9	3x3=9	3x2=6
	Mitigation				
	Discussions with directorate / department leads to ensure priority of work, as part of work planning for 2023. Business case considered for ER team				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC2	Leadership visits will not occur due to failure of leaders to attend, or due to lack of support in coordinating.	2x3=6	2x2=4	2x1=2
	Mitigation				
	Annual calendar of visits published in June, and reported to EMB – DNA's to be challenged.				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC3	Scoping of risk underway by project group (to be updated)			
	Mitigation				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC4	There is a risk the program of work will not be adequately resourced	4x3=12	4x3=12	4x1=4
	Mitigation				
	Weekly project group established to monitor and unblock barriers to resourcing, options paper being developed for EMB regarding ongoing resources required.				

Goal 2		Making internal processes effective	
In Year Objectives	**PC5**	**Supporting our leaders completing appraisals by actively removing blockers**	
	Measure	**Supporting our leaders completing appraisals by actively removing blockers**	Q4
	PC6	**We will give our managers the time to prioritise 1:1s**	
	Measure	1:1s happening for all colleagues measured through Leadership/Quality Visits	Q1-4
	PC7	**Project to analyse and make changes to improve compliance against overruns**	
	Measure	Reduction in LSO% and Mean overrun time by TBC	Q2
	PC8	**Continue to deliver the fundamentals leadership training for first-line managers**	
	Measure	>95% completion of first line management fundamentals	Q4

In year progress with the achievement of the Strategic Goal is Green because all actions on track and high confidence level for delivery as planned.

Progress to-date:
Define "1:1" and communicate with our people - draft statement in discussion.
A Task & Finish group will be established to recommend how all our people will have access to at least 30 minutes of 1:1 time with their manager per month, and explore options for recording and reporting the interactions. – not yet started

Goal 2		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	PC5	Protected time unable to be facilitated due to operational pressures	3x3=9	3x2=6	3x1=3
	Mitigation				
	All operational people have had time scheduled for FY, reported and monitored through IQR				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC6	Time unable to be facilitated due to operational pressures	3x3=9	3x3=6	3x1=3
	Mitigation				
	Mitigation to be considered in upcoming planning work				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC7	Scoping of risk underway by project group (to be updated)			
	Mitigation				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC8	Nil current risks identified, action on track			
	Mitigation				

Goal 3		Improving the experience of our people	
In Year Objectives	**PC9**	**Improve capacity and capability of our formal processes (ER and FTSU)**	
	Measure	>85% compliance for all formal processes	Q4
	PC10	**Bring our Policies in-date and make them fit-for-purpose**	
	Measure	>95% up to date policies by end of the year	Q4
	PC11	**Management essentials to be rolled out (building on Fundamentals)**	
	Measure	95% of identified managers completed management essentials	Q4
	PC12	**ACAS mediation process**	
	Measure	Positive feedback from TU and Trust in the post-mediation evaluation	Q2

In year progress with the achievement of the Strategic Goal is Green because all actions on track and high confidence level for delivery as planned.

Progress to-date:
No Q1 outcomes planned

Goal 3		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	PC9	Inability to address open cases due to resource constraints	4x4=16	4x4=16	4X2=8
	Mitigation				
	ER team recruitment business case in progress				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC10	Unable to resource the development of the policy work. Unable to gain agreement through the necessary groups, to gain approval of policies	4x4=16	4x3=12	4x1=4
	Mitigation				
	Policies have been shared across management groups, to share workload. Meeting with ACAS to improve relationship with Trade Unions, updating policy for the management of policies to allow greater approval mechanisms internally				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC11	Protected time unable to be facilitated due to operational pressures and competing priorities for managers	3x4=12	3x4=12	3x1=3
	Mitigation				
	Mitigations under development by OD leads developing project				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	PC12	No risks identified at present			
	Mitigation				

Responsive Care

Goal 1		Deliver safe, effective, and timely response times for our patients	
In Year Objective	**RC 1**	**A Category 2 Mean response time that is improved and closer to National Standards**	
	Measure	Mean C2 response time of 30 minutes	Q1-4
	RC 2	**A Call Answer Mean time of 10 seconds**	
	Measure	Mean Call Answer time of 5 seconds	Q1
	RC 3	**Implementation of dispatch improvement actions to improve effectiveness of resource utilisation (RPI, cross-border working)**	
	Measure	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	Q3

Progress to-date:

- RC1: C2 mean of 24mins 23secs.
- RC2: Call answering mean 17 secs.
- RC3: Mean activity on own dispatch desk 100.6%, however 3 desks more than 110% and 2 at 85% or less (variation at >50% between highest and lowest).

Focus on improving resource capacity through:

1. Reduction in sickness – improvements particularly seen in Field Operations approx. 8% for Q1 to date.
2. Commencement of implementation of new rotas in Field Operations – due for completion in early June, with focus on improved scheduling (hourly compliance 90%, up from 87% Jan-Mar 2023).
3. Continued recruitment of EMAs in EOC – Ongoing challenging position, monitored weekly, also reducing impact on other ambulance services via IRP.
4. Continued collaborative working with Acute partners focusing on hospital handovers has seen an average daily handover move from 19mins 25sec (165hrs lost per day) in Jan-Mar 2023 to 17min 23sec (137 hrs lost per day) in Q1 to date.
5. Continuation of Dispatch Improvement Programme, prioritising the recommendations within the report – initially relating to support, training, and team structure/capacity.

Goal 1		Risk Description	Initial Score	Current Score	Target Score
In Year Risks to achieving the objectives	RC1, 2 & 3	Sustained delivery of all actions contributing to the delivery of this trajectory (note: as work progresses, risks will be broken down in greater detail)	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
	Mitigations				
	• Implementation of Operational Change Portfolio Group with all programmes moving to a more robust oversight and accountability approach – linked to the efficiencies programme. • The new Performance and Governance Framework commences implementation with 4 dispatch desks in June 2023 – providing accountability against a developing suite of metrics against the 4 priority areas at dispatch desk level. • This is a key deliverable during Q1 to support the sustained delivery across the 2023-24 year.			

Goal 2		Implement smarter and safer approaches to how we respond to patients	
In Year Objectives	**RC 4**	**Improvements in our 'Hear and Treat' rate to a minimum of 14%**	
	Measure	Heart and Treat of 14%	Q1-4
	RC 5	**Continued working on key/national programmes – 999 IRP, ~~111 SVCC~~, response to Manchester Arena Inquiry recommendations**	
	Measure	• ~~Volume calls taken by other in IRP/SVCC at 0% unplanned~~ • 85% completion of Major Incident Training programme	Q1-4
	RC 6	**Improved utilisation of all clinical resources from volunteers to specialist practitioners to achieve improved performance**	
	Measure	Reduction in RPI through CCD review of C1 resource allocation versus likely clinical need (whether CCP assigned or not) Increase in CCP utilisation through clinical interrogation of C1, C2 and C3 calls by CCD Improved support for crews and reduction in scene time by proactive crew call back at 20 minutes scene time for high acuity calls Improved efficiency by reducing scene time where there is a CCP present (exception – cardiac arrest, EoL, entrapped) Reduction in RPI when CCP is dispatched through CCD review of resources required based on clinical/logistic needs - all call categories (exceptions: multi-patient incidents, cardiac arrest, HEMS also dispatched) Improve JCT by improving CCP mobilisation times (exception: data transmission issues)	Q1-4

Progress to-date:

RC4:

- ‘Hear & Treat’ for April remained above 10% - this places SECAmb 6th out of the 11 English ambulance trusts (ranging from 6.3% to 16.5%).
- Initial cohorts of Paramedics within field operations to support C3 & C4 validation and call-backs have completed training and are now delivering clinician hours to support EOC.

RC5:

- Due to the reduction in the 111 budget, the service will no longer meet the required staffing level to enable its inclusion in the 111 Single Virtual Contact Centre.
- The Trust continues to engage with IRP – the most recent reports show minimal over-flow from all trusts across the system.
- The Major Incident Training Day has commenced with positive feedback from many attendees, and some challenge around location of delivery for travel issues – staff have been scheduled across the FY to achieve the 85%.
- Continued working with partner emergency services in the South East region and with national ambulance programme on the suite of recommendations from the Inquiry.

RC6:

- C2 30 min mean workstream has been set up with cross-directorate support.
- Specialist practitioners have been asked to scope how they can support the C2 30min mean work.
- Joint meeting between Operations and Medical Directorate has been arranged to nurture a co-production of objectives to support this work.

In addition:

- Consider options to grow the clinical workforce providing ‘hear & treat’/revalidation functions in and/or linked to EOC – this has commenced with further work ongoing to estimate the maximum support possible from field operations without it negatively impacting on mentoring support for new NQPs etc.
- Review of additional options/processes to support the hear and treat function within EOC – now overseen via weekly Operational Change Portfolio Group.
- Continue to engage with national programmes as listed – senior leaders in all service lines are involved in ongoing developments.
- Operational and Medical teams working in partnership to consider how greater efficiencies can be identified within the Specialist Paramedic and volunteer workforces.

Goal 2		Risk Description	Initial Score	Current Score	Target Score
In Year Risks to achieving the objectives	RC4	Inability to create additional capacity to support the delivery of the increase in 'hear and treat' rate.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
	Mitigation				
	• Implementation of Operational Change Portfolio Group with all programmes moving to a more robust oversight and accountability approach – linked to the efficiencies programme.				
		Risk Description	**Initial Score**	**Current Score**	**Target Score**
	RC6	Limited quantitative and qualitative reporting on activity and impact of all specialists and volunteers – linked to agreeing meaningful metrics and ease of accurate reporting.	3 x 4 = 12	3 x 4 = 12	3 x 2 = 6
	Mitigation				
	• Working with clinical leads on scoping the need and developing options/improvements for implementation				

Goal 3		Provide exceptional support for our people delivering patient care	
In Year Objectives	**RC 7**	**An improvement in on-day out of service, late shift over-runs both a % of shifts and mean over-run time**	
	Measure	• On-Day Out-Of-Service (ODOOS) target of 4% max – with all DD moving to be in line with best in class performance. • Late sign-off (LOS)/over-runs: reduction in proportion of shifts registering an over-run and mean over-run time	Q1-4
	RC 8	**Integration of EOC, 111 and MRC operations in one site at Medway**	
	Measure	Successful go-live of 111, MRC and EOC operations in line with project milestones. We will ask colleagues about their experience.	Q3
	RC 9	**A new Ambulance design and Fleet strategy that meets our needs for the future**	
	Measure	We will replace the manual FIAT DCAs and decide a new ambulance design to continue our fleet replacement	Q4

Progress to date:

- RC7:
  - ODOOS performance QTD is 4.11% with variation from 3.06% to 6.06%
  - LSO performance has shown an improvement on Jan-Mar due to better balance of demand v resourcing.
- RC8: Move to the new building on track as per current timeline (MRC moves in first on 08/06/23)
- RC9: Commissioners are supportive of SECAmb approach. We have started engaging suppliers and colleagues on the development of the new specification, and the Fleet team have undergone QI training to adopt Design Thinking techniques in the way they take feedback and use it to develop the new specification. One staff engagement day has taken place to review the MAN vehicle from St Johns with the Driver User Group, with positive feedback.

- ODOOS & LSO programmes under development to set targets and actions at a dispatch desk level.
- Practical completion of the building took place on 6 April 2023. The RAG has moved from RAG rated Red to Amber as although all the critical snags have been completed, teams cannot occupy the building until IT have completed their commissioning phase, which is currently on track and due to be completed at the end of this month. Highlight reports provided from the Project team key risks, recent and pending decisions.
- Start to engage suppliers, colleagues and partners in the development of a new DCA specification. The next milestone is in Q3 (November) when a proposal will go to FIC on the proposed specification

In Year Risks to achieving the objectives					
Goal 3		**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
	RC7	Non, programme under development			
	Mitigation				
		Risk Description	**Initial Score**	**Current Score**	**Target Score**
	RC8	Risks related to the move to Medway are comprehensively captured in the highlight report from the programme board.			
	Mitigation				
		Risk Description	**Initial Score**	**Current Score**	**Target Score**
	RC9	There is a risk that we don't secure commissioner of NHSE derogation if our specification is not aligned to the national specification	4x4 = 16	4x2 = 8	4x2 = 8
	Mitigation				
	The Fleet Manager is involved at a national level to influence the national specification, and the national team have agreed that multiple options of fleet will be provided in the next iteration, so that ideally we do not require a derogation to procure the vehicles that best fit our colleagues' feedback. We continue to have strong support from our lead ICB, following the extensive data-driven exercise done in 22/23 to identify the challenges associated to the current FIAT DCA fleet.			

Sustainability & Partnerships

Goal 1		Develop a refreshed vision and strategy for SECAmb and our operating model	
In Year Objectives	**SP 1**	**A new Clinical and Quality strategy that meets the needs of our patients now and in the future**	
	Measure	Strategy sign-off in Q2, as a milestone of the development of our long-term strategy	Q2
	SP 2	**A new long-term mission, vision and strategy, based on collaboration and co-design with our patients, people and partners**	
	Measure	Evaluating successful involvement of our people, patients and partners Strategy sign-off in Q4 at Board	Q4

In year progress with the achievement of the Strategic Goal is **AMBER** because we remain on-track with the original milestone plan and there is good momentum at Board behind the development of the Strategy, with good system partnership buy-in. However there's a risk in continuity of resources to support delivery and potential delays until a programme plan is confirmed through the procurement process in June and taking on-board the views of our selected partner.

Progress to date:

- Develop a framework for the development of a Strategy with the Board and new CEO.
- Choose approach to delivery, engaging with a wide range of stakeholders before we get started.
- Award by end of May, with a view to start the work by 1st of June.

These have been achieved, with engagement with the Board, senior teams, partners, patient groups, and staff groups feeding into the initial framing. However, original timelines have been protracted, as well as resource constraints due to the lack in an in-house Strategy team. We are progressing with a robust selection process to ensure we on-board the right strategic partner (consultancy) to support this development.

Goal 1		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	SP1/SP2	There is a risk of resource continuity interruptions and delays until a program plan is confirmed through the June procurement process.	3X3=9	3X3=9	3X2=6
	Mitigation				
	We are progressing with a robust selection process to ensure we onboard the right strategic partner to support this development. In Q2 and Q3, the work should be completed, and pending a project plan from partners, we are still aiming for a December Board approval. The latest approval can be in January to ensure we can develop the outcomes of the strategy into our 24/25 planning.				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	n/a	n/a			
	Mitigation				
	n/a				

Goal 2		**Be a great system partner, establishing SECAmb as a system leaders in the UEC arena, becoming the partner of choice**	
In Year Objectives	**SP 3**	**Optimised Urgent and Community referral pathways, avoiding conveyance to EDs, and improving the use of the ICS SPOAs**	
	Measure	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]	Q1-4
	SP 4	**A new internal and external governance that aligns strongly to our ICBs, helping us strengthen relationships and ways of working**	
	Measure	New governance go live in Q1 and effectiveness evaluated in Q3	Q1
	SP 5	**A joint workforce plan for our systems, strengthening development pathways for our clinicians and creating long-term sustainability in our paramedic workforce**	
	Measure	Long term workforce strategy and plan agreed with ICBs Reduction in leavers in the organisation to other parts of the system	Q3

Commented [DRC1]: @David Ruiz-Celada

Commented [DRC2]: @Ali Mohammed I think this is an outcome of the Strategy work, are you happy if I link it to that work, or is there anything else we want to say?

In year progress with the achievement of the Strategic Goal is **AMBER.** The new governance arrangements are being finalised and alignment between quality meetings at a system level and ICB level are already in place. However, we have not concluded the changes fully and evaluation. There remain challenges in the data to evaluate SP3, however an initial baseline has been developed, and the workforce plan will depend on the strategy development work which isn't due until Q3.

Progress to date:

- SP3:
  - Establish a multi-directorate working group to report into the operational change board
  - Provide clarity around the KPIs and regular reporting and improvement based on identifying bottlenecks and sharing information with system partners to improve utilisation of alternative pathways.
- SP4:
  - Review of the governance model and align internal and external governance to ICS, around Quality and Patient Safety. This includes a review of the contract review meetings, strategic commissioning board, and SAM arrangements.
  - Go live of the new model
- SP5:
  - No plans in Q1
  - Plans in Q2 and Q3 are to develop the long term workforce plan as an output of the Strategy development, working back from the patient needs and the target operating model.

We haven't been explicit about the metrics we are using to evaluate impact of the improved patient flows into alternative pathways, in particular across UCR-2h, Mental Health, Primary Care.

Out Hear and Treat remains at 10% vs a 14% year target.

In Year Risks to achieving the objectives					
Goal 2		**Risk Description**	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP3	There is a risk we can effectively measure improvements due to data limitations	4X3=12	4X3=12	4X2=8
	Mitigation				
	The current data remains a limitation. Current datasets show very low utilisation levels, and provide us with a baseline starting point - UCR is <1% of outcomes - 40-50% of our total Hear and Treat are referrals to alternative non-ED pathways - Only 10% of our S&T activity is to alternative pathways. The working group is mitigating this by working closely in alignment with the Ambulance Dataset (ADS) programme which should provide better patient flow end to end data by September. In the meantime, we will provide further assurances to Board by integrating the details from the Community Dataset into our IQR by system, so that the Board have visibility of the performance at a granular level.			
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP4	There is a risk that the governance of the system does not support SECAmb in delivering it's objectives	4x4 = 16	4x3 = 12	4x2 = 8
	Mitigation				
	A proposal for the updated governance model has been developed between the lead ICB and our partnerships team. This has been delayed due to uncertainty around the move from Surrey Heartlands to Sussex, and the work is not progressing with the assumption that the move will not happen soon. Parts of the model have gone live, and we will be adopting further changes in Q2, starting with SAM, and then progressively re-establishing the Strategic Commissioning Board as a mechanism to engage system partners in the Strategy development. Full alignment to the external governance model can only happen once our operating structure has aligned to Kent, Surrey (+Frimley), and Sussex. There is no current timeline for this to happen.			
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP5	See BAF Strategic Risk 255			
	Mitigation				

Goal 3		Become a Sustainable Urgent and Emergency healthcare provider	
In Year Objectives	**SP 6**	**Meet our financial commitments as agreed with commissioners for FY 23/24**	
	Measure	Plan delivered in line with planned break-even result	Q1-4
	SP 7	**Cost efficiency improvements to ensure our resources are focussed on delivering patient care**	
	Measure	Internal savings identified £9m of which at least 75% will be recurrent	Q1-4
	SP 8	**Our de-carbonisation commitments as set out by our Green Plan**	
	Measure	Completion of electric RRV trial EV Strategy approved at Board Entonox removal improvement case approved	Q4

In year progress with the achievement of the Strategic Goal is Green because progress is in line with the plan.

Progress to date:
We are expected to deliver break-even each quarter. At month 1 we are £0.1m in deficit however we expect that to improve to break-even by the end of the quarter. The key corrective action is to reduce and eliminate the overspend compared to budget in operations.

We are expected to develop and sign off the detailed cost savings plans by the end of Q1 and to be delivering against the trajectory. We are on track to achieve this but with some risk as not all the schemes to date have been identified. The corrective action is that the efficiencies group is meeting with weekly with clear actions to progress each week.

SP8 - Green Plan
Work is on-going with Arcadis through Q1 in line with our plans, to complete the EV strategy that supports delivery of our Green Plan. Board training was originally planned at the end of the programme and this will now be scheduled later year due to other Board commitments around development. The fully costed plan will be reviewed at FIC.

In addition, in Q1 the Green Staff Network has been established.

In Year Risks to achieving the objectives					
Goal 3		**Risk Description**	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP6	There is a risk the overspending compared to budget in operations will continue resulting is an overall deficit.	4X3=12	4X3=12	4x2=8
	Mitigation				
	A deep dive into the month 1 operations financial variances is being carried out and an action plan linked to this is being developed.				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP7	There is a risk that we will not develop enough schemes to be able to deliver £9m for the year.	4X4=16	4X4=16	4x3=12
	Mitigation				
	The efficiencies group is meeting with weekly with clear actions to progress each week. Ideas are being shared from other ambulance Trusts.				
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP8	There is a risk we will not be able to deliver our in-year targets for carbon reduction in line with the plan	2x3=6 (in year) 4x3=12 (long term)	2x3=6 (in year) 4x3=12 (long term)	2x3=6
	Mitigation				
	The Green Plan work sets out a 10year plan to reduce 80% of our carbon emissions. We are already complying with procurement guidelines around weighting of sustainability. The risk remains low due to the current in-year low consequence of non-delivery, and long-term delivery of the Green Plan will be contingent on identifying a detailed delivery plan that will come out of the Green Plan at the end of the Arcadis work in Q2. 57% of our scope 1 emissions are due to fleet activity, and c.18% due to medical gases. Alongside estate efficiency, these will be the main areas the plan will focus on, alongside colleague engagement in reduction of waste.				

Board Assurance Framework
Section 2: Strategic Risks

BAF Dashboard

Quality Improvement	People & Culture	Responsive Care	Sustainability & Partnershi
We listen, we learn and improve	Everyone is listened to, respected and well supported	Delivering modern healthcare for our patients	Developing partnerships to collectively design and develo innovative and sustainable mo care

Risk ref	Thematic Risk Title	Oversight Committee	Strategic Goal(s) Impacted					Initial risk	Current Risk (Current Position)								Change	Target score
			QI	PC	RC	SP			Mar 22	May 22	Aug 22	Sep 22	Dec 22	Feb 23	Apr 23	Jun 23		
14	*Operating Model*	QPSC	-	-	1-3	1-3		20	16	16	16	20	20	20	20	20	⇔	08
255	*Workforce Plan*	PC	-	-	1-3	1		20				16	16	16	16	16	⇔	08
348	*Culture & Leadership*	PC	-	1-3	-	-		16					16	16	16	16	⇔	08
16	*Financial Sustainability*	FIC	-	-	-	3		16	12	12	12	16	16	16	12	12	⇔	08

BAF Risks

	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	People 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	Ass
Appointed a Programme Director (Cultural Transformation) to take forward the delivery of the P&C strategy P&C Strategy / Delivery Plan established. Implementing programme of early resolution/mediation training Trust Board development sessions in Q4 2022/23 Programmes of management development Increase in resourcing for FTSU service All staff to attend a full day 'culture and values' workshop in FY Priority areas for 2023/24 agreed as part of the delivery plan	**WF-44** "Grievance mean case length days"	•	
	WF-41 "Count of Until it Stops (Sexual Safety) Cases"	•	

Gaps in Control

- P&C delivery plan established in May – will require time to have impact.
- Culture Dashboard
- Pace of delivery due to inadequate resources, vacancies and under-resourced for volume of work
- NHSE P&C Plan yet to be introduced.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Employee relations data reviewed regularly at SMG and by HRBPs (+) regular reporting of ER and FTSU cases to commence to Leadership Team, PC and Trust Board to improve visibility and monitor progress/highlight areas of concern (-) WRES, staff surveys, quarterly national pulse surveys (-) Exit interview data	Business case for ER team restructure to be approved.

	BAF Risk ID 255 Workforce Plan	**Target Date:** **March 2024**

Underlying Cause / Source of Risk:

Risk that we do not achieve the recruitment plan to increase our frontline workforce as set out in the 2023/24 Workforce 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.

Accountable Director	Executive Director of HR
Committee	People Committee
Initial Risk Score	**20** (Consequence 4 x Likelih
Current Risk Score	**16** (Consequence 4 x Likelih
Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
Target Risk Score	**08** (Consequence 4 x Likelih

Controls in place (what are we doing currently to manage the risk)	**Integrated Quality Report Metrics for Assurance**	**Variation**	**As**
Workforce Plan Agreed The People and Culture Strategy makes a commitment to reduce TTH and onboarding to achieve the 60 days target as one of a number of priority areas identified for people and cultural change.	**WF-1** "Number of Staff WTE"		
	WF-3 "Time to hire"		
	999-12 "999 Frontline Hours Provided %"		

Gaps in Control

Funding for international recruitment ends in Sept 2023
Clinical Education Resourcing

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) WTE gap carried forward from 2022/23 (-) On road hours significantly below target (-) Time to Hire (-) Retention	Sustainability of International Recruitment

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**
A Quality Improvement project to improve TTH and onboarding	Director of HR	TBC	Commenced on 23 May 2023.
Clinical Education resourcing plan for 2023/24	Chief Medical Officer	TBC	Due to be reviewed at EMB on 31 May 2023

	BAF Risk ID 16 Financial Sustainability	Target Date: March 2024

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	As
▪ For 22/23, the Trust delivered a break-even result following remedial action plans with each directorate to deliver recurrent savings. ▪ A break-even plan has been signed off by the Board for 23/24. ▪ In order to continue the focus on financial delivery the Monthly review meetings for each directorate are continuing ensuring each area delivers on plan and its efficiencies.	**WF-1** "Number of Staff WTE"		
	F-9 "Income (£000s) YTD"	NA	
	F-10 "Operating Expenditure (£000s) YTD"	NA	
	F-6 "Surplus/Deficit (£000s) Month	NA	

Gaps in Control

Sources of Assurance: Positive (+) or Negative (-)	Gaps In Assurance
(+) financial management: achieving plan (-) underlying funding gap / deficit (-) Cost Improvement Plan	We have a break-even plan signed off which relies on non-recurrent means (£4.5m) achieve that plan. The plan is based on delivering Category 2 mean performance of minutes. In accordance with the guidance this is expected to improve to the 18 minu in future years, which presents a risk either to financial sustainability or performance funding is not available or significant improvements are found.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Robust Cost savings plan developed and delivery tracking	Chief Finance Officer	Q1	Update included in the finance report
Monthly Directorate meetings to ensure focus on financial delivery and develop culture of delivery against plan	Chief Finance Officer	Ongoing	

	BAF Risk ID 14 Operating Model	Target Date:

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 until we address this, we will be unable to achieve the Ambulance Response Programme standards and therefore deliver 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	Ass
	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

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress

Board Assurance Framework
SECTION 3: 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 Pharmac
Actions: Prescribing drugs only when adequate knowledge of patient's health is established and satisfaction gained that the drugs serve the patient's n Monitor for drug-seeking behaviour when prescribing medications with addictive potential. Implementing a consistent and locally agreed approach to assessment that is respectful, non-judgmental, and proportionate to the person's presenting vulnerabilities. **Board Oversight**: Quality & Patient Safety Committee. Next review scheduled Q1.					
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
Actions: Addressing the ongoing capacity and demand issues that are making it difficult to guarantee an appropriate response to incidents or events. In measures such as increasing staffing levels, providing additional training and support to staff, and implementing processes and technologies to improve efficiency of incident response. Regularly reviewing and updating the Trust's Major Incident Plan and NHS EPRR Framework to ensure that they are in current best practices and legal requirements. Including conducting regular drills and exercises to test the effectiveness of the plan and framework, and involving staff and stakeholders in the review and update process to ensure that their needs and concerns are addressed. Regular monitoring and asse the Trust's incident response capabilities and making adjustments as needed may help ensure that the Trust is able to respond effectively to EPRR inci					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
	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.				
Actions: Improving the process of tagging medicine pouches to ensure it is working effectively. Including providing additional training / guidance to para on how to correctly complete paperwork following their daily assurance checks. Implementing quality control measures - regular audits and checks to id and correct pouch tagging errors. **Board Oversight**: Quality & Patient Safety Committee. Medicines risks last reviewed in March - see latest Board Escalation Report.					
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* *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*	15	15	10	Director of Pla
Actions: Reviewing investment plans to allocate funds towards meeting decarbonisation targets. Reviewing operating model and clinical strategy to ens that they are aligned with the goal of achieving environmental sustainability. NHS England has also established an NHS Net Zero Expert Panel and has conducted extensive analysis and modelling to understand how and when the NHS can reach net zero emissions. SECAmb to leverage this expertise a follow the guidance provided by NHS England to reduce their carbon footprint. Green Plan is in development.					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
	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.				
Actions: Increase in the resilience stock at the Medicines Distribution Centre (MDC) to ensure that there is an adequate supply of medicines to meet in demand. Including regular reviews and adjustments of stock levels based on demand patterns, and implementing processes to ensure timely replenishr stock. Actively recruiting for the Clinical Pharmacy post or providing additional training and support to existing staff to help them take on some of the responsibilities of this role. This would ensure that medicines portfolio work such as PGD reviews can continue to take place, leading to improved medic optimization and service improvement. Regular reviews and assessments to determine the effectiveness of these measures and making adjustments as needed. **Board Oversight**: Quality & Patient Safety Committee. Medicines risks last review in March - see latest Board Escalation Report.					
New 357	**Delivery of Clinical Education Strategy** Following approval and launch of the Clinical Education and Training Strategy 2022-25 there is a risk that the strategy will fail to be delivered in full. As a result of the Clinical Education and Training re-structure not being supported due to financial constraints within the Trust, many deliverables of the Clinical Education and Training Strategy will not be able to be implemented in full (or part). This will lead to the inability of the department to flex and respond to the changing needs of the Trust to include the commencement of educational programmes and onboarding for new colleagues. It is likely therefore to impact upon the Trusts ability to deliver the workforce plan(s) each fiscal year and upon the quality of educaiton and training activity provided to our colleagues, in turn risking career development, retention and staff satisfaction.	15	**15**	06	Consultant Pa

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
Board Oversight: People Committee. Last reviewed in May – see Board Escalation Report.					
New 364	**HR Data Subject Access Requests** There is a risk of data breaches as a result of the increasing volume and complexity of requests being received.	16	**16**	08	Director of HR
Actions: Implementing robust data management and security protocols including regular data backups, encryption of sensitive data, and access contro ensure that only authorised personnel can access HR data. Providing training and support to HR staff on how to properly handle and process data subj access requests. Including guidance on how to verify the identity of the requester, how to redact sensitive information, and how to securely transmit the requested data. Regular reviews and updating of data management and security protocols to ensure they are in line with current best practices and lega requirements. **Board Oversight:** Audit & Risk Committee. Will be considered at the next meeting in July.					

Board Assurance Framework
Section 4: National Oversight Framework

The Board Assurance Framework now includes a summary evaluation of the NOF requirements, shifting from the specific Improvement Jour reports provided in 22/23. This change reflects the Board's transition from regulatory focus to strategic focus. Our 23/24 strategic themes, go objectives aim to enhance patient care quality, workplace culture, sustainability, and overall performance, thus supporting our NOF requireme fulfillment.

The May evaluation against the RSP exit criteria is provided below. The Board will discuss the potential exit date during the second part of th meeting on June 1, 2023.

RSP ref.	Requirement description - The trust must:	Position Statement	SECAmb Progress V
RSP-L1	Interim CEO appointed and the Trust's Board-level leadership seen as stable.	This is amber, reflecting our team's performance assessment. Despite interim appointments and expected Board turnover, our focus is on executing the planned Executive and Board Development for stability.	
RSP-L2	Clear lines of responsibility and accountability for individual executives.	Executive roles are now clear, but there's a teamwork gap identified in our development plan. ED Objectives, which will further clarify expectations, will be set by early June.	
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.	The BAF, now aligned with our Improvement Journey and Annual Board objectives, explicitly details in-year risks. Although it doesn't address strategic risks due to our current lack of strategy, it underscores strategic areas needing Board focus and resolution. The IQR, aligned with our priorities, presents a clear business cycle linking assurance with objectives, providing Board visibility on progress and areas needing improvement, especially concerning patient safety metrics in the IQR and cultural enhancement.	
RSP-L4	Improved communication and engagement channels between the frontline and the Board, inclusive of routes of escalation for risks and concerns.	An externally-reviewed Strategy was approved by the Board in April and an improvement plan was developed. However, it lacks a defined resource plan for execution, which will be EMB's focus in June. Quality visits, Performance Management Framework, and leadership visits have been implemented to support risk escalation and evidence triangulation at the Board level. This remains A/R until a suitable resource plan aligns with the communication strategy.	

	and SECAmb as part of the improvement journey evidence framework to avoid duplication		
RSP-L6	External Well-Led review co-commissioned and all key recommendations acted on effectively.	An independent review conducted by the ID was completed in Q4 22/23, with another planned in Q3/4 23/24 aligned with the exit date. The action plans are integrated into the board and executive development plans, and regularly reviewed at the Steering Group.	
RSP-L7	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	As above	
RSP-L8	The ICS and NHS England are assured that significant improvement found against all Warning Notice and Must Do findings/recommendations, taking into consideration any CQC reinspection findings.	Progress was demonstrated to CQC on January 31st via Management and Evidence presentations. With no further Warning notices in place, the IJ plan is now incorporated into the organization's Annual Objectives and plan.	
RSP-Q1	Comprehensive improvement plan developed to deliver the Trust's improvement priorities including CQC's May 2022 findings and recommendations and the areas for improvement highlighted in the 2021 Staff Survey.	As above	
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.	This has been completed through our re-vamped IQR to the Board and alignemnt of the BAF. The objectives are clearly aligned to our priorities and patient safety, and the ARP challenges are embedded in our approved plan for 23/24.	
RSP-Q3	Trust F2SU policy/process has received board assurance and oversight and has been appropriately	Our Trust's F2SU policy/process has received board assurance and appropriate resources, as shown by our three dedicated guardians and improved dashboard. The Board has a sound understanding, and a policy draft is underway. Despite these advancements, we recognise culture of speak-up and psicological safety needs further	

		the narrative and progress made to support credible trajectories of improvement by Q4 23/24. One of our 3 main priorities in the Culture space is to address the c. 40 "housekeeping" actions identified in the Staff Survey and other recent reviews.	
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.	Our workforce plan is clearer thanks to improved planning. However, there's debate on whether the plan explains the 'what' more than the 'how'. Some believe it effectively outlines the 'how', demonstrated by our recruitment strategies, training plans, and provisions for attrition. However, regional assurance is lacking, necessitating a stronger narrative. **Action:** We'll arrange for an external review of our workforce plan. AM will engage Michael Pantlin for this independent assessment to identify any potential gaps.	
RSP-P3	Trust career development and career pathways strengthened in line with the Board-approved clinical education strategy.	This remains red as the Clinical Education Strategy has not yet been resourced. This is due to EMB on the 31st of May for phase 1, at which point we will review this rating.	
RSP-P4	Trust not an outlier with ambulance service peers for staff retention or sickness absence.	Sickness rates show a positive trajectory, improving by 3.5% in the last year. However, retention at 18% exceeds the 10% target. **Action**: To gain perspective, we'll collect data from other ambulance services. AM will contact the AACE/HRD group. The situation can't be RAG-rated until we obtain a comparator.	
RSP-P5	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	The region is rated amber/red, as they want clarity on how the Board is handling data/information. EMB believes data has improved and is now monitored by committees, suggesting an amber rating. However, this broad criteria requires specificity, for instance, defining which HR systems are in focus.	
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.	A robust plan has been submitted, and whilst there's some risk in our efficiencies, these are well tracked and there's a clear focus plan to address them.	
	Shared Trust and system		

RSP-F3	Trust can evidence delivery of financial trajectories for at least two most recent quarters.	This will remain amber until the efficiencies programme is deliver and trailed to the date of the exit. We delivered our plans for 22/23.	

Appendix 1 - Risk Scoring

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

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 fatali Multiple permanent injur irreversible health effect
Quality of Patient	Unsatisfactory patient experience not directly related	Readily resolvable unsatisfactory patient experience directly	Mismanagement of patient care	Mismanagement of care with	Totally unsatisfactory pa outcome or experience i

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 essentia 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) national interest Multiple claims or high v 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 obje service due to lack/loss Critical error(s) due to le competency (individual
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 re
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 / re 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 – 20%	21 – 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 m significantly **HIGHER**. Assurance cannot be given as a target has not be
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	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the m significantly **HIGHER**. Assurance cannot be given as a target has not be
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				Special cause variation where **UP** is neither impro concern.
				Special cause variation where **DOWN** is neither in nor concern.
				Special cause or common cause cannot be given a

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – June 2023

Reporting Period: March & April 2023

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

Contents

Improving Quality of Information to Board – June 2023

- Following additional Board development sessions with NHSE in 22/23, 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.
  - 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.
- 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.
- 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.
- **Update June:** The BI team have focussed on developing the infrastructure required to produce "Balanced Scorecards" for each Dispatch Desk level to support the development. This will become an effective localised IQR and utilised to support the Performance and Quality Management Framework going live in Q1 23/23. Subsequently, there has been limited development time in the published IQR. However, several Data Clinique's are on-going with medical and quality and nursing colleagues to re-develop the Quality Improvement section of the IQ. This was originally due in June but overall availability and prioritisation of development for dispatch-desk level KPIs means this is likely to be delivered in Q2 instead.

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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				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.

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Quality Improvement

QUALITY IMPROVEMENT

Summary

April 2023

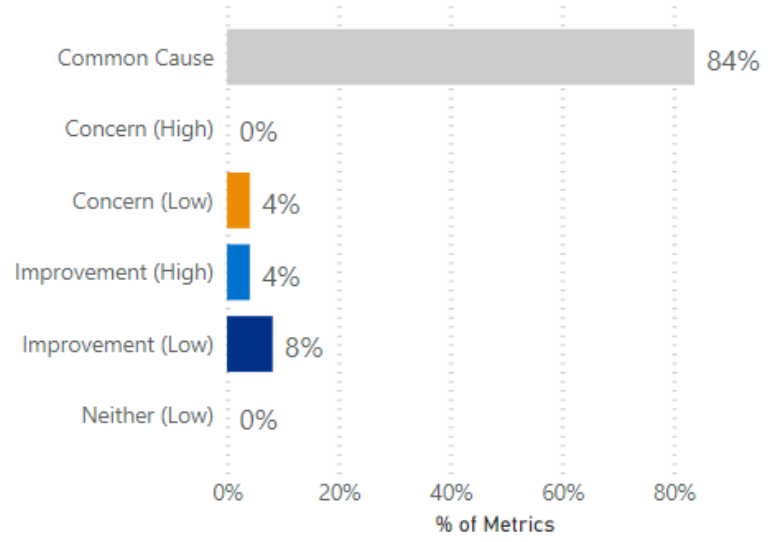
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Cardiac Survival ALL % Required NHS Pathways Audits Completed (Clinical) %		Count of Low Harm Incidents Count of No Harm Incidents Complaints relating to privacy and respect % Outstanding Actions Relating to SIs, Outside of Timescales
Common 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 Stroke - Call to Hospital Arrival Mean	Number of Medicines Incidents Number of Datix Incidents Number of Incidents Reported as SIs Violence and Aggression Incidents (Number of Victims - St... Health & Safety Incidents Manual Handling Incidents Proportion of Complaints Relating to Crew Attitude % 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		Safeguarding Training Completed (Children) Level 2 % Compliant NHS Pathways Audits (Clinical) %		

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.

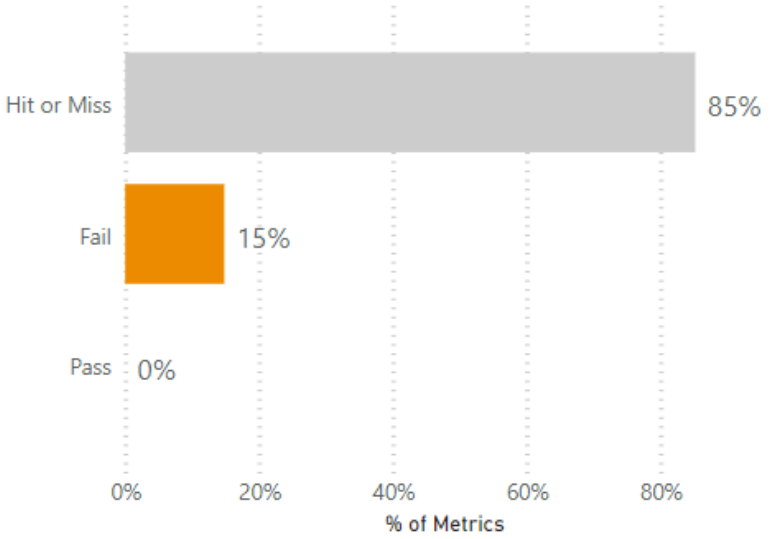
QUALITY IMPROVEMENT

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Apr-2023	158		87.29	151.55	215.81		
Number of CD Breakages	Quality Improvement	Apr-2023	18	0	3.39	20.05	36.71		
Number of Datix Incidents	Quality Improvement	Apr-2023	1486		898.55	1399.05	1899.55		
Number of Incidents Reported as SIs	Quality Improvement	Apr-2023	8		-4.2	4.9	14		
Duty of Candour Compliance %	Quality Improvement	Apr-2023	100%	100%	54.18%	85.95%	117.72%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Apr-2023	124		53.32	101.2	149.08		
Number of RIDDOR Reports	Quality Improvement	Apr-2023	12		-0.46	11.3	23.06		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Feb-2023	5		35.2	62.29	89.39		
Health & Safety Incidents	Quality Improvement	Apr-2023	25		13.83	27.55	41.27		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Feb-2023	43	0	8.1	36.11	64.12		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Feb-2023	25	0	-20.35	64.61	149.57		
Medicines Management % of Audits Completed	Quality Improvement	Apr-2023	92.3%	100%	74.37%	88.54%	102.7%		

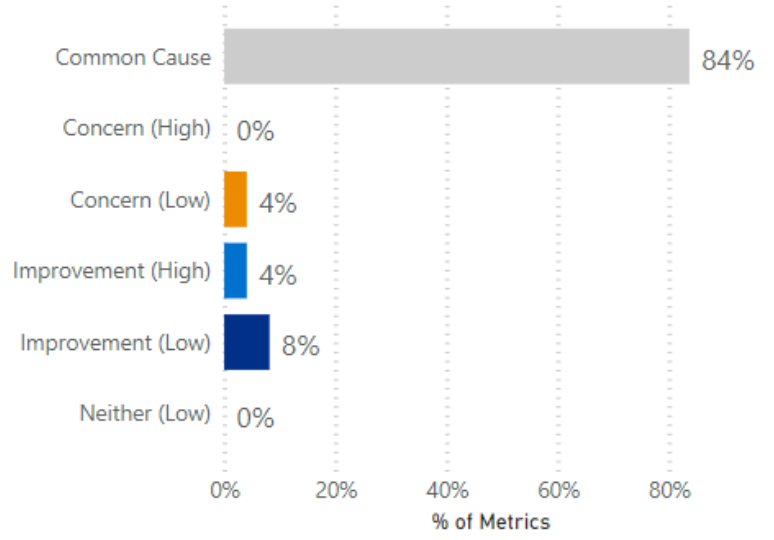
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Apr-2023	0%		-0.07%	0.02%	0.1%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Apr-2023	80%		44.38%	64.4%	84.42%		
Complaints Reporting Timeliness %	Quality Improvement	Apr-2023	74%	95%	23.53%	70.15%	116.77%		
Number of Complaints	Quality Improvement	Apr-2023	40		32.85	74.85	116.85		
Complaints per 1000 999 Calls Answered	Quality Improvement	Apr-2023	0.59		-189.27	104.24	397.75		
Number of Compliments	Quality Improvement	Apr-2023	131		69.63	167.89	266.15		

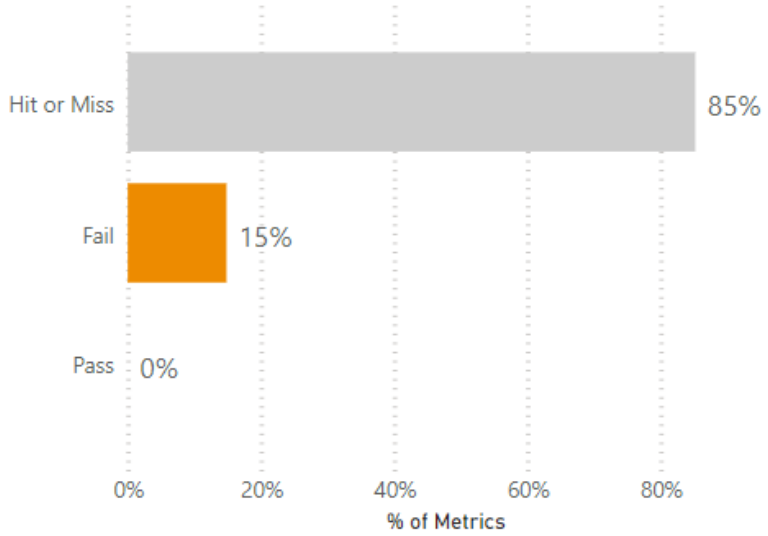
QUALITY IMPROVEMENT

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	Mar-2023	51.4%	45.1%	26.89%	48.57%	70.25%		
**Cardiac ROSC ALL %	Quality Improvement	Mar-2023	29.6%	23.8%	16.91%	26.04%	35.17%		
**Sepsis Care Bundle %	Quality Improvement	Mar-2023	87.9%	85%	81.82%	86.26%	90.69%		
**Cardiac Survival Utstein %	Quality Improvement	Jan-2023	12.5%	25.6%	6.01%	25.46%	44.91%		
**Cardiac Survival ALL %	Quality Improvement	Jan-2023	41.7%	9.6%	2.26%	12.72%	23.17%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Mar-2023	69.4%	76.8%	58.46%	72.93%	87.39%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Mar-2023	66.7%	64.7%	54.14%	67.25%	80.36%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Nov-2022	02:34:00	02:22:00	02:12:05	02:33:56	02:55:47		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Nov-2022	03:39:00	03:14:00	02:55:03	03:39:08	04:23:13		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Nov-2022	01:41:00	01:29:00	01:31:02	01:41:52	01:52:42		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Nov-2022	02:46:00	02:20:00	02:04:52	02:40:12	03:15:32		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Mar-2023	97.5%	96.3%	95.44%	97.33%	99.22%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Mar-2023	89.7%	93.8%	85.54%	93.33%	101.11%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Mar-2023	77%	77.9%	66.02%	78.93%	91.85%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Apr-2023	104.4%		73.51%	100.98%	128.45%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Apr-2023	85.7%	100%	74.35%	85.23%	96.1%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Apr-2023	81.2%	100%	77.75%	90.55%	103.35%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Apr-2023	102.1%	100%	85.99%	98.22%	110.44%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Apr-2023	30.2%		16.74%	66.46%	116.17%		

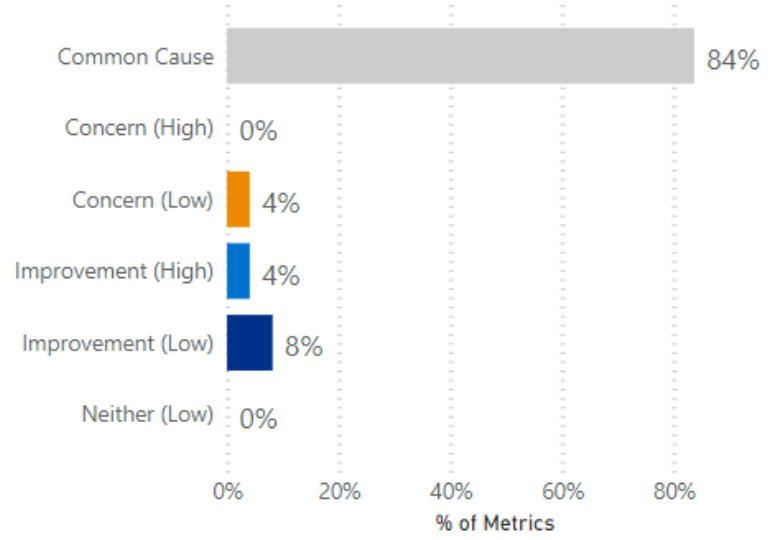
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Apr-2023	92.1%	90%	72.73%	87.25%	101.76%		
Deep Clean Compliance %	Quality Improvement	Apr-2023	91%	95%	60.38%	84.84%	109.3%		

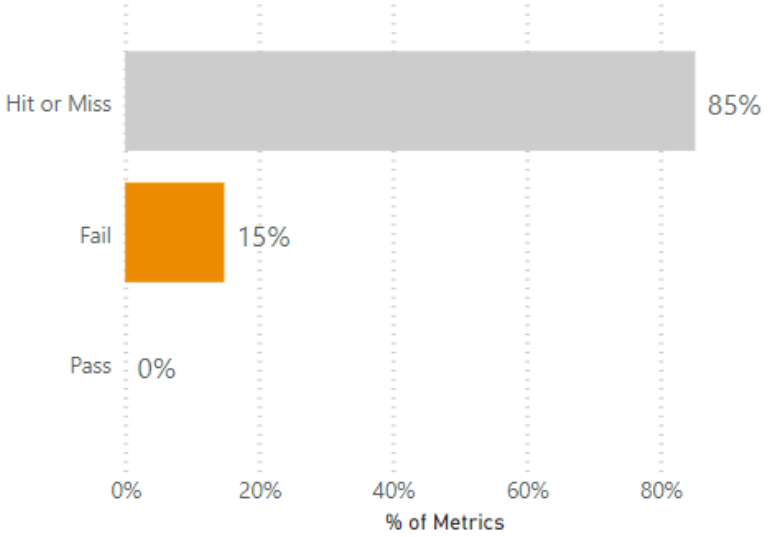
QUALITY IMPROVEMENT

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	Apr-2023	68.5%	85%	76.94%	81.81%	86.68%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Apr-2023	72%	85%		63.61%			
Manual Handling Incidents	Quality Improvement	Apr-2023	26		11.06	27.3	43.54		
Organisational Risks Outstanding Review %	Quality Improvement	Feb-2023	38%	30%	2.63%	43.59%	84.56%		

QUALITY IMPROVEMENT

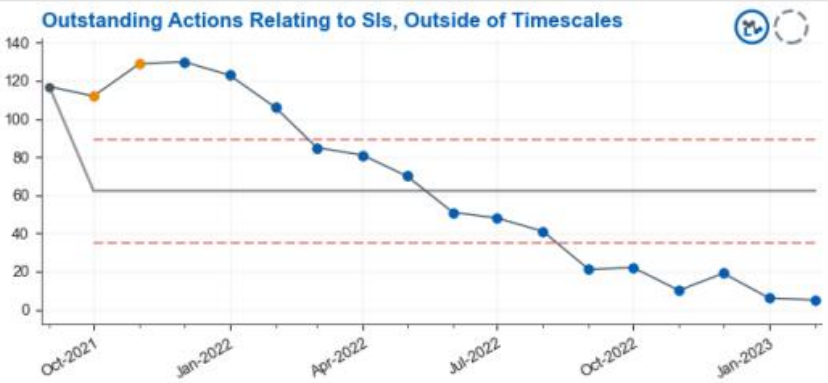
SIs, Incidents, & Duty of Candour

QS-2
Dept: Quality & Safety
IP: Quality Improvement
Latest: 8

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: 1486

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: 100%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

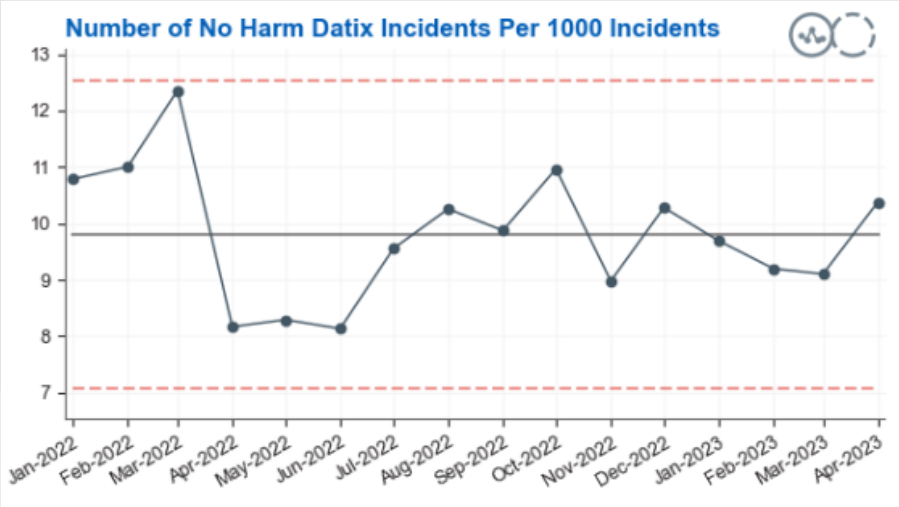
Summary
(QS-1) Non-SI incidents - The Trust continues to support an effective culture of incident reporting with a process that is in control.
(QS-17) SI actions – The number of outstanding actions relating to SIs outside of timescales has reduced significantly in a downward, improving trend since December 2021 reflecting the hard work of the team in supporting these.
(QS-2) SI numbers – The no. of incidents reported as SIs shows normal variation in line with the effective culture of incident reporting described above.
(QS-3) DoC – Improved position for the past two months where 100% of duty of candour compliance has been achieved following a redesign of the process.

What actions are we taking?
(QS-1) Non-SI incidents and (QS-2 / 17) SI actions
- To continue to support a positive culture of reporting incidents at SECAmb and ensuring feedback to individuals / team and organisational wide learning.
- Work has begun on the implementation of PSIRF.

(QS-3) DoC
- Discussions have commenced on the role of DoC within PSIRF. This is to improve the experience for patients/carers within this process.

QUALITY IMPROVEMENT

Harm (1 of 2)



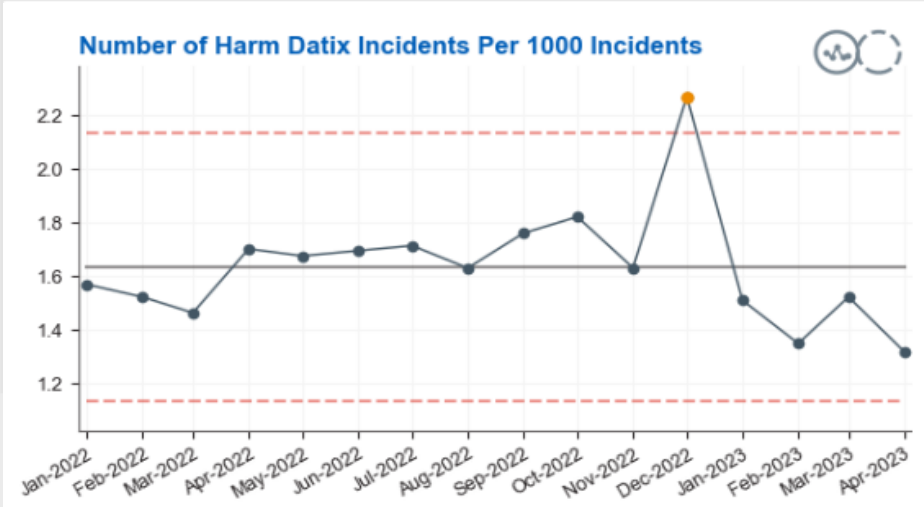
QS-28

Dept: Quality & Safety

IP: Quality Improvement

Latest: 10.4

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



QS-29

Dept: Quality & Safety

IP: Quality Improvement

Latest: 1.3

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

Summary

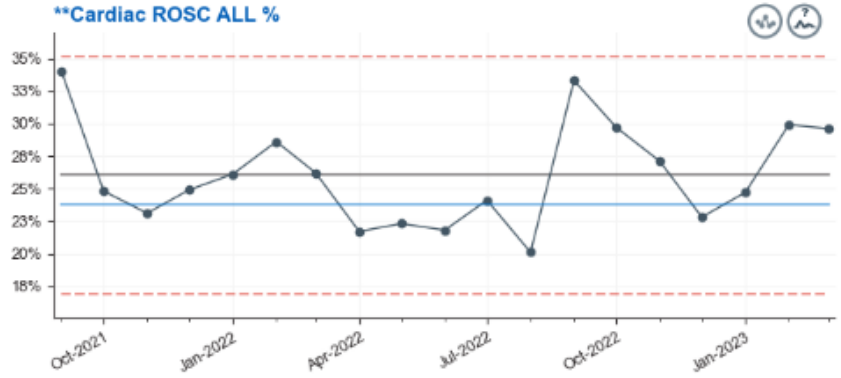
- There are 1.32 incidents of harm per 1000 incidents which is positive. In April, this equates to a 99.86% of all reported incidents being no harm/low harm
- This has remained consistent over the last four months with an average of 1.43 incidents of harm per 1000 across Jan-Apr
- There is a positive reporting culture of incidents across the Trust

What actions are we taking?

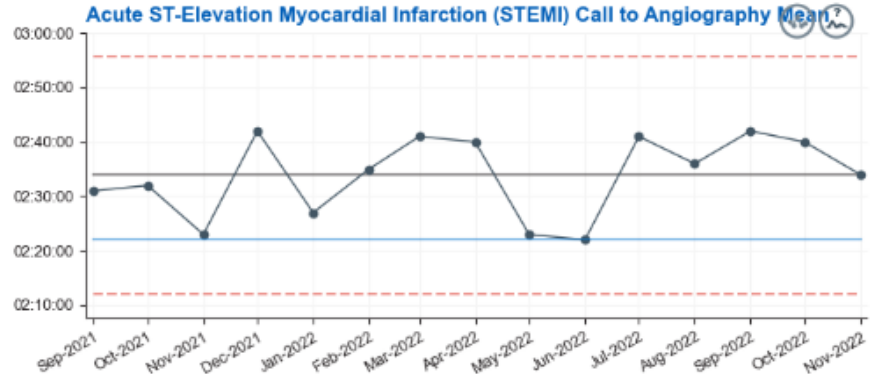
- To continue to support a positive culture of reporting incidents at SECAmb and ensuring feedback to individuals / team and organisational wide learning.
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support continuous improvement.
- A deep dive into the harm recorded for December where the Trust last peaked at 2.27 incident will be compared to the reasons for reporting in 2023

QUALITY IMPROVEMENT

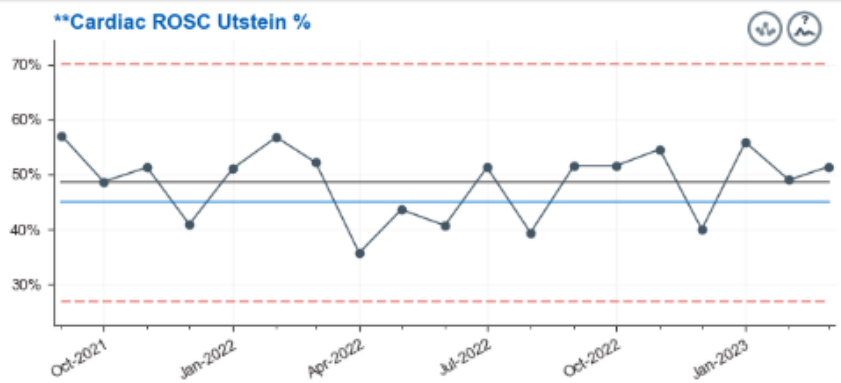
Impact on Patient Care - Cardiac



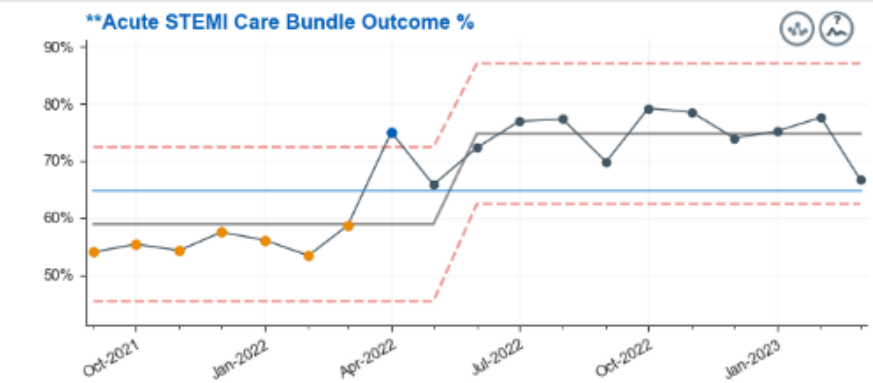
M-2
Dept: Medical
IP: Quality Improvement
Latest: 29.6%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:34:00
Target: 02:22:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-1
Dept: Medical
IP: Quality Improvement
Latest: 51.4%
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: 66.7%
Target: 64.7%
Common cause variation, no significant change. 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 published during Q4 reporting a validated one year sample, which provides greater accuracy. 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 and long journey times and partly due to crew behaviour on scene such as non-registrants waiting on scene for back-up, multiple attempts at ECG transmission or administration of the STEMI care bundle before leaving 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. Little more can be done without direct engagement with individual staff members when there is a long on-scene time without documented explanation.

Acute STEMI care bundle outcome

NASMeD are due to review 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 (1 of 2)

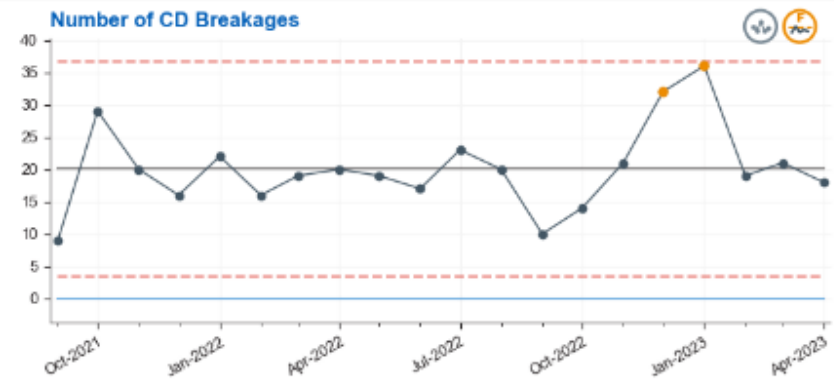
MM-1

Dept: Medicines Management
IP: Quality Improvement
Latest: 158

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

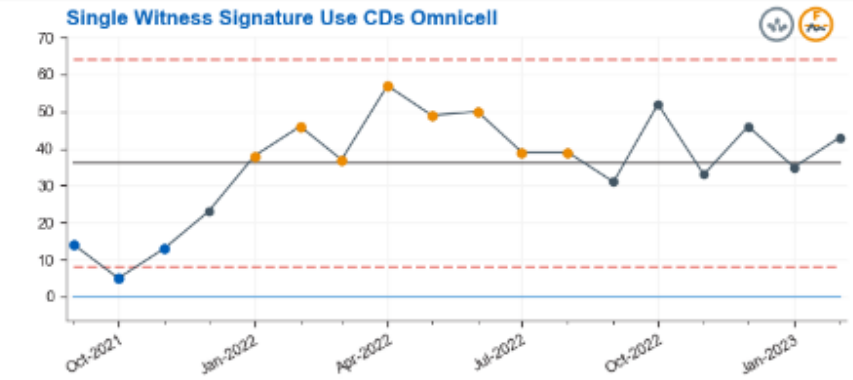
MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 92.3%
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: 18
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: 43
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

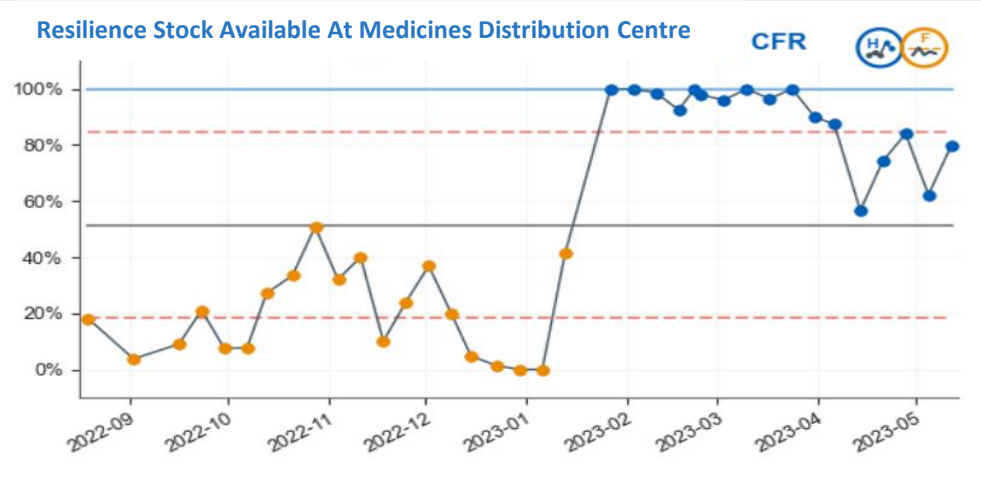
Note: Work is ongoing around reporting medicines incidents. Key skills 2023/24 has medicines in its lesson plan so this will be reported on going forward for assurance and oversight in the Trust.
Non compliance to medicines audits is being picked up through Medicines Governance Group and Senior Operations 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 end June 2023.

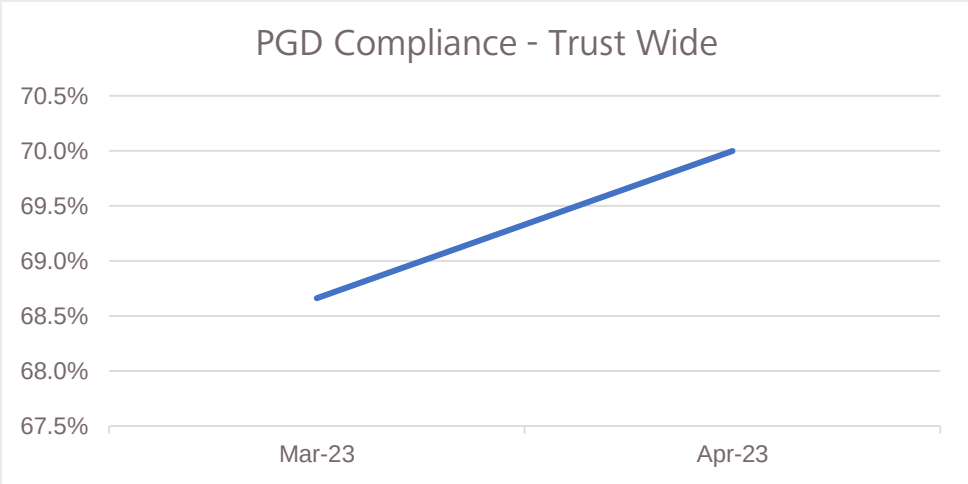
What actions are we taking?

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

Medicines Management (2 of 2)





Summary

The graph on the Trusts medicines resilience stock available at the Medicines Distribution centre (MDC) illustrates a steady rise in our medicines pouches available for medicines orders at the MDC. We need to ensure we maintain this level of stock at the MDC to ensure medicines provision of pouches across Kent, Surrey and Sussex at all times, including peak demand and staff shortages.

Patient Group Direction (PGD) Compliance in line with MD11 has gone from 69% to 70% in only one month and further engagement with ops and specialist teams is now planned.

What actions are we taking?

Resilience stock recorded at MDC weekly. Alternative duty staff mobilised into support building this stock currently.

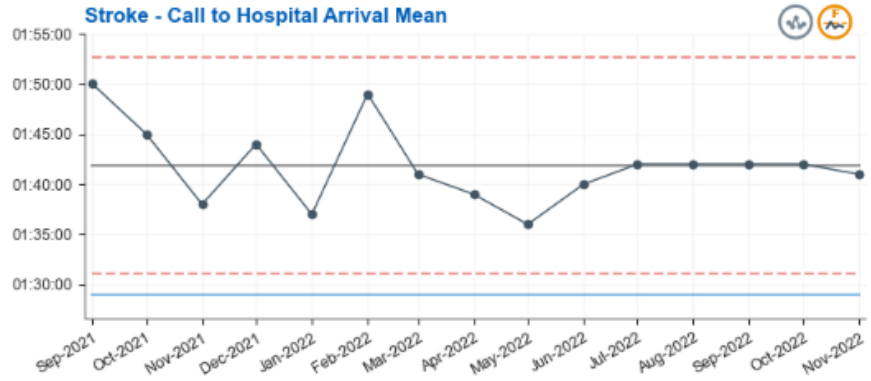
PGD report down to practitioner level being shared with OUMs monthly. Targeting OUs and cohorts of under-compliance, with a target to achieve >95% by end of Q2.

PGD compliance standing agenda item for discussion at PGD working group. Medicines leads across the Trust supporting in increasing compliance.

PGD case study on key skills lesson plan for discussion (directly linked to MD11 CQC must do)

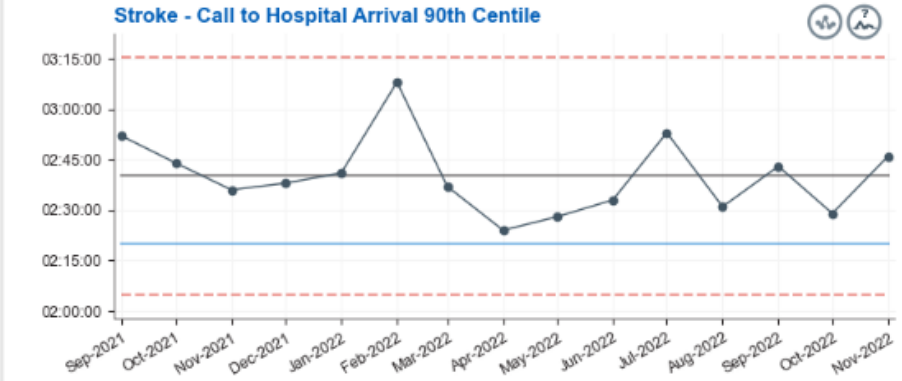
QUALITY IMPROVEMENT

Impact on Patient Care – Stroke



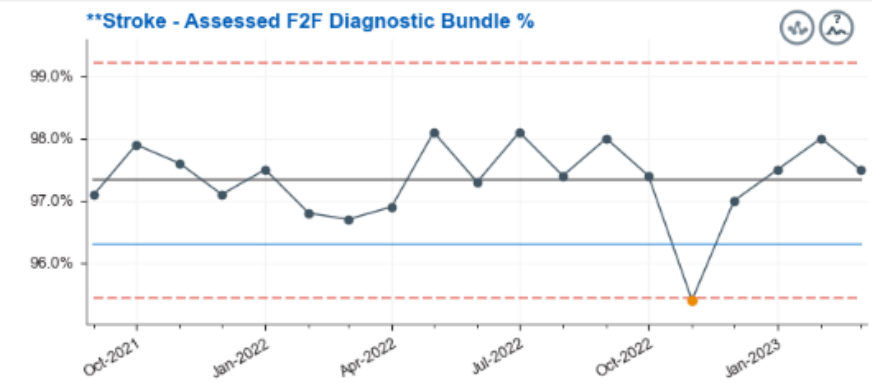
M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:41:00
Target: 01:29:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



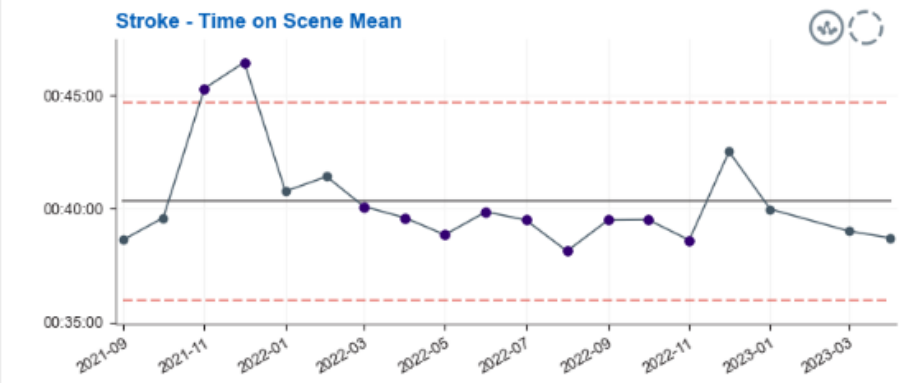
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:46:00
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: 00:38:43

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

Summary

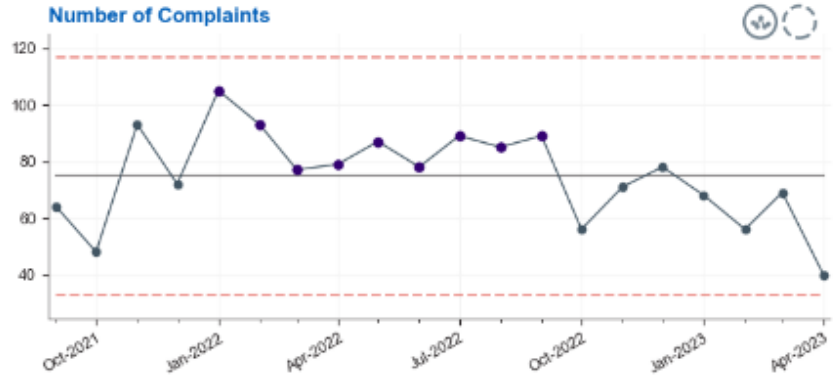
Stroke – Common cause variation continues. We are not meeting the national targets for Stroke patients due to overall delays in arrival at scene, however, once we arrive with the patient, compliance against the Diagnostic Bundle has largely been above target since August 2021. Whilst there's no special 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 study of stroke telemedicine to evaluate if stroke telemedicine extends time on scene. Audit results indicates minimal extra tiime (about 3-5 minutes) for Kent telemedicine centres, with Frimley achieving the second best time on scene for all stroke units in SECAmb in spite of using telemedicine. 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 34. 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, although a QI dashboard which allows individual feedback to staff regarding their time on scene would probably reduce time on scene further.

QUALITY IMPROVEMENT

Patient Experience



QS-5

Dept: Quality & Safety
IP: Quality Improvement
Latest: 40

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

QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 74%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

QS-10

Dept: Quality & Safety
IP: Quality Improvement
Latest: 80%

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

Summary

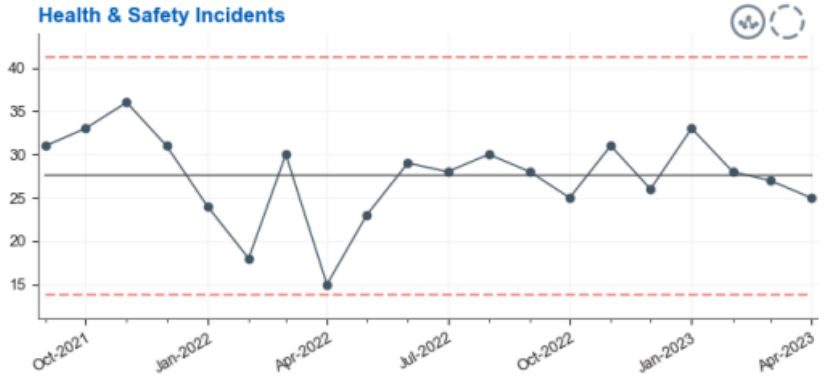
- The number of complaints received within the organisation is within normal variation as is the complaints reporting timeliness and proportion of complaints reporting to crew attitude.
- Crew attitude continues to be a significant theme within complaints. We continue to learn and support individual and team feedback regarding this. Consequently, there are few individuals that receive a complaint more than once in respect of crew attitude. Over the last 6 years, the Trust has received, on average, 4.4 compliments to every 1 complaint.

What actions are we taking?

- The aim is to be responding to 95% complaints within timescales by the end of May 2023, as at 15/05/2023 there have been 36 complaints closed, 31 within timescale, 86%.
- An ongoing QI project is in place to review the complaints and compliments process and to ensure this process is as efficient and effective as possible.

QUALITY IMPROVEMENT

Safety in the Workplace (1 of 3)



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 25

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: 26

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

Health & Safety Incidents

During March 2023 (27) Health and Safety incidents were reported. This represents normal variation.

Manual Handling Incidents

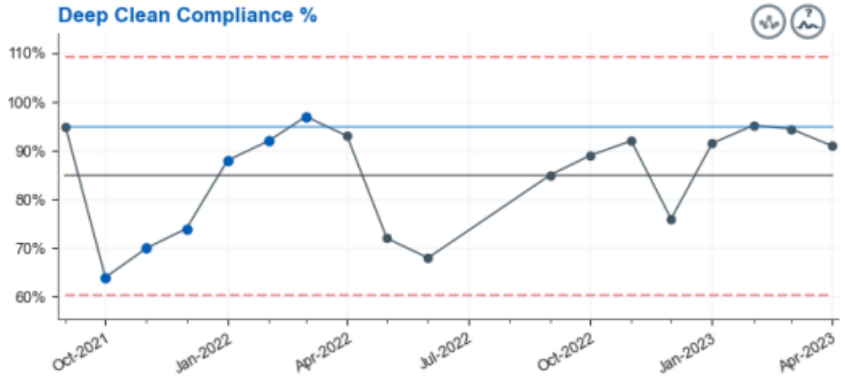
Manual handling incidents reported in March 2023 were 23, again this represents normal variation.

What are we doing

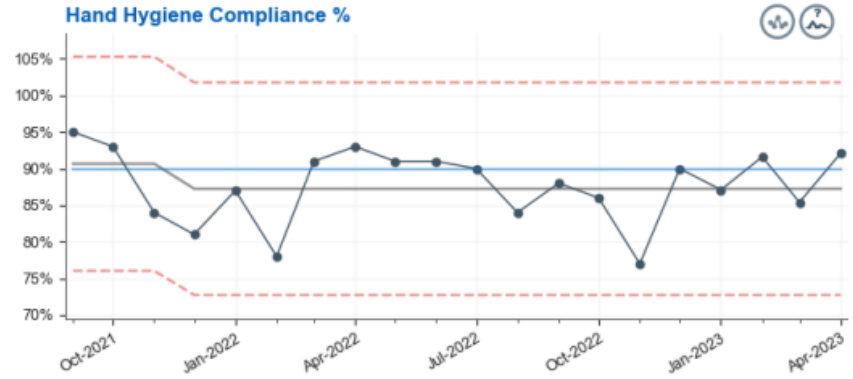
- The regional and Trust Health & Safety group will continue monitoring incident trends. H&S Committee now led by Exec team with H&D Lead to ensure assurance is provided on all regulatory aspects and action plans agreed and acted on.

QUALITY IMPROVEMENT

Safety in the Workplace (2 of 3)



QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 91%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



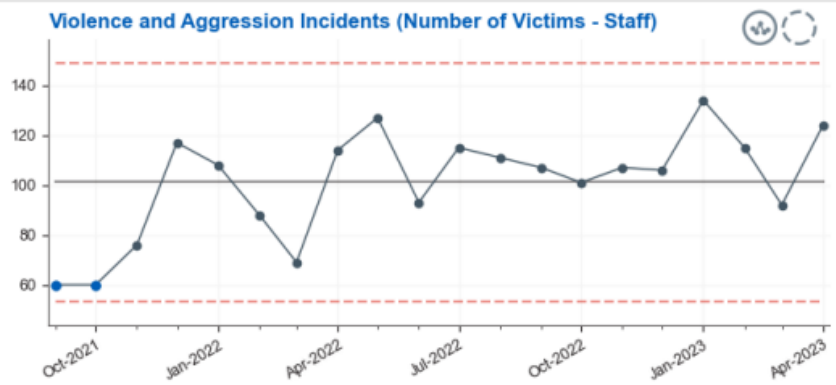
QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 92.1%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Hand Hygiene Compliance – There is no variation so remains within target range

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: 124

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

Violence & Aggression

No significant variation.

Staff reported 92 violence and aggression related incidents in March 2023, sub-categories being:

- 31 verbal abuse
- 27 Anti-Social Behaviour
- 17 assaults

Staff reported 124 violence and aggression related incidents in April 2023, sub-categories being:

- 53 verbal abuse
- 32 Anti-Social Behaviour
- 18 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 partnership meetings 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.
- Violence Prevention and Reduction Strategy complete and ready for presentation to Board for ratification. Review of policies relating to violence reduction complete. Currently for consultation & review with a preliminary Equality Impact Assessment completed..

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
- Increased sharing of BWC and CCTV Data with police partners to increase sanctions.
- 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, particularly in call handling centres.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

April 2023

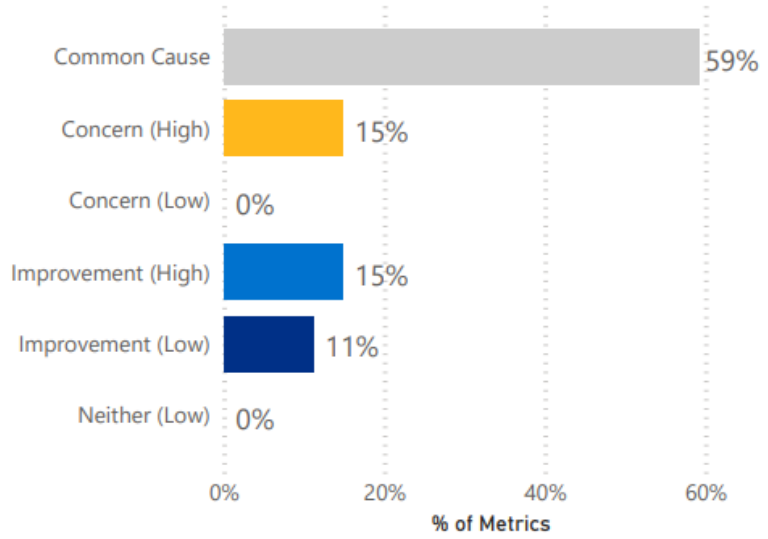
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Bullying & Harrassment Internal Disciplinary Cases	Number of Staff WTE (Excl bank and agency) Sickness Absence % Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Current licence details held for Operational Staff %	
Common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

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.

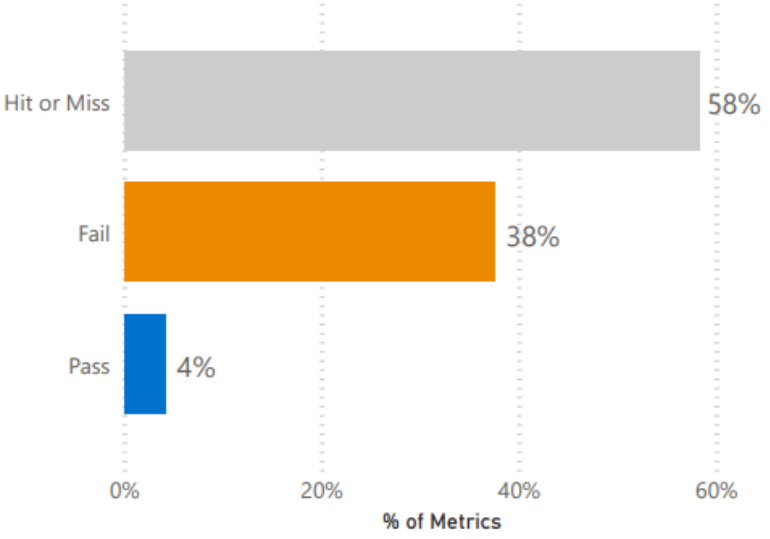
PEOPLE & CULTURE

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	Apr-2023	4075.78	4260	3900.57	3973.37	4046.17		
Vacancy Rate %	People & Culture	Apr-2023	12.5%	5%	1.12%	4.83%	8.54%		
Turnover Rate %	People & Culture	Apr-2023	1.7%	0.8%	0.81%	1.47%	2.12%		
Annual Rolling Turnover Rate	People & Culture	Apr-2023	18.2%	10%	16.76%	17.68%	18.6%		
Sickness Absence %	People & Culture	Apr-2023	6.8%	5%	7.35%	9.38%	11.41%		
DBS Compliance %	People & Culture	Apr-2023	100%	90%	100%	100%	100%		
Current licence details held for Operational Staff %	People & Culture	Apr-2023	97.4%	100%	88.98%	94.07%	99.17%		
Time to Hire Volume (Days)	People & Culture	Mar-2023	125.96	60		105.69			
Time to Hire Ad-Hoc (Days)	People & Culture	Mar-2023	94.87	60		62.99			

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Apr-2023	77%	85%	60.49%	71.29%	82.08%		
Appraisals Rolling Year %	People & Culture	Apr-2023	62.1%	85%	35.91%	43.05%	50.19%		

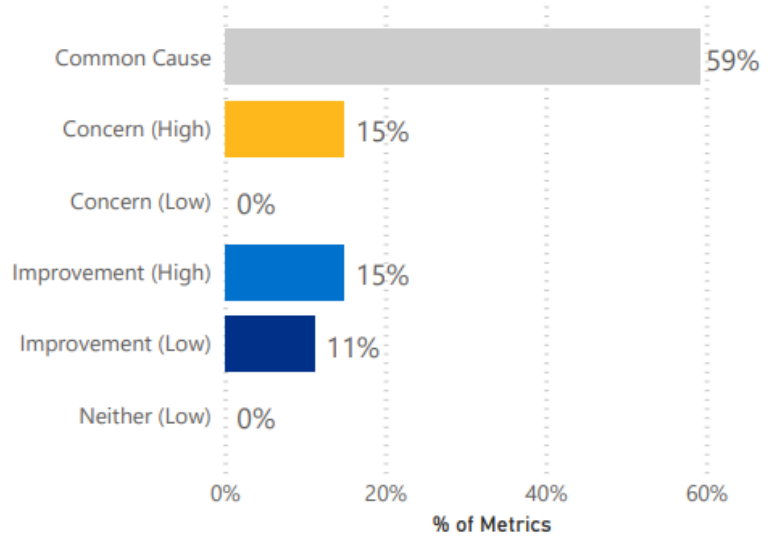
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Apr-2023	45.8%	45%	45.45%	51.01%	56.57%		
Average Late Finish/Over-Run Time	People & Culture	Apr-2023	00:37:00		00:35:32	00:40:41	00:45:49		
% of Meal Breaks Taken	People & Culture	Apr-2023	98.8%	98%	96.2%	97.96%	99.72%		
% of Meal Breaks Outside of Window	People & Culture	Apr-2023	49.8%		29.25%	56.55%	83.85%		

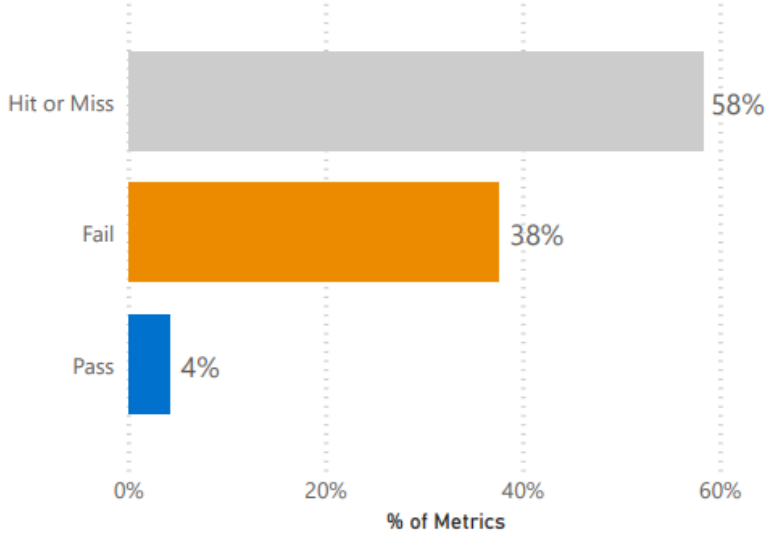
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

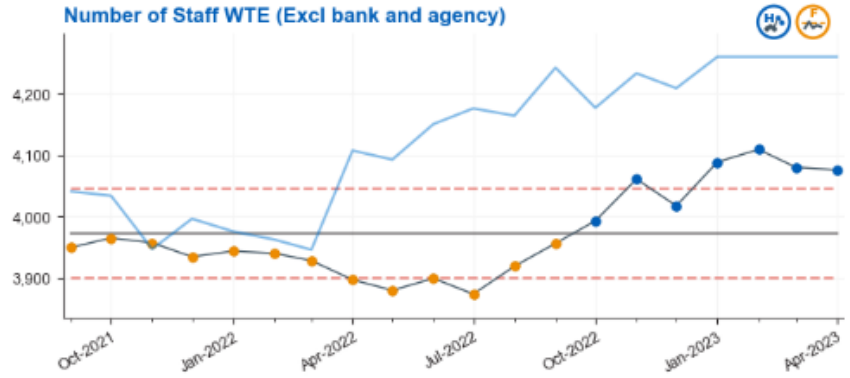
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Apr-2023	7	5	-1.94	10.8	23.54		
Collective Grievances Open	People & Culture	Apr-2023	0	1	-1.63	1.45	4.53		
Count of Grievances Closed	People & Culture	Apr-2023	13	3	-3.09	11.05	25.19		
Grievances Mean Case Length (Days)	People & Culture	Apr-2023	150.43	93	13.42	81.25	149.08		
Bullying & Harrassment Internal	People & Culture	Apr-2023	0	2	-4	2.3	8.6		
Disciplinary Cases	People & Culture	Apr-2023	0	3	-1.47	3.85	9.17		
Freedom to Speak Up: Total Open Cases	People & Culture	Apr-2023	20			16.43			
Freedom to Speak up: Cases Opened in Month	People & Culture	Apr-2023	7	3	-2.67	8.95	20.57		
Freedom to Speak up: Cases Closed in Month	People & Culture	Apr-2023	7		-7.84	7.7	23.24		
Policies & Procedures Outstanding Review %	People & Culture	Feb-2023	73.1%	0%		48.47%			
Count of Until it Stops Cases	People & Culture	Apr-2023	0	3	-4.39	3.74	11.86		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Apr-2023	106	86	21.21	96.94	172.68		

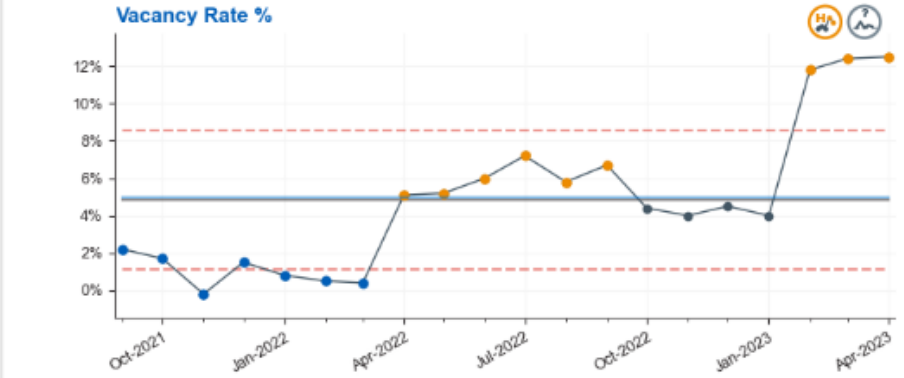
PEOPLE & CULTURE

Workforce (1 of 3)



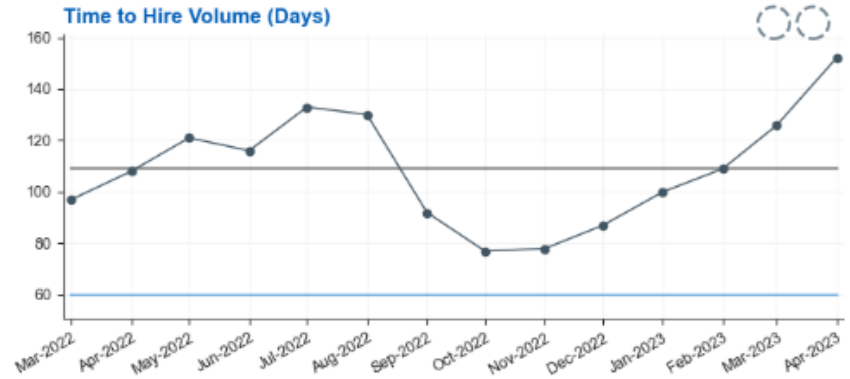
WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 4075.78
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.



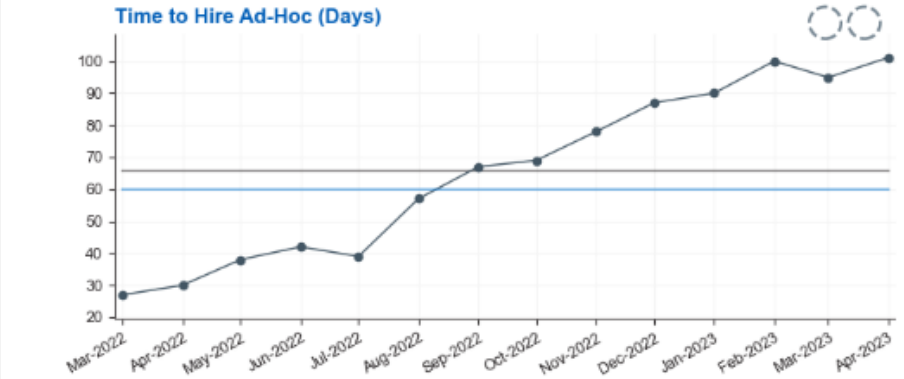
WF-4

Dept: Workforce HR
IP: People & Culture
Latest: 12.5%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



WF-43

Dept: Workforce HR
IP: People & Culture
Latest: 152.2
Target: 60
Special cause or common cause cannot be given as there are an insufficient number of points.



WF-51

Dept: Workforce HR
IP: People & Culture
Latest: 101.11
Target: 60
Special cause or common cause cannot be given as there are an insufficient number of points.

- 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. This has been mitigated and now cohort recruitment for EMAs and frontline staff are reported separately to ad-hoc recruitment.
- 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.
- Still using the March 2023 Budget which provides an incorrect vacancy rates picture. This will be resolved in the next IQR

What actions are we taking?

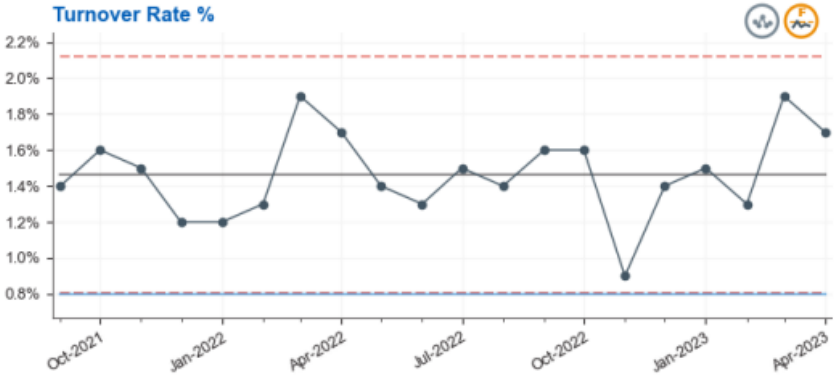
The Recruitment and Onboarding project commenced on 23/05/2023 and aims to streamline our onboarding process using the DMAIC methodology. The project will focus on time to hire, readiness of new hires and drop-off rates.
The project will cater to four main cohorts: permanent cohort, ad-hoc, international and bank. Initial focus is on where the biggest positive impact can be made, and this is in EOC/111.

Data is being extracted on the end-to-end recruitment process from initial identification of a vacancy to when the individual is sat ready to work. This will allow the team to both prove the concept of approach to the project and allow analysis of the data to see where the blockages may be and subsequently provide solutions to reduce the overall time to recruit.

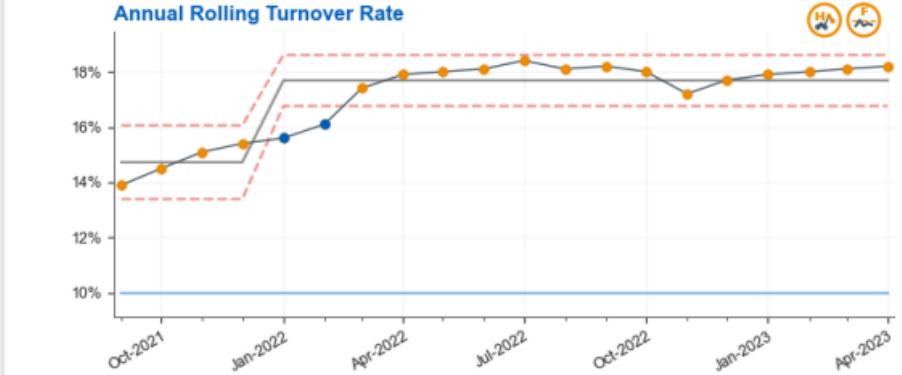
The project has been set with a 3-6 month delivery time so will work at pace to complete.

PEOPLE & CULTURE

Workforce (2 of 3)



WF-48
Dept: Workforce HR
IP: People & Culture
Latest: 1.7%
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: 18.2%
Target: 10%
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

Summary: These are the areas we are concerned about.

Our Trust Turnover continues to be affected by Burn Out/Exhaustion/Excessive Workload, High Sickness Absence/Health and Wellbeing/Mental Health. All of which impact on retention and sickness absence (although the latter currently is showing an improving YoY trend.

Failing probation in EOC/111 is tracking at 25%.

Narrowing our Exit Interview Data Parameters to 2023 reveals:
- Better Work Life Balance as the number one challenge

What actions are we taking?

We are reviewing the Retention initiatives from the 2022/24 plan to ensure that they are on track. We will provide an assurance paper to the People Committee in June 2023. We continue to drive 121/Appraisal completion as this is key to colleague engagement. motivation, and development. This is part of the Year 1 actions in the People and Culture Strategy – building foundations consistently.

We may see some stabilisation in turnover from the lower pay bands from July 2023 now that the pay deal and non-consolidated (backdated) element has been agreed (except for Unite), bringing an end to a majority of the industrial action. SECAmb will make payment in June (24th) in line with other National Ambulance Trusts.

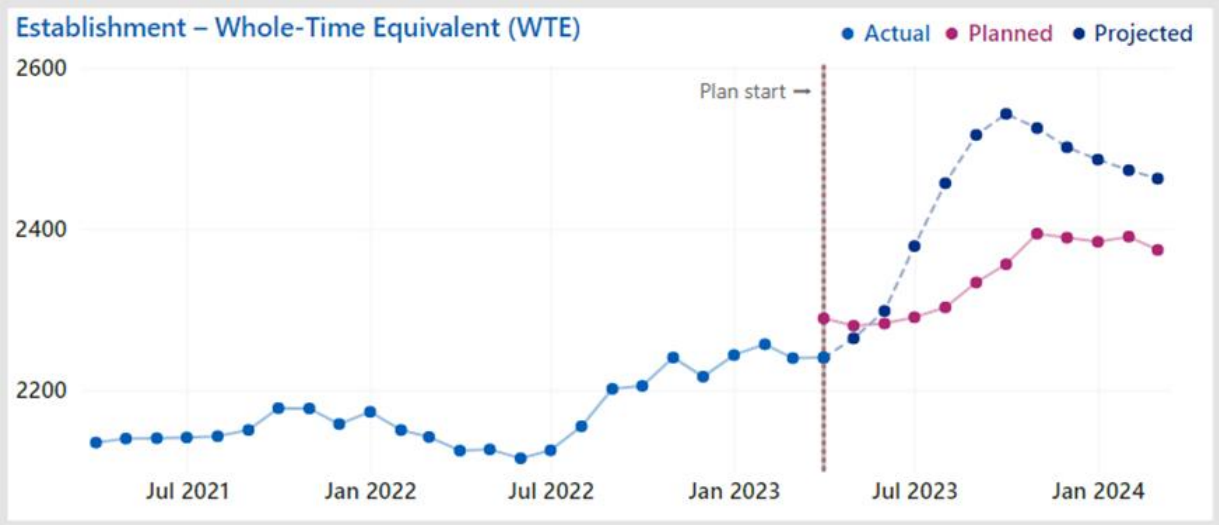
EOC Retention (Culture Change) Moorhouse Report – This programme of work looks to address the 50% turnover in EOC and 111, which is almost double that of other Trusts. 25% of the total turnover related to failure of probation.
Nine quick wins, identified as part of the Culture Change work, have been achieved to date, although these will not be reflected in retention data currently.

The 12-week sprint to deliver the six priorities areas of recruitment & onboarding, EVP, development pathways, succession planning, grievances, and 121's & Management discussions is on track for mid July 2023 completion.

PEOPLE & CULTURE

Workforce (3 of 3)

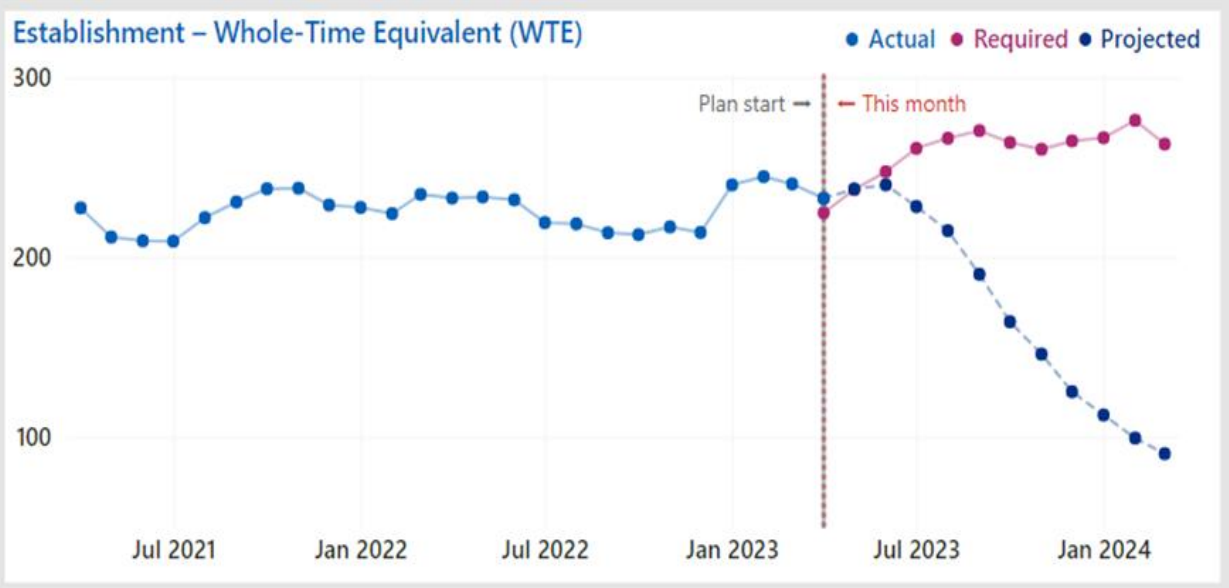
(999 Frontline)



Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
The Trust has started the new financial year 49FTE behind the workforce plan.
NQP recruitment has started in a strong position for 23/24 with more confirmed than the plan. This is likely to reduce as there will be a drop in actuals as many candidates apply to various Trusts and the inflated offers over plan will help mitigate this.

Mitigating actions – 999 Frontline
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
EMA establishment has started over the planned 224.80 with an additional 8.0 WTE in post. This will help to mitigate some of the gap further in the plan as attrition continues at a high rate.
The Trust continues to focus on recruitment and training to bridge this gap.

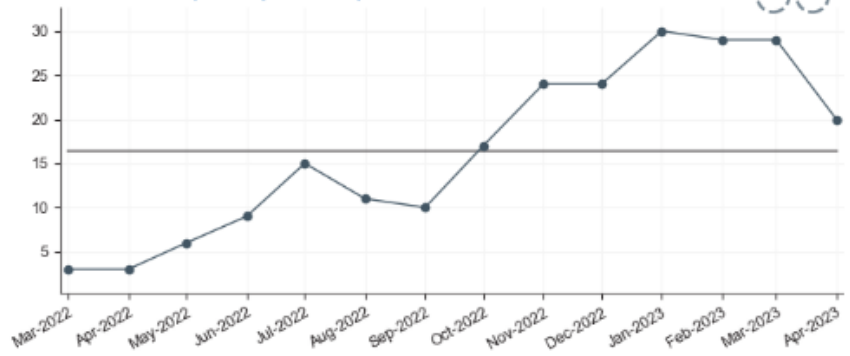
Mitigating actions – EOC EMA
Attrition is planned at 72.3% across 23/24. The attrition plan has been calculated based on a 2-year average, and an additional 30% attrition from the East EOC that has been phased from Sept 23 to March 24 with the move from Coxheath to Medway is currently planned.
This plan 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 headcount that will need to be recruited and trained across the year.

PEOPLE & CULTURE

Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

Freedom to Speak Up: Total Open Cases

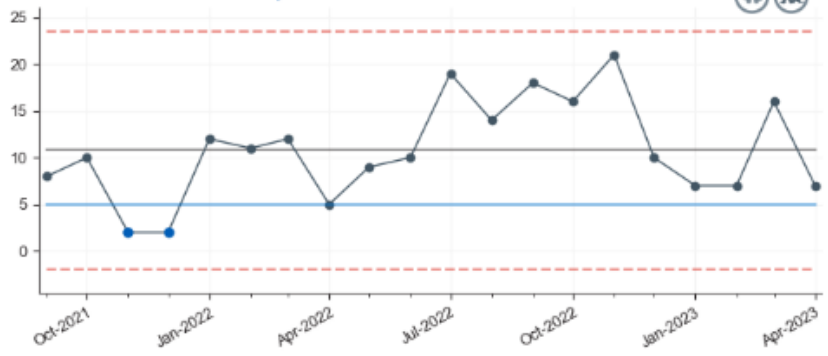


QS-27

Dept: Quality & Safety
IP: People & Culture
Latest: 20

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.

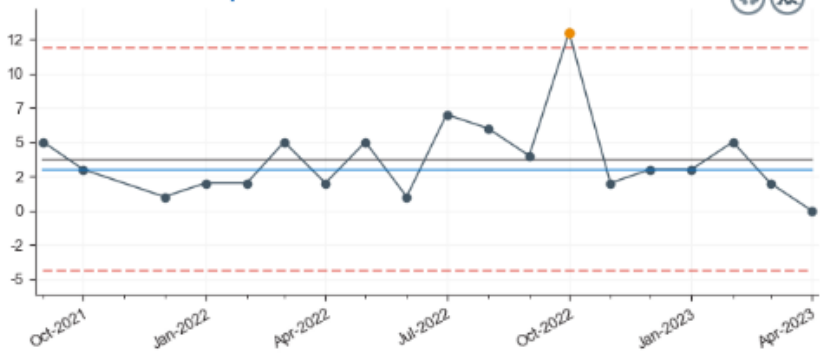
Individual Grievances Open



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.

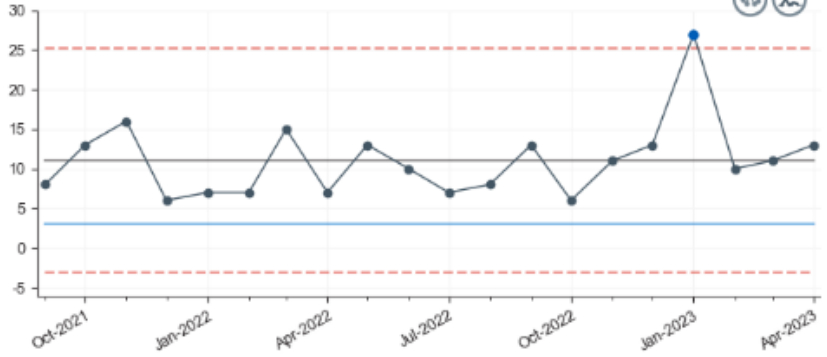
Count of Until it Stops Cases



WF-41

Dept: Workforce HR
IP: People & Culture
Latest: 0
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

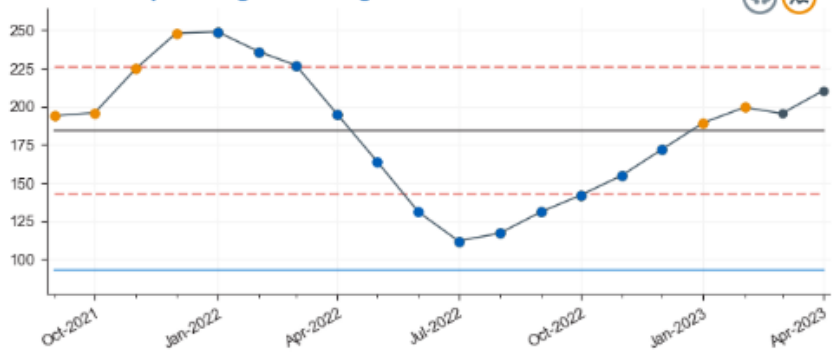
Count of Grievances Closed



WF-42

Dept: Workforce HR
IP: People & Culture
Latest: 13
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Until it Stops Average Case Length



WF-50

Dept: Workforce HR
IP: People & Culture
Latest: 210.4
Target: 93
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Grievances Mean Case Length (Days)

WF-44

Dept: Workforce HR
IP: People & Culture
Latest: 150.43
Target: 93
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

PEOPLE & CULTURE

Culture (2 of 2)

Summary

Until is Stops Workstream

Following an evaluation of the Sexual Safety Workshops delivered in 2022, the following recommendations were made:

1. Managers ensure that they are having open conversations about bullying and harassment in their team meetings, creating a safe environment for team members to raise their concerns and reassure them that they will be treated seriously.
2. Training is provided for every member of staff on bullying and harassment. Additional learning should be scoped and resourced to achieve the Equality & Human Rights Commission recommendation of providing every member of staff with training in sexual harassment.
3. Resources are provided to develop an impactful communication and engagement campaign underpinned by the Trust's values outlining the acceptable and unacceptable behaviours.

Until it stops Grievances:- The Trust has carried out 14 formal hearings concerning sexual harassment cases leading on from grievances raised between April 22- March 23. 24 cases remain open and are being managed and reviewed on a weekly basis by Managers and the HR Team. The volume of the most serious cases is decreasing. This has been confirmed by the number of live suspensions we have compared to this time last year. We are also starting to see the level of complaints stabilise. However, we will continually drive to change the culture of the Trust to see these complaints decrease. We do recognise that the average time to resolve these cases have increased, this has highlighted that investigations have been delayed. This has also identified structural gaps within the HRBP Team due to capacity, management development (skills) gaps and lack of time our managers have to complete the investigations alongside their day job of managing the Operating Units.

Individual Grievances /Count of Grievances– We did see an increase in March however in April we continued to see a reduction in the number of opened grievances in month, with increased emphasis on early and informal resolution supported by the HR team with managers.

What actions are we taking?

Until it Stops workstream & Culture - Going forward values and behaviour including sexual harassment will be covered in the new Trust Induction. Initially, as part of the Operations Directorate Onboarding project, the new programme will be implemented from June 2023 ensuring that all new colleagues know what they can expect from SECAmb and the expectations of them in regard to living the Trust's values.

During 2022, training has focussed on the manager community. Training via eLearning for all colleagues is to be developed. *Culture & Values development w*ill be rolled out for all Trust colleagues. This will include an element addressing harassment and bullying including sexual harassment, listening and respectful resolution.

'We're Listening – Visits Framework – A new process to improve listening and the visibility of the Leadership Team in response to feedback through the NHS Staff Survey and CQC report has been agreed based on the concept of a Gemba Walk. The framework will provide a vehicle for the Trust to improve knowledge, decision-making and improvement opportunities.

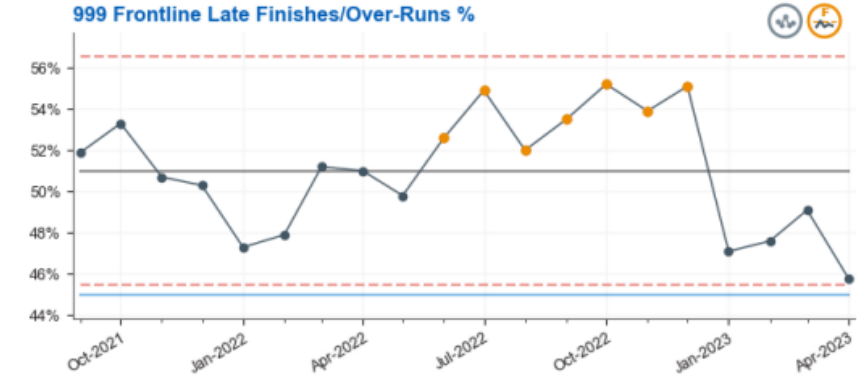
Until it stops Grievances:- The Trust will continue to prioritise train our colleagues and managers on expected behaviours and engage with colleagues who experience these poor behaviours in a supportive manner, ensuring our Managers use the HR policies to ensure a fair investigation and hearing takes place. The HR Senior Team have designed a new ER Structure to support the level and complexity of these cases. EMB have approved the change in principle and this is now the subject of an Improvement Case. Subject to rapid approval of the investment, this new specialist ER team will be in place within the next 16 weeks.

Individual Grievances/ Count of Grievances – A training course on managing concerns is under design and will be rolled out mid-June 2023 to train and support our managers on how individual cases can be managed informally.

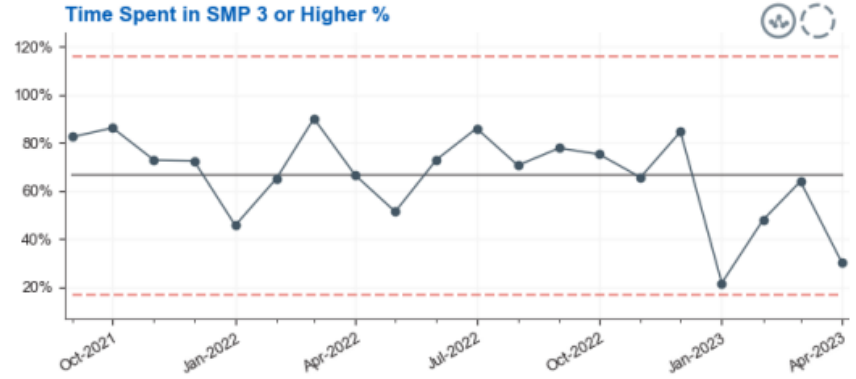
We will continue to emphasise early informal resolution over formal routes; the introduction to the new ER structure will also support training to support the average time to conclude a grievance.

PEOPLE & CULTURE

Employee Experience

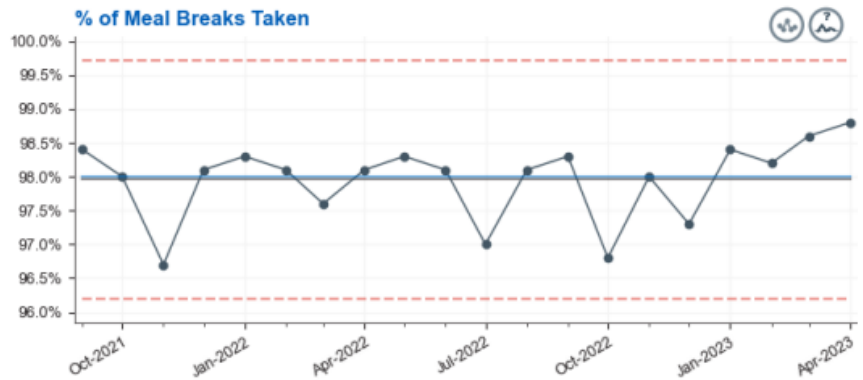


999-15
Dept: Operations 999
IP: People & Culture
Latest: 45.8%
Target: 45%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-14
Dept: Operations 999
IP: Quality Improvement
Latest: 30.2%

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



999-27
Dept: Operations 999
IP: People & Culture
Latest: 98.8%
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

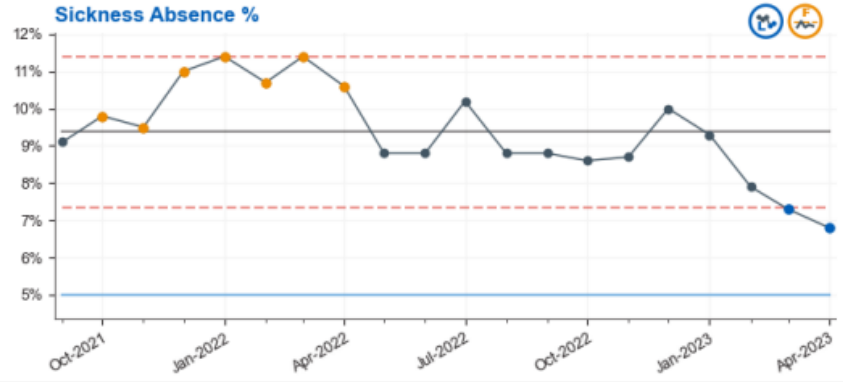
- Late finishes/over-runs for H1 to achieve a sustained Trust-level 45% and during this time, using the performance & quality framework, to develop improvement trajectories for % of over-runs and duration of over-run on an individual dispatch desk basis. This approach follows the paper presented to WWC 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?

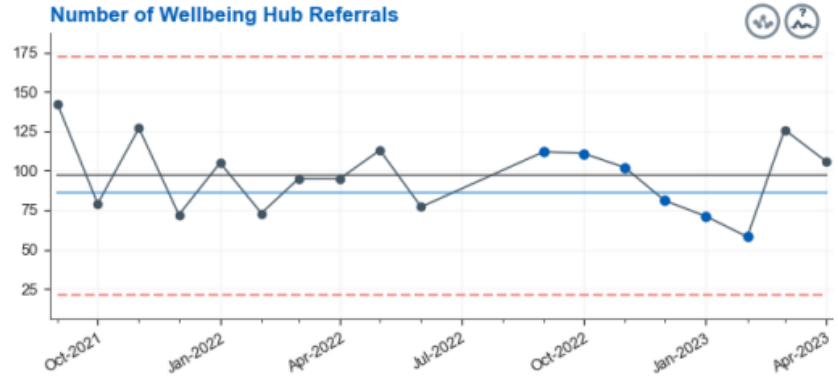
- The development of the IQR through an Operations performance and quality management framework has advanced, with the intention to drill down data to dispatch desk. A monthly cycle of review and challenge is being incorporated with involvement from all directorates.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 6.8%
Target: 5%
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



WF-25
Dept: Workforce Wellbeing
IP: People & Culture
Latest: 106
Target: 86
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

The Trust provides a daily sickness absence report to NACC, which collates all returns and submits to NHSE regional and central teams but is not shared back to Trusts. However, data for January 16th was shared informally and this showed that out of the 8 Ambulance Trusts, NEAS was the highest at 10.10% , compared to WMAS the lowest at 3.71%. SECAmb was 9.42%, sitting at the higher quartile.

Since January, seven Operating Units have been targeted to reduce their absence resulting in the downward trend above. Six out of the seven OU's have all seen a reduction in their absence figures. EOC demonstrating the largest improvement of 1.42%.

Year on year sickness has reduced from 9.42% in January 2022 to 6.8% in April 2023.

What actions are we taking?

The Trust will continue with our targeted actions plans, are by the end of June, a reviewed action plan will address any other outliers to address the overall Trust absence %. Senior Ops and HRBP's review each OU on a monthly basis. In addition, the policy that was due to be refreshed in April, will be prioritised over the coming 8 weeks.

The first module of the made@secamb leadership and management development framework's Management Essentials (technical series) workshops **Managing Attendance and Absence** was piloted on the 24 May 2023. The workshop was attended by 8 colleagues including 6 first line managers, from EOC, field operations and corporate directorates. The workshop was well received by participants. Early feedback indicates that some changes are required to the content, presentation and length of the workshop to improve learner engagement, interaction and opportunity for discussion.

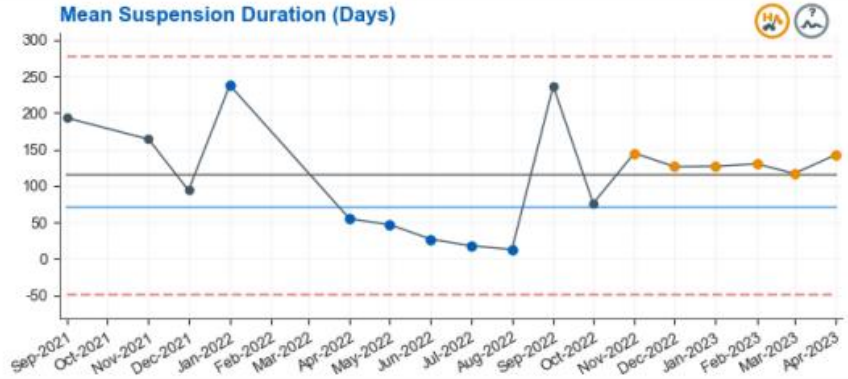
With the additional funding from NHS Charities that we mentioned in April, we have now successfully recruited the two FTC mental health wellbeing practitioners for EOC/111 and Medway. Both will start in the next couple of weeks.

Referral numbers relate to wellbeing hub and physiotherapy but exclude TRiM, alternative duties, and other wellbeing interactions. We are working to get these figure combined for a more accurate picture and to allow for more detailed reporting of actions.

PEOPLE & CULTURE

Employee Suspensions

WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 6
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: 142.36
Target: 70
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

WF-45
Dept: Workforce HR
IP: People & Culture
Latest: 0
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 case has been opened, four cases have been booked for formal hearings. The mean duration of suspensions remains high at 142 days but reflects some of our mos. Three of the seven suspension cases were impacted by Industrial Action in terms of management and union representation capacity to meet; these cases are expected to be resolved by July and should reduce the mean duration to c. 65 days.

Our two highest reasons for suspension remain bullying and harassment and sexual misconduct.

What actions are we taking?

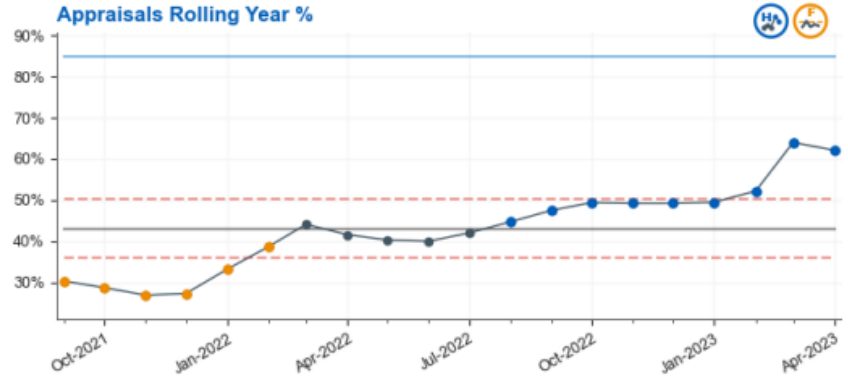
Suspensions: cases continue to be reviewed on a weekly basis by the HRBP Team with the Executive Directors of HR & OD and Operations.

Two of these cases are being managed along with Safeguarding.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 77%
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: 62.1%
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

Fundamentals First Line Managers Programme

Investment in our managers continues through the Fundamentals Programme for first line managers. Cohort 11 of the programme was held 9 to 11 May 2023. Each cohort has capacity for a maximum of 20 participants, 11 were booked to attend, 2 did not attend and 2 withdrew before the start of the programme. To date participants have attended a programme overall.

Statutory & Mandatory Training

The emphasis on improving compliance to achieve the Statutory and Mandatory training target continues. The overall compliance rate for April 2023 was 86.87%.

Appraisals

The Appraisal Task & Finish Group has met twice. The objectives for the group are:

- To identify short term solutions to ensure all completed appraisals are recorded.
- To identify long term solutions to deliver an appraisal system that is fit for purpose.
- To lead the evaluation of the implementation of ESR Appraisal, deliver lessons learnt and make recommendations for improvement such as technical/digital solutions and additional functions to improve recording of completed appraisals.
- Review and consider other options for recording appraisals and monitoring completions.
- Review the Appraisal Policy and make recommendations as required to the HR Working Group

What actions are we taking?

Statutory & Mandatory Training

Compliance will continue to be monitored, issues will be escalated to the Education, Training and Development Group.

Appraisals

Short term actions to be taken:

- The T&F Group has identified that Proxy Access to ESR Appraisal can be provided to a selection of colleagues to ensure all completed appraisals are recorded. This will be provided to identified colleagues by end May 2023
- Proposed actions from the T&F group are to be submitted to the Education, Training and Development Group by end June 2023.
- The Interim Deputy Director of HR&OD is planning a bimonthly HR drop in teams call for people managers to provide information about current topics and relevant updates that impact people management.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

April 2023

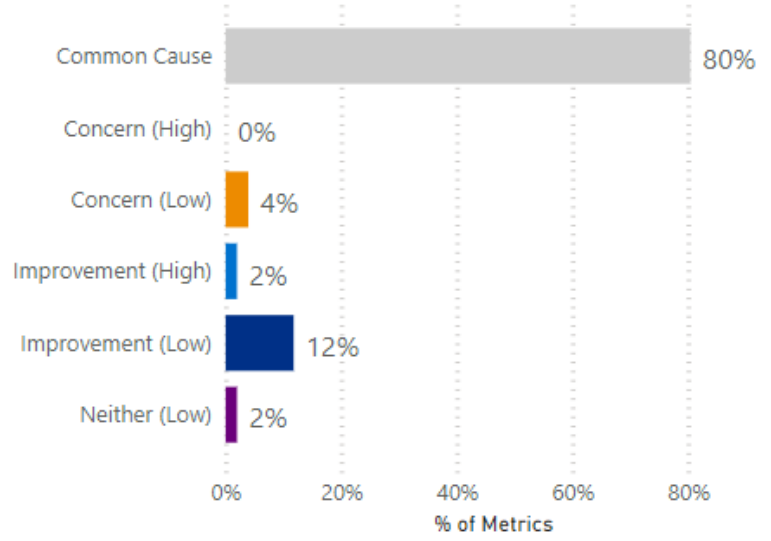
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %	Clinical Contact %		JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as a Proportion of Provided Hours... Number of Hours Lost at Hospital Handover Duplicate Calls % 999 Referrals
Common Cause	Cat 1T 90th Centile Cat 1T Mean Ambulance Validation %	111 Calls Abandoned - (Offered) % A&E Dispositions % Cat 2 Mean 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	JCT Allocation to Clear at Scene Mean ECAL Mean Response Time Vehicles Off Road (VOR) % Critical Vehicle Failure Rate (CVFR) % of planned vehicle services completed Incidents Cat 2 Proportion (Cat 1-4) 999 Calls Answered Incidents
Special Cause Concern				FFR Attendances CFR 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.

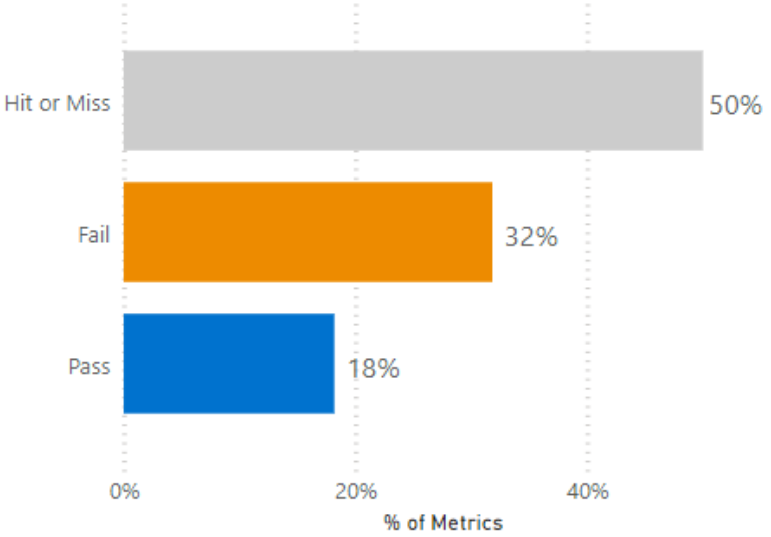
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

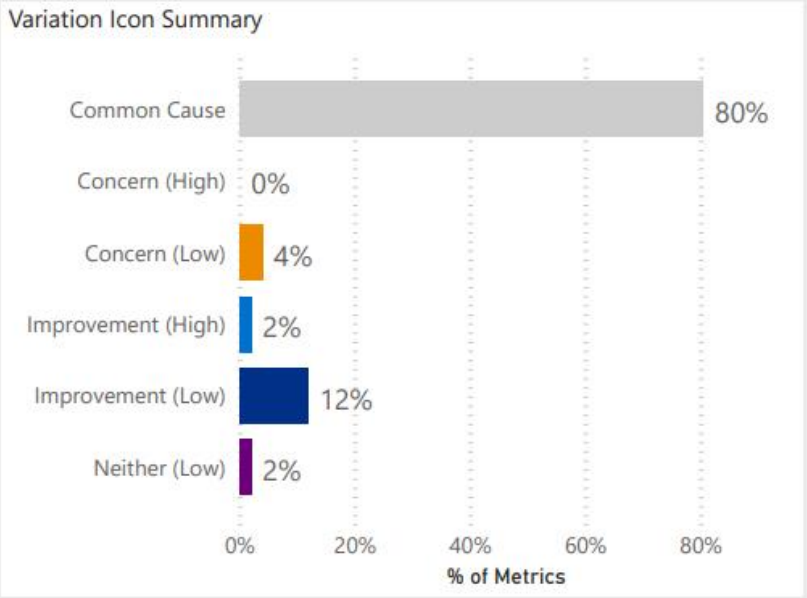
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Apr-2023	01:58:54			00:41:24			
Section 136 Mean Response Time	Responsive Care	Apr-2023	00:21:38		00:12:40	00:26:59	00:41:19		
Cat 1 Mean	Responsive Care	Apr-2023	00:08:22	00:07:00	00:07:41	00:09:08	00:10:35		
Cat 1 90th Centile	Responsive Care	Apr-2023	00:15:16	00:15:00	00:14:30	00:16:32	00:18:33		
Cat 1T Mean	Responsive Care	Apr-2023	00:09:54	00:19:00	00:09:18	00:11:01	00:12:43		
Cat 1T 90th Centile	Responsive Care	Apr-2023	00:18:33	00:30:00	00:17:24	00:20:11	00:22:58		
Cat 2 Mean	Responsive Care	Apr-2023	00:24:42	00:30:00	00:17:58	00:33:45	00:49:31		
Cat 2 90th Centile	Responsive Care	Apr-2023	00:50:18	00:40:00	00:33:54	01:09:11	01:44:27		
Cat 3 90th Centile	Responsive Care	Apr-2023	03:56:43	02:00:00	01:26:55	06:19:24	11:11:54		
Cat 4 90th Centile	Responsive Care	Apr-2023	04:41:20	03:00:00	02:36:08	08:16:59	13:57:51		
HCP 3 Mean	Responsive Care	Apr-2023	01:41:01		01:00:43	02:59:31	04:58:19		
HCP 3 90th Centile	Responsive Care	Apr-2023	03:44:07		00:56:56	06:57:15	12:57:34		
HCP 4 Mean	Responsive Care	Apr-2023	02:12:43		01:23:35	03:47:35	06:11:35		
HCP 4 90th Centile	Responsive Care	Apr-2023	05:20:45		02:27:23	08:51:54	15:16:24		

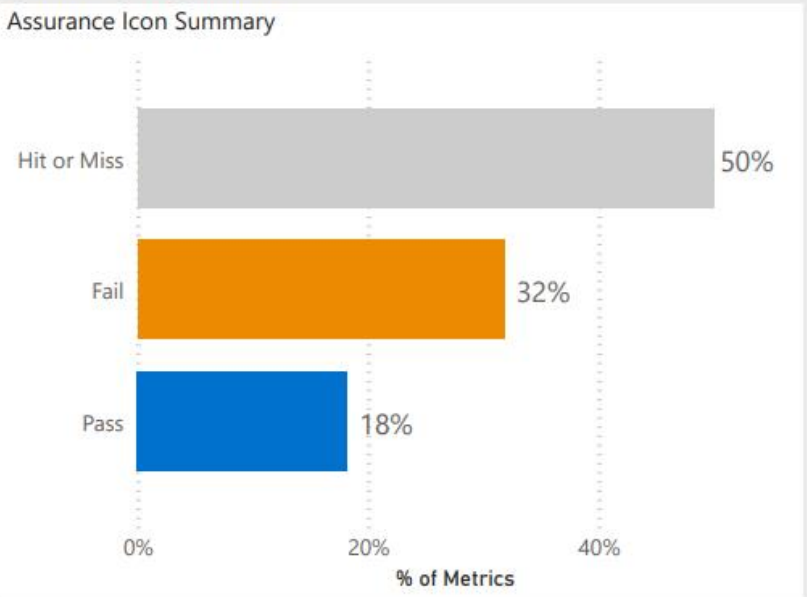
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Apr-2023	21.7%		19.74%	24.78%	29.82%		
999 Calls Answered	Responsive Care	Apr-2023	62305		50169.61	74407.25	98644.89		
999 Call Answer Mean	Responsive Care	Apr-2023	00:00:12	00:00:05	00:00:31	00:00:37	00:01:44		
999 Call Answer 90th Centile	Responsive Care	Apr-2023	00:00:33	00:00:10	00:01:01	00:01:56	00:04:53		

RESPONSIVE CARE

Overview (2 of 3)





Utilisation

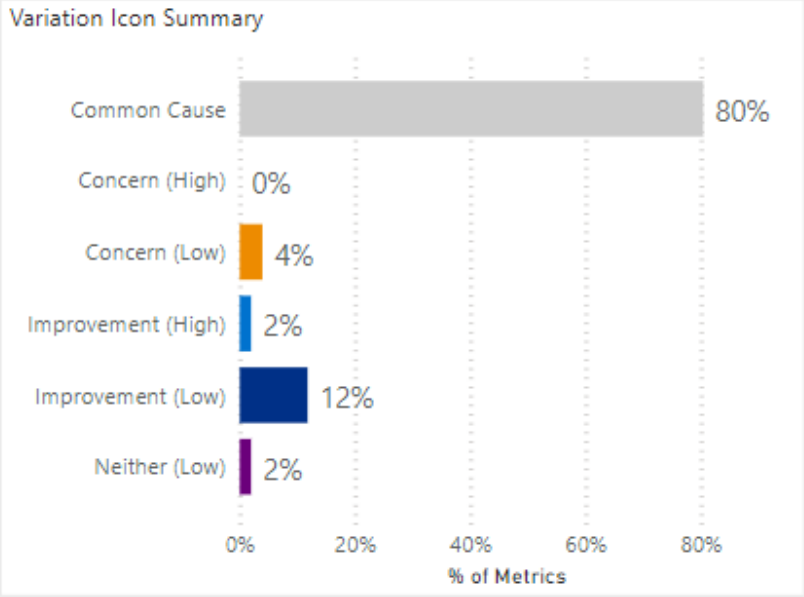
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Apr-2023	92.2%	100%	83.1%	90.3%	97.49%		
Provided Bank Hours %	Responsive Care	Dec-2022	0.7%		0.36%	0.7%	1.04%		
Provided Overtime Hours %	Responsive Care	Dec-2022	7.7%		7.48%	10.58%	13.68%		
Provided PAP Hours %	Responsive Care	Dec-2022	5.9%		4.9%	5.84%	6.78%		
999 Operational Abstraction Rate %	Responsive Care	Dec-2022	34.5%	28%		34.98%			
999 Remaining Annual Leave FY	Responsive Care	Dec-2022	17.4%			36.43%			
Vehicles Off Road (VOR) %	Responsive Care	Apr-2023	11%		8.69%	11.9%	15.11%		
% of DCA vehicles off road (VOR)	Responsive Care	Apr-2023	12%		10.39%	12.77%	15.15%		
% of SRV vehicles off road (VOR)	Responsive Care	Apr-2023	4.6%		-7.56%	8.24%	24.05%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Apr-2023	148		81.1	183.3	285.5		
Number of RTCs per 10k miles travelled	Responsive Care	Apr-2023	0.66		0.23	0.69	1.14		
% of planned vehicle services completed	Responsive Care	Apr-2023	68%		55.92%	75.25%	94.58%		
% 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	Apr-2023	62.3%		58.22%	62.97%	67.72%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Apr-2023	6%	13%	6.12%	7.48%	8.84%		
Incidents	Responsive Care	Apr-2023	58005		52283.44	60330.5	68377.56		

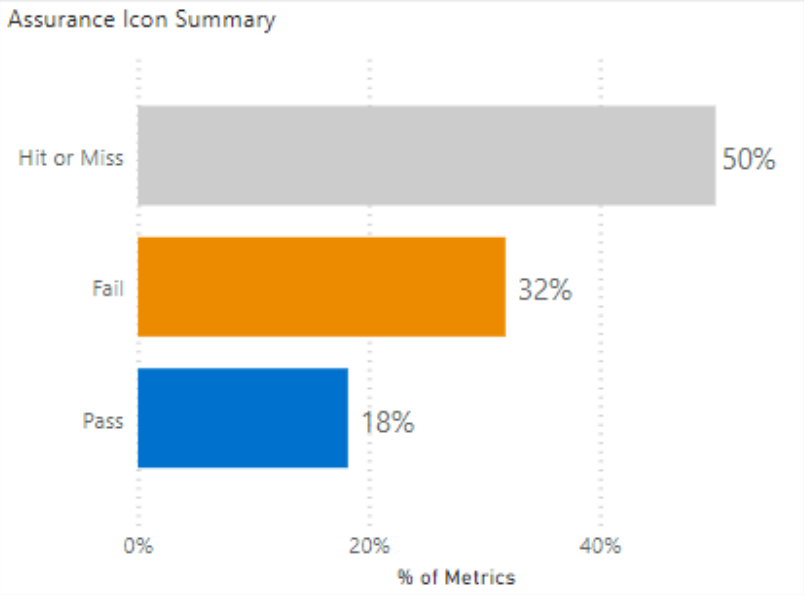
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Apr-2023	104975		71210.27	114202.45	157194.63		
111 Calls Answered in 60 Seconds %	Responsive Care	Apr-2023	39%	95%	-4.09%	30%	64.09%		
111 Calls Abandoned - (Offered) %	Responsive Care	Apr-2023	14.6%	5%	1.03%	20.75%	40.46%		
999 Referrals	Responsive Care	Apr-2023	4752		4664.35	6072.05	7479.75		

RESPONSIVE CARE

Overview (3 of 3)





999 Frontline

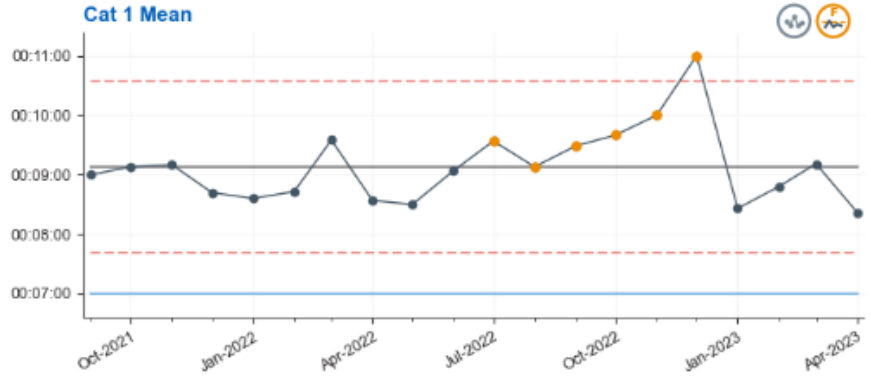
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Apr-2023	01:17:35		01:16:21	01:18:07	01:19:54		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Apr-2023	01:50:39		01:51:07	01:55:59	02:00:51		
Responses Per Incident	Responsive Care	Apr-2023	1.1	1.09	1.08	1.1	1.11		
CFR Attendances	Responsive Care	Apr-2023	702		849.58	1339.3	1829.02		
FFR Attendances	Responsive Care	Apr-2023	182		139.64	247.3	354.96		
ECAL Mean Response Time	Responsive Care	Apr-2023	00:22:32		00:21:23	00:23:27	00:25:31		
Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	Responsive Care	Jan-2022	30.2%			29.8%			
Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	Responsive Care	Jan-2022	17.9%			45.4%			
Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	Responsive Care	Jan-2022	51.8%			24.78%			

111/999 System Impacts

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Apr-2023	10%	14%	7.83%	9.68%	11.53%		
See & Treat %	Responsive Care	Apr-2023	31.4%	35%	29.95%	31.73%	33.51%		
See & Convey %	Responsive Care	Apr-2023	58.5%	55%	56.02%	58.47%	60.92%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Apr-2023	0.8%		0.79%	1.54%	2.28%		
Number of Hours Lost at Hospital Handover	Responsive Care	Apr-2023	2308.09		2180.96	4212.95	6244.95		
Average Wrap Up Time	Responsive Care	Apr-2023	00:17:14	00:15:00	00:16:48	00:17:27	00:18:06		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Apr-2023	46.3%		45.09%	48.02%	50.94%		
A&E Dispositions %	Responsive Care	Apr-2023	7.7%	9%	6.98%	8.69%	10.39%		
A&E Dispositions	Responsive Care	Apr-2023	6095		5599.11	7018.85	8438.59		
Clinical Contact %	Responsive Care	Apr-2023	52.7%	50%	46.48%	50.53%	54.57%		
Ambulance Validation %	Responsive Care	Apr-2023	95.1%	85%	94%	95.99%	97.97%		

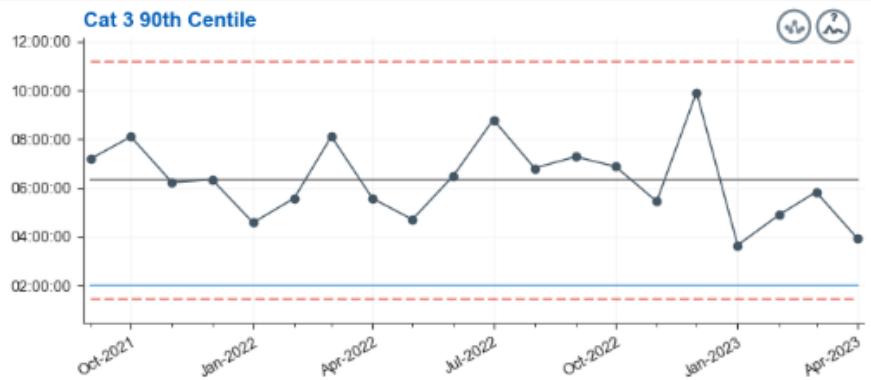
RESPONSIVE CARE

Response Times

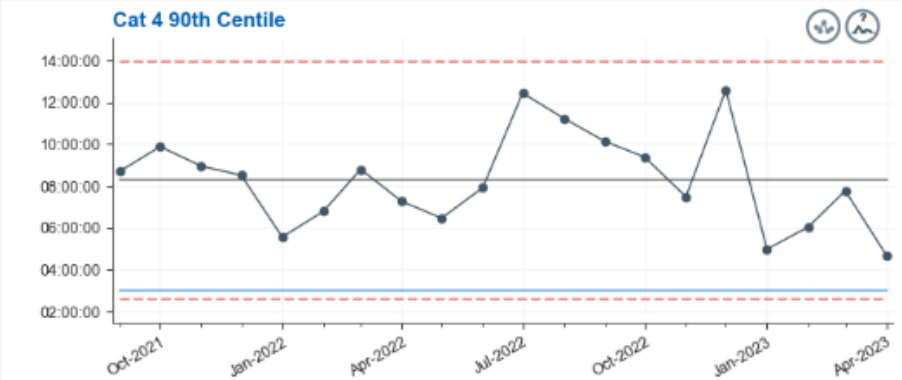


999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:22
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:24:42
Target: 00:30:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-5
Dept: Operations 999
IP: Responsive Care
Latest: 03:56:43
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: 04:41:20
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

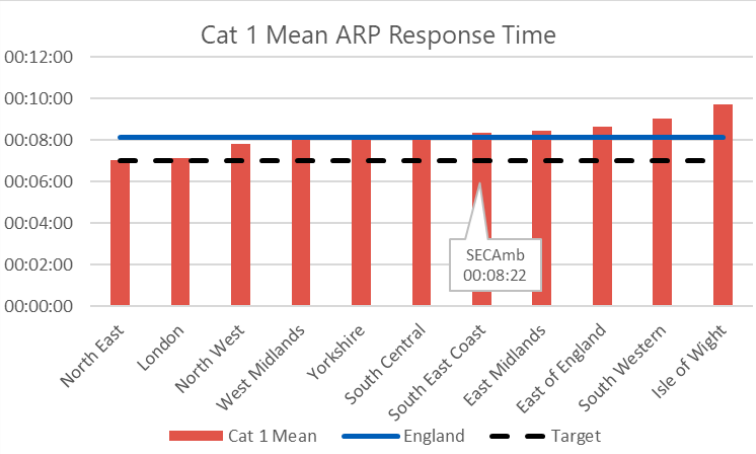
Summary

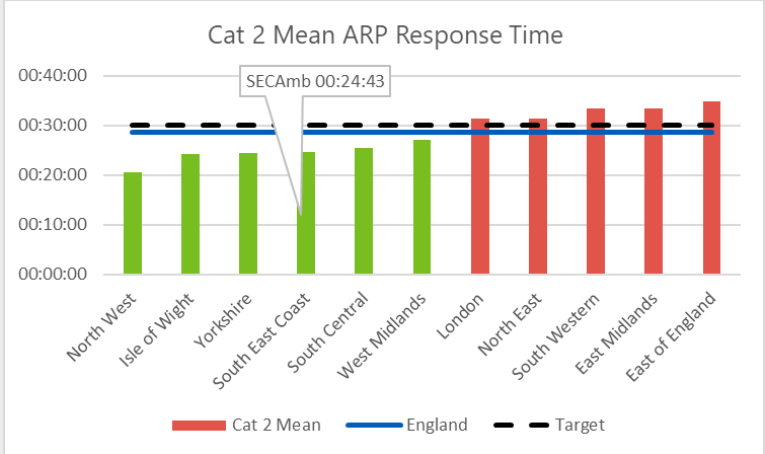
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The overall improvement during Jan-Apr has been due to an improved balance between demand and resource provision during this time.

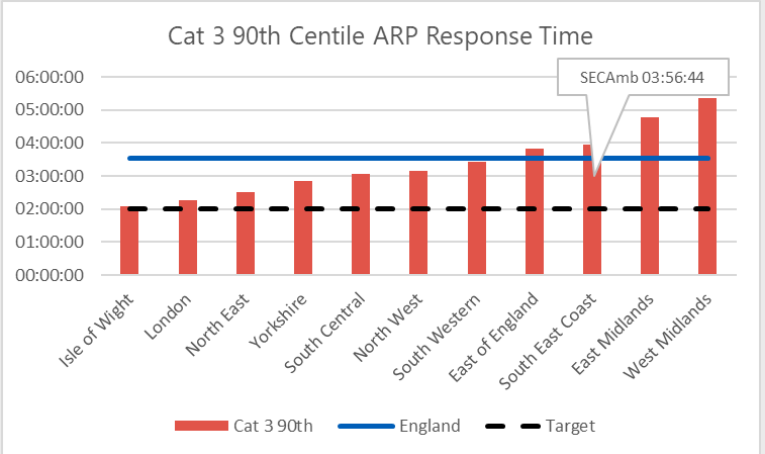
What actions are we taking?

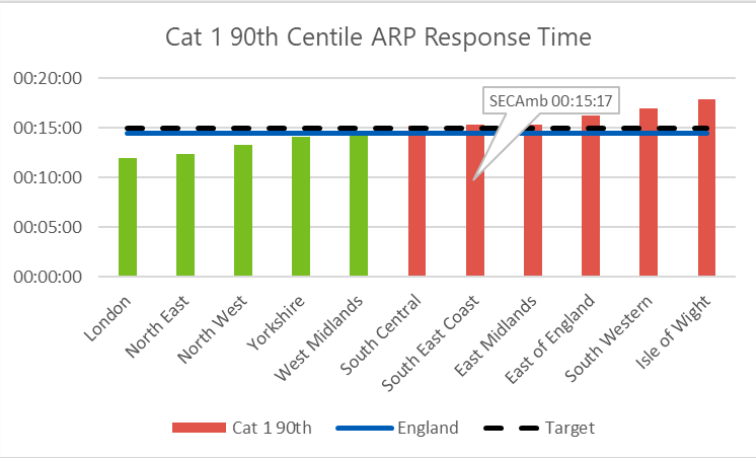
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (95.1% for April - consistent with the previous 3 months).
- Introduction of C3 & C4 Clinical Validation in EOC in January, with focused clinical staffing in EOC to maintain patient safety and support apposite ambulance dispatch
- Focused attention on abstraction management, particularly on sicknes management and training planning.
- 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 develop a new Trust strategy from which the vision of the operating model will be developed.

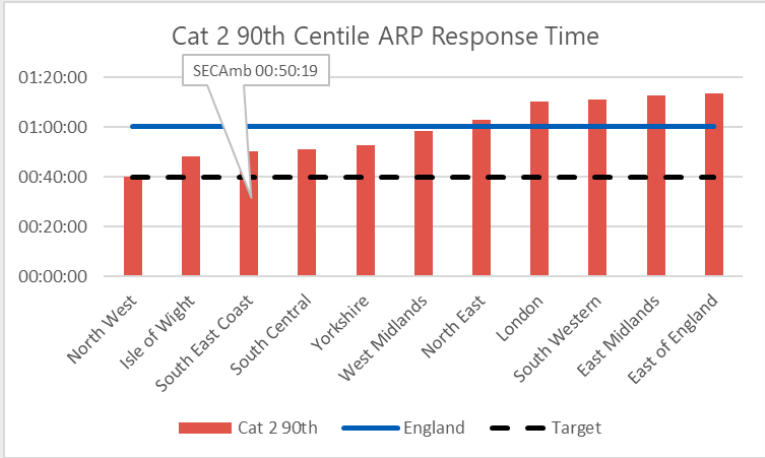
ARP Response Time Benchmarking (April 2023)

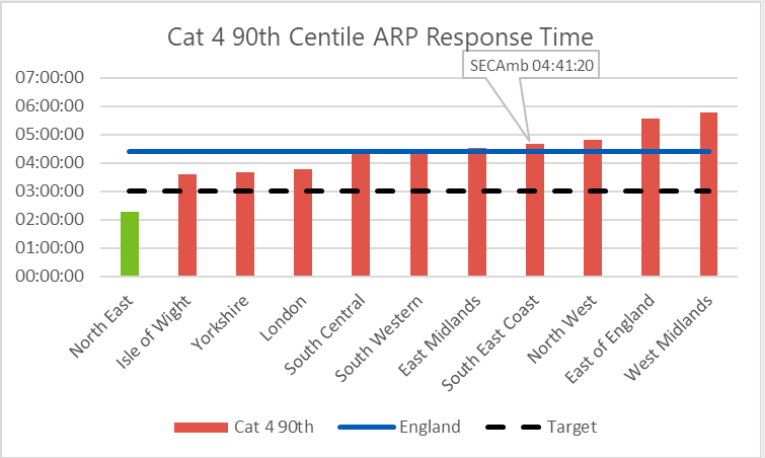










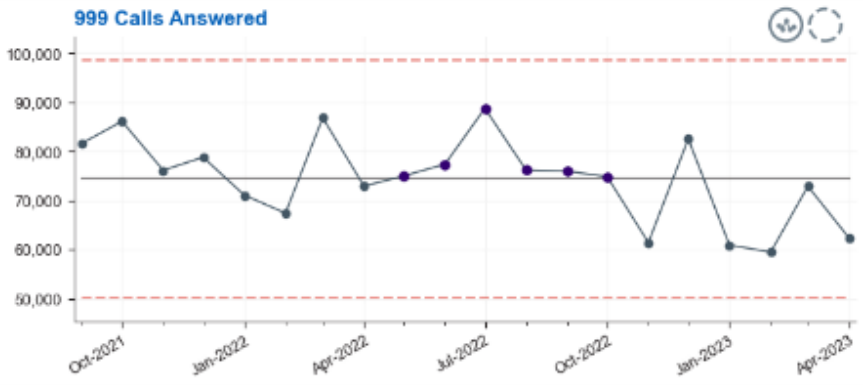


Summary

- The Trust ARP performance Improved in April as compared to March – 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 April

RESPONSIVE CARE

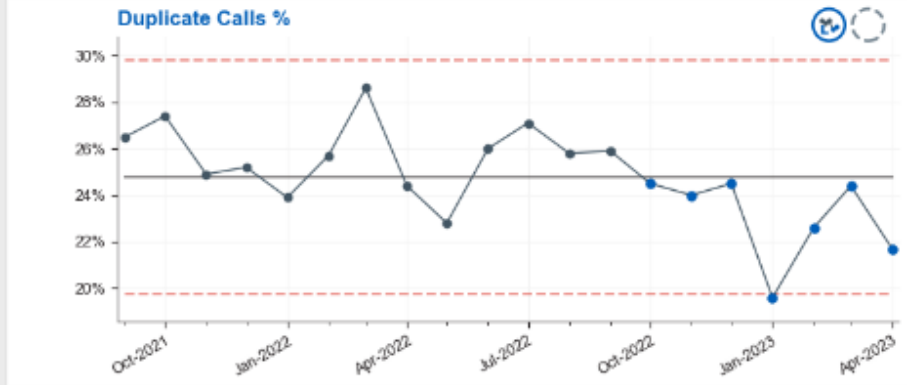
EOC Emergency Medical Advisors



999-10

Dept: Operations 999
IP: Responsive Care
Latest: 62305

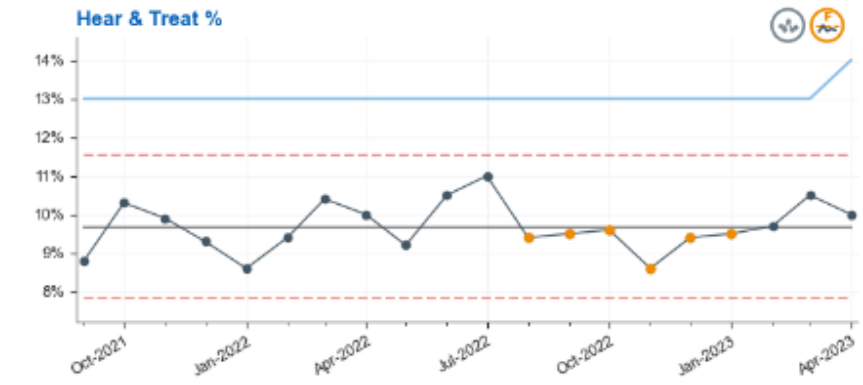
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-33

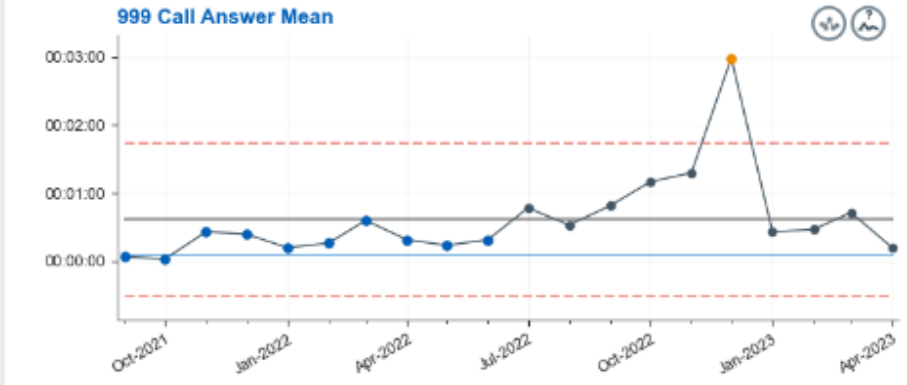
Dept: Operations 999
IP: Responsive Care
Latest: 21.7%

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



999-9

Dept: Operations 999
IP: Responsive Care
Latest: 10%
Target: 14%
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: 00:00:12
Target: 00:00:05
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

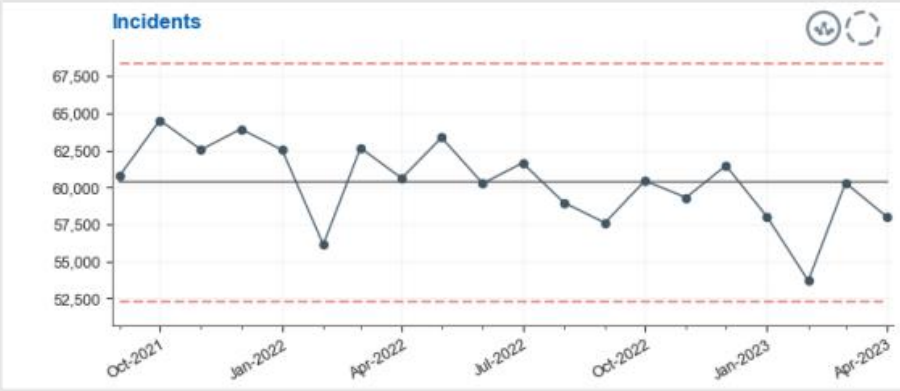
- Call answer mean time has shown improvement in the past two months, underpinned by better staffing and reducing call volumes – this metric is strongly aligned to the EMA resourcing levels over the same period.
- Over the duration of the past 9 months, there have been a more recent decrease in the number of ***calls answered*** which can be seen to have some correlation with the reduction in the level of ***duplicate calls***. This is influenced by improved staffing levels over this period as well as a decrease in overall call-answering efficiency as newly qualified call handlers became proficient.
- ***Hear and Treat*** performance is now stable, above 10% for the previous 2 months (mid-pack in the English ambulance league table), 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 21 WTEs below the planned levels for Feb. Of this 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.
- Recognition of increasing recruitment challenges in the Gatwick area and the impact on the move to the new site in Gillingham due mid-2023.
- Hear & Treat is a specific workstream within the Improvement Journey Programme – supported by a detailed action plan including learning from other Trusts. Our target is to achieve 14% by year-end through introducing the C3 & C4 clinical validation model, as well as scoping C2 segmentation for implementation in July.
- 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

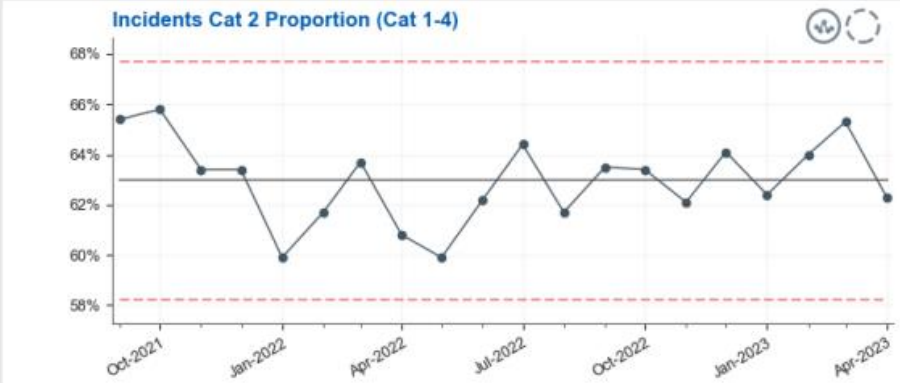
Utilisation



999-10
Dept: Operations 999
IP: Responsive Care
Latest: 58005

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: 92.2%
Target: 100%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-32
Dept: Operations 999
IP: Responsive Care
Latest: 62.3%

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%
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

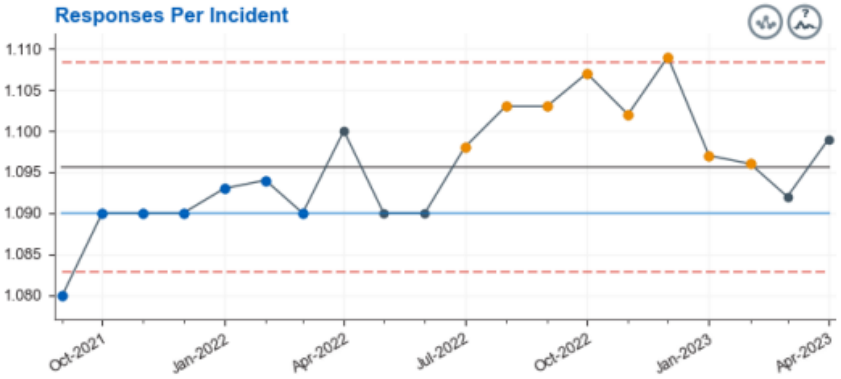
- From the Trust's 111 service, there is a very high revalidation rate for all calls being proposed to be passed to 999 (consistently above 95%) which is resulting in the reduced ambulance referral rate from 111 in Kent and Sussex.
- From the above, since May 2021, there has been very significant fluctuations in **frontline hours** provided – this has directly impacted on the Trust's ability to respond physically to incidents.
- The national industrial action seen in December and January had a significant impact on the reduction of calls/incidents received however this impact reduced through the days of industrial action in February through May.
- 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?

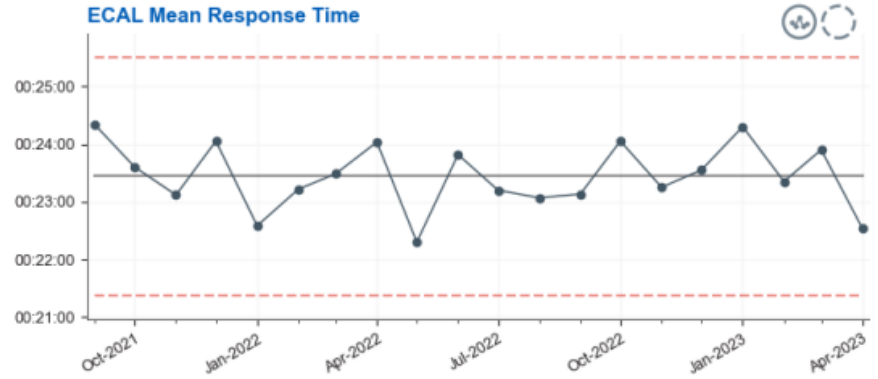
- Continued effective clinical validation of non-emergency ambulance calls from Kent, Medway and Sussex's 111 service, significantly above the contractual requirements to protect 999 - (95.5% for Feb)
- Continued focus on optimising resources through abstraction management and optimisation of overtime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

RESPONSIVE CARE

999 Frontline

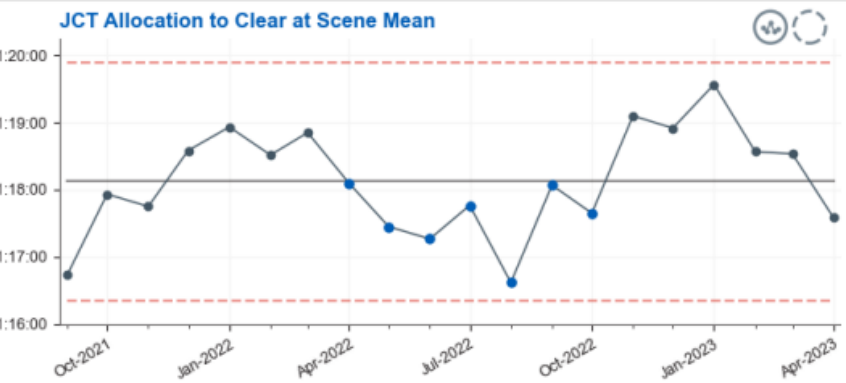


999-17
Dept: Operations 999
IP: Responsive Care
Latest: 1.1
Target: 1.09
Common cause variation, no significant change. This process will not consistently hit or miss the target.



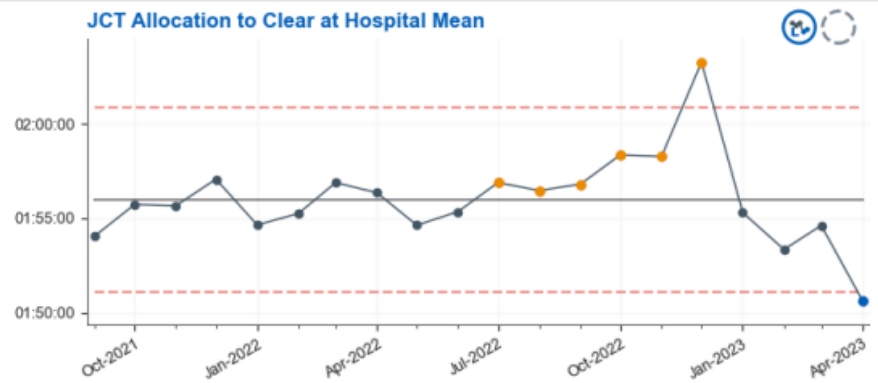
999-13
Dept: Operations 999
IP: Responsive Care
Latest: 00:22:32

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



999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:17:35

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: 01:50:39

Special cause of an improving nature where the measure is significantly LOWER. 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 deterioration in April.
- **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: 7.7%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

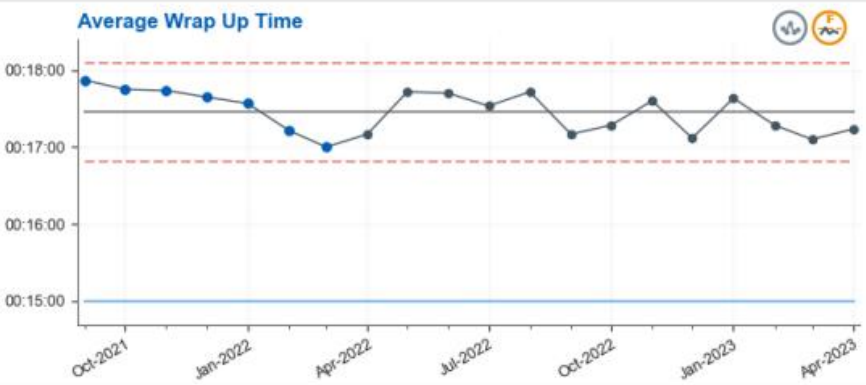
999-9

Dept: Operations 999
IP: Responsive Care
Latest: 31.4%
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: 2308.09

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



999-31

Dept: Operations 999
IP: Responsive Care
Latest: 00:17:14
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

- 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 35.1% with Dartford at 26.9%. 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: 104975

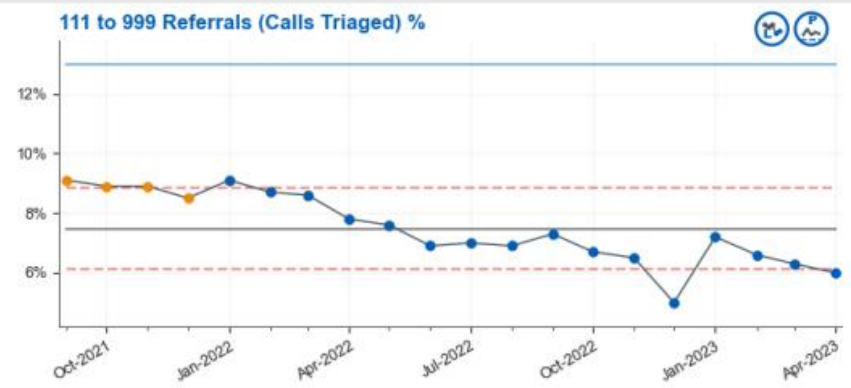
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

111-2

Dept: Operations 111
IP: Responsive Care
Latest: 39%
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: 14.6%
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%
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

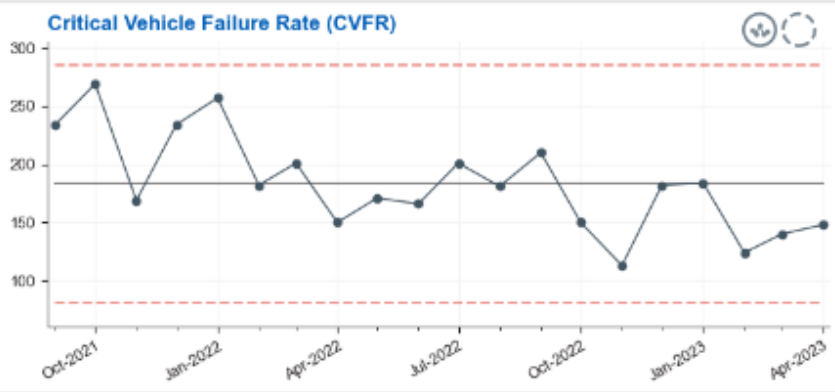
- The service's operational responsiveness remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned call.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment challenges 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 and Direct Access Booking.

What actions are we taking?

- The Trust is realigning the service model to the budget settlement with the Kent & Sussex commissioners which is a significant reduction on the 2022-23 settlement.
- 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 the first 4 months of 2023 on a 18hrs per day, 7-days a week basis.

RESPONSIVE CARE

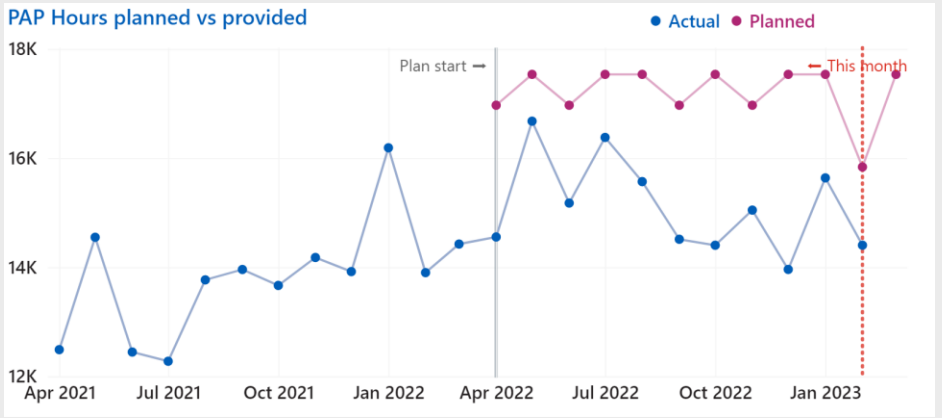
Support Services
Fleet and Private Ambulance Providers

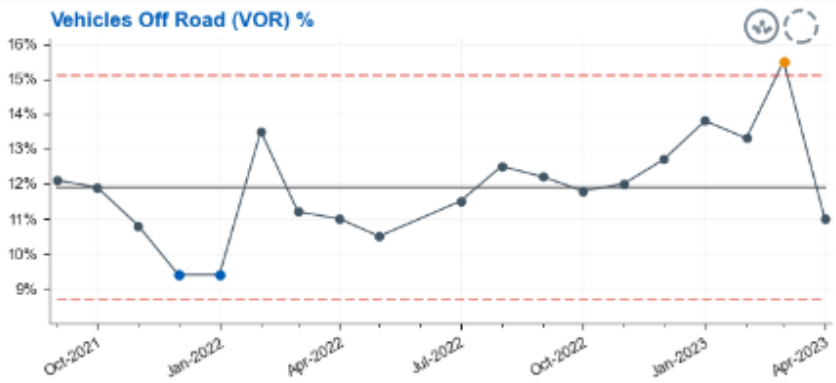


FL-12

Dept: Fleet
IP: Responsive Care
Latest: 148

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: 11%

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

FL-3

Dept: Fleet
IP: Responsive Care
Latest: 68%

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 2022.
Note – there is a data quality query for April, so the Board should note a special cause variation in the trend for VOR. This is due to the reliability issues with new FIAT vehicles and supply chain challenges with workshops and parts.

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. We continue to have 5 VMT vacancies, and an alternative route to recruitment for this cohort of staff has been approved in May to support quicker and more reliable recruitment, outside of the NHS jobs platforms which are not attractive to VMTs.

What actions are we taking?

The Fleet team have started to review alternative DCA options ahead of the purchase cycle in 24/25. An option similar to that adopted by LAS and St.John (MAN vehicle) has been reviewed by the driver user group, and a fuller plan of engagement is being put in place with other suppliers through Q2 to provide the Board with a recommendation by November 2023.

Our **PAP** hour provision has continued at a lower level of around 120WTE vs 150WTE contracted for 23/24. The current plan has been reviewed to 120WTE and we are in contract negotiations to adjust the contract. The capacity has been absorbed through core recruitment as part of the workforce plan in 23/24.

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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

	April 2023				Year to April 2023				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Income	£26.0m	£26.1m	£0.0m	✓	£26.0m	£26.1m	£0.0m	✓	£312.2m	£312.3m	£0.0m	✓
Underlying Expenditure	£26.0m	£26.2m	(£0.1m)	✗	£26.0m	£26.2m	(£0.1m)	✗	£312.2m	£312.3m	£0.0m	✓
Trust Surplus / (Deficit)	£0.0m	(£0.1m)	(£0.1m)	✗	£0.0m	(£0.1m)	(£0.1m)	✗	(£0.0m)	(£0.0m)	£0.0m	✓
System 'Control' Adjustments	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Reported Surplus / (Deficit)	**£0.0m**	**(£0.1m)**	**(£0.1m)**	✗	**£0.0m**	**(£0.1m)**	**(£0.1m)**	✗	**£0.0m**	**£0.0m**	**£0.0m**	✓
Efficiency Programme	£0.1m	£0.0m	(£0.1m)	✗	£0.1m	£0.0m	(£0.1m)	✗	£9.0m	£9.0m	£0.0m	✓
Cash	£42.2m	£40.1m	(£2.2m)	✗	£42.2m	£40.1m	(£2.2m)	✗	£50.4m	£50.4m	£0.0m	✓
Capital Expenditure	£1.3m	£1.5m	(£0.2m)	✗	£1.3m	£1.5m	(£0.2m)	✗	£25.9m	£25.9m	£0.0m	✓

Summary

1. The Trust's financial performance for the month to 30th April 2023 was £0.1m lower than plan.
2. The main reason is the main reason is the £0.5m adverse variance in operations, partially offset by benefit in other areas.
3. Work continues on developing the robust cost savings programme. No savings have been recorded in month 1 which gives a £0.1m negative variance.
4. Cash is £2.2m behind plan, with the major factor being the non-receipt of the SECAMB share of the additional ambulance funding.
5. Capital expenditure was £1.5m in the month which is £0.2m behind plan.

What actions are we taking?

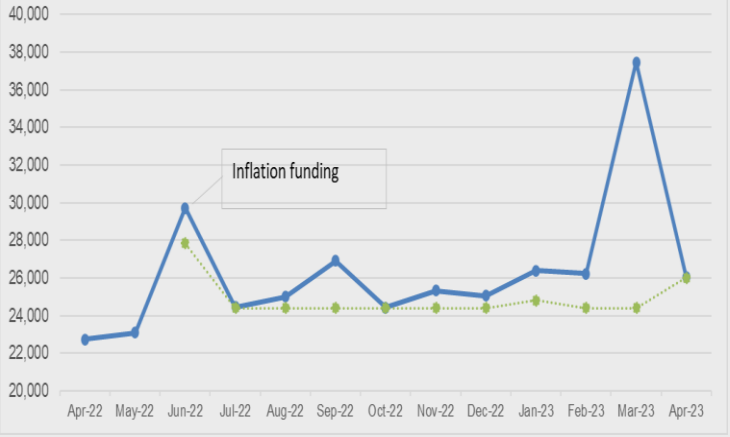
1. A robust cost savings plan is being developed in order to ensure that the £9m savings plan can be delivered. Progress on this is slower than expected and will be reviewed further at the Finance and Investment Committee.
2. Monthly Executive lead directorate meetings are continuing to ensure that each area delivers on their financial plan and on their cost savings in the plan.
3. A deep dive is being carried out on the negative variance in operations to ensure that the issues are identified and then action is taken to rectify.

SUSTAINABILITY & PARTNERSHIPS

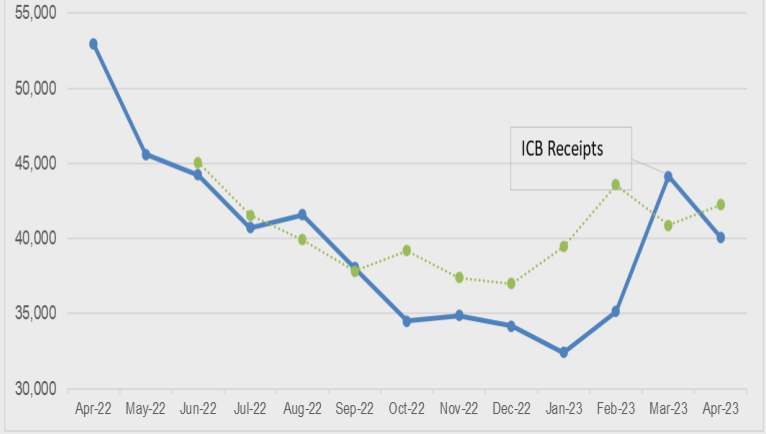
Delivered Against Plan

Actual Plan

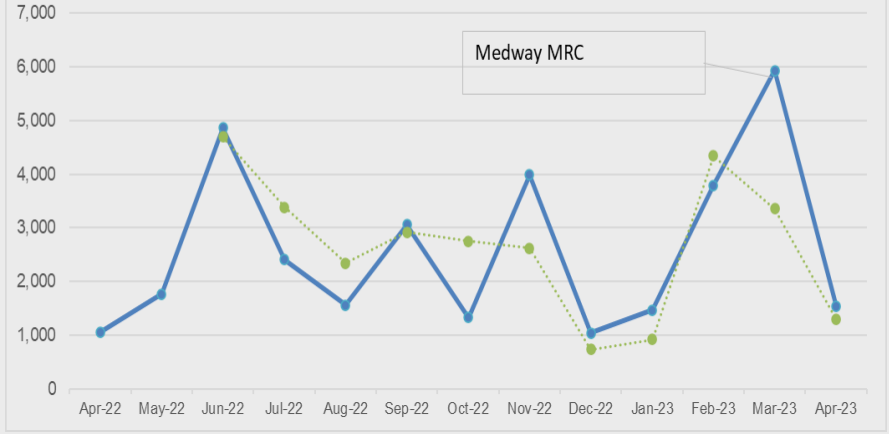
Income £000s



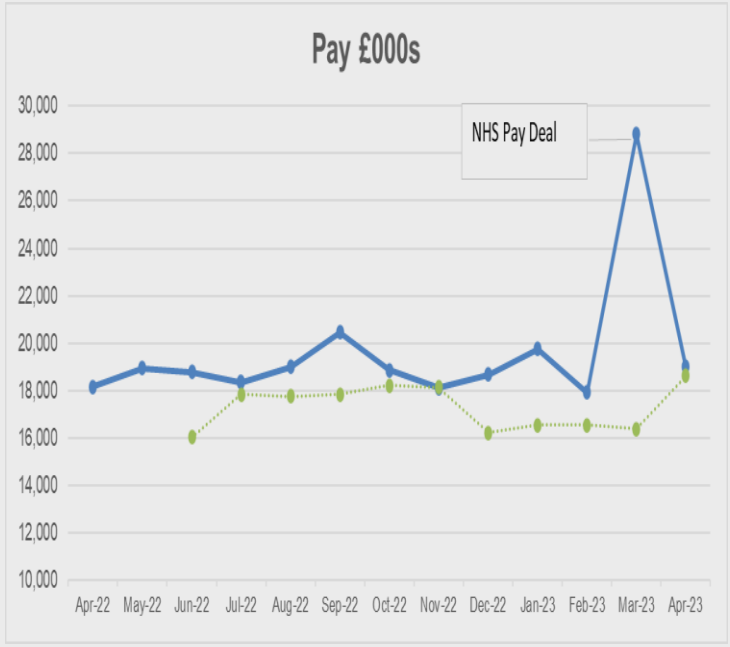
Cash £000s



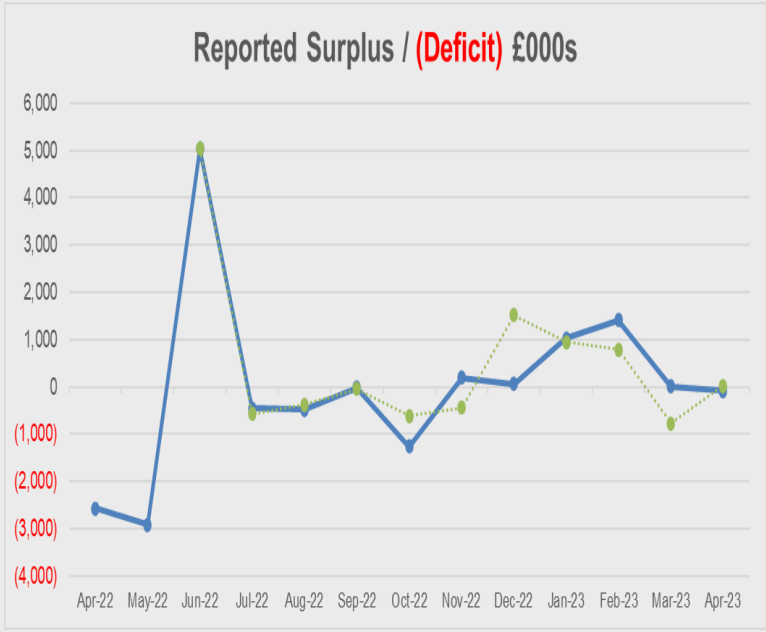
Capital Expenditure £000s



Pay £000s



Reported Surplus / (Deficit) £000s



Summary

- The Trust's financial performance for the month to 30th April 2023 was £0.1m lower than plan.
- The main reason is the main reason is the £0.5m adverse variance in operations, partially offset by benefit in other areas.
- The main areas to highlight from the graphs are the additional cost and income in March 23 relating to the NHS pay deal, ICB cash receipts and Capital expenditure on Medway.

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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
NHS Foundation Trust

Item No	24-23

Name of meeting	Trust Board
Date	01.06.2023
Name of paper	Board Story
Executive sponsor	Rachel Oaten, Chief Medical Officer
Author name and role	Janine Compton, Head of Communications
Synopsis	The Board Story focuses on the work being led by our Consultant Midwife to improve the pre-hospital maternity care provided by our clinician, including the work being done to tackle biases in maternity care and the health equality of pregnant people of Black and Asian backgrounds. It also includes a case study involving a member of staff who gave birth en-route to a birthing centre and how her experience has led to us requesting changes to NHS Pathways.
Recommendations, decisions or actions sought	The Board is asked to consider this story related to the Trust's role in ensuring effective maternity care, which links to one of the escalations from the Quality & Patient Safety Committee.

South East Coast Ambulance Service NHS Foundation Trust

		Agenda No	24-23
Name of meeting	Board		
Date	01 June 2023		
Name of paper	Keeping Patients Safe Executive Summary		
Strategic Theme	**Quality Improvement**		
Author / Lead Director	Margaret Dalziel, Executive Director of Quality & Nursing (interim)		

Quality Priorities

1 – To build and embed an approach to Quality Improvement at all levels

QI Project Keeping Patients Safe in the Stack
One of the priorities for the Trust this year is the Keeping Patients Safe in the Stack (KPSITS) QI project. This contributes to addressing BAF Risk 14 (Operating model) by informing the development of a sustainable, safe, and effective operating model within EOC/111.

This QI project is on track with the plan meeting all milestones:

- Stakeholder engagement has been completed alongside analysis of data.
- The improvement strategy agreed focuses on reducing non-value adding activity, thus reducing the cognitive burden on clinicians and allow them sufficient time to assess and identify high risk patients.
- A root cause analysis session took place on 22 May 2023 and the outcome of this is currently being analysed. Once this is complete, recommendations will be made by the project team regarding improvements to be implemented by the end of June 2023.

QI Management System
Progress is being made in developing and implementing a QI management system approach throughout the organisation (BAF Risk 14). Substantial progress has been made on developing a methodological framework, undertaking stakeholder engagement, implementing a training and development plan, and commencing QI projects.

Several actions have been undertaken to create interest, motivation, and engagement in QI across the organisation:

- A QI community has been commenced on Yammer and has 98 active members.
- A QI page has been commenced on the intranet with news articles and information.
- Three articles have gone out about QI in the organisations weekly message since the beginning of January 2023.

To date, three ‘Introduction to QI’ training sessions have been attended by 64 members of staff across the organisation. Participants complete a Training Evaluation Form assessing their level of QI knowledge, confidence, and motivation before and after the training. 57 responses have been received that show a significant improvement in QI capability post training.

Two QI Facilitators started within the QI Team at the beginning of May, and we are looking forward to welcoming a Head of QI and QI Project Support Officer to the team at the beginning of July.

A QI strategy outlining our ambition and delivery plan for the next two years in currently being written and this will be available for the next Board meeting.

2 - Become an organisation that learns from our patients, staff, and partners (MD7, MD 4)

Incident Management Process

The IQR reflects that the significant improvements achieved in ensuring all incidents are completed in a timely fashion continues to be maintained as currently there are no breached SI reports, with only 15 active cases in total being investigated, all of which have trajectories for completion within the due date. The same improvement has been maintained with SI actions.

The number of overall Datix incidents that have overrun the 45-day cycle that has reduced from circa 21% in March to 16% 19/05, with a trial being currently undertaken within 111 to manage those incidents outside of our control differently, maintaining reporting to the commissioners to process as appropriate. If the trial is successful, this will enable the further reduction of a high proportion of these incidents all graded as low/no harm. In addition, an intervention is in place to remove the current backlog within 111, that will further contribute to this position reducing to the target set for Q2 of 10%.

We continue to see that circa 98% of all reported incidents are graded as no harm/low harm. The IQR also depicts that there is less than one incident of harm per 1000 incidents which is positive as 4.5 no harm incidents per 1000 incidents suggest a positive reporting culture of incidents across the Trust.

Complaints

At the March 2023 QPSC we set out improvements within the complaints process that enabled us to be at circa 93.5% in March, though this has moved to 86% response times as of 15/05, but still with no backlogs in any areas. The target remains at 95%, and extra intervention is being planned to understand the move of position in the past 6 weeks.

Patient Safety Incident Response Framework (PSIRF)

The PSIRF Implementation Lead commenced with SECAmb on 08 May 2023, and is rapidly progressing the work commenced by the Incident Management Steering Group. The programme is on track with all current milestones set within the programme plan with the 3-year data review required to develop the PSIRF Plan being well developed. This is a critical enabler for the Trust to identify and agree on the top five areas of patient safety concerns that will be focused on at depth in 2024/25 – this is planned to come to Board for agreement in Q3 in line with national expectations and prior to ICS sign-off.

Patient Engagement

The Patient Experience and Engagement delivery plan Is aligned with the improvement work from CQC, our QI strategy and the Patient and Family/Carer Experience Strategy (2020-2025).

The focus of the delivery plan is:

- To develop and implement a process for the implementation of Patient Experience Questionnaire's (PEQs) for our 999-service including consideration of how this data will be utilised to drive improvement across the organisation.
- To develop a bi-monthly community/patient virtual forum
- Recruitment of patient/community volunteers to support QI projects across the organisation as well as other service improvement / change programmes.

Achievements to date:

- Engagement with professional networks to support collaborative working as well as Voluntary, Community and Social Enterprise (VCSE) groups to consider equal opportunities.
- Development of a first draft of the 999 PEQ on Microsoft forms.

- Consideration of how to best promote and publicise a community forum with the Trust Communications team.
- Development of a draft patient engagement volunteer agreement that can be utilised to support co-production and partnership with members of our community. This is due to be approved PEG in June 2023.
- Assurance and oversight of the work that has been achieved via regular updates provided to Quality Governance Groups, Joint Teams B, Membership Development Committee (MDC) and Patient Experience Group. Feedback from Healthwatch.
- Planning for four community engagement events across our regions in the next financial year for which the outcomes will be monitored through the CQUIN for patient engagement. This is also one of the three Quality Account priorities for 2023/24.

3 - Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk (RSP-L3, RSP-Q2, MD 6, MD 14)

Risk management process

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 195 risks currently in the risk register, 136 have been reviewed as required with 59 falling out of the timescales. This is an improving picture and remains a priority for the Trust, addressed at RAG holding Directorates to account to fulfil this requirement as set out in policy.

There are 8 risks that are rated extreme risks on the corporate risk register as tabled below, and referenced in Section E of BAF. Activity over this period is outlined below:

- **New Risk 143:** Security concerns at Hastings MRC. Opened May 2023, score of 15.
- **Reduction in score**: four risks have decreased in score, resulting in their removal from the extreme risk report.
    - **Risk 17:** the integration of the 111 & EOC. Reduced to target score of 8 with proposal for closure. Rationale: NHS England has withdrawn its national mandate for a Single Virtual Contact Centre.
    - **Risk 36:** potential trend of poor identification of STEMIs by SECAmb Clinicians. Reduced score of 8 with a target score of 6. Rationale: Assurances have been provided through strengthened training in Keyskills 2023-24, which addresses the need for repeat ECGs and changes in destination if accepted for pPCI.
    - **Risk 361**: capacity of HR to resolve employee relations (ER) cases within established timescales. Reduced to score of 12 with a target score of 8. Rationale: Controls strengthened and reviewed mitigating some of the risk.
    - **Risk 273:** Industrial Action, reduced to a score of 10 - referred to further in the People Board Paper.

The extreme risks for the organisation are listed as follows, with further detail on those that fall within Quality and Clinical priorities:

ID	Risk Title	Current Risk Score
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
143	Security – Site Integrity (Hastings)	15
304	SECAmb's Ability to reach the Net Zero Target set by NHS England	15

357	Delivery of the Clinical Education Strategy	**15**
364	HR Data Subject Access Requests	**16**

- **Risk 28:** Medicines Management
  The risk is that patients seeking addictive medicines may use a range of methods to obtain their supply of these medications via our 111 service. A meeting was held with directors on 22nd May 2023 to discuss possible changes to the way the software records requests for medication including the introduction of a mandatory field for 'indication'. It was also felt that this was no longer a risk as it was a current issue. The risk review group will consider taking this off the risk register as it is a current issue that needs addressing.

- **Risk 34**: Medicines Management
  Following the approval of the business case for additional staff for the corporate medicines optimisation team, recruitment has taken place to most of the posts advertised. As people are on-boarded in June, this risk score will reduce, and the risk may be removed from the register.

- **Risk 136**: Medicines Management
  The risk that medicines pouches are not tagged correctly may lead to a crew not having the required drugs when treating a patient. A renewal of the way the Trust handles the distribution of the medicines pouches will require investment through the business case process.

Quality Assurance Framework (RSP-L3)

Over the past months we have been developing a Quality Assurance Framework (QAF) founded on these principles,

- An integrated approach aligning the four Trust Strategic Priorities (Improvement Journey pillars) of QI, People & Culture. Responsive Care and Sustainability, (Appendix 1)
- ensuring effort is united and accountability shared across Directorates,
- looking to continually triangulate and improve all aspect of patient safety and experience and staff experience and welfare.
- placing our patients and people at the core of it all

This approach has enabled us to build an infrastructure that continuously evaluates the 'SO WHAT?' in relation to the impact of all we do.

Each aspect of the QAF combines the CQC Key Lines of Enquiry and regulatory standards along with Trust priorities. The intent is to provide the tools to directly link floor to Board addressing the gap we have identified in how management uses data to triangulate and identify areas and teams requiring more focused support.

Elements of the framework are diagrammatically depicted on Appendix 2 and are as follows-

- The implementation of **Performance and Quality Management Reviews** (Appendix 3), through Operations-led reviews at local dispatch desk and contact centre level, with each area having an integrated dashboard of own metrics covering performance, workforce, quality and sustainability enabling triangulation of data and richer holistic understanding of performance. All directorates will be represented at senior levels to make this a meaningful two-way engagement forum ensuring action and accountability is appropriately held. These will occur monthly for all areas and report into the Executive Management Board. In turn this will improve reporting to the Board via the BAF and IQR. The local based dashboards are in development now with a view to launch this in shadow form within 4 operating units in June and across Field Operations from Q2 2023.

- Clustered into regional groups will be **Quality & Patient Safety Governance Groups and Incident Review Groups** – led by Quality & Clinical Leads at a regional level. For field operations this provides a more focused iteration of the current singular field operations Quality Governance Group to provide assurance that patient safety, patient experience and staff experience along with compliance meets the standards expected of the KLOE's, highlighting risks and identifying emerging risks across a geographical area. All patient safety functions, for example the SI incident review groups, will align to this structure to enable ICS-level focus that then reports into the Trust wide Quality Clinical Governance Group, and through to Board. The intention is to have the Incident Review groups live in Quarter 3, enabling establishment of the PSIRF framework, with regional QGG also developing over this period.

- Monthly Trust wide **Quality & Clinical Governance Group** is already established but will be undergoing transformation from September to ensure triangulation across setting standards, operational delivery, monitoring and improving. This will also enable further integration and a move away from silo-based portfolios.

- Also established but key to the QAF is the bi-monthly **Quality and Patient Safety Committee.** This is a Board sub-committee chaired by a Non-Executive Director that ensures scrutiny across all aspects of Quality and Clinical care, and seeks assurance of Trust's internal quality governance.

- All these elements are underpinned by a planned cycle of **Quality Assurance & Engagement Visits** across all sites and functions that test and challenge compliance to all KLOE and assesses the impact of delivery from all areas of the Trust to the front line. These engagement sessions are sighted on patient safety, patient experience, effectiveness and staff welfare, seeking evidence of the impact of "What we SAY against what we actually DO and EXPERIENCE".
  These visits commenced in April 2023, with the second pilot undertaken 24-25 May and are already planned for the next 12 months with one Unit being visited each month. They will inform the performance & quality reviews, that will incorporate improvement plans and hold all directorates to account for actions needed to ensure compliance and improvements can happen.

People & Culture Strategic Priorities

1. Getting our Foundations right consistently (BAF Risk 255, RSP P2)

The QI team are supporting the People and Culture workstream to facilitate a QI project on recruitment and onboarding. The initial meeting was held on 23 May with a project team comprising QI, HR, and Data Analytics.

The aim of the initial meeting was to process map how people are recruited into the Trust. Key findings are:

- There are currently different processes for separate roles.
- There is 'block' continuous rolling, fortnightly recruitment, for call handler roles that do not have an agreed process.
- Some roles appear to have an unnecessarily protracted process, with many levels of authorisation, and where some of the stages do not add value.
- There are some roles where SECAmb cannot directly influence some aspects of recruitment timeframes, e.g., Paramedics, the inter-dependency being course completion dates.

The initial focus is on where the biggest positive impact can be made, and data suggests that this is in EOC/111. Data is being extracted on the end-to-end recruitment process from initial identification of a vacancy to when the individual is sat ready to work. This will identify bottlenecks and potential improvements to reduce the overall time to recruit. High-level progress against plan will be reported through this paper to Board.

2. Improvement Journey

a. RSP-Q3: Trust F2SU policy/process has received board assurance and oversight and has been appropriately resourced.

A separate paper from the FTSU guardian is on the agenda for this month's Board so this report will not cover any updates on progress but refer the Board to that document.

b. MD 8 – Analysis of EOL Care data to be shared with ICS in order to reduce unanticipated EOL care.

This workstream is on track though now being affected by lack of capacity. Progress evidenced at the IJ steering group presentation on 24 May 2023 include:

- Date set in July for first external meeting with key stakeholders across the three Regions to share the analysis and set out issues to be addressed or further actions needed to understand the outcomes.
- An early version of the dashboard has now developed and is being refined with data analysis indicating demand and nature of calls including geographical hot spots of demand across the region.

Key actions to achieve next milestones identified were:

- A thematic analysis of the EOL data to be undertaken by the data scientist. Request is for this to be completed by July prior to the first external meeting.
- Further analysis into the unanticipated calls during the day from care homes and hospices to understand the reason for the volume when other services available.
- e-PCR & coding development (ADS)
- Directorates to explore options to increase capacity to support further analysis and networking needed.

Recommendations

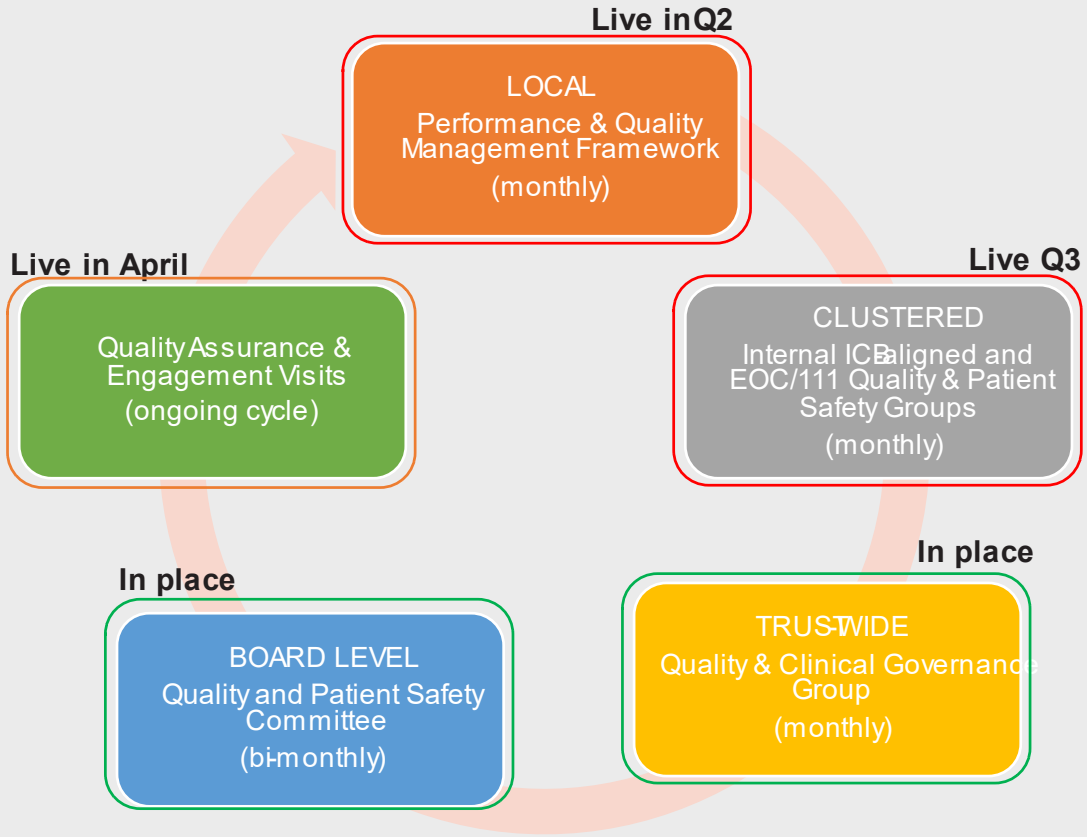
1. That the Board note the current BAF and corporate (extreme) risks impacting this Trust Priority Area.
2. That the Board note the associated metrics within the Integrated Quality Report – their performance levels against targets and/or trends over time including the SPC assessments.
3. That the Board note the actions being undertaken to address/mitigate the risks and improve performance within these areas.
4. The Board is asked to test whether there is sufficient progress with the corporate objectives, and the controls and mitigating actions against the relevant risks, as set out in the Board Assurance Framework and Integrated Quality Report.
5. Where it identifies gaps In assurance, that the Board agree what corrective action needs to be taken by the Executive.

Appendix 1: Integrated approach to QAF

Golden thread for assurance

Appendix 2: Quality Assurance Framework

Quality Assurance Framework

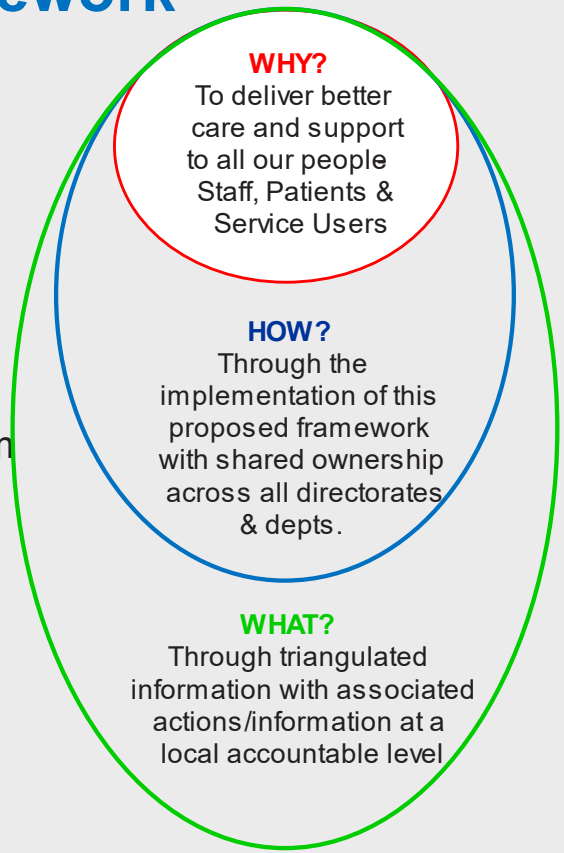


Appendix 3: Integrated Performance & Quality Reviews (monthly at dispatch desk level)

Starts with the patient and the staff:
Integrated Quality & Performance Framework

AIM: To deliver an integrated framework to provide:

- A reporting/delivery structure from Team to Board to Team focused on our people
- A framework providing integrated metrics to provide a holistic overview of patient safety, patient experience and staff experience
- 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



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Agenda No	24-23

Name of meeting	Trust Board
Date	1 June 2023
Name of paper	Quality & Patient Safety Committee Escalation Report – April 2023
Author	Tom Quinn, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 13.04.2023 and confirms whether any matters require specific intervention by the Trust Board.

Item	Purpose	Link to BAF
Incidents Backlog	This was a management response requested last time to update the committee on the backlog of incidents that are taking longer than expected to close.	QI Objective 3 - Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF.

There has been significant improvement made with the back log of incidents. While the paper confirmed that 23.8% (247) of all open incidents had breached the 45-day cycle, which is above the tolerance level of 20% set by the Quality Improvement Group as the initial target for improvement (of these, 29 are graded as Low (minimal) Harm, and the remaining 218 are graded as No Known Harm), the committee was updated that in the previous two weeks this had reduced to 18%.

The oldest breach dated back to 13 June 2022. The head of risk is working through each of the incidents with the relevant management leads.

The committee also noted that a number of the incidents we report are more for the system than for the Trust, especially in 111, and management is working with commissioners in this, which is thought to enable the tolerance level to reduce to 10%.

The committee received a good level of assurance with this update, but asked for clearer timeframes next time against the actions that were set out in the paper.

Medicines Management	A management response to provide an update on the agreed timelines to resolve the risks and issues around Medicines Management (RN). To include clarity on the business case timeline and what risks will be mitigated by this move.	Extreme Risk 34 – Sustainability of the medicines team

The committee reviewed the medicines risks, with particular focus on the mitigating actions related to people and estate. The Architect is in place to design something that will meet the needs of service, given the long-standing issues at Paddock Wood. In terms of people, the team's capacity is increasing following the investment agreed earlier in the year. The H&S risks will be mitigated with the plan to move to the ground floor. The clinical risk also relates to the estate and the current space not being sufficient to enable

an effective service, which the Architect is working to resolve. However, until the drawings are complete it remains unclear what can reasonably be achieved.

Public Access Defibs	To confirm the rescue readiness of the 900 Public Access Defibs (PADs) since the implementation of The British Heart Foundations Circuit and to update the Committee on the plans to support communities improve survival from cardiac arrest.	QI Objective 5 – Improvements in out of hospital cardiac arrest survival rates.

This paper was requested to understand whether the circa 900 defibrillators for which we do not have details, as not on The Circuit, would remain on the CAD. The volunteer guardians of these sites are not compelled to register them on The Circuit, and while we have tried to influence at the community level to increase registration, this has had limited impact.

In terms of the broader strategy to improve cardiac arrest survival, the CMO confirmed that the clinical strategy is being developed with two priorities, one being resus. This will recognise the value of volunteer and community engagement, e.g. engage with schemes in school and local education events.

A management response was requested for June to provide more information on this.

Keeping Patients Safe	To seek assurance that progress is being made with this QI project.	QI Objective 1 – Keeping patients safe in the stack

The committee reviewed the plan which is on track to deliver. In terms of risk to delivery, the committee noted the pressure on operations team to support the project, although this has been adequately mitigated to-date. Another key risk relates to critical systems and the ability of Cleric to make timely changes to the CAD, as many improvements with be digital / automation. The Critical System Board has been asked to prioritise requests to ensure Cleric can keep up.

This project aims to reduce the harm for patients waiting for a response. While committee acknowledged the importance of working through the QI methodology to really understand the problems and gather data (to ensure the right and sustained improvements), the committee expressed some concern about pace. The QI lead explained that the problems have been defined using the data and the process mapping identifies where we improvement can be made, with KPIs/metrics for improvement having been agreed. The project will therefore soon move on to the 'change' part of the cycle. Management therefore felt that it is on track and making progress.

Complaints Management	This was a request from the Board in December to test the processes that ensure timely responses to complaints, following the IQR showing Special Cause Concern.	N/A

This demonstrates how the board assurance cycle has worked to good effect. In reviewing the IQR in December, the Board challenged the executive on the Special Cause Variation related to complaints management. Using the new QI capability introduced in January, management undertook a process mapping exercise using QI methodology and identified ways to reduce the backlog and improve efficiency. Action was then taken, overseen by the Executive Management Board and, as in March compliance was close to the 95% target.

Hear & Treat	In February the Board asked the committee to seek assurance that the work to increase H&T was being done safely to ensure positive impact on patients.	RC objective 4 – Improvements in H&T

The committee explored how we are improving H&T in a way that ensures a positive impact on patients. The premise is that improving H&T rates is essential to make better use of resources; specifically being more targeted in when to send an ambulance. The assumption is that a safer service is provided by having more resources to attend the sickest patients. In terms of assuring that appropriate care is always provided to those patients who do not receive a face-to-face assessment, the committee noted the work still needed to confirm the indicators / metrics. In the meantime, the provider collaborative work will help to understand this more clearly, as currently we don't always get outcomes once patients leave our service. It is not possible therefore to be fully assured on this and we will continue to assess other existing indicators such as incidents and complaints.

Clinical Audit	To seek assurance on the delivery of the agreed clinical audit plan for 2022-23	N/A

Good assurance was received both in relation to the delivery of the 2022-23 plan, and the development of the plan for 2023-24. The plan is informed by quality data and engagement with operations to establish the areas of priority. In next year's plan, the team are looking to also risk rate audit results, to ensure the improvement activities are proportionate to the risk and/or non-compliance identified.

Positive highlights included improvement in STEMI care bundle - 58% to 78%, and cardiac survival which demonstrated significant improvement as set out in the annual report the Board received in February.

The committee did challenge the executive to ensure clearer links between incidents and clinical audit and asked this is reflected in the Patient Safety Report that the committee receives each quarter.

Clinical Strategy Development Update

An update was given explaining that this will likely evolve into an integrated patient care strategy. There is a draft outline of what to include and plans are being made to engage our people and partners. The aim will be to deliver this by the end of the year.

Specific Escalation(s) for Board Action	The committee would like to highlight the positive escalation related to complaints management. This is a good example of the Board's use of the assurance cycle, and use of our QI function.
	Maternity Care – at the start of the meeting under matters arising the committee explored an issue related to maternity care and lack of additional funding following the Ockenden report. The CMO and CFO are following this up and so it is escalated for the Board's awareness.
	Also for awareness, there is still too much variability in quality of papers and so the executive has been asked to ensure better consistency; the committee will continue to provide clarity on expectations and assurances being sought.
	As set out in the committee's annual plan, it will focus its meetings on the relevant strategic goals / objectives agreed by the Board in April.

Board Effectiveness Actions

Recommendation	Progress to-date

Review committee membership to ensure robust linkage across corporate functions	The membership of this committee was reviewed in Q2 2022-23 and approved by the Board. The updated TOR will be received by the Board in June 2023.
Chair to introduce Committee Planning Meetings involving other committee members, to agree the agenda, timings, papers and Key Lines of Enquiry	These planning meetings were put in place immediately. Referring to the cycle of business, these meetings consider the BAF, IQR and Improvement Journey to ensure the committee constantly focusses on the right issues. As confirmed in the report to the Board in June, the committee has re-aligned its annual plan to ensure oversight of delivery of the strategic goals, agreed by the Board in April. Agendas now include a summary of the purpose of each agenda item and the assurance question(s) the committee is seeking to explore. This helps management in the preparation of assurance papers and keeps the meetings focussed.
Introduce a rolling cycle of Committee Business to ensure the committee addresses all topics.	The cycle of business was already in place. It informs the planning of each meeting but is used as a guide in light of the approach outlined above.
To ensure the structure of the agenda is aligned to the Organisational risks – use the relevant BAF risks to shape the Agenda	In addition to the agendas now setting out the purpose and assurance questions, they also cross reference to the relevant BAF risk. The same is also confirmed in the committee's escalation report to Board.
Ensure all actions are clear, with a Lead and timescale for delivery stipulated	The action log currently sets out each action (as agreed as per the relevant minute) and has action owners assigned with a specific timescale.
Ensure all papers have front sheets that provide a summary of key issues, action required from committee members, links to corporate objectives and BAF risks, and a level of assurance being provided.	Work is ongoing to improve the cover sheets, in particular with regards the level of assurance being provided.
Lead Executives to ensure they have read all papers that they are lead for, prior to papers coming to Committee and that key risks and mitigations are clear within papers when appropriate	Ongoing
Use standardised SPC methodology and analysis when presenting data.	Ongoing
Training to be given to senior managers preparing and presenting papers to Trust Board Committees. Writing for assurance rather than reassurance.	Ongoing - we are exploring how and when to provide training on effective report writing for senior managers.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	25-23

Name of meeting	Trust Board
Date	1 June 2023
Name of paper	People and Culture - Executive Summary to the Board
Strategic Theme	**People & Culture**
Lead Director	Ali Mohammed, Executive Director of HR and OD

Executive Summary

Risk Overview

The BAF includes two strategic risks related to Culture and Leadership (risk 348) and Workforce Planning (risk 255).

We continue to experience additional workforce pressure due to higher than planned staff turnover and sickness.

The IQR is reflective of the current risks (except for industrial action) through the key metrics set out in the Overview (slide 22).

Industrial action has been paused by most unions now. Some further action may be possible by the RCN and UNITE. Action by the BMA, primarily in hospital partners, continues. A national pay arrangement is being implemented in June 2024.

Workforce Plan

The time to hire has increased since the last Board report, however, as per the last Board report, the chart now shows both 'volume' or cohort and 'ad hoc' recruitment. The former are to fill spaces on both contact centre and field operations planned courses, whilst the latter are to fill vacancies in other positions that arise throughout the year.

A Quality Improvement project to improve TTH and onboarding has commenced on 23 May 2023 and an update is provided in the IQR from the initial meeting.

The People and Culture Strategy makes a commitment to reduce TTH and onboarding to achieve the 60 days target as one of a number of priority areas identified for people and cultural change.

Work continues to refine the Trust's vision for wellbeing at work (action 71-22). This will continue to be monitored by the People Committee.

Retention

Staff retention remains a high concern and the shortfall in recruitment in 22/23 will place an additional demand and strain to meet the increased 23/24 workforce plans.

Sickness absence is reducing but, at 6.8% is still above our target of 5%. We are not an outlier compared to other ambulance Trusts. Monthly scrutiny of action plans at Operations Senior Leadership meetings continue with support from HR Advisors. Slide 31 of the IQR shows natural variation in the number of wellbeing referrals and so it is likely that this has now reached a stable picture in terms of overall Wellbeing Hub referrals. There is now a capacity gap however as external ICB support has been withdrawn by closure of the three ICB Resilience Hubs.

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 Trust Board agreed a new People and Culture Strategy at its April 2023 meeting. A full version of that strategy will be considered at this meeting. The executive team has worked together to identify Year 1 priorities, actions and KPIs. It will be critical to ensure that the implementation of the strategy is communicated to, seen and felt by all our people particularly as this strategy also now effectively forms our response to the Staff Survey by focusing on actions which our people have asked us to consider in the survey.

An executive team development programme is being developed under the leadership of the new CEO and initial options were considered at the EMB on 24 May 2023.

In terms of updated progress with sanctions applied to alleged sexual misconduct cases, it was previously reported that we now have a full year's data from April 22 to March 23. This showed that we were now 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). Industrial action has affected some cases in terms of management and union capacity to attend employment processes. Our most complex cases are now anticipated to be completed during June and July – these therefore remain active currently but have weekly review by two executives to ensure progress is as fast as it can be. 527 managers have now attended the Sexual Safety Training workshops.

An Improvement Case (formerly business case) is being developed to increase employee relations capacity by creating a specialist ER team separate to the HR Business Partner team. Initial approval to progress this case was provided by EMB.

As updated at the last Board, the next steps on the work with ACAS mediation to improve working relationships with TUs proceeds. A proposal from ACAS was received and agreed to by the Trust and its five recognised unions. An initial meeting is planned for the Trust Executive to meet with the senior ACAS mediator on 26 May 2023 to gain consensus from a management perspective on the relationship.

The latest National Quarterly Pulse Survey has been received and is currently being prepared for internal dissemination.

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. See the separate FTSU Guardian Report.

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.

	The development and approval of a new People and Culture Strategy is an important and critical step forward in our aspiration to create a better place of work for our people. 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.

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People & Culture Strategy

2023-2025

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Contents

Introduction

Foreword

We are really pleased to be able to share with you our People Strategy.

We can not always see the challenges that we all face daily. Both within the workplace and within the broader community. The demand on health services and staff shortages have an impact both within and outside of the workplace. As a result, we are all having to reflect on how we can face up to those challenges. At the same time, we need to see how, within SECAmb, we can jointly create an inclusive culture and working environment where all of us can feel safe, healthy, recognised for what we do and therefore more positive and proud to be part of the SECAmb team.

Thank you for all the feedback that has been given over time in different staff surveys, focus groups and a variety of other ways. As a result, it has been possible to develop this strategy based on a better understanding of what really matters to us all and what is needed most to feel proud working for the patients and communities that we are all here for at SECAmb. We are determined to focus on meeting those needs.

Our People and Culture Strategy provides our roadmap to a better place to work for all of us.

Simon Weldon
Chief Executive Officer

Ali Mohammed
Executive Director of Human Resources and Organisational Development

Purpose of this Strategy

This strategy has been developed ahead of our new corporate strategy.

We are revising our overarching strategic direction for the Trust and intend to undertake this piece of work through comprehensive and meaningful engagement. This will take time but the improvements we need to make to our culture can-not wait.

Therefore, we have developed this Strategy to help guide the early phases of our cultural transformation.

Once we have agreed the final Trust strategy we expect the development of the supporting strategies, such as a workforce strategy, to naturally expire this strategy. For this reason the life span of this strategy is intentionally short.

Development of the Strategy

This strategy has been created relatively quickly and we recognise that not everyone who may have wanted to contribute was able to. However, the strategy was developed through engagement with our people.

A draft was developed through an initial research and engagement exercise and this was then taken to over 100 individuals for further feedback and development.

The strategy was amended following the feedback and it was agreed not to modify the language and to use the wording of our people.

The strategy contains a number of quotes that identify the ambition from our people .

"I understand my role and its value in the organisation's improvement journey"

"I am valued and appreciated for the work I do and recognised and thanked for great work"

"My personal circumstances are acknowledged and supported where they can be"

Context

The NHS People Plan

Our People & Culture Strategy has been framed within the wider NHS People Plan.

The NHS People Plan was published in July 2020 and has been developed with the aim of having more people, working differently, in a compassionate and inclusive culture right across the NHS.

To achieve this ambition, the NHS People Plan sets out specific actions within six areas:

- Responding to new challenges and opportunities
- Belonging to the NHS
- Growing for the future
- Looking after our people
- New ways of working and delivering care
- Supporting our people now and for the long term

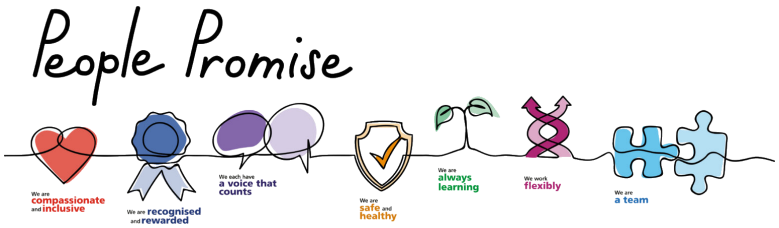
Whilst our People & Culture Strategy does not specifically address these individual areas, the ambitions within this Strategy are consistent with the aims of the People Plan.

The People Promise

Supporting the NHS People Plan is a People Promise. Published alongside the overarching People Plan, the Promise challenges us all to make the NHS a better place to work. The themes and wording came directly from those that work in the NHS and they are captured by seven themes.

- 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

We fully support the People Promise and the ambitions within our People & Culture Strategy are consistent with the People Promise. We too have used the words of our people to describe our ambitions.



"I am engaged in decisions that impact my role and my ideas for improvements are listened to"

"My manager leads our team with consistency, fairness, transparency and compassion"

"My organisation understands the importance of wellbeing and my own needs"

Our Trust Strategy

The Trust is currently developing a new vision and strategy for the organisation. This will be a clinically led strategy that identifies our strategic direction and our priorities. Our new strategy will be launched later in 2023. Until this is agreed, the Board has approved a number of strategic priorities for 2023/2024. These are closely aligned to the domains within our improvement journey.

Our strategic priorities within the four domains of our improvement journey

	Quality Improvement	People & Culture	Responsive Care	Sustainability & Partnerships
We will	QI1—Build and embed an approach to Quality Improvement at all levels	PC1—Getting our foundations right consistently	RC1—Deliver safe, effective and timely response times for our patients	SP1— Develop a refreshed vision and strategy for SECAmb and our operating model
	QI2—Become an organisation that learns from our patients, staff, and partners	PC2— Making Internal Processes Effective	RC2—Implement smarter and safer approaches to how we respond to patients	SP2—Be a great system partner, establishing SECAmb as a system leader in the UEC arena, becoming the partner of choice
	QI3—Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk	PC3— Improving the Experience of our People	RC3—Provide exceptional support for our people delivering patient care	SP3—Become a sustainable Urgent and Emergency healthcare provider

What have we done so far?

Our People and Culture is one of the four priority areas. This reflects the NHS Long Term Plan's commitment to ensure NHS staff receive the support they need to continue to deliver outstanding care and can deliver the aspirations of the Long Term Plan. However, it also recognises that we understand we also need to rapidly address some of the issues our own people face.

We have received honest feedback from our people in the most recent annual staff surveys and the high number of grievances, and the number of people leaving us, tells us that the changes we need to make are significant.

We genuinely want to make SECAmb a better place to work. We aim to be an employer of choice where people feel empowered to carry out their work to the best of their ability. In order to make some progress we have already made some changes and have started to put into place some of the necessary foundations.

These interventions include:

- Joining the NHS Culture & Leadership programme
- Training for Board members
- Training in Sexual Safety for our people
- Investing in Freedom to Speak Up
- Initiating a no-tolerance approach to sexually inappropriate behaviour
- Increasing visibility of the leadership and the leadership of culture transformation
- Developing a communication and engagement strategy
- Developing specific work within our Emergency Operations Centres
- Setting the ambition to become a learning organisation through Quality Improvement
- Revising the Trust values

Joining the NHS Culture & Leadership Programme

The programme is hosted by NHS England and supports organisations through a structured programme of transformation. The emphasis is on developing a programme of work that is in partnership and inclusive with our people to develop compassionate culture change. We have used this framework to undertake some early diagnostic work and will return to the programme later in our transformation work.

Training for the Board

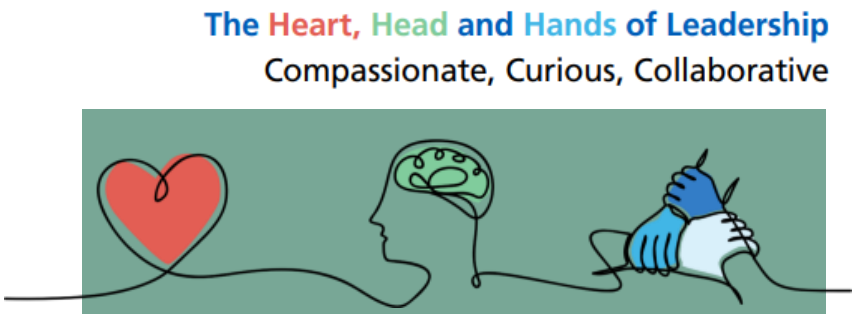
We aim for our Board to be able to lead this transformation work. This means every Board member being able to demonstrate the necessary leadership behaviour. Therefore, we have undertaken a number of development sessions with the Board that draws on the principles of "Our Leadership Way" from the NHS leadership academy. We took the following three principles to frame our discussions and actions

- Becoming more compassionate
- Becoming more curious
- Becoming more collaborative

Training on Sexual Safety

We developed training for our people. This raises awareness of sexual harassment in the workplace. This includes advice for our people on

- What sexual harassment in the workplace looks like
- Provides information on what to do if people witness or experience sexual harassment
- Promotes the right to a workplace free of sexual harassment
- Explains reporting routes and encourages the use of them
- Explains how people should address sexual harassment from third parties, such as partner organisations, service users and the public.



"I am treated with kindness, compassion, respect and Civility"

No Tolerance

In July 2022, via our weekly message, our Chief Executive made it clear that poor behaviour, including bullying and sexually inappropriate behaviour are completely unacceptable.

Increasing visibility of the leadership and the leadership of culture transformation

We have implemented a programme where all members of the leadership team undertake purposeful listening activities on a monthly basis. Feedback is now formally gathered and shared.

We have increased the leadership to our culture transformation by appointing a Programme Director to visibly lead this work.

Investing in Freedom to Speak Up

We recognise that our people tell us they find it difficult to speak out about issues that concern them. We wish to develop a more open speak-up culture but this will take time as people need to feel supported and trusted. We have made further investment in the formal Freedom to Speak Up pathway by creating two deputy guardian posts.

Developing a Communications and Engagement Strategy

The Trust approved a new Communications and Engagement Strategy in 2023. This identifies a number of outcomes

- Colleagues will have a better understanding of SECAmb's role, values, and priorities
- Key external stakeholders will have a better understanding of SECAmb's role, values, and priorities
- There will be improved opportunities for stakeholders, including our people, to shape key areas of work
- We will be able to clearly demonstrate and share that we listen to our people and act on their feedback
- We will be better able to identify and share good news and successes

We each have **a voice that counts**

"I feel part of a team and we work collaboratively with others"

Undertaken bespoke work in our Emergency Operations Centres

We took the decision to engage an external company to help us design and launch some bespoke work with the people in our Emergency Operations centre.

As part of this work we undertook a diagnostic to try and identify a number of interventions that could be implemented to make rapid improvements for the people within this department.

This has also helped provide insights into a methodology for rolling out this work into other areas and will inform the wider planning of our culture transformation.

Becoming a learning organisation and embedding Quality Improvement

We recognise that we need to become an organisation that places learning at the heart of what we do. We already have the basics and offer accredited training but we need to translate this learning culture right across the service.

To help us, we have appointed an expert in Quality Improvement methodology. Through their work they will engage more people in quality improvement and introduce a methodology that can be applied to drive improvements to clinical quality, staff experience and organisational culture.

As more people become familiar with the process we hope to gain a momentum by empowering people to make local quality improvements.

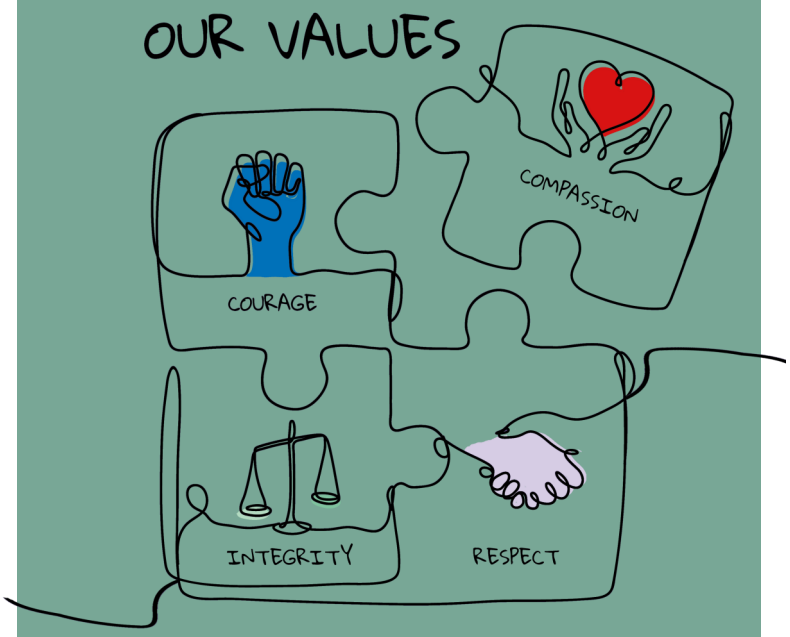
Refreshing the Trusts Values

We have also taken the opportunity to refresh the Trust values. The general impression was that we had too many values and a refresh would give a new energy to how they are socialised and used.

Following an engagement exercise with the Trust the values were distilled into four

- Courage
- Integrity
- Respect
- Compassion

These will form the template of how we conduct our business and how we hold ourselves to account for our behaviour, actions and decisions.



Our People

By our people we mean everybody who works in our Trust to help us deliver our service. This includes our employees, students and volunteers.

Similar to mental health providers we do not have a service heavily dependent upon equipment. Our people are our service. Our call takers and our front line have to respond, give a preliminary diagnosis, and then make critical decisions, either with, or on behalf of the patient.

However, providing a high quality clinical service is a team effort. As well as our front line roles we employ a large number of people that undertake essential support roles. These include Finance, Informatics, Human Resources, Fleet Managers and mechanics, secretarial and administrative people. Without all of these people pulling together we would not be able to provide a service to our patients.

We know that a good working environment for our people not only helps us to retain our skilled people but it also means better care for our patients. People who feel supported are more likely to make less mistakes and make the right decisions.

"I am trusted to do my job and I understand what's expected of me"

Therefore, we need to do better for our people. We are committed to making the improvements our people have requested. But, we know that to make a real difference everyone will need to make adjustments. This will take time. So, to help us lay the right foundations we have identified a number of early ambitions. They will not be the whole story and, as we work up our transformation plans and our strategy, new ideas will emerge and be included.

Our people numbers

Number of patient	2375
Number of	602
Number of	400
Number of	14
Number of	57
Number of	43
Number of	134
Number of	241

Our ambitions

The following pages identify our strategic ambitions for our People & Culture strategy and outline the model for delivery

Our Ambitions

Up until we developed this strategy we were undertaking a variety of interventions to try and improve the working environment for our people but these lacked cohesion and consequently the big impact has yet to be felt by our people.

The identified ambitions bring the necessary focus to our culture transformation. This prioritisation will make a larger impact and will ensure we address a number of the issues that our people have raised. This will help us make a quicker impact for more of our people and the improvement methodology will also lay the foundations to a process that can be used to identify the next steps.

The strategy contains 16 ambitions. These have been identified through engagement with our people and the words of the ambitions have been carefully chosen by our people.

The 16 ambitions reach across four specific domains.

- Ready for work
- Happy at work
- Supported by work
- Contributing at work

These domains have been identified to reflect how these ambitions collectively impact on the experience of our people.

Our 16 ambitions within the four domains

READY FOR WORK

- We will work with partners to recruit diverse talent from our communities.
- We will train and equip our people with the tools and skills they need to do the best for our patients.
- We will ensure people joining us are set up for success with a great recruitment and onboarding experience.
- We will promote SECAmb as the local employer of choice in our communities and roles in our services as aspiring careers.

HAPPY AT WORK

- We will offer creative and flexible career pathways in collaboration with system partners.
- We will promote diversity in all its forms and eradicate discrimination, harassment, bullying and incivility.
- With our patients at the centre, we will be flexible so that our people can achieve their work/life balance.
- We will recognise good work and celebrate achievements and excellent practice.

SUPPORTED BY WORK

- We will actively engage and listen to our people's concerns and respond to them in a timely way.
- We will ensure our working environments are safe and that the wellbeing of our people is paramount.
- We will be an organisation that learns and shares the findings from events and incidents and help those involved to do the same.
- We will invest in our managers so that they can effectively and compassionately lead our people.

CONTRIBUTING AT WORK

- We will have patient care and safety at the forefront of everything we do.
- We will all make a personal commitment to each other to act with kindness, compassion, and respect.
- We will strive to create a one team approach, eliminating silo working and increasing collaboration.
- We will encourage and support the delivery of change at a local and organisational level.

"There are clear career pathways and I have developed opportunities in my role"

Delivery

We have decided to focus delivery on the 16 ambitions could lead to a transactional change that may not be sustained. Therefore, we have identified broader priority areas of work across a 2 year programme. By addressing these priority areas we will make improvements across all 16 ambitions and will use these ambitions to measure impact and progress.

Priority Area 1

Getting our foundations right consistently

We have a number of challenges that we need to overcome. For example, the current work pattern of our patient facing people does not easily facilitate regular meetings with line management. We will need to address this in order for us to reach the ambitions within three of the domains, Happy at Work, Supported by Work and Contributing at Work.

Challenges, actions and impact of Priority Area 1 - Getting the Foundations Right

Key Challenges

Low level of Appraisals

-

Not all of our people have 1:1s with their managers

-

Poor welfare due to too many shift overruns for ops staff

-

Historic under-investment in Management development

Year 1 – Actions to be taken

Supporting our leaders completing appraisals by actively removing blockers

-

We will give our managers the time to prioritise 1:1s

-

Project to analyse and make changes to improve compliance against overruns

-

Continue to deliver the fundamentals leadership training for first-line managers

Impact KPIs

Appraisals >85%

-

1:1s happening for all colleagues (leadership visits, QA, PS, SS)

-

Reduction in number and duration of overruns

-

>95% first-line managers have completed fundamentals training

"I work for an organisation that values diversity in all its forms"

Priority Area 2

Making Internal Processes Effective

We have a number of challenges with our internal processes, for example, it takes us too long to recruit new people and to resolve the issues raised by our people.

Our people tell us that our policies do not appear to be consistently applied and it is vital that we address this if we wish to be a fair and inclusive employer.

We also need to build stronger partnerships with our trade unions We will need to address this in order for us to reach the ambitions within all four of the domains, Ready for Work, Happy at Work, Supported by Work and Contributing at Work.

Challenges, actions and impact of Priority Area 2—Making Internal Processes Effective

Key Challenges

It takes too long to resolve formal concerns through ER and FTSU

-

Inconsistent application of our Policies, with some critical ones being out of date

-

Under-developed people management skills

-

Poor TU relationships

Year 1 – Actions to be taken

Improve capacity and capability of our formal processes (ER and FTSU)

-

Bring our Policies in-date and make them fit-for-purpose

-

Management essentials to be rolled out (building on Fundamentals)

-

ACAS mediation process

Impact KPIs

% cases completed within 93 days >85%

(for FTSU and ER)

-

>95% up to date policies by end of year

-

>95% identified managers have completed "management essentials"

-

Positive feedback from Trade Union Colleagues and Trust as part of post-ACAS mediation evaluation

"I am treated fairly when I make a mistake and supported to learn from it"

Priority Area 3

Improving the Experience of our People

We have to improve the experience for our people. We know some of our people feel their contributions are not valued and for some of our people they feel unable to speak up. We will need to address this in order for us to reach the ambitions within all four of the domains, Ready for Work, Happy at Work, Supported by Work and Contributing at Work.

"I enjoy my job and I am proud to work for SECAmb"

Challenges, actions and impact of Priority Area 3—Improving the Experience of our People

Key Challenges

Our people feel that their leaders are not consistently listening and acting on their concerns

-

It takes too long to welcome people into new roles and getting them ready for work

-

Number of incidents of B&H and Sexual misconduct cases

Year 1 - Actions to be taken

Respond to issues raised in Staff survey and recent reviews (housekeeping)

-

Implement new leadership visit process consistent with C&E Strategy

-

Rapid on-boarding QI project

-

Comprehensive package of training for managers, awareness days for our people and robust application of our policies

Impact KPIs

>95% of Housekeeping Actions completed

-

Programme of visits >90% compliance (visits completed, reported and action loop closed)

-

Time to Hire<60 Days

Increase successful probation at 6 months

-

Engagement, Safety and Morale scores improved as measured through appropriate metrics

Governance

We will develop a detailed delivery plan to support this transitional strategy and we will also develop a Culture Dashboard that will give an indication that improvements are being made. This will join a suite of other metrics that the Trust uses to maintain oversight. These include,

- Performance Management Framework and the Integrated Quality Dashboard
- A new culture dashboard
- A delivery plan and status reports
- Periodic temperature checks on what it is like to work at the Trust
- Annual Staff Survey
- Assurance reporting from the People Committee

We are restructuring our governance reporting which aims to give greater clarity between delivery, governance and assurance.

Assurance will remain with the Board People Committee. This committee will assure the Board that progress and impact is being made on the delivery of this strategy. Governance of the delivery will be maintained by the Executive Management Board and oversight of delivery will be maintained by the appropriate Task & Finish group.

The South East Coast Ambulance Service NHS Foundation Trust

People & Culture Strategy 2023

Trust Leads

Ali Mohammed , Executive Director of Human Resources and Organisational Development

Tina Ivanov, Programme Director, Culture Transformation

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	25-23

Name of meeting	Executive Management Board
Date	1st June 2023
Name of paper	Freedom to Speak Up
Executive sponsor	Margaret Dalziel – Executive Director of Quality & Nursing
Author name and role	Kim Blakeburn Freedom to Speak up Guardian
Executive Summary	The purpose of this paper is to provide the Trust Board with an overview of the progress and development of the FTSU service. The paper also includes hotspots and themes arising from the cases received by the Freedom to Speak Up Guardian (FTSUG) from October 2022 to 31st April 2023. Finally, the paper highlights key risks and actions planned for the coming year. **Key highlights from the paper are follows:** • The Freedom to Speak Up Team received concerns from a total of 52 staff during Q3 of 2022/2023 and 60 concerns for Q4. The number is similar with the same period of 2021/2022. • The locations with the highest number of concerns raised during Q4 and Q1 22/23 were 111/EOC/ East Operations and Finance. • The top three themes raised during Q4 and Q1 22/23 were Leadership, Bullying & Harassment and Culture.
Recommendations, decisions or actions sought	**The Board is asked to:** ➢ Confirm assurance that the Trust Board is actively involved in shaping the Trust's vision for Freedom to Speak Up and are proactive in learning from speak up concerns. ➢ Commit to commissioning a review of the areas with the highest number of concerns raised. ➢ Consider reviewing/renewing Executive FTSU pledges in preparation for National speak month in October.

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).	**No**

South East Coast Ambulance Service NHS Foundation Trust

Trust Board – 01 June 2023

Freedom to Speak Up Guardians Board report

Introduction and Background

The importance of raising concerns is not just to ensure that patients receive the best care but also to protect the safety of workers. The Trust is committed to providing outstanding care to service users and staff to achieve the highest standards of conduct, openness, and accountability.

Speaking up is about anything that gets in the way of doing a good job. If we think something might go wrong, it's important that we all feel able to speak up to stop potential harm. Even when things are good, but could be even better, we should feel able to say something and be confident that our suggestion will be taking seriously and used as an opportunity for learning and improvement.

The Director of Quality & Nursing is the named Executive Lead for FTSU and is accountable for ensuring that FTSU arrangements meet the needs of the staff across the Trust. The Non-Executive Director (NED) responsible for FTSU is available to the Guardian to seek second opinions and support as required.

The Guardian has direct access to the CEO, NED, and Chair, with regular meetings scheduled to discuss all elements of FTSU activity.

The FTSU Guardian is co-chair for the National Ambulance Network and a member of the South East Regional FTSU network. These provide opportunities for learning to be shared and national themes to be addressed, alongside guardian peer support.

The Guardian is up to date with the National Guardian refresher training to ensure she is working in line with suggested best practice.

The Trust has several routes where staff can raise concerns that is outlined in the Trust's policy (Freedom to speak up: Raising Concerns (whistleblowing) Policy). These include line management, Human Resources, the Whistleblowing Hotline, Bullying & Harassment Hotline, Union reps and the Freedom to Speak Up Guardian (FTSUG). The Trust policy is in the final stages of being reviewed and aligned to the NHS England, National Freedom to Speak Up Policy.

SECAmb FTSU escalation process

When a concern is first bought to the attention of the FTSU team, a risk assessment is done to ensure the right support is offered. At times during this triage process, the person raising the concern may disclose something that would determine the concern as a priority, identifying an immediate risk to patient or worker safety, this ensures the concern is fast tracked for an immediate response.

Standard concerns sit within the 93-day tracker. It is worth noting that 93 days is in line with other Trust policies where there are clear timelines for completion.

93-day tracker

In the 2022 NHSE FTSU report the following recommendations was made:

To ensure all managers know what is expected of them the Trust should consider using both a clear escalation process and a manager's toolkit for handling FTSU concerns. These should be widely publicised and available via internal communications channels. When a concern is sent to a manager these tools can be also shared directly at this point.

The table below gives an overview of how the escalation process would work at SECAmb.

	93-day Overview			
Days/ratings	***0 to 31 days***	***32-75 days***	***76 to 93 days***	***Over 93 days***
Escalations	**Concern Open** Pass to first appropriate manager	Escalation to next level manager	Escalation to senior manager level (AD/DD)	Escalation to Exec
FTSU lead	Deputy FTSUG	Deputy FTSUG & FTSUG	FTSUG	FTSU Executive
Reporting	Managed through monthly reporting to teams		Escalation to safeguarding sub-group	QGG

A manager's toolkit has been created and is provided to managers offering them advice and guidance on how to handle concerns.

Mandatory Training

Module	**Staff grade/level**	**Time allocated**	**Frequency**
Speak Up	All workers/Managers/Senior Leaders	1.5hrs	Occurring every 2 years
Listen Up	Managers/Senior Leaders	1.5hrs	Occurring every 2 years
Follow Up	Senior Leaders	1.5hrs	Occurring every 2 years

FTSU training is mandatory for all staff within SECAmb, these training modules, created in collaboration between the National Guardians office and Health Education England, are important to help us understand the vital role we all play in creating a healthy speak up culture which protects both patient and worker safety. Compliance figures are regularly monitored by the Guardian. The FTSU training modules have been active at SECAmb since October 2022. The current compliance figure for all staff as of 31/04/23, Speak Up 1783 (39.5%), Listen Up 179, Follow Up 70.

The FTSUG will work with leadership teams to aim for a compliance target for Speak Up of above 85% by end of Q4 23-24.

Freedom to Speak Up data

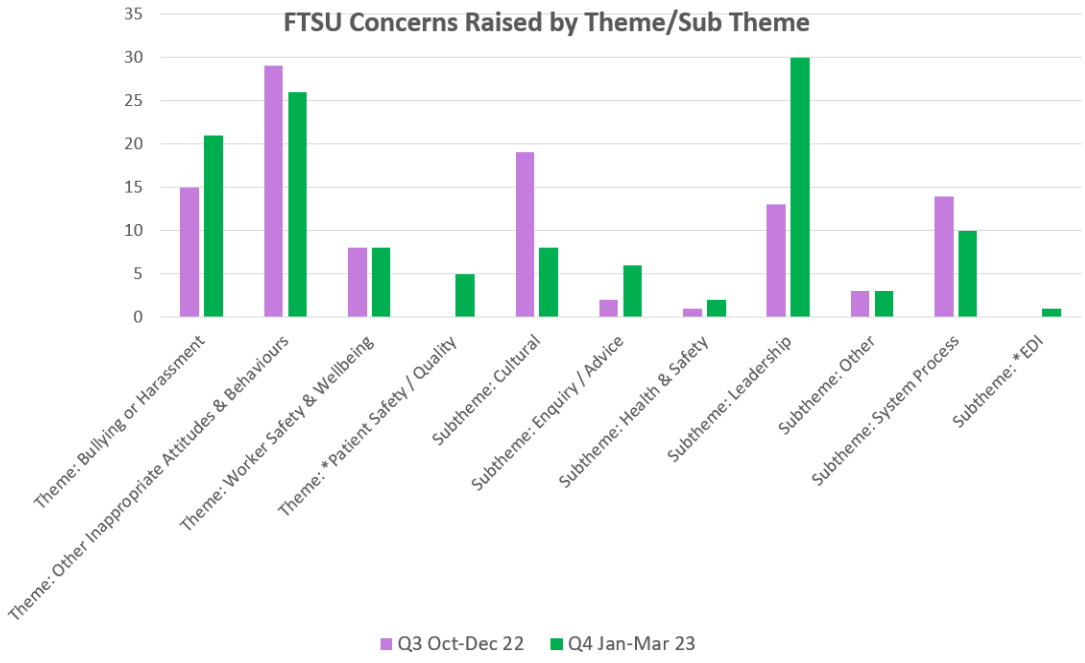
This table shows the number of concerns raised for years 20-21 and 22-23. Overall, there has been in an increase in the number of concerns per quarter. The exception to this is during Q3 which shows a slight reduction in the number of concerns for 22-23.

This could be explained by the induction of two new deputy guardians during this time, and the time needed to onboard and train our new FTSU colleagues.

2021-2022	Number of FTSU Concerns Raised	2022-2023	Number of FTSU Concerns Raised
Q1 Apr-June	19	Q1 Apr-June	20
Q2 July-Sept	19	Q2 July-Sept	35
Q3 Oct-Dec	60	Q3 Oct-Dec	52
Q4 Jan-Mar	46	Q4 Jan-Mar	60
Total	**144**	**Total**	**167**

The graph below shows concerns raised by themes and subthemes across the organisation. Themes are collected to align with national requirements, subthemes have been created at SECAmb to ensure a more detailed overview of the types of concerns being raised.

The top three themes raised during Q4 and Q1 22/23 were leadership, bullying & harassment and culture.



* Indicates new theme added to existing categories in Q4 (*Patient Safety/Quality & *EDI)

FTSU Examples related to the three main themes:

Example 1 – Leadership: "I asked for a change to my line management because I felt extremely uncomfortable talking about some very personal health concerns to someone of the opposite sex and I felt that they were uncomfortable when I had to speak to them about it to. My request was declined by several layers of management. I raised this to FTSU and unfortunately it took involvement from Executive level management for the request to be granted".

Example 2 – Bullying & harassment: "I spoke up to my managers after witnessing a racist comment, I was encouraged to write a witness statement and promised it would be in confidence. The statement was sent to the person who made the comment with my name attached and now her best friend who is my manager is bullying me".

NB: This has remained unresolved and is now being managed through formal HR processes.

Example 3 – Inappropriate attitudes & behaviours: "I work with colleagues who feel uncomfortable around a member of staff. They overstep the boundaries and keeps asking some colleagues out and declaring a negative impact on their mental health if they are declined. This individual has turned up uninvited outside of work at a location knowing that a particular colleague was there. It's been raised with senior management; this individual has had several informal warnings and a recent formal written warning, but their inappropriate behaviour continues and is now ignored by management".

Concerns broken down by main hotspots & themes raised during Q3 & Q4 2022/23

The locations with the highest number of concerns raised during Q4 and Q1 22/23 were 111/EOC/ East Operations and Finance.

111 (East & West)							
Main Themes		**Subthemes**		**Detriment**		**Anon**	
Bullying & Harassment	6	**Cultural**	6	**Total**	6	**Total**	0
Other inappropriate attitudes or Behaviours	5	**Leadership**	3				
Worker safety or wellbeing	1	**System Process**	3				
						Total number of concerns 12	

EOC (East & West)							
Main Themes		**Subthemes**		**Detriment**		**Anon**	
Bullying & Harassment	7	**Cultural**	9	**Total**	7	**Total**	5
Other inappropriate attitudes or Behaviours	7	**Leadership**	3				
Worker safety or wellbeing	4	**System Process**	8				
Patient safety	3	**Health & safety**	1				
						Total number of concerns 21	

East Operations (top 3 Dartford, Thanet, Paddock Wood)							
Main Themes		**Subthemes**		**Detriment**		**Anon**	
Bullying & Harassment	8	**Cultural**	5	**Total**	10	**Total**	6
Other inappropriate attitudes or Behaviours	10	**Leadership**	10				
Worker safety or wellbeing	4	**System Process**	2				
Patient safety	1	**Health & Safety**	1				
		Enq/Adv	3				
		Other	2				
						Total number of concerns 23	

Finance							
Main Themes		**Subthemes**		**Detriment**		**Anon**	
Bullying & Harassment	4	**Cultural**	1	**Total**	1	**Total**	0
Other inappropriate attitudes or Behaviours	9	**Leadership**	8				
		System Process	2				
		Enq/Adv	2				
						Total number of concerns 13	

There are a significant number of concerns raised relating to inappropriate attitudes or behaviours, leadership and bullying and harassment. We are committed to addressing these

themes and continue to build compassion into our leadership behaviours. It is also important that we ensure we work closely with HR colleagues to look at ways to improve staff experience when going through a formal process.

A large proportion of staff are choosing to raise concerns confidentially rather than openly, the reasons given for this is almost entirely due to a feeling of a lack of safety/fear of detriment. The FTSU team are working with some of the executive team to run several FTSU workshops starting in September 2023. It's hoped that improving the way in which leaders respond to concern will mean an increase in the number of concerns that are raised openly.

FTSU Engagement

The FTSU team ensure regular visits across all areas of the organisation, a map showing places recently visited areas is shared on staff intranet pages. The team also provide online clinics to ensure times are available for colleagues who may exclusively work, evenings/nights. The team also attend evening webinars provided for our Community First Responders.

October is national speak up month and this year FTSU will be looking to work with staff engagement teams and Comms to build a programme that connects to as many of our colleagues as possible, with a particular focus of the nationally recognised groups, who are often less likely to speak up.

Feedback to FTSU

> Thank you so much for your support I have been going through this process for a year and a half and honestly do not feel I would not have got anywhere without your support and input which I very much appreciate.

> I have been really satisfied with the FTSU service however I am disappointed that there has been no resolution or learning achieved from raising my concerns.

Honest feedback is important to improve the speaking up experience for our staff. The Guardian continues to monitor feedback forms and explore ways to encourage an increase in numbers of feedback forms received.

National Guardian Office (NGO) Updates

In February 2023 the NGO published 'Listening to Workers a Speak Up Review into the ambulance trusts in England'. These recommendations have in part, informed the priorities set out below. Recommendations 2 and 4 are relevant to SECAmb, whilst recommendations 1 and 3 are for the system wide/national attention of AACE, CQC, NHS England and the National Guardians Office.

The recommendations can be seen in Appendix A.

Priorities for FTSU

- **FTSU champions:** Recruiting a network of FTSU champions that will help to promote freedom to speak up locally and in addition support aspects of the FTSU policy by signposting staff to the right places to resolve their concerns. Over time. this may help to reduce the number of direct referrals to the FTSU service. This also addresses a recommendation made in the NGO's review into Speaking up.

- **Further analysis of highest referral areas:** Conduct a further review of the areas with the highest number of concerns raised. This is an opportunity to triangulate further data which suggests a culture of bullying & harassment and a fear of detriment and support the respective managers. 111 and EOC in particular have remained significant areas of concerns for the last 4 years of FTSU reporting.

- **NGO Review:** The FTSUG will work with leadership teams at SECAmb, National FTSU ambulance colleagues and AACE to ensure improvements are made both at SECAmb and nationally to create a workplace where staff feel safe to speak up, learning is achieved and encouraged, and patient safety is improved as a result.

- **FTSU Workshops:** The FTSU team will work alongside some of our Exec leads to plan and deliver a FTSU workshop, focussing on creating a psychologically safe space to speak up at SECAmb; understanding FTSU mechanisms, processes and outcomes; learning from concerns.

- **Vulnerable staff groups:** The FTSU team will continue to review how to improve equality monitoring and evaluation feedback to ensure all staff groups feel safe to speak up. A particular focus on improving links with our BAME colleagues, new starters and students will be a focus during National Speak Up month in October.

- **FTSU Training:** The FTSU team will seek to improve compliance figures for FTSU training.

- **Staff onboarding & Induction:** Working with both recruitment and L&OD to ensure knowledge on raising concerns is shared with staff from the earliest possible opportunity and improvements are made to delivering FTSU at corporate inductions.

- **Learning outcomes achieved**: Utilise QI for improvements to achieving learning from concerns raised and how these are embedded at a local and organisational level.

Summary

- **Number of reported cases and trends:** The number of cases reported compared to the previous financial year has increased slightly. The number is still considered high compared to similar size ambulance Trust and the Themes remain the same.

- **Data Quality:** FTSU at SECAmb worked with the Power Business Intelligence team to collect data in a centralise place to enable better access, analysis and reporting. FTSU data is represented on the Integrated Quality Dashboard. The dashboard has

been recognised nationally as a good example of how to effectively capture FTSU data and is being shared with NHS colleagues as best practice. It has also been shared with several police forces at their request. Developing on from this will be creating a national ambulance dashboard to feed directly into AACE.

The Board is asked to:

- Confirm assurance that the Trust Board is actively involved in shaping the Trust's vision for Freedom to Speak Up and are proactive in learning from speak up concerns.
- Commit to commissioning a review of the areas with the highest number of concerns raised.
- Consider reviewing/renewing Executive FTSU pledges in preparation for National speak month in October.

APPENDIX A

Recommendations from 'Listening to Workers – A speak up review of ambulance trusts in England, Feb 2023' Recommendations 2 & 4 being relevant to SECAMB, recommendation 1 & 3 being for system-wide/national attention.

For attention of SECAmb

Recommendation 2: Make speaking up in ambulance trusts business as usual:

This recommendation requires all ambulance trusts to:

- Mandate training on speaking up - in line with guidance from the National Guardian's Office - for all their workers, including volunteers, bank and agency staff, as well as senior leaders and board members.
- Ambulance trust leadership (including managers, senior leaders and board members) to fully engage with Freedom to Speak Up, evidenced by board members undertaking development sessions, delivered by the National Guardian's Office, with a view to role model effective speaking up, including purposefully providing and seeking feedback in the carrying out of their leadership roles.
- Embed speaking up into all aspects of the trusts' work by proactive engagement by leadership, managers and Freedom to Speak Up guardians across ambulance trusts through regular communications. Trust leadership teams should identify the professional groups/areas within the trust that need support in implementing Freedom to Speak up by diagnosing root causes and putting in place support mechanisms for managers and workers to feel psychologically safe when speaking up and reduce detriment.
- Ambulance Trust Boards to annually evaluate the effectiveness of speaking up arrangements; including effectiveness of facilitating all workers, including those from groups facing barriers to speaking up, being able to speak up about all types of issues and action being taken in response to speaking up. Trust boards will report on this evaluation publicly in their annual reports.

Recommendation 4: Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers.

This recommendation requires all ambulance trusts to:

- Meaningfully invest in the Freedom to Speak Up Guardian role. In discussion with their Freedom to Speak Up Guardian(s), leaders should identify the time and resources needed to meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions and board plans for implementing Freedom to Speak Up roles should be clear on resource implications and set realistic timescales.
- The National Guardian's Office suggests that as a minimum, the equivalent to three full-time workers is needed to carry out the reactive and proactive parts of the Freedom to Speak Up Guardian role in ambulance trusts. This is because of the characteristics of ambulance trusts, including their complex geographical footprint, and broader cultural and operational issues. The National Guardian's Office and NHS England will support, review and challenge the rationale arrived at by ambulance trusts about how much time is allocated to the role.
- The recruitment process used for the appointment of Freedom to Speak Up guardians must be fair, open and transparent and comply with current good practice in recruitment and equality, diversity, inclusion and belonging principles. This will help

ensure that people appointed have the confidence of, and are representative of, the workers they support.

- Create (if not already in place), maintain and regularly evaluate a network of Freedom to Speak Up Champions/Ambassadors to support raising awareness and promoting the value of speaking up, listening up and following up. Consideration to the organisation's size, geographical footprint and the nature of their work should be given to ensure support for workers, especially those facing barriers to speaking up.
- Provide emotional and psychological well-being support to Freedom to Speak Up Guardian(s). This support should reflect the challenges of the role and ensure the need for confidentiality. There should also be periodic check-ins with Freedom to Speak Up Guardian(s) about the

For System wide/national attention

Recommendation 1: Review broader cultural matters in ambulance trusts:

- This recommendation calls for an independent cultural review. The cultural review should consider management and leadership behaviours and focus on worker wellbeing, as well as:
- The effectiveness of governance/leadership structures, particularly considering the complex geographical footprint of ambulance trusts.
- Models/expressions of leadership, including 'command and control'.
- Defensiveness and 'just' culture.
- Arrangements for appointments, including fair and open recruitment and values-based recruitment.
- Operational and workforce pressures.
- Bullying and harassment including sexual harassment.
- Discrimination, particularly on the grounds of ethnicity, gender and gender identity, sexual orientation and disability.

Recommendation 3: Effectively regulate, inspect and support the improvement of speaking up culture in ambulance trusts.

- Ensure workers' voices are effectively captured and reflected in regulators' decisions when reviewing their frameworks and treated with parity to those of patients' voice.
- Implement mandatory and regular training on speaking up - in line with guidance from the National Guardian's Office - for all workers (including senior leaders) involved in the regulation, inspection, and improvement support of ambulance trusts.
- Make assessment of the speaking up culture and arrangements a cornerstone of their regulatory and oversight frameworks, recognising that the safety of patients and the public - as well as the sustainability of the health service - depends on workers' ability to speak up and for regulators to listen and follow up when they do.
- The Care Quality Commission to continue to improve their inspection methodology around the rigorous assessment of speak up culture and psychological safety.
- Communication and partnership working among national bodies to share information about speaking up culture and arrangements. The National Guardian's Office commits to the following:
- Support training for NHS England and the Care Quality Commission workers on speaking up.

- Leading the collaboration with partners including the Department of Health and Social Care, the Care Quality Commission and NHS England. CONFIDENTIAL – NOT FOR ONWARD SHARING 11
- Working with NHS England and the Care Quality Commission to strengthen their approach to addressing detriment.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	25-23

Name of meeting	Trust Board
Date	1 June 2023
Name of paper	People Committee Escalation Report – May 2023
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 11.05.2023 and confirms whether any matters require specific intervention by the Trust Board.

Item	**Purpose**	**Link to BAF**
Before the main agenda began the following issues were raised under Executive Escalation:		
Executive Escalation	The executive has the opportunity to escalate to the committee any urgent matters not on the agenda	n/a

There were three issues:

a) Cohort of International Recruits

The committee noted related to competency issues identified in one cohort, the process is now concluded with each of the individuals. The executive is seeking advice from external bodies such as HCPC, to help ensure learning. This will be reported to the committee in due course, to pick up the wider learning as it is aware some not related to this cohort have not had good experiences and have returned home.

b) Industrial Action

Following the national pay agreement staff will receive the back-pay in June, although some unions continue to have a mandate for strike action.

c) Appraisals Compliance

The committee was updated on the improvement work underway to increase completion rates; it is currently 63% rolling year. This includes a potential issue with use of the ESR system (to record appraisals) and the committee needs more assurance that these difficulties are not an excuse for poor compliance.

Recruitment Internal Audit	Purpose: Requested by the Audit & Risk Committee, to update on the management action plan for Internal Audit related to time to hire.	P&C Objective 3 – Rapid On-Boarding BAF Risk 255 – Workforce Planning

	Assurance: To seek assurance that the actions agreed have been taken and have had the impact set out, i.e. to reduce time to hire from 12 to 8 weeks	
The committee is not assured as progress has not been made. A new approach has been agreed by the executive to make changes via a QI project, which seems to be a positive step. This is one of the People & Culture objectives (see BAF). The committee will receive regular updates to ensure the outputs of this result in the impact needed.		
Stat / Man Training	Purpose: An update on the management action plan related to this Internal Audit. Assurance: To seek assurance that the actions agreed have been taken and have improved compliance.	P&C Objective 4 – Training
Good progress has been made with this which is also a CQC 'Must Do' - we are at 84.5% rolling year compliance. The Committee has assurance that a new policy has been created and approved and new internal governance arrangements are in place to ensure executive oversight However, the committee noted that the timeframe for some of the management actions have been extended from March to August. See reference to this in the Audit Committee's Board Report.		
People & Culture	Purpose: Having agreed the strategy, to inform the committee on the approach and specific objectives to deliver cultural change. Assurance: To seek assurance that there is a robust plan in place, which is coherent, aligned with the strategy, has milestones and is outcome based.	P&C Strategic Goals 1-3 BAF Risk 348 – Culture & Leadership
The executive set out its work to define the delivery plan which will ensure a close link to what staff care about most, as they have repeatedly fed back via the staff survey and in other ways. The starting point therefore is to help rebuild trust as people see action being taken. This will therefore be one plan that incorporates our response to the staff survey. The committee is assured that the full executive is aligned and working together on this and that it is the voice of our people driving the focus. It reinforced the need to ensure responsibility for change is seen as everyone's role, not just the executive / senior leadership. However, the committee is concerned about impact given the history of slow delivery. It asked that in the development of the plan there is clarity on how the impact will be measured, and it will seek assurance that the 'housekeeping' items are delivered in a short time frame to build trust with our people.		

EOC Culture / Retention	Purpose: Update on the approach being taken supported by Moorhouse; progress to-date; and how this will transition from Moorhouse to the management team. Assurance: To seek assurance that this intervention is having a positive impact and that there is a clear plan in place to take forward the actions that will be recommended as a result.	P&C Objective 1 BAF Risk 348 – Culture & Leadership BAF Risk 255 – Workforce Planning
Moorhouse provided an objective view and enabled us to reflect on what we need to do. Most of what they highlighted we knew about, so the focus has been on exploring the barriers preventing us to take action. It is assuring that the whole executive team have leaned into this to own the issues. The action is included in the P&C strategy delivery plan which is objective 1 (See the BAF).		
HR Review	Purpose: Report on progress against the actions from this external review, to include data on ER cases. Assurance: To seek assurance that the actions agreed have been taken and that they are having the intended impact, to include assurance that there is adequate and sustained improvement on the management of ER cases.	P&C Objective 9 – Improve capacity and capability of our formal processes (ER / FTSU) P&C Objective 10 – Ensure policies in date and fit for purpose.
The committee has scheduled a review of specific areas of this review at each meeting. This meeting focussed on ER capacity and the committee explored the rationale for the improvement case and investment in new roles to manage the ER workload. At the next meeting the committee will review the entire plan to ensure the recommendations are being adequately addressed, with the impact expected.		
Clinical Education	Purpose: Provide details of the Clinical Education Plan for 2023/24; how the executive intends to report progress in-year. Assurance: To seek assurance the plan is robust and includes clear milestones.	S&P Objective 5 – Joint Workforce Plan BAF Risk 255 – Workforce Planning Extreme Risk 357 – Delivery of CE Strategy
A helpful paper was reviewed setting out the plan, progress and risks. There is confidence that this will support the delivery of the workforce plan this year, but it is clear that the operating model will change as		

part of development of our new strategy. As this changes the approach from clinical education will need to flex.

The committee also noted that culture transformation starts with students and so the work on culture will be linked into clinical education.

Good overall assurance. However, there is concern about the business case as some aspects are yet to be resourced. This is critical to delivery of the workforce plan. Phase 1 this year will be cost neutral and the investment needed for 2024/25 will come through in due course aligned to the implications of the new Trust strategy.

999 Workforce Plan	Purpose: Provide details of the workforce plan for 2023/24; how the executive intends to report progress in-year. Assurance: To seek assurance the plan is robust, has cross-directorate alignment, e.g. with clinical education, operations, and the HR recruitment teams, and includes clear milestones.	S&P Objective 5 – Joint Workforce Plan BAF Risk 255 – Workforce Planning

As the Board is aware, the shortfall in the workforce plan last year has been added to this year's plan – shortfall is 130 WTE in field operations and 37 WTE in EOC. The plan has been developed in conjunction with clinical education. The main risk to the plan is attrition; it sets out what we expect for each quarter.

There has clearly been close collaboration between teams which is essential. The success of the workforce plan requires close collaboration between HR Recruitment, Clinical Education and Operations. Weekly tactical meetings are held whereby opportunities and challenges can be identified and discussed with resolution sought. The committee is assured by this.

Our reliance on international recruitment is acknowledged and there is a question of whether this is sustainable.

The committee will review progress against the plan at each meeting and will also be reviewing the workforce plan for 111 and corporate services.

Specific Escalation(s) for Board Action	There are no specific escalations for the Board's intervention. However, the Board is asked to note the following: Evaluation of sexual safety courses This was considered under matters arising. The committee challenged the executive on completion as while attending the workshop is a mandatory requirement it did not meet the Trust's target for statutory and mandatory training of 85%. However, the response to the training has been positive. The feedback suggests that participants have been emboldened to discuss the subject openly with their teams, are more aware of the issues

	and more likely to challenge poor behaviour when they witness it. The committee will receive a report later in the year on the metrics that help determine the *impact* of these interventions. <u>Quality of papers</u> While papers are generally improving, with assurance being supported by data, the committee has reinforced the need for papers to be more concise. In particular with clarity on delivery and gaps, and how the assurance provided helps mitigate relevant risks. And lastly, for awareness, the committee has asked to have a presentation from Professional Standards Unit to seek assurance on their role in improving our culture.

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.

Recommendation	**Progress to-date**
To ensure the structure of the agenda is aligned to the organisation risks	It is aligned with the BAF
To ensure the assurance method is appropriate to the level of assurance required	The assurance required by the committee is set out in advance and on the agenda
To ensure the cycle of business is explicit to the whole membership and any omissions are recorded and carried forward	The COB has been revised and will highlight any omissions.
To ensure the minutes are a factual, concise summary of the discussion	Ongoing
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	As above
The committee to consider how the dashboard can be maximised to provide assurance on the BAU oversight and also on the items on the agenda.	This action has bene superseded as there is currently no dashboard. The COB sets out areas of focus, and the committee is also directed by the Board as it identified gaps in assurance, including from the metrics in the IQR.
the chair to consider what assurance is required from subject matter leads in advance of documentation being supplied	Complete – as above.
The Chair and Trust Chair to consider if quarterly meetings offer the necessary assurance for the Board..	The meetings are now bi-monthly, consistent with the other board committees.

The Chair to consider if the Director of Quality & Nursing needs to be a core member of the committee. If not, then consideration needs to be given as to how Health & Safety connects with the committee.	They attend as needed, and always when H&S is being reviewed.
The Chair to consider how the committee can champion the corporate values (an opportunity to lead the way)	Ongoing
To ensure papers are assurance driven.	Linked to the items above re clarity on the assurance needed by the committee, as reflected in the report to the Board.
The Board development programme to include the culture of challenge within its development plan	Complete – see the Board Development Plan.
Consider how the committee connects up and down to the Trust Board.	The committee is directed by the Board and after each meeting provides escalation reports to the Board.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	26-23

Name of meeting	Trust Board
Date	01 June 2023
Name of paper	Operational Performance & Efficiency Executive Summary
Strategic Theme	**Responsive Care**
Author / Lead Director	Emma Williams, Executive Director of Operations

Executive Summary

This paper provides additional context and details relating to content relating to the Responsive Care pillar that is found in the Integrated Quality Report and the Board Assurance Framework. This is divided into the three Trust strategic priorities within the pillar:

1. Deliver safe, effective, and timely response times for our patients,
2. Implement smarter and safer approaches to how we respond to patients,
3. Provide exceptional support for our people delivering patient care.

Responsive Care

Goal 1	Deliver safe, effective, and timely response times for our patients
RC 1	A Category 2 Mean response time that is improved and closer to National Standards
RC 2	A Call Answer Mean time of 10 seconds
RC 3	Implementation of dispatch improvement actions to improve effectiveness of resource utilisation (RPI, cross-border working)

The Trust has committed to the target of a 30min C2 mean performance for the financial year. The analysis undertaken to deliver this is reliant on tangible, sustainable actions. Operational organisational change groups have been set up to oversee the delivery of these programmes of work with benefits to date including improved governance and accountability and interdependencies both within this programme and linked to other pillar programmes.

Key points to note:

- All ARP metrics are above the national standards with recent improvements primarily due to an improved relationship between demand and resource availability. Whist there is a commitment to recruit to the plan (and budget) and implement the programme of efficiencies, which should support this continued trend, we will continue to focus on ensuring we meet this 30min C2 mean target.
- Call answer performance has improved in this past month, including in relation to other ambulance services, however workforce challenges continue, particularly in the Crawley area.

Goal 2	Implement smarter and safer approaches to how we respond to patients
RC 4	Improvements in our 'Hear and Treat' rate to a minimum of 14%
RC 5	Continued working on key/national programmes – 999 IRP, ~~111 SVCC~~, response to Manchester Arena Inquiry recommendations
RC 6	Improved utilisation of all clinical resources from volunteers to specialist practitioners to achieve improved performance

The range of activities within this goal are in different stages of development/evolution during Q1, recognising the scale and variety of levels of partner engagement requirement across the list.

Key points to note:

- The 'Hear & Treat' programme has seen the first cohort of Paramedics go 'live' within the pilot scheme for Paramedics within their dispatch desk to be able to support local patients who are suitable for a clinical call-back. This opportunity provides improved capacity to support 'Hear and Treat' and creates a development/diversification opportunity for Paramedics who may wish to undertake a range/variety of functions.
- Collaborative working with emergency service partners on the recommendations from the Manchester Arena Inquiry progressed with a second workshop in April, specifically considering interoperability and potential co-delivery of actions as well as options to develop a shared working structure across the region which.
- The work on the improved utilisation of volunteers and specialist practitioners, is focusing on the falls programme for Community First Responders and additional functions with EOC – namely the use of Urgent Care Pathways and the implementation of the C2 segmentation function.

Goal 3	Provide exceptional support for our people delivering patient care
RC 7	An improvement in on-day out of service, late shift over-runs both a % of shifts and mean over-run time
RC 8	Integration of EOC, 111 and MRC operations in one site at Medway
RC 9	A new Ambulance design and Fleet strategy that meets our needs for the future

Key points to note:

- As per the paper taken to the People Committee – due to the complexity of contributory factors influencing the on-day-out-of-service and shift over-runs, this needs to be addressed at both a local and trust level. A programme of work has commenced, led by local leaders to identify and quantify actions to deliver a trajectory of improvement.
- April saw the final stages of snagging and preparation to hand over the new Medway MRC. A huge amount of work has gone into getting everyone and everything to this position with the planned move in date for 8th June.

South East Coast Ambulance Service
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Agenda No	27-23

Name of meeting	Board
Date	01.06.2023
Name of paper	Achieving Sustainability & Working with Partners Executive Summary
Strategic Theme	**Sustainability & Partnerships**
Author / Lead Director	Charles Porter, Interim Chief Finance Officer David Ruiz-Celada, Executive Director for Strategic Planning and Transformation

Executive Summary

Finance

The Trust's financial performance for the month to 30th April 2023 was £0.1m lower than plan. The main reason is the main reason is the £0.5m adverse variance in operations, partially offset by benefit in other areas. A deep dive is being carried out in this area. Work continues on developing the robust cost savings programme. These support the key Trust requirement to have a break-even plan and then deliver against it for each quarter of the year.

Partnerships Working (SP3, SP4)

As part of our annual plans, there are key system partnership enablers that will allow us to perform better and improve patient care:

- UEC Recovery Plan focussing on increasing our capacity and reduction in handovers
- Urgent Community Response improving appropriate pathways for patients into non-ED
- Regional Mental Health response plans

This work compliments our internal targets of improved Hear and Treat to 14% and are key to meeting Category 2 Mean of 30 minutes under Responsive Care annual objectives and it's a collaborative work between Quality, Partnerships, Data, and Clinical EOC colleagues, providing support to Operations.

Data availability continues to be a challenge, with still poor visibility of the full pathway data as reported in April. The ADS work should provide us with better visibility from September, and this remains a focal point for the Patient Flow Working group.

In addition, we are engaged in the Joint Forward Plan development for our 4 ICBs. The Partnership update provides an overview of the key areas of focus of each ICB, and we are including a more detailed review of the commonalities and gaps across our operating patch as part of the strategy development work.

These priorities support our CQC deliverable MD5, ensuring we are working in collaboration with system partners to improve ARP responses.

Strategy Development (SP1 and SP2)

Following the Board approval to progress a new Strategy for SECAmb in April, several framing and engagement sessions have taken place. Input from COG, Board, and Senior Management teams, as well as consultation with our lead ICB and Staff Network and Union colleagues has taken place to inform our approach to develop the Strategy. This will support our delivery of the objectives SP1 and SP2 for the year and will help us frame the BAF going forward into 24/25.

This work will also define our operating model, and will define the mitigating actions for BAF Risk 14 (operating model) and 255 (workforce), by providing us with long-term answers to these strategic risks.	
Recommendations, decisions or actions sought	The Board is asked to test whether there is sufficient progress with the corporate objectives, and the controls and mitigating actions against the relevant risks, as set out in the Board Assurance Framework and Integrated Quality Report. Where it identifies gaps in assurance, agree what corrective action needs to be taken by the Executive.

Agenda No	**27-23**

Name of meeting	**SECAmb Board**
Date	01.06.2023
Name of paper	Strategy Development – Progress Update Report
Strategic Theme	**Sustainability and Partnerships**
Lead Director(s)	David Ruiz-Celada, Executive Director for Strategic Planning and Transformation Rachel Oaten, Chief Medical Officer
Author	Peter Inkpen, AD Planning & Development
BAF Objectives	SP1, SP2
Synopsis	The SECAmb Strategic Development Framework outlines a six-stage process for shaping our future direction, based on the successful Monitor Toolkit, and has been adapted based on initial workshops with the Board and Councill of Governors, as well as input from the CAG and commissioners. Each phase is designed to ensure comprehensive, inclusive, and data-driven strategic planning, taking into account the needs of our patients, colleagues, and partners. **Diagnose** focuses on understanding our current operations and stakeholder landscape. **Forecast** aims to anticipate future trends and challenges. **Generate Options** explores potential strategic scenarios. **Prioritise** determines the most viable options based on various criteria. **Deliver** implements the chosen strategy, with robust governance models and resource allocations. **Evolve** ensures the flexibility and longevity of our strategy through continuous review and adaptation. This document serves as an update to the Board on what has been achieved so far on our journey to develop a trust strategy, and in addition, a proposed timeframe.
Recommendations, decisions or actions sought	Board to note progress against the plan to develop the Strategy by December 2023.

BOARD UPDATE ON STRATEGY DEVELOPMENT

1. Introduction

In December 2022, the Board gave clear direction that SECAmb will shift from being regulatory driven to strategically driven. Feedback received across the trust indicated that delivery of a safe quality service was not seen our prime focus, and the current model does not support sustainable delivery of ARP standards. In addition, it was felt that we do not meet the expectations of our patients and unless we change the way we operate this will not improve.

To address these gaps, the Board agreed to progress the development of a clinically led, data informed new long-term strategy for SECAmb in April 2023, with a view that it should be ready in time for planning our priorities in 2024/2025 and to give us a platform on which to build the future SECAmb beyond CQC and NOF4 actions.

The overall aim is to create an ambitious and innovative long-term strategy that ensures SECAmb can sustainably deliver high-quality, equitable and efficient care to patients, whilst maintaining our financial envelopes, enhancing the experience of our people, and protecting our environment.

2. What have we done so far?

Established principles for engagement following facilitated workshops across the Senior Management, Executive, Board and Council of Governors. These are:

- *"We need a strategy so we can be innovative and ambitious, clear about what we stand for and who we are, sustainable, inclusive, and focussed on delivering high-quality patient care while fostering a positive working environment for our people."*
- *"We want our people and partners to feel engaged, valued, and included in the strategy development process, fostering a sense of ownership and excitement about the organisation's future".*
- *"We want to involve our stakeholders in a collaborative and inclusive process to ensure diverse perspectives are considered, and the resulting strategy reflects their collective needs and priorities".*

The capacity and know-how to properly develop a co-designed strategy was not evident within the trust and so it was agreed that external support would be required to assist us in this ambition, therefore a procurement process is underway to select a strategic partner that will complement our internal expertise and support our leadership in its development.

The proposed process and framework have been shared widely across the trust and externally to our ICS colleagues and NHSE. Positive feedback has been received on our approach and some useful suggestions on how we might work with colleagues moving forwards. Overall, there has been extremely positive comments and all our partners are supportive of the approach to develop the strategy now and that we are seeking the support of an external strategic partner.

3. What are the next steps?

- The Procurement process is underway, and the Tender pack is being sent out to prospective partners week ending 2 June 23.
- A mini competition will take place, tentatively planned for week commencing 12 Jun 23 with a 2-part process to ensure the potential partner 'fits' with the organisational values and also a more formal interview panel where a robust assessment process will score each potential partner.
- It is anticipated that the trust commences working with the successful partner at the start of July.

- The final details of the selection process and evaluation are being confirmed and will be published in due course. The selection panel is being drawn from all areas of the trust to ensure complete inclusion and diversity in the selection process.
- There is a small amount of tolerance built into the timeframe to allow overrun of selection panel and award of contract but a small (1/2 week) slippage in the start date is considered acceptable to ensure the trust engage the correct and most appropriate partner that will work with us to deliver on our strategic objectives and align to our organisational values.

4. Proposed Timeline

Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
w/c 15/05/2023	w/c 22/05/2023	w/c 29/05/2023	w/c 05/06/2023	w/c/ 12/06/2023	w/c/ 19/06/2023
Complete proposal and submit to Procurement		1) Tender release and invitation to potential consultancy agencies 2) Begin the procurement process	1) Continue tender process 2) Allow consultancy agencies time to review the tender pack and ask clarifying questions if needed. (Submission deadline - 09/06/2023)	1) Selection Panel and Award 2) Evaluation of proposals and selection of preferred consultancy agency	*Spare week for any necessary follow-up or adjustment in the procurement process*

Week 7	Week 8	Weeks 9-25	Week 26
w/c 26/06/2023	w/c/ 03/07/2023	17 weeks	w/c 06/11/2023
1) Preliminary work with the selected consultancy agency 2) Contract negotiation and finalisation	** Project go-live ** Officially initiate strategy development programme	1) Co-design Trust Strategy 2) Engage with consultancy agency in collaborative strategy development, including data analysis, stakeholder engagement, and goal-setting	1) Draft Strategy review by SMG, EMB and Board members 2) Collect feedback and incorporate revisions

Week 27	Week 28	Week 29	Week 30	Weeks 31-32
w/c 13/11/2023	w/c 20/11/2023	w/c 27/11/2023	w/c 04/12/2023	2 weeks
Changes and additions to draft Strategy based on review feedback	Continued refinement and finalisation of final strategy draft	*Spare week for any necessary follow-up or adjustment in the development process*	1) Co-presentation of final strategy to Trust Board 2) Seek approval and endorsement of the strategy	1) Wrap up remaining tasks, documentation, and implementation planning 2) Transition to next phase of strategy execution and implementation.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	27-23

Name of meeting	Trust Board
Date	01/06/2023
Name of paper	System Partnerships Update
Strategic Goal	**Sustainability and Partnerships**
Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning & Transformation
Author(s)	Matt Webb, Associate Director of Strategic Partnerships & System Engagement Ray Savage, Interim Head of Strategic Partnerships
BAF Objectives	SP3, SP4, RC4, RC1

This report provides an update on the progress of the four ongoing regional Urgent & Emergency Care (UEC) priority areas: the UEC Recovery Plan, ICB Joint Forward Plans (JFP), Regional Ageing Well (UCR) programme, and Regional UEC Mental Health response.

Urgent & Emergency Care (UEC) Recovery Plan

The Leadership Team has reviewed the NHSE Urgent & Emergency Care (UEC) Recovery Plan, which aims to stabilise services and meet recovery ambitions. The Trust is actively involved in priority UEC recovery focus areas, including capacity increase, clinical assessment improvements, workforce development, and mental health access enhancement. The report highlights alignment with the integrated care systems (ICSs) and ongoing collaboration with stakeholders.

ICB Joint Forward Plans (JFPs)

The JFPs developed by the ICSs demonstrate strategic alignment and focus on reducing health inequalities, improving access to care, and addressing key priorities. The report provides updates on the JFPs of NHS Kent & Medway, NHS Sussex, NHS Surrey Heartlands, and NHS Frimley, highlighting key initiatives, such as UEC pathway development, support for frailty and End-of-Life Care, and addressing mental health needs and crisis intervention. The Trust is actively engaged in the JFP development process and will continue to collaborate with the ICSs.

Regional Ageing Well (UCR) Programme

The Trust has established a Patient Flow Steering Group to optimise Hear & Treat and See & Treat pathways. The report outlines the objectives of the steering group, including identifying gaps in primary care and community service (non-ED) pathways and enhancing monitoring and referrals. The Trust's engagement with community service providers and ICSs aims to improve patient outcomes, and resource efficiency, and reduce unnecessary conveyances.

Regional UEC Mental Health Response

The Trust remains actively engaged in collaboration with NHSE, mental health and UEC commissioners, and providers to establish a regional mental health response. The report highlights the Trust's implementation of initiatives, such as Mental Health First Aid training and collaboration models. Key focus areas include streamlining integrated care pathways, enhancing staff skills, promoting collaborative service delivery, and data sharing.

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 August (2023).

1. 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 Q1 (2023/24).

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

2. Urgent & Emergency Care (UEC) Recovery Plan

The Leadership Team has evaluated the NHSE's Urgent & Emergency Care (UEC) Recovery Plan with aims to stabilise services and achieve 76% A&E four-hour performance by March 2024, and improve ambulance response times to 30 minutes. Applicable UEC recovery areas, being led by members of various teams, encompass increasing capacity via non-emergency pathways, reducing unnecessary conveyance, enhancing clinical call assessments, minimising staff absence, and providing more access to mental health expertise.

Our integrated care boards are aligning the UEC Recovery Plan priorities to existing workstreams. These efforts, overseen by each ICS's UEC Board and supported by our Strategic Partnerships team, focus on reducing falls-conveyances, maximising non-emergency pathways, improving call response times, and refining Hear & Treat processes including 999/111 referrals into community services.

3. ICB Joint Forward Plans (JFPs)

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 finalising its JFP in consultation with its partner provider and foundation trusts. The first JFP (NHS Kent & Medway) having been shared with the Trust for Executive Management Board review in April 2023.

ICB	Draft received	EMB consideration	Noted at Trust Board	NHSE deadline
NHS Kent & Medway	27/03/2023	05/04/2023	06/04/2023	30/06/2023
NHS Surrey	15/05/2023	24/05/2023	01/06/2023	30/06/2023
NHS Sussex	18/05/2023	31/05/2023	01/06/2023	30/06/2023
NHS Frimley	24/04/2023	31/05/2023	01/06/2023	30/06/2023

3.1. NHS Kent & Medway

As reported in April 2023, the NHS Kent & Medway ICS has developed a JFP aligned with their Integrated Care Strategy. This roadmap aims to diminish health inequalities, optimise access to care, and enhance regional healthcare services, with effective partnership working and strategy-driven priorities.

The JFP focuses on operational and strategic ICS objectives, like developing efficient UEC pathways for improved patient outcomes and resource optimisation, particularly regarding frailty care. It proposes measures to refine care pathways and decrease avoidable ambulance deployments. The document also prioritises comprehensive End-of-Life Care, advocating collaboration with local hospices for personalised, seamless care.

Additionally, the JFP emphasises addressing mental health needs and crisis intervention, underlining the significance of early and community-based access to services, offering alternatives to 999, NHS 111 and emergency departments for timely and appropriate crisis support.

3.2. NHS Sussex

NHS Sussex's Shared Delivery Plan (SDP), reflecting the Sussex Integrated Health and Care Strategy, is structured into four main sectors: Long-term Improvement Priorities, Immediate Improvement Priorities, Continuous Improvement Areas, and Health and Wellbeing Strategies. The associated Urgent and Emergency Care workstream, led by the CEO of University Hospitals Sussex NHS Foundation Trust, targets improvements in 999 response times, A&E waiting times, suitable non-ED pathways, and collaborative care models.

The SDP aims to enhance UEC services, improve emergency responses, and enrich patient experiences through integrated teams, workforce development, digital technology, primary care enhancement, streamlined discharges, and reduced health inequalities.

The SDP's effective execution is overseen by Sussex CEOs leading 11 workstreams, with NHS Sussex dedicated to achieving enduring improvements, addressing current priorities, and promoting continuous enhancement. An internal review of the NHS Sussex SDP, assessing impacts, risks, and opportunities from a UEC standpoint, will be presented to the EMB on 31 May 2023.

3.3. NHS Surrey Heartlands:

Three strategic aims guide the NHS Surrey Heartlands JFP: Prevention, Delivering Care Differently, and Key Functions. ‘Prevention’ aims at promoting physical and mental well-being and considering wider health determinants. ‘Delivering Care Differently’ involves establishing neighbourhood teams and provider collaboratives for broader and cooperative care, whilst ‘Key Functions’ ensure community involvement in healthcare services, address workforce needs, manage finances, foster research and innovation, harness digital technology and data, and optimise estate infrastructure.

The JFP aims to enhance healthcare delivery, improve outcomes, and promote well-being within Surrey. It provides a strategic ICS roadmap, addressing regional healthcare challenges through collaboration, innovation, prevention, and alternate care delivery methods. A full internal assessment by the Strategic Partnerships team will be reported to the EMB on 31 May 2023.

3.4. NHS Frimley

NHS Frimley's JFP, aligned with the ICS strategy, highlights its contributions to shared ICS goals. It sets three overarching objectives: enhancing local community health and well-being, delivering high-quality patient care, and ensuring service sustainability.

To support these aims, the JFP sets goals including reducing health inequalities, increasing healthy life expectancy, developing clinical services for improved outcomes and experiences, supporting the workforce, enhancing service delivery capacity, and optimising shared resources for long-term financial sustainability.

An internal assessment of the NHS Frimley JFP, reviewing impacts, risks, and opportunities, will be presented to the EMB on 31 May 2023.

3.5. Conclusion

The ongoing internal assessments of the JFPs will provide valuable insights for the Trust's developing Strategy in 2023/24, ensuring that the Trust's goals and priorities are strategically aligned with the broader system objectives.

The next steps for the Trust involve actively collaborating with the ICSs to align strategies and objectives. This includes:

- Developing UEC pathways
- Better-integrating technology and data
- Prioritising joint workforce development and planning
- Participating in performance monitoring and evaluation.

4. Regional Ageing Well (UCR) Programme

The Trust has formed a "Patient Flow Steering Group" to maximise Hear & Treat and See & Treat pathways through primary care and community services like Urgent Community Response and mental health crisis teams. The group, comprised of senior representatives from various departments, aims to align the Trust with the national and regional Ageing Well and UEC Recovery programme priorities. Its focus includes reducing unnecessary conveyance and hospital admissions, improving patient outcomes, and resource efficiency.

Key group objectives include:

- Identifying and enhancing primary care and community service pathways
- Boosting referral efficiency
- Developing cross-system standard operating procedures and principles
- Establishing a consistency community referral tracking method
- Promoting best practices
- Evaluating referral pathway effectiveness using KPIs.

The Trust's Integrated Urgent Care (999/111) team is collaborating with the four ICSs and community providers to organise daily calls with their Urgent Community Response teams. This will help to identify incidents appropriate for community response, reducing ambulance deployment and hospital admissions. The programme commenced in May 2023, and while still early, one community provider has been involved in daily calls and accepting suitable referrals. Other providers are expected to join soon, validating the proof of concept, and exploring further digital integration opportunities.

5. Regional UEC Mental Health Response

The Trust is actively collaborating with NHSE, mental health and UEC commissioners, and providers to establish a regional mental health response in accordance with the Mental Health Commissioning Guidance for Ambulance Services (2022). Several recommendations from the guidance have already been implemented, such as Mental Health First Aid training and increased mental health clinician coverage in 999/111 services. The Trust is also exploring collaboration models between Trust clinicians and mental health practitioners at-scene where appropriate.

Regional MH UEC initiatives the Trust is involved in include on-scene or virtual assessment by mental health professionals, reducing ED conveyances, and avoiding inappropriate transportation in police vehicles. The Trust has tested response models like Blue Light Triage (BLT) within the Sussex ICS, resulting in decreased ED conveyances and Section 136 detentions, improved patient safety, and enhanced patient experience.

The Trust, though not leading the Mental Health Response Vehicle bid at the regional level, remains dedicated to supporting the development of a regional MH UEC strategy. It focuses on streamlining integrated care pathways for mental health crises and exploring educational opportunities to enhance clinician knowledge and skills. It also advocates for collaborative service delivery models and improved data-sharing mechanisms to promote patient-centred care planning and support.

The Trust is also part of an ongoing NHSE-led MH UEC governance review, ensuring strategic alignment between internal and external system governance and providing a clear strategic commissioning governance framework.

Conclusion

In conclusion, this Board report highlights the Trust's commitment to working with partners to enhance healthcare services, improve patient outcomes, and reduce health inequalities through its engagement in the four ongoing regional UEC priority areas. The Trust's strategic alignment with the ICSs and active collaboration with stakeholders demonstrates its dedication to achieving regional goals and priorities.

Further visibility of the key performance indicators that are driven by effective partnership working is a development for early Q2 in line with our Patient Flow programme of work. This will enable us to understand better the capacity available for different pathways across the four systems we operate within and evaluate the effectiveness of utilisation of referrals to those alternative appropriate pathways.

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 August (2023).

Item No	27-23

Name of meeting	Trust Board
Date	01.06.2023
Name of paper	Finance Report
Executive sponsor	Charles Porter Interim Chief Financial Officer
Authors names and roles	Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Acting Deputy Chief Finance Officer), 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 1 (as at 30 April 2023). The Trust is reporting a £0.1m deficit for the first month, £0.1m worse than plan. The Trust is expecting to achieve break-even position against its financial plan for the year. The Trust is embarking on achieving recurrent efficiencies of £9.0m to underpin the achievement of this plan. Our cash position is £40m which is £2m below plan.
Recommendations, decisions, or actions sought	The Board is asked to note the financial performance against plan, and the continuing drive to deliver a balanced budget.

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**

2023/24

Finance Report to the Board of Directors

1 Month to 30 April 2023

Contents

Executive Summary

Values are shown in millions and are subject to rounding.

	April 2023				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Income	£26.0m	£26.1m	£0.0m	✓	£312.2m	£312.3m	£0.0m	✓
Underlying Expenditure	£26.0m	£26.2m	(£0.2m)	✗	£312.2m	£312.3m	£0.0m	✓
Trust Surplus / (Deficit)	£0.0m	(£0.1m)	(£0.1m)	✗	(£0.0m)	(£0.0m)	£0.0m	✓
System 'Control' Adjustments	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Reported Surplus / (Deficit)	**£0.0m**	**(£0.1m)**	**(£0.1m)**	✗	**£0.0m**	**£0.0m**	**£0.0m**	✓
Efficiency Programme	£0.1m	£0.0m	(£0.1m)	✗	£9.0m	£9.0m	£0.0m	✓
Cash	£42.2m	£40.1m	(£2.2m)	✗	£50.4m	£50.4m	£0.0m	✓
Capital Expenditure	£1.3m	£1.5m	(£0.2m)	✗	£25.9m	£25.9m	£0.0m	✓

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

In Month

- The Trust is reporting a £0.1m deficit against it plans, driven by higher than anticipated expenditure.

- £0.1m planned efficiencies for the month are yet to be realised as we focus on developing the pipeline of schemes. £6.4m schemes have been confirmed against the target of £9.0m.

- The cash position reduced by £4.0m this month to £40.1m. This is £2.2m below plan due to lower than anticipated income received from commissioners. The key issue is in relation to not yet receiving the Trust's share of the additional £200m funding made available to ambulance services. The Trust is working with the ICB and NHSE to resolve this and is expecting to receive its allocation.

- Capital expenditure of £1.5m is £0.2m above plan and is expected to break-even by the end of March 2024.

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

1. Income

	April 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
999 Income	£23.4m	£23.4m	£0.0m	✓	£280.5m	£280.5m	£0.0m	✓
111 Income	£2.2m	£2.2m	£0.0m	✓	£26.4m	£26.4m	£0.0m	✓
HEE Income	£0.2m	£0.2m	£0.0m	✓	£2.2m	£2.2m	£0.0m	✓
Other Income	£0.3m	£0.3m	£0.0m	✓	£3.2m	£3.2m	£0.0m	✓
Total Income	**£26.0m**	**£26.1m**	**£0.0m**	✓	**£312.2m**	**£312.3m**	**£0.0m**	✓

- 999 income is as planned. The plan is based on the latest financial envelop proposed by its commissioners and includes the additional £8.9m from NHS England to support Ambulance capacity to achieve the C2 mean of 30 minutes.

- 111 income is as planned, based on the contract value. Vocare has continued to take circa 3,000-3,500 calls per week (c.15%) between 6.00am to 10.00pm to help support our call answering performance, as part of an agreement with NHS England, this is planned to finish in May 2023.

- HEE income is as planned. The Trust is awaiting the funding schedules for 2023/24. Health Education England has now been merged with NHS England.

- Other income includes funding for the Neo-Natal contract and continuation of SORT training as well as supporting international paramedic recruitment.

2. Expenditure

By Directorate	April 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Chief Executive Office	£0.4m	£0.3m	£0.1m	✓	£4.2m	£4.1m	£0.1m	✓
Finance	£1.9m	£1.9m	£0.0m	✓	£22.5m	£22.5m	£0.0m	✓
Quality and Safety	£0.3m	£0.3m	£0.0m	✓	£3.5m	£3.4m	£0.0m	✓
Medical	£1.0m	£0.9m	£0.1m	✓	£12.6m	£12.5m	£0.1m	✓
Operations	£14.9m	£15.4m	(£0.5m)	✗	£183.7m	£184.2m	(£0.5m)	✗
Operations - 111	£2.1m	£2.2m	(£0.1m)	✗	£25.5m	£25.6m	(£0.1m)	✗
Strategic Planning & Transformation	£2.3m	£2.2m	£0.1m	✓	£27.3m	£27.2m	£0.1m	✓
Human Resources	£0.4m	£0.5m	(£0.1m)	✗	£5.0m	£5.1m	(£0.1m)	✗
Total Directorate Expenditure	**£23.2m**	**£23.6m**	**(£0.4m)**	✗	**£284.2m**	**£284.7m**	**(£0.4m)**	✗
Depreciation^	£1.4m	£1.4m	£0.1m	✓	£19.1m	£19.0m	£0.1m	✓
Financing Costs	£0.2m	£0.0m	£0.2m	✓	£2.3m	£2.2m	£0.2m	✓
Corporate Expenditure	£1.4m	£1.5m	(£0.1m)	✗	£9.5m	£9.3m	£0.1m	✓
Total Underlying Expenditure	**£26.2m**	**£26.5m**	**(£0.3m)**	✗	**£315.1m**	**£315.1m**	**£0.0m**	✓
Further Trust Savings Required	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Non-Recurrent Adjustments	(£0.2m)	(£0.3m)	£0.1m	✓	(£2.9m)	(£2.9m)	£0.0m	✓
Total Expenditure	**£26.0m**	**£26.2m**	**(£0.2m)**	✗	**£312.2m**	**£312.3m**	**£0.0m**	✓

^Depreciation now includes Rights of Use Asset depreciation, previously shown as part of directorate values (e.g. ambulance leases)

In Month performance against plan

- Total expenditure for April was £26.2m, £0.2m higher than plan.
- The main drivers are £0.5m higher than planned spend in the Operations service area and £0.1m in NHS 111.
- A deep dive is being carried out on the negative variance in operations to ensure that the issues are identified and then action is taken to rectify. The initial work carried has shown that the productive hourly rate (based on hours 'on the road') of £38.96, was 12.6 percent higher than plan and contributes to the overspend. This was offset by underspend against Pay in several directorates that are actively recruiting to fill vacancies within their department.
- The provision of substantive staff hours was below plan by 12.4 percent amidst the recruitment challenges although is slightly compensated by the positive abstraction level of 31 percent (plan: 31.9 percent).
- The shortfall in hours was partly mitigated by overtime hours. This led to an increase in the utilisation of overtime at 8 per cent rather than the expected 2.6 percent average total hours, at an extra cost of £0.4m. This was further exacerbated by the recognition of additional Time of in lieu (TOIL) costs of £0.1m for the two bank holidays in April.
- NHS 111 spent £0.1m more than planned due to the reliance on agency clinicians and overtime to facilitate safe service delivery including the bank holidays.
- Partly offsetting these, are vacancies in support and back-office functions due to timing of recruitment and a favourable variance in finance costs relating to additional bank interest in reflection of the high interest rate.
- Depreciation and Rights of Use are slightly below plan by £0.1m due to timing.

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

NHSEI Categories	April 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Pay/Staff Costs	£18.2m	£18.4m	(£0.2m)	✗	£222.8m	£223.0m	(£0.2m)	✗
Depreciation (including Rights of Use Assets)	£1.5m	£1.3m	£0.2m	✓	£19.1m	£19.0m	£0.1m	✓
Premises Costs	£1.5m	£1.5m	£0.0m	✓	£18.0m	£18.0m	£0.0m	✓
Transport Costs	£1.5m	£1.3m	£0.2m	✓	£17.9m	£17.7m	£0.2m	✓
Purchase of Healthcare (PAPs;IC24;HEMS)	£1.1m	£1.2m	(£0.1m)	✗	£13.7m	£13.7m	£0.0m	✓
Supplies and Services	£0.6m	£0.7m	(£0.1m)	✗	£9.3m	£9.4m	(£0.1m)	✗
Establishment	£0.4m	£0.4m	£0.0m	✓	£5.0m	£5.0m	£0.0m	✓
Education Costs	£0.2m	£0.1m	£0.1m	✓	£2.6m	£2.4m	£0.2m	✓
Operating Lease Expenditure	£0.2m	£0.2m	£0.0m	✓	£2.0m	£2.0m	£0.0m	✓
Finance Costs	£0.1m	(£0.1m)	£0.2m	✓	£2.0m	£1.8m	£0.2m	✓
Clinical Negligence (CNST)	£0.2m	£0.2m	£0.0m	✓	£1.9m	£1.9m	£0.0m	✓
Gains / Losses on Asset Disposal	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Other	£0.7m	£1.3m	(£0.5m)	✗	£0.8m	£1.3m	(£0.4m)	✗
Total Underlying Expenditure	**£26.2m**	**£26.5m**	**(£0.2m)**	✗	**£315.1m**	**£315.2m**	**(£0.0m)**	✗
Further Trust Savings Required	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Non-Recurrent Adjustments	(£0.2m)	(£0.3m)	£0.1m	✓	(£2.9m)	(£2.9m)	£0.0m	✓
Total Expenditure	**£26.0m**	**£26.2m**	**(£0.1m)**	✗	**£312.2m**	**£312.3m**	**£0.0m**	✓

Full year performance against plan

- The Trust is expecting to achieve the planned break-even figure for the year.

3. System 'Control' Adjustments

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

- For the year to date there has been no significant adjustments to reported position.

Reconciliation to system reported position	Year to April 2023
Trust Surplus / (Deficit)	(£0.1m)
System 'Control' Adjustments:	
Remove impact of Donated Assets	£0.0m
Remove impact of Impairments	£0.0m
Reported Surplus / (Deficit)	**(£0.1m)**

4. Efficiency Programme

Scheme Name	Recurrent Type	Category	Risk	Status	Total Proposed Scheme £'000	Total Scoped £'000	Gap to identify £'000	%
Improvement in Hear and Treat	Pay - Recurrent	Skill mix reviews		Plans in Progress	2,082	2,130	48	2%
Reduction in sickness levels	Pay - Recurrent	Policy review		Plans in Progress	1,268	1,381	113	9%
Reduction in unplanned overtime - rota review/end of shift	Pay - Recurrent	Skill mix reviews		Plans in Progress	1,000	246	(754)	-75%
Fleet efficiency	Non-pay - Recurrent	Fleet optimisation		Plans in Progress	500	632	132	26%
IT productivity & solutions	Non-pay - Recurrent	Corporate services transformation		Plans in Progress	400	400	-	0%
Contract reviews	Non-pay - Recurrent	Procurement -non-clinical		Plans in Progress	300	300	-	0%
Estates & Facilities review	Non-pay - Recurrent	Estates and Premises usage optimalisation		Plans in Progress	300	323	23	8%
	Non-pay - Recurrent	Process & controls		Plans in Progress	250		(250)	-100%
Optimisation in establishment - non clinical	Pay - Recurrent	Corporate services transformation		Plans in Progress	250	101	(149)	-60%
Uniform review	Non-pay - Recurrent	Process & controls		Plans in Progress	250		(250)	-100%
Make Ready and Logistics optimization	Non-pay - Recurrent	Supply Chain review		Plans in Progress	200	319	119	60%
Medicines Management - Consumables & Equipment	Non-pay - Recurrent	Procurement (excl drugs) - medical devices and clinical consumables		Plans in Progress	100	138	38	38%
Other Operations efficiency	Pay - Recurrent	Skill mix reviews		Plans in Progress		342	342	
24 Cover Doctors review	Non-pay - Recurrent	Skill mix reviews		Plans in Progress		100	100	
				Opportunity				
Other efficiency				Unidentified	2,100		(2,100)	
Total					9,000	6,411	(2,589)	

- The Trust's efficiency target for the financial year of £9.0m that represents 3 percent of operating expenses.

- The Trust has set up a cross directorate weekly efficiency meeting to develop the programme and ensure that robust plans with milestones and KPIs support each scheme which was not in place when the programme was reviewed as part of the budget sign off.
- The table above shows the progress on developing the plans. Schemes to the value of £6.4m have been scoped, subject to CFO/ Director sign off and QIA review. This represents 71 percent of the total £9m included in the plan.

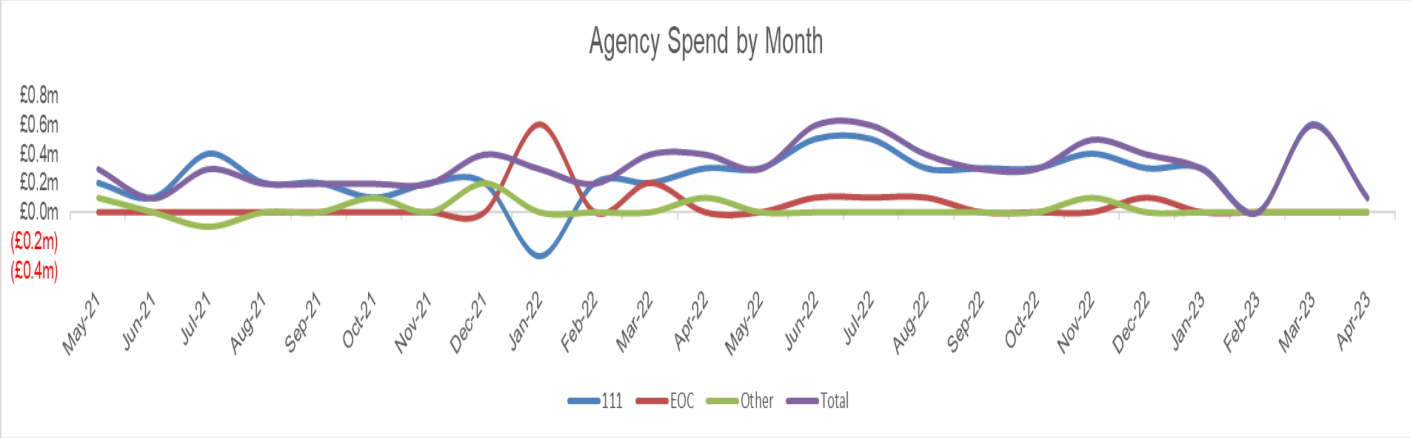
- Progress has been slower than expected but there are still 20 further schemes being reviewed and developed as part of the focus on identifying further £2.6m schemes and to develop a pipeline of sustainable schemes for 2023/24 and beyond. We therefore expect to identify £9m of efficiency projects. A further review and update will be given to the Finance and Investment Committee in June and future Board meetings.

- Further work is ongoing through the new Efficiency Programme Group to enhance the delivery of productivity and to engender an efficiency improvement culture across the Trust. A communication programme is being developed.

5. Agency

	April 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Agency Expenditure	**£0.2m**	**£0.1m**	**£0.0m**	✓	**£1.8m**	**£1.8m**	**£0.0m**	✓

- Overall spend with agencies was slightly lower than planned. Majority of the agency spend was in NHS 111.



6. Cash and Balance Sheet

The cash position reduced by £4.0m this month to £40.1m. This is £2.2m below plan due to lower than anticipated income received from commissioners, with the main reason being in relation to the Trust share of the additional £200m funding made available to ambulance services. The Trust is working with ICB and NHSE colleagues to resolve this and is expecting to receive its allocation.

7. Capital

	April 2023				Forecast to March 2023			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Estates	£0.0m	£0.1m	(£0.1m)	✗	£0.6m	£0.6m	£0.0m	✓
Strategic Estates	£0.8m	£0.1m	£0.7m	✓	£2.4m	£2.4m	£0.0m	✓
IT	£0.2m	£1.4m	(£1.1m)	✗	£4.7m	£4.7m	£0.0m	✓
Fleet	£0.0m	£0.0m	£0.0m	✓	£4.2m	£4.2m	£0.0m	✓
Clinical Operations	£0.0m	£0.1m	(£0.1m)	✗	£0.4m	£0.5m	£0.0m	✓
Total 'System' Capital (CDEL*)	**£1.1m**	**£1.5m**	**(£0.5m)**	✗	**£12.3m**	**£12.3m**	**£0.0m**	✓
Right of Use Assets (Leases)	£0.2m	£0.0m	£0.2m	✓	£13.5m	£13.5m	£0.0m	✓
Total Capital	**£1.3m**	**£1.5m**	**(£0.2m)**	✗	**£25.9m**	**£25.9m**	**£0.0m**	✓

*CDEL - Capital Delegated Expenditure Limit

- The capital spend is £1.5m compared to the plan of £1.3m. The overspend of £0.2m is caused by additional IT spend including Cyber Security.

- The Trust expects to meet its allocation and plan.

8. Risks and Opportunities

Risk	Impact	Likelihood	Score
The Trust's future capital expenditure plans could be constrained by capital limits (CDEL) imposed on our host ICB.	>£2.0m	Likely >50%<=80%	20
While the Trust currently has adequate liquid resources to meet its short-term plans, there is a need to generate cash surpluses to ensure sufficient funds for future investment to sustain and improve our services.	>£1.0m <=£1.5m	Likely >50%<=80%	12
While the Trust currently has adequate liquid resources to meet its short-term plans, there is a need to generate cash surpluses to ensure sufficient funds for future investment to sustain and improve our services.	>£1.0m <=£1.5m	Likely >50%<=80%	12
The Trust has a challenging cash releasing efficiency target. Slippage in achieving this target could have an impact on the Trusts ability to meet its I&E target	>£1.5m <=£2.0m	Possible 50/50	12
Funding for the NHS pay award is being assessed against the impact of the pay award on the Trusts cost base.	>£1.0m <=£1.5m	Possible 50/50	9

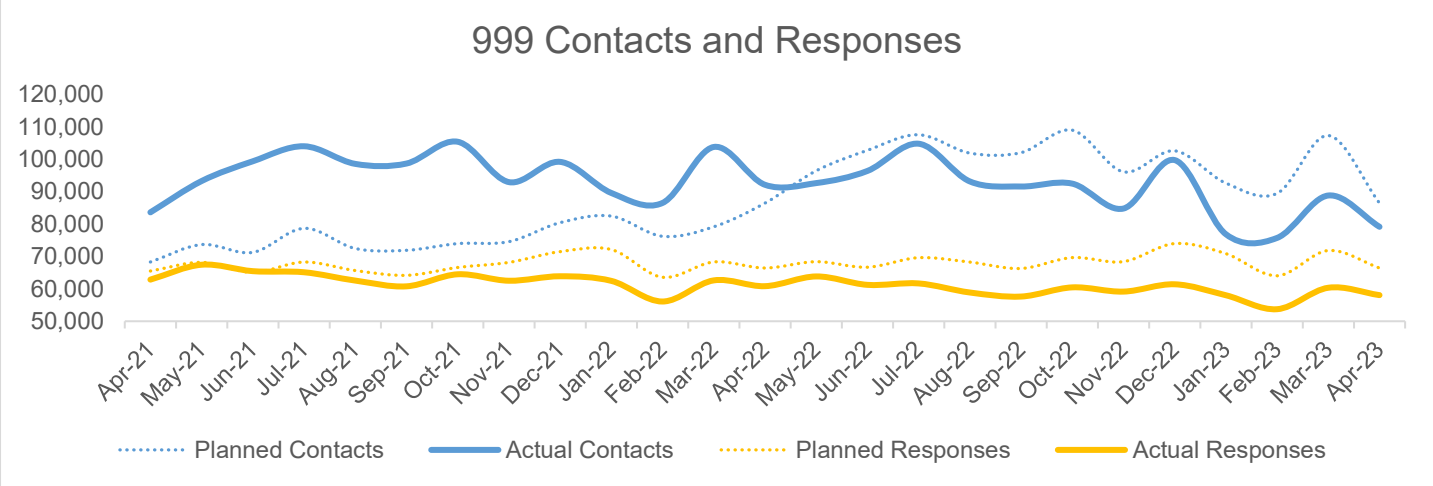
- The table above shows those risks to achieving this year's financial target.

Opportunities	Impact	Likelihood
Impact of inflation, including the potential reduction in run rate due to reduced inflation especially with regards to fuel and energy costs.	>£0.0m <=£0.5m	Likely >50%<=80%
Sale of Trusts unused properties would improve the I&E position and increase the capital expenditure (CDEL) limit, which would allow the Trust to invest further than planned	>£2.0m	Possible 50/50

Appendices

A. Activity

999 Activity:

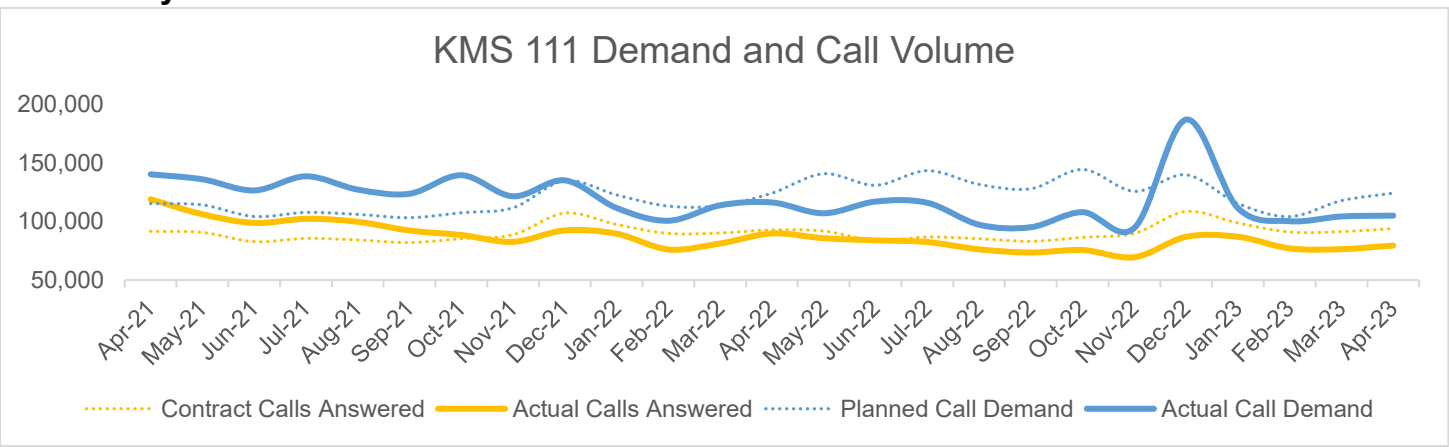


999 contacts (demand) is 14.1 percent down against the last year, with response activity 3.3 percent lower.

Category 2 mean response times has improved versus last year, with the C2 mean improving to 24.7 minutes compared to 33.3 minutes last April, mainly because of the demand being lower and improved handover delays.

Handover delays have an impact on the availability of crews to reach patients in time, 2,595 hours less were lost in the year to April 2023 compared to last year.

111 Activity:



April 2023 saw demand (calls offered) continue to remain static with demand on the service being 5.4 percent higher than March 2023.

Both demand and activity are down versus the same period last year with demand 9.7 percent lower and activity 11.5 percent down. This trend would indicate the Trust requires less staff to meet future demand.

Calls answered in 60 seconds performance has improved to 39.1 percent for April against 31.7 percent in March 2023.