South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors Meeting to be held in public

22 June 2023 10:00-13:00 held in person

Crawley HQ - Nexus House, 4 Gatwick Rd, Crawley RH10 9BG – McIndoe Boardroom

Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
001/23	10:00	Chair's Introduction	-	-	Chair
002/23	10:01	Apologies for Absence	-	-	Chair
003/23	10:01	Declarations of Interest	-	-	Chair
004/23	10:02	Minutes from the previous meeting, Action Log and Matters Arising	Y	-	Chair
Statutory duties: performance and holding to account					
005/23	10:05	Chief Executive's Report	Y	To receive an update from the CEO	Simon Weldon
006/23	10:20	Strategy Development	To follow		David Ruis-Celada
007/23	10:35	**Areas of assurance:** • Financial forecast • Attrition, retention, sickness, appraisals, and staff morale • People and culture strategy development • IT failure update • Staff survey results In order to drive the discussions above, included are the Board Committee Escalation Reports, the Integrated Quality Report and the Board Assurance Framework Report.	Y	Holding to account, assurance and discussion	All Non-Executive Directors present
11:45 - COMFORT BREAK					
Statutory duties: member and public engagement					
008/23	12:00	Membership Development Committee Report	Y	Information	Brian Chester
Committees and reports					
009/23	12:10	Nomination Committee Report	Y	Information	MW

010/23	12:20	Governor Development Committee Report	**Y**	Information	Leigh Westwood
011/23	12:30	Governor Activities and Queries Report	**Y**	Information	Leigh Westwood
General					
012/23	12:40	Any Other Business (AOB)	**-**	-	Chair
013/23	12:50	Questions from the public	**-**	Accountability	Chair
014/23	-	Areas to highlight to Non-Executive Directors	**-**	Assurance	Chair
015/23	-	Review of meeting effectiveness	**-**	-	Chair
		Date of Next Meeting: Formal CoG and AMM – 14 September 2023	**-**	-	Chair

Questions submitted by the public for this meeting will have their name and a summary of their question and the response included in the minutes of the meeting.

PLEASE NOTE: This meeting of the Council is being held in person at **Crawley HQ - Nexus House, 4 Gatwick Rd, Crawley RH10 9BG – McIndoe Boardroom,** in addition to using Microsoft Teams. The meeting will be video-recorded and made available for public viewing following the meeting. Anyone who asks a question gives consent to being recorded and the publication of their participation in the meeting.

There is a section of the agenda for questions from the public. During the rest of the meeting, attendees who are not members of the Council are asked to remain on mute with their video off in order to help the meeting run smoothly. *This is a strict rule and anyone not following this will be removed from the meeting.*

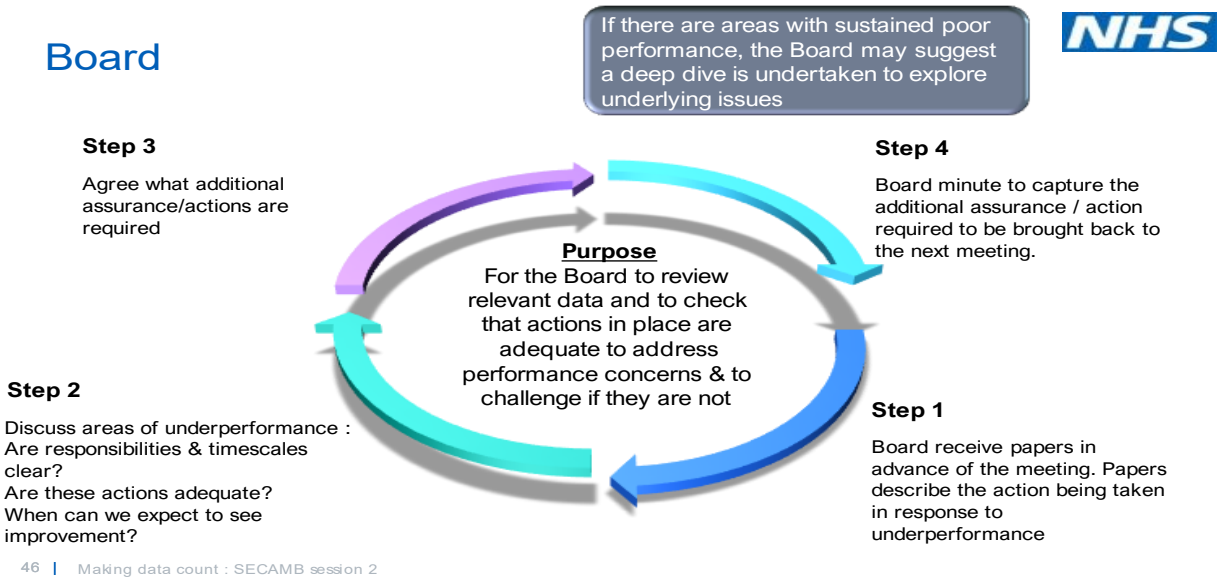
this meeting is followed by private Part 2 meeting (1330-1400) and by a Council development session (1400-1600):
Ali Mohamed/Yvette Bryan roundtable discussion around the People Plan

		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 Foundation Trust

Council of Governors

Meeting held in public – 23 February 2023

Present:

David Astley	(DA)	Chair
Brian Chester	(BC)	Public Governor, Upper West
Leigh Westwood	(LW)	Public Governor, Lower East
Chris Burton	(CB)	Staff Governor (operational)
Martin Brand	(MB)	Public Governor, Upper West
Linda Caine	(LC)	Public Governor, Upper East
Kirsty Booth	(KB)	Staff Governor (non-operational)
David Romaine	(DR)	Public Governor, Lower East
Ann Osler	(AO)	Appointed Governor – Upper West
Angela Glynn	(AG)	Appointed Governor – University of Brighton
Lisa Bell	(LB)	Appointed Governor – Sussex Police
Colin Hall	(CH)	Public Governor, Upper East
Harvey Nash	(HN)	Newly elected Governor
Peter Shore	(PS)	Newly elected Governor

In attendance:

Siobhan Melia	(SM)	Chief Executive
Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee, Chair of Operational Performance Committee
Paul Brocklehurst	(PB)	NED
Michael Whitehouse	(MW)	NED and Chair of Audit Committee and Senior Independent Director
Tom Quinn	(TQ)	NED
Liz Sharp	(LS)	NED
Max Puller	(MP)	NED
Peter Lee	(PL)	Company Secretary

Apologies:

Nigel Robinson	(NR)	Public Governor, Lower West
Stuart Dane	(SD)	Staff Governor (operational)
Michael Tebbutt	(MT)	Public Governor, Upper East
Subo Shanmuganathan	(SS)	NED
Chris Gonde	(CG)	NED
Andrew Latham	(AL)	Public Governor, Lower West
Nicholas Harrison	(NH)	Staff Governor (operational)
Mark Rist	(MR)	Appointed Governor – Fire Service
Amanda Cool	(AC)	Public Governor, Upper West
Sinead Mooney	(SM)	Appointed Governor – Local Authority

Minute taker: Julie Harris (JH) Assistant Company Secretary

Item No.	Introduction and matters arising
135/22	**Introduction** DH welcomed all, including our new non-executive director Max Puller, as well as newly elected governors Peter Shore and Harvey Nash.
136/22	**Apologies for Absence** As above
137/22	**Declarations of Interest** None
138/22	**Minutes from the previous meeting, action log and matters arising** The minutes were taken as an accurate record of the meeting with minor edits. The action log was reviewed with no outstanding actions
	Statutory duties: performance and holding to account
139/22	**Chief Executive's report** SM tabled the public board report which included: - Internal social media platform (Yammer) - Commissioned external support to look at approach to communications and engagement which concluded that the communications approach is very good, but that the culture at SECAmb is the cause of the communications blockage - Communications and engagement strategy due 6 April at Trust Board - Volunteer emergency responder trial (CFR) - Industrial action (last Monday - midday to 2am), behaviours changing (hardening of position from the unions), good derogation agreement but more people voted with their feet. Dispute between government and national unions. Unison ballot did not reach strike requirement but Unite has. - Improvement journey – progress against the four warning notices was presented to CQC, feedback has been positive, still more work to do surrounding the pace to deliver culture transformation. Warning notices have expired and now focusing on culture transformation and pace of the improvement journey. MD questioned if we have received mutual aid. SM confirmed that we have utilised military support. Harm reviews are being looked at in line with industrial action timings, but we don't know if there are any link or triangulation at this time. AG questioned how students are being managed during industrial action dates. SM confirmed that this position would be firmed up and noted that we are not permitted to over-staff. MD questioned the balance between patient safety and staff right to strike. SM confirmed that it is a delicate balance, but we (in the South) have been in a better position than other Trusts in other parts of the country.

	DR noted the trend of GP surgeries 'poaching' paramedics and questioned how this is affecting attrition. SM confirmed that the future is portfolio careers, more flexibility, and a modern workforce plan. DA confirmed the same. HN questioned if we receive any assistance from other ambulance providers. SM confirmed that we do have support from the commercial sector (private ambulance service). KB questioned the potential of changes in derogations with Unite and GMB. SM confirmed that there was a request to re-negotiate the derogations based on what Unite agree and what the RCN negotiates with the government. CB spoke to the 'poaching' of paramedics and suggested that we be better at communicating the benefits (Agenda for Change) of working for SECAmb. CB further warned the dangers of blended working offers. CH questioned what the Trust is doing about mental health issues within the Trust SM confirmed that we are putting the materials to promote the fact that there is help out there and are looking at ways to measure the impact of communications.
	Statutory duties: performance and holding to account
140/22	**Board Assurance Committees' escalation reports to include the key achievements, risks and challenges:** **Areas of assurance (determined at the GDC meeting):** - Patient safety in terms of wider health service, Industrial action risks and mitigations - Culture - Morale/turnover/attrition/sickness management - Priorities for 2023/2024 – assurance in how the board is finalising priorities and moving to a delivery phase DA provided an overview of the change in format of this agenda item noting specific areas of assurance discussed at the last Governor's Development Committee meeting. MW reflected his observations with regard to the culture within the Trust, including: - appraisals, - sexual safety, - culture starts at the top of the organisation, - people's strategy - skills and attributes to maintain the changes (director of culture) - recruitment and empowerment of staff - defining what culture we want to adopt/expect. HN questioned the turnover in call centres and the BAF risk alignment and noted that that focus on people needs to be included in the risk. MW agreed and noted that historically SECAmb's culture has been one of command and control and the current leadership needs to be challenged to do more. HG noted the quality improvement methodology will make a step-change on the issue of staff engagement. MP confirmed that it's early days in the move from a hierarchical command and control environment to a transformational change for meaningful engagement. HN noted the importance of impact on people for any planned change.

	KB questioned the lack of NED challenge on culture change, noting specifically the call centre environment with the lack of outlet to advise of unhappiness, lack of leadership, bad decisions being made due to command/control. PL noted there is a new plan/programme of work to better understand the issues at EOC. MW confirmed that the board is looking at the leadership structure of the EOC model. CB requested to implement a decompression centre/programme for the EOC (right leadership in place, welfare support, practical incentives, etc.) and noted without it we will continue to lose good people, thus impacting patient care and safety (200 calls outstanding at the end of a shift). MB questioned the status of the single virtual contact centre. PB confirmed that the programme has slowed down a bit to correct issues that have been raised and that although it is early days, it is the hope that this will reduce pressures. CB commended the mental health support staff and noted that this benefit needs to be communicated fully. KB questioned the status of PSERF (learning platform). PB confirmed that this is a challenge/significant change, but that work is underway. MB questioned our business continuity in terms of emergency responsiveness (major incident preparedness) and medicine distribution centre. MW confirmed that this is a system wide issue that is not distinct to SECAmb and agreed we have a good relationship with other blue light services. LB agreed that the relationships are strong, and we are in a positive position. PL provided context surrounding the medicines distribution centre noting that there is a 3-5 solution being put in place. LW confirmed there is a resourcing issue with packing medicines. KB agreed to take this issue to the Chief pharmacist. BC questioned the lack of report regarding the IT failure incidents. PL confirmed that the final report is due at the audit committee on 15 March 2023. PB confirmed that there were two issues, one of which has been corrected (increase in traffic) and are awaiting the report to ascertain the reasons for the increase in traffic, issues with the cloud. MB questioned the break-even position, efficiency target, and cash reserves level in the report appendices. HG confirmed that there is going to be a shortfall (on a recurrent basis) of approximately £2M and in terms of the savings plan there is a significant shortfall (just under £4M). Non-recurrent savings have been found in other areas to bridge the gap and felt confident that we will reach break-even point by year end. **ACTION: Council to receive the budget plan for next fiscal year.** CH questioned the status of Medway in terms of financial implications. HG confirmed that the total costs incurred from Medway was £24.5.
141/22	**Comfort Break**
Statutory duties: member and public engagement	
142/22	**Membership Development Committee Report** BC took the paper as read and noted that it was one of the best meetings undertaken in a long while. Work is being undertaken to determine the most effective use of time and resources in terms of events and membership recruitments. Work is also being undertaken to review the displays, communications, messages, SWAG.

	BC confirmed that he will be standing down as chair and therefore will be looking for a willing volunteer in due course. MB requested an additional input to determine the delta of membership post event. **ACTION: Jodie to add to the report delta statistics post events.** **ACTION: Governors to focus on communications to staff membership, include in inductions.** LB suggested that we do a corporate video (not unlike the policing services). DA noted that similar videos are available on YouTube and noted that great quality videos are being produced inhouse by Liz. MP suggested different messaging for different videos. LC noted the importance of using all social and public forums to engage membership. LB noted the opportunity to give a greater insight (using videos) to address the work challenges (psychological preparedness) for people taking on these roles. CoG approved the report.
Committees and reports	
143/22	**Nomination Committee Report** DA took the report as read, noting the re-appointment of Howard and Tom and the new appointment of Max.
144/22	**Governor Development Committee Report** LW took the report as read, noting the increased activity of the Governors. MB noted that if we scheduled MDC and GDC in person on one day, we may get more attendance. CoG approved the report.
145/22	**Governor Activities and Queries Report** LW took the report as read. CoG approved the report.
General	
146/22	**Any other business** KB requested assurance on the status of the first-floor situation in terms of lack of HQ, lack of engagement with staff, oppressive site, disengaged corporate staff, not a good impression of the Trust, plays into the culture of the organisation. **ACTION: MW to escalate the status of the first-floor area to board and report back to the Council of Governors.**

	LB questioned if there was an estate strategy in place that would define occupancy requirements, workforce personas, space per capita, space utilisation – would speak to the culture piece of the organisation. AG noted that this is a very hot topic (hybrid working with younger generation) and questioned what the contractual responsibilities to the employees are, challenges to performance managed and agreed to share her organisational policies surrounding this with the Trust. MP suggested that this is a great opportunity to engage with the staff to aid in drafting the expectations surrounding hybrid working. LB added that bookable space might be key here noting averages being 0.7 desks per staff member and 10-12 sqm and agile/flexible working may assist with attraction and retention of course. LC suggested considering office space already available through our partners. AG noted the lack of representation from SECAmb at recent engagement meetings with the university. CB added that this is a management team culture issue, that similar issues have been seen in multi-organisational opportunities where SECAmb is given a seat but doesn't show up.
147/22	**Questions from the public** None
148/22	**Areas to highlight to Non-Executive Directors** - Hybrid working - Cultural issues (recruitment, positive experience, patient and work experience point of view) - Industrial action and impact on patients - Communications and engagement
149/22	**Review of meeting effectiveness** - Noted the change of the agenda, reflection that it promoted discussion and holding to account and a more rounded discussion.
	Date of next Formal Council of Governors Meeting: • **Joint Trust Board/CoG - 27 April 2023** • **Formal CoG – 22 June 2023**

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

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

Key
Closed
Due

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	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

Shaping our Future Together

Update for Councill of Governors and Board

South East Coast Ambulance Service NHS Foundation Trust
June 2023

Foreword

We are pleased to share this first update on our Strategy development, following our kick-off at the end of April.

Over the last month, we have developed the tender specification and engaged widely with managers, system partners and staff networks and unions to shape what our approach to engagement and inclusion will be. We will be starting the “Big Conversation” with all our colleagues on the 29th June via an all-hands sessions.

Over the next month, we will be building on the engagement by expanding the discussion. Most critically, we have invited our Operating Unit leaders to tell us what will they need on-stations to make this meaningful to most of our colleagues, as we recognise the challenges associated with engaging with over 4,500 people over our expanded geography.

The executive team are particularly interested in how we will tackle health inequalities, and we invite members to watch the recently published AACE video on this subject.

We remain committed to the five key principles agreed at our kick-off and we will welcome your support in ensuring we stay true to these in the coming months:

- ✓ **Stakeholder Engagement**
- ✓ **Strong Partnerships**
- ✓ **Transparent Communication**
- ✓ **Focused Engagement**
- ✓ **Listening and Learning**

We will provide the COG and Board with mid-monthly written updates on the engagement, insights, decisions, and ideas generated by our colleagues. This will complement the workshops and formal touchpoints and will be designed to ensure you are clearly and transparently updated.

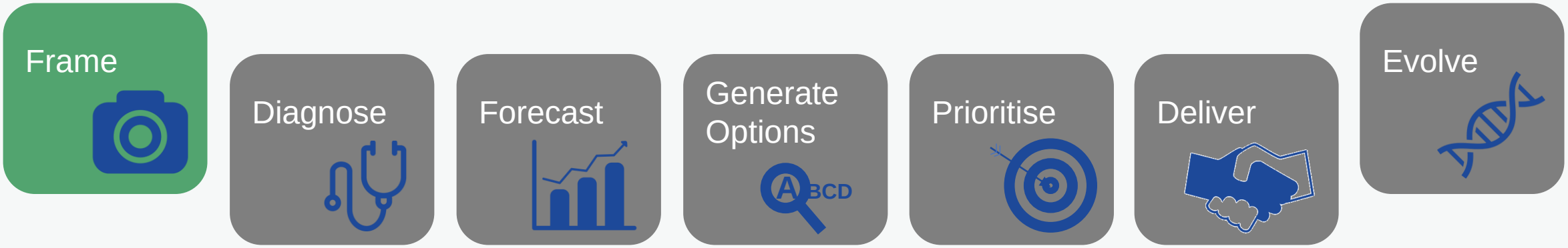
We also look forward to the procurement panels which we will be seeking support from the Governorship and Board groups in early July.

Rachel Oaten, Chief Medical Officer

David Ruiz-Celada, Executive Director for Strategic Planning and Transformation

Where are we?

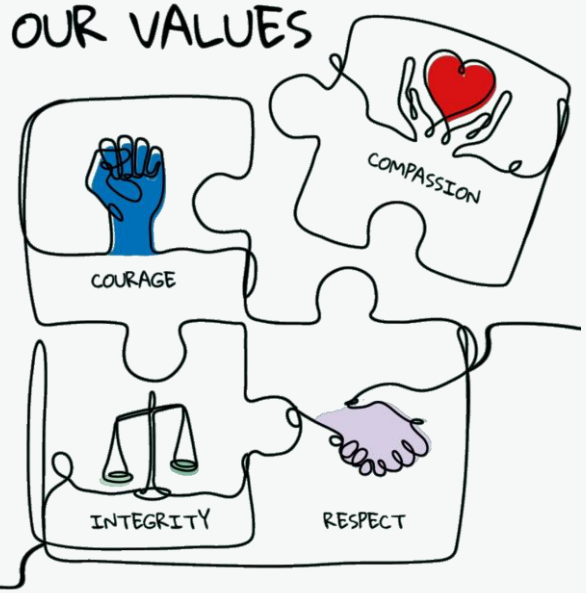
- ✓ Developed an in-year strategic narrative that articulates our priorities and our focus on the Future
- ✓ Extensive stakeholder engagement and input into our requirements to choose a strategic partner to help us deliver the strategy
- ✓ Stakeholder mapping and engagement plan developed
- ✓ Developed and published Tender document to over 21 interested bidders
- ✓ Secured NHSE and Commissioner support for this work, using it as an anchor to help us move away from Recovery Support Programme



Narrative for this year, bridging us to a new vision

Our Vision 2023 / 2024

CARING FOR PEOPLE



Our Goals

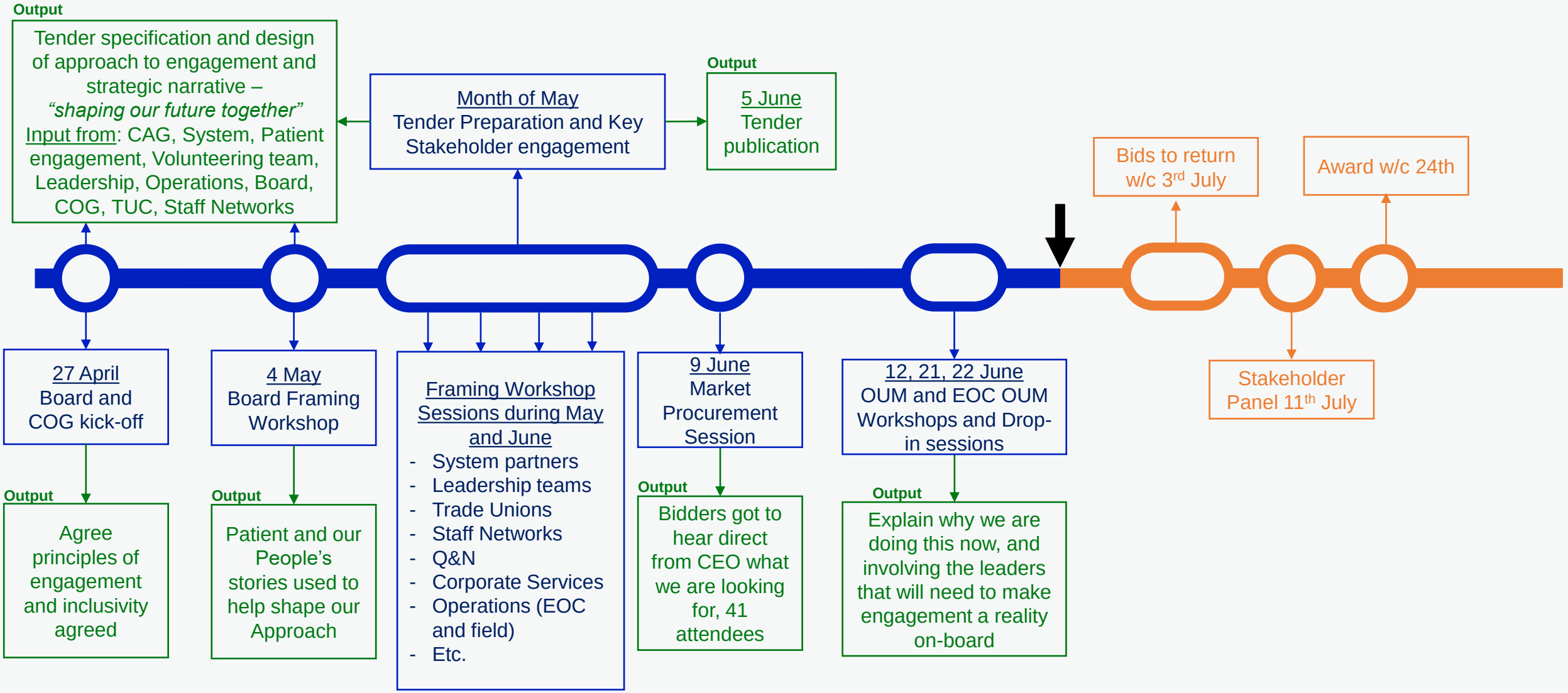
Our Plans

- ❑ UEC Recovery Plan
- ❑ Appropriate use of pathways and UCR
- ❑ QI Culture and Learning (PSIRF)
- ❑ Improved Quality and Performance Assurance
- ❑ Address colleague feedback
- ❑ Invest in Training and Leadership Development
- ❑ More effective Recruitment and On-boarding
- ❑ Delivery of our Financial Plans
- ❑ Start our journey towards sustainability
- ❑ Develop a clear clinical vision for our Future

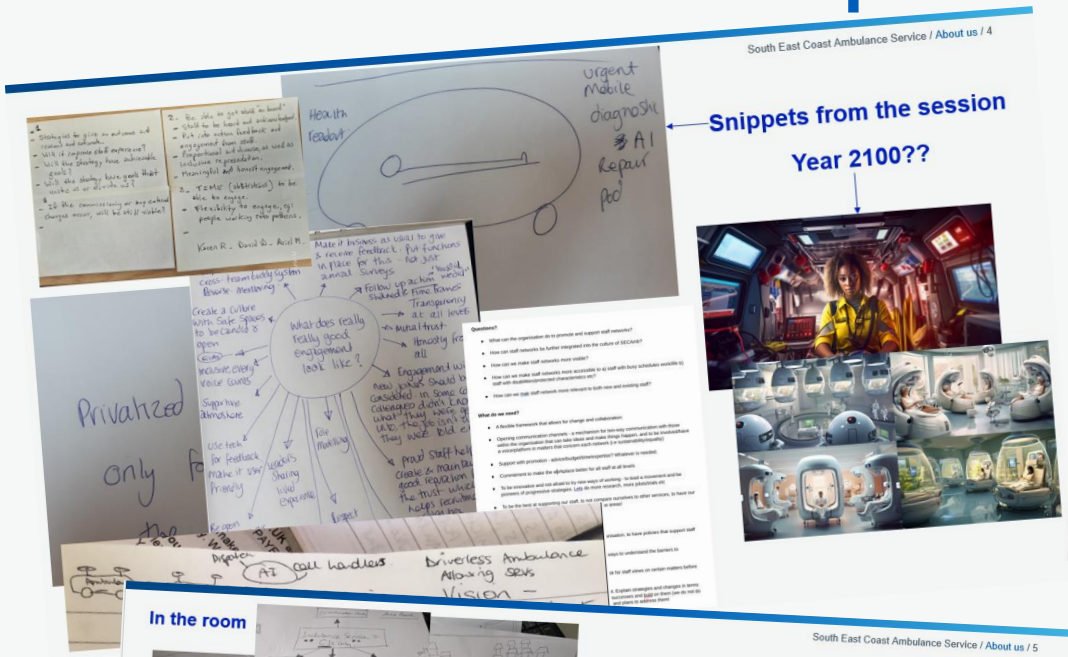
Our Outcomes

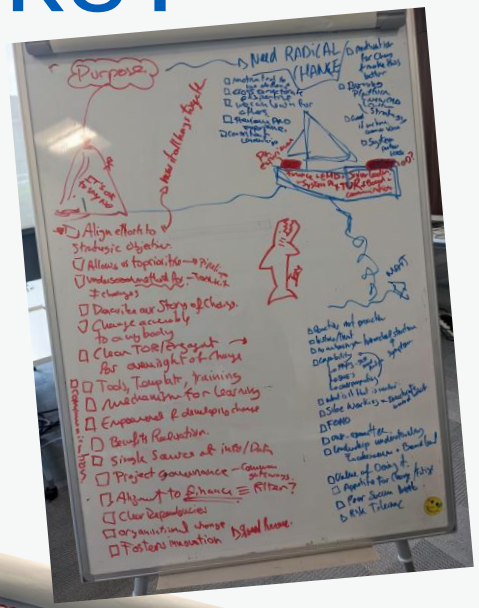
- ✓ Category 2 Mean Answer of 30 min
- ✓ Go-live Medway
- ✓ Reduce LSO and ODOOS
- ✓ Delivery £9m cost - efficiencies
- ✓ Update all policies impacting colleague experience
- ✓ New DCA Ambulance selection
- ✓ Call Answer Mean time of 10 sec
- ✓ Grow our clinical career development capacity
- ✓ Increased psychological safety and healthy speak up culture
- ✓ Hear and Treat increase to 14%
- ✓ Increase clinical workforce
- ✓ A new Strategy approved by the Board that provides clarity about our direction of travel
- ✓ Maximising use of Community, Frailty and Mental Health pathways
- ✓ Leadership Fundamentals and Management Essentials Training rollout
- ✓ Meaningful Engagement
- Learning to improve maternity and cardiac patient's experience
- ✓ Meaningful empowerment for our leaders
- ✓ Publication of our Green Plan and delivery of our year-1 targets

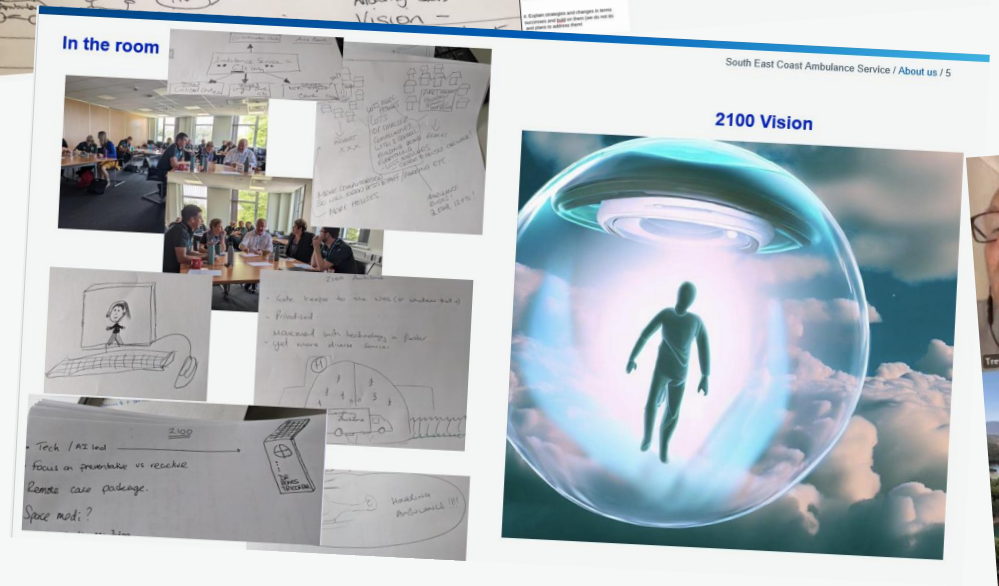
Engagement and key outcomes so far

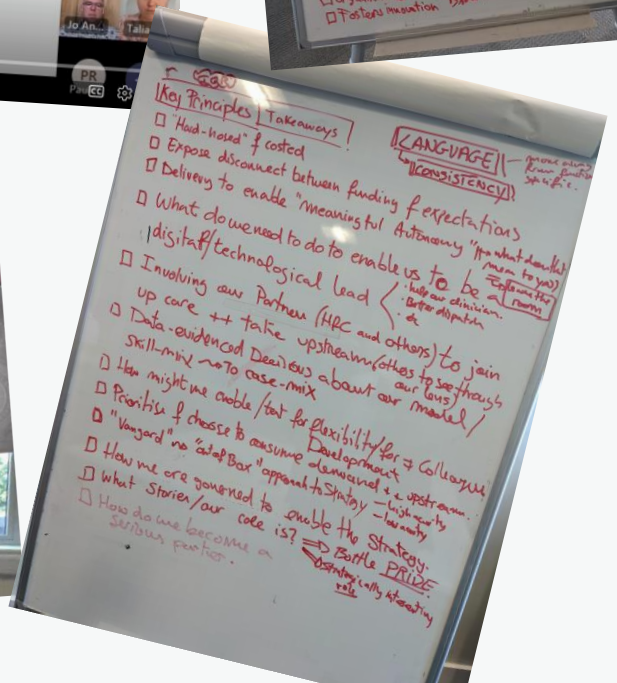


What has this period looked and felt like?









Stakeholder insights – what have we heard?

1. Vision & Strategic Focus

- Empowerment: Embed a culture that empowers staff to be a part of strategic development and delivery.
- Operational Clarity: Clearly articulate the future operational model of the ambulance service.
- Patient-centric Approach: Prioritize patients' needs, direct them to appropriate services, and minimize pressure on the wider healthcare system.
- Technological Efficiency: Leverage technology to enhance efficiency and patient care.
- Financial Sustainability: Ensure financial affordability and secure funding arrangements.

2. Workforce Planning

- Future-proof Skills: Define future workforce composition and training plans to meet patient needs.
- Attraction & Retention: Develop a plan to attract and retain employees.
- Culture Change & Collaboration: Foster a culture of quality, enable organizational changes, and promote collaboration.

3. Inclusive Stakeholder Engagement

- Co-Design Strategy: Enable all staff, including middle management, to contribute in shaping the strategy.
- Flexible & Accessible: Adapt engagement practices to suit various teams and schedules.
- Visible Leadership: Ensure senior leadership is actively involved in strategy development.

4. Inclusion & Diversity

- Equal Opportunity: Address observed inequalities and promote diversity, using knowledge from SN, FTSU, TUC.
- Staff Network Integration: Integrate and support staff networks to have meaningful input into the strategy.
- Psychological Safety: Create an environment that prioritizes staff well-being, engagement, and development.

5. Realism & Courage

- Clear Direction: Be explicit and realistic in strategy direction and targets.
- Brave Thinking: Foster bravery and outward thinking in approach and implementation.

6. Communication

- Simplicity: Use simple language to ensure understanding across all levels.
- Avoid Email Overload: Diversify communication channels beyond email.
- Continuity: Align all decisions and actions with the overarching strategy once it’s published.

7. Additional Considerations

- Resource Support: Provide resources for staff to attend engagement events.
- Celebrating Values: Uphold positive values and encourage cross-team collaboration.

What does this mean for what we are looking for in a strategic partner?

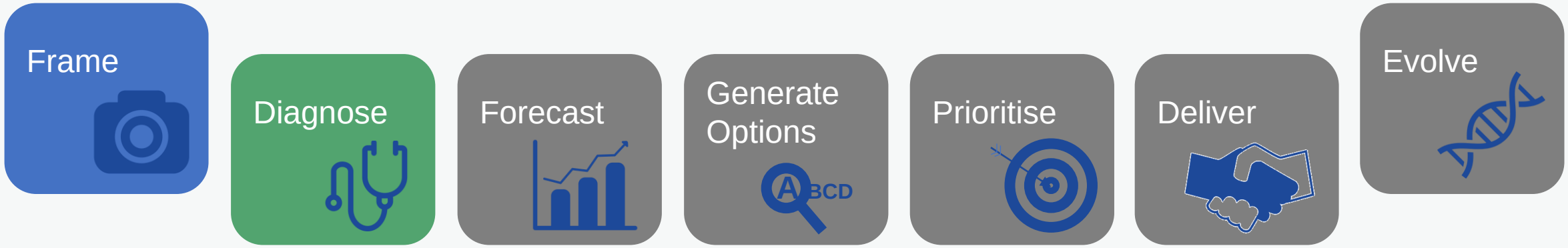
Quality	**75%**
Clinically led leveraging our existing talent	17.50%
The provider must show how they'll create a strategy focused on the patient, tied to public health, national and regional plans, and factors causing future change.	
The provider must show how they'll collaborate with our clinical experts to find key innovation and improvement opportunities, develop future care models, and assess the best options for progress.	
The provider should have a history of creating strategies that mirror the collaborative approach of the modern NHS, preferably with experience in working with other UEC/Ambulance Trusts and in integrated care systems.	
The provider must show how they'll use evidence to guide decisions at every stage of the strategy development.	
Technology and Innovation	12.50%
The provider must show how they'll push us to think creatively about using technology and innovation to overcome challenges in achieving our vision and designing our future models of care.	
Social Value and Equalities	10.00%
The proposal must show how it helps us become an environmentally sustainable organization and reach our Net Zero goals, considering our existing Green Plans	
The proposal must include an approach to tackle health inequalities, and overall improve the population health of the communities served by SECAmb	
Stakeholder Engagement, Communication, and Inclusivity	17.50%
The proposal must show how it ensures a wide range of voices are heard through an inclusive engagement process.	
The proposal must facilitate communication among stakeholders, including our people, patients, and external partners.	
The proposal must foster a transparent, inclusive environment encouraging engagement and participation.	
The proposal must include successful past experiences of the provider developing strategies inclusively, making sure all stakeholders' voices are heard, and with evidence that all parties have been taken along on the journey to develop a common vision.	
The proposal must show how it will help launch the strategy to support our on-going cultural change and improvement plans	
Making the Strategy a reality	17.50%
The proposal must detail how the providers will assess the impact of the Strategy Development throughout its creation, including how it will use that information to provide visibility to the Board on the conditions of success post-launch.	
The proposal must explain how the Trust will take substantial action via delivery plan, challenging the Trust to implement changes and bridge from strategy development into transformation to ensure we realize our new vision.	
The proposal must detail how the provider will collaborate with our internal team and experts to create the Strategy, sharing their expertise and best practices with SECAmb colleagues and growing the in-house capability.	
The proposal must show how the provider will collaborate with our leadership to foster a sense of collective ownership of the evolving strategy.	
The provider should have a history of introducing fresh ideas from external sources to help us craft solutions to implement the strategy.	
The provider should have references or testimonials from other NHS organizations showing their ability to assist Trusts in achieving outcomes beyond their own capabilities.	
Price	**25%**
	100.00%

Objectives for the upcoming period

- Complete “Frame” by finalising Governance arrangements from Road to Board and awarding of the contract

- Starting “Diagnosis” by extending the conversation to all of our people, starting with *The Big Conversation* on the 29 June, and starting a collation of our as-is data

- Designing of engagement roadmap for the next 4 weeks (short term plan) and next 6 months (long term plan) in detail alongside strategic partner



How can Governors and Board colleagues get involved over the next month?

- Join *The Big Conversation* event on the 29 June at 11.15 AM
- Expressions of interest needed to support procurement panels on the 4th July (desktop review of initial bids) and presentations of shortlisted bids on the 11th July
- Talk about the future with colleagues when you are doing visits, and tell us what you hear. What do our people expect from the future?
- A Task and Finish Committee of the Board to be established from July
- **Help needed:** Can you help us engage with the SECAmb membership?

Useful complimentary materials

- Tender specification: (06) Programme specification v1.0.docx

- Marketplace session (video): Marketplace Session (DRC)-20230609_110319-Meeting Recording.mp4

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

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

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Quality Improvement

QUALITY IMPROVEMENT

Summary

April 2023

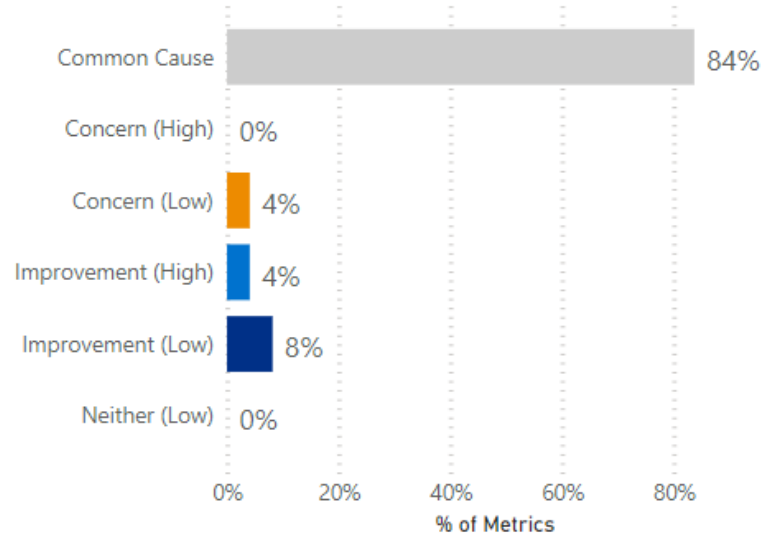
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Cardiac Survival ALL % Required NHS Pathways Audits Completed (Clinical) %		Count of Low Harm Incidents Count of No Harm Incidents Complaints relating to privacy and respect % Outstanding Actions Relating to SIs, Outside of Timescales
Common 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.

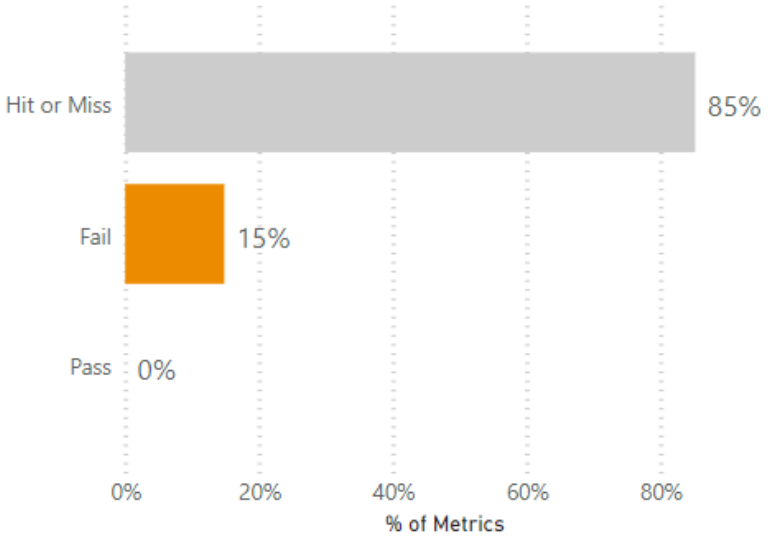
QUALITY IMPROVEMENT

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%		

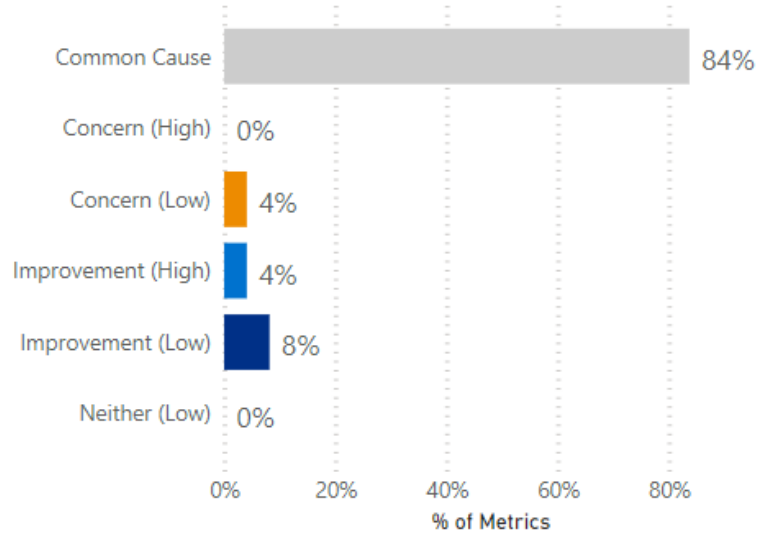
Patient Experience

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		

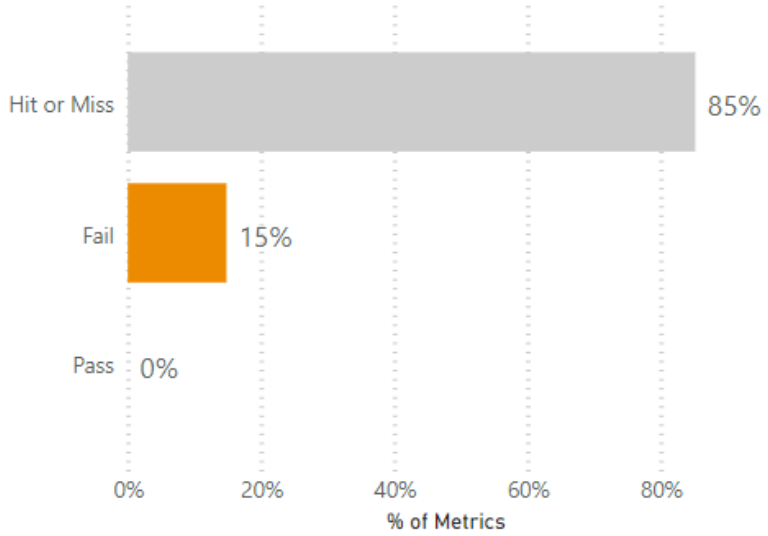
QUALITY IMPROVEMENT

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%		

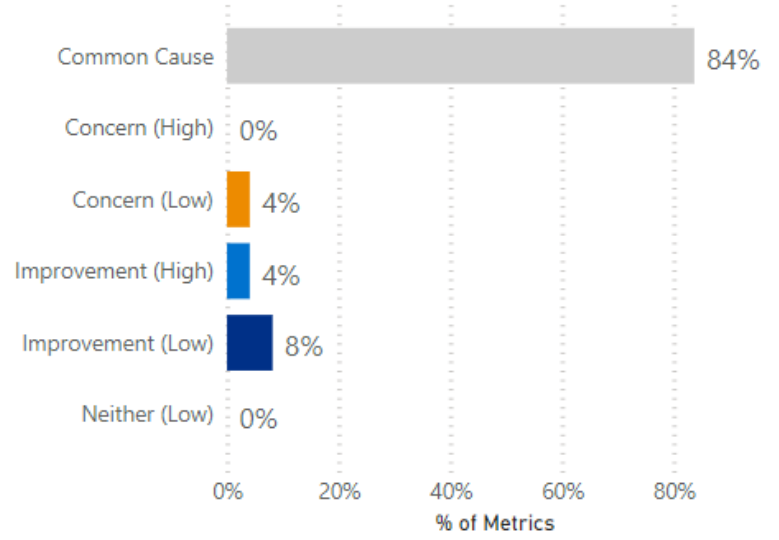
Infection Prevention Control

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%		

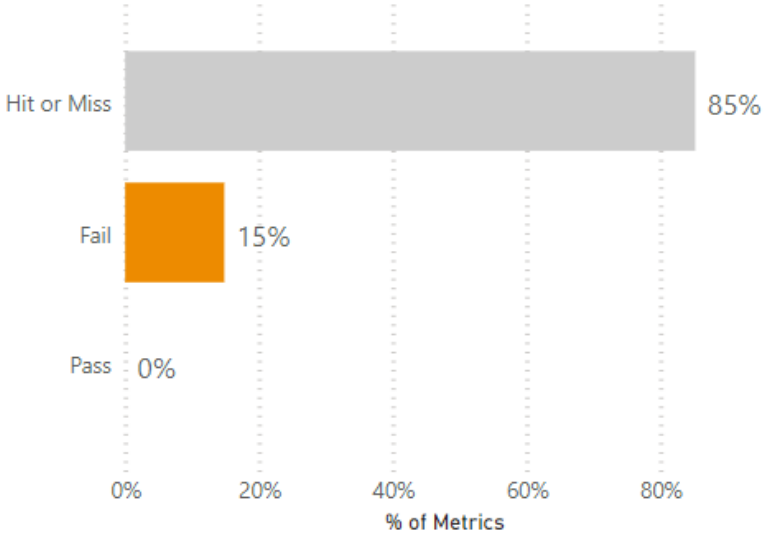
QUALITY IMPROVEMENT

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

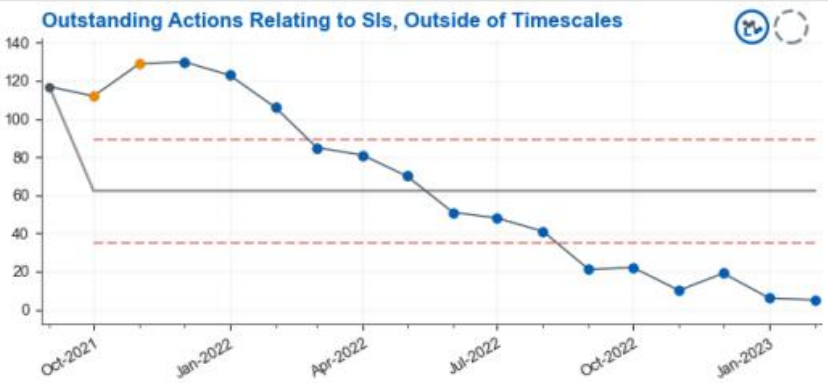
SIs, Incidents, & Duty of Candour

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.

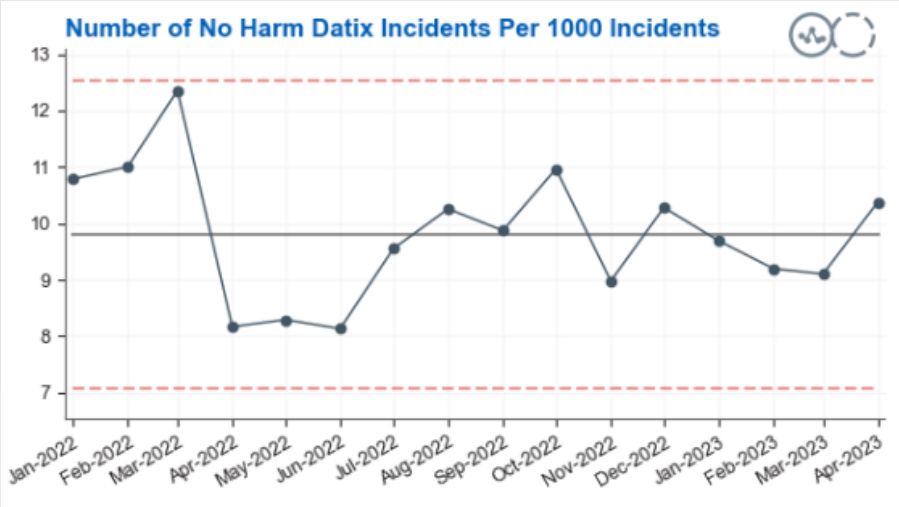
Summary
(QS-1) Non-SI incidents - The Trust continues to support an effective culture of incident reporting with a process that is in control.
(QS-17) SI actions – The number of outstanding actions relating to SIs outside of timescales has reduced significantly in a downward, improving trend since December 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)



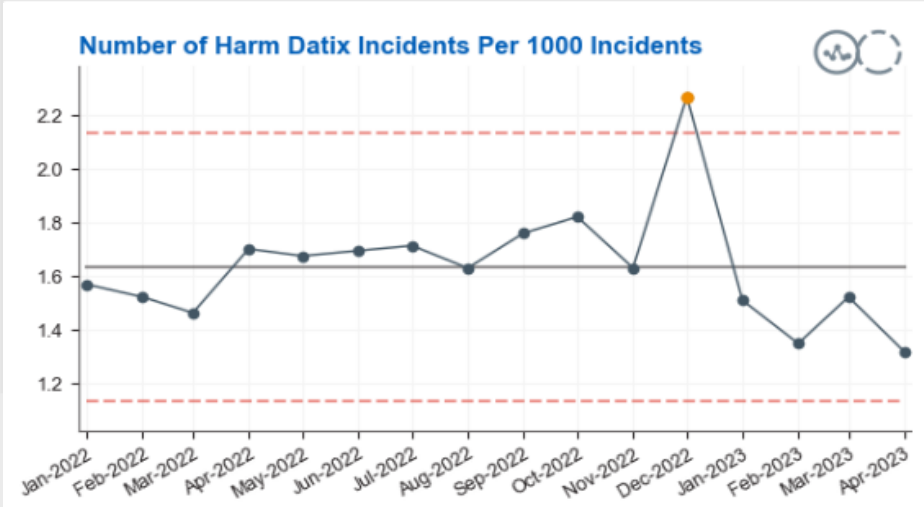
QS-28

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

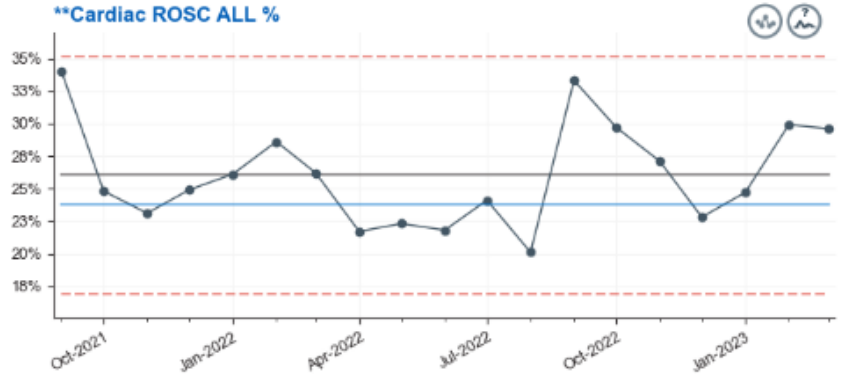
- There are 1.32 incidents of harm per 1000 incidents which is positive. In April, this equates to a 99.86% of all reported incidents being no harm/low harm
- This has remained consistent over the last four months with an average of 1.43 incidents of harm per 1000 across Jan-Apr
- There is a positive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

What actions are we taking?

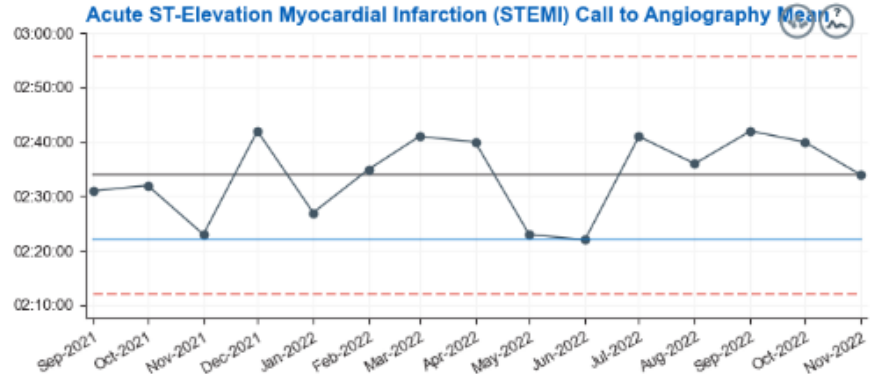
- To continue to support a positive culture of reporting incidents at SECAmb and ensuring feedback to individuals / team and organisational wide learning.
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support 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

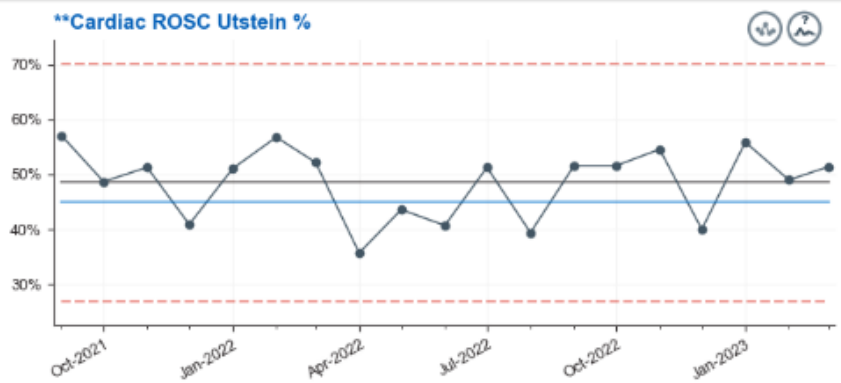
Impact on Patient Care - Cardiac



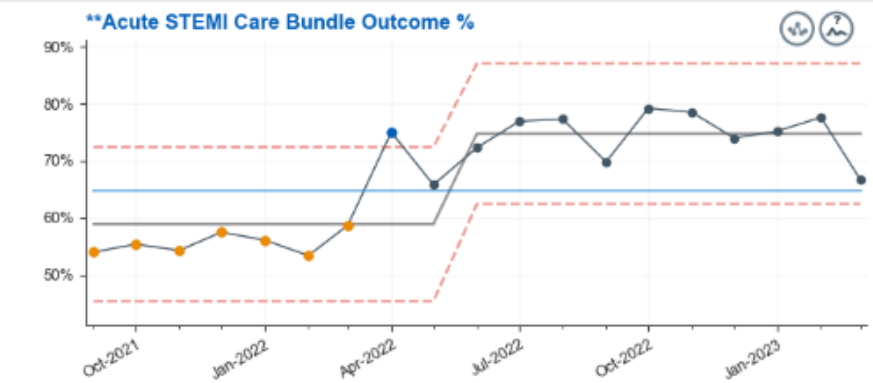
M-2
Dept: Medical
IP: Quality Improvement
Latest: 29.6%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



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)

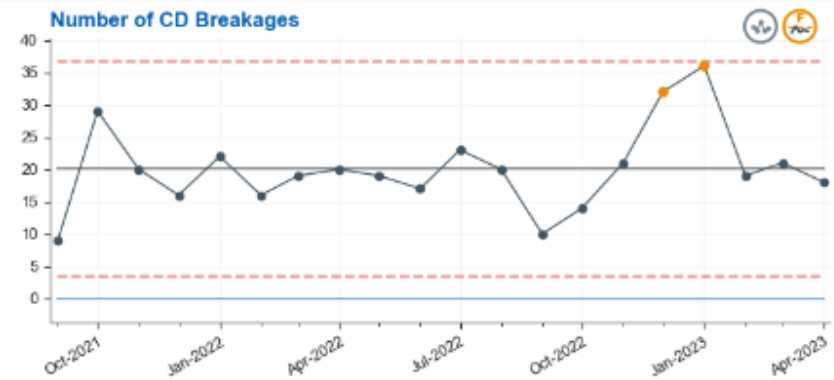
MM-1

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.

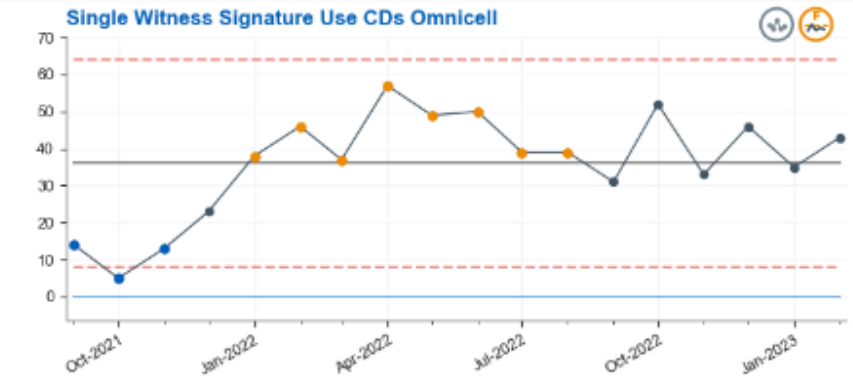
MM-7

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

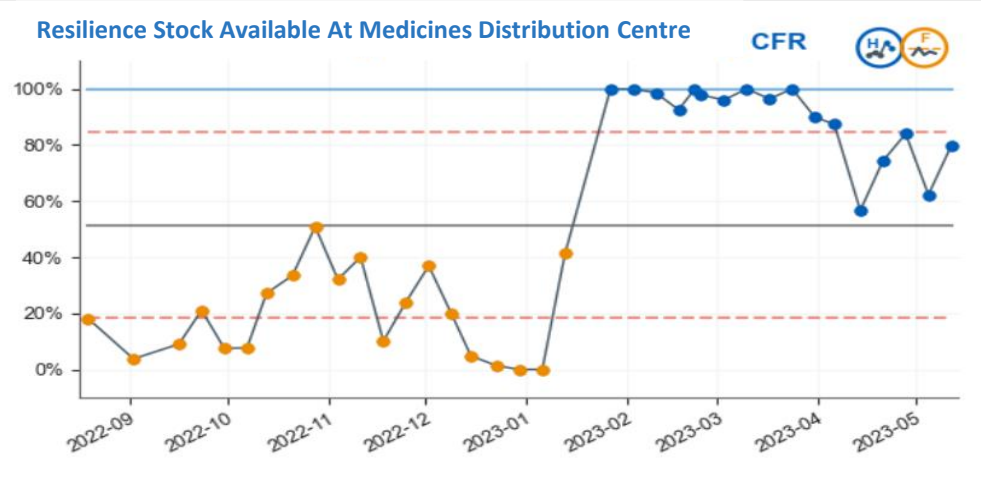
Note: Work is ongoing around reporting medicines incidents. Key skills 2023/24 has medicines in its lesson plan so this will be reported on going forward for assurance and oversight in the Trust.
Non compliance to medicines audits is being picked up through Medicines Governance Group and Senior Operations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

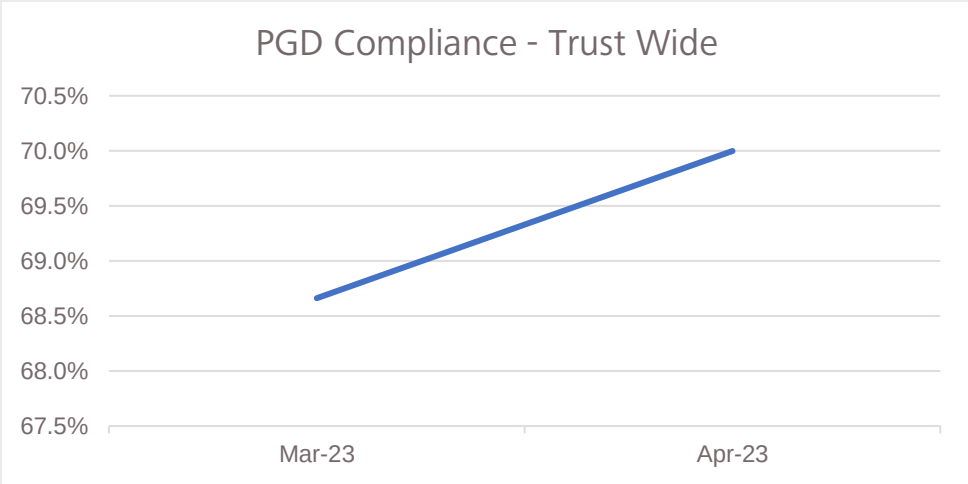
What actions are we taking?

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.

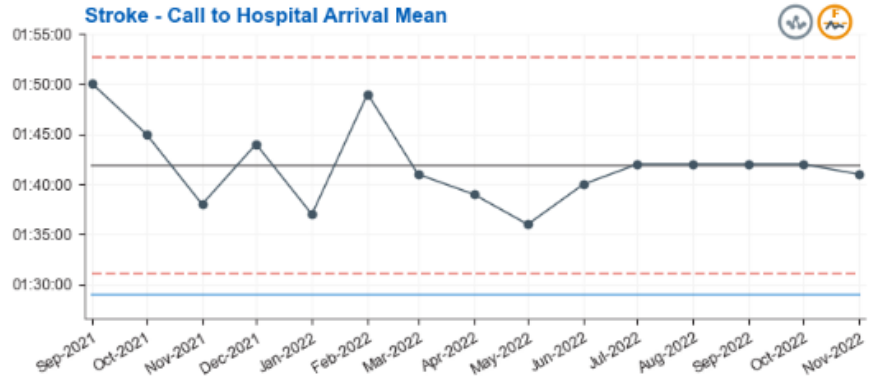
PGD report down to practitioner level being shared with OUMs monthly. Targeting OUs and cohorts of under-compliance, with a target to achieve >95% by end of Q2.

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)

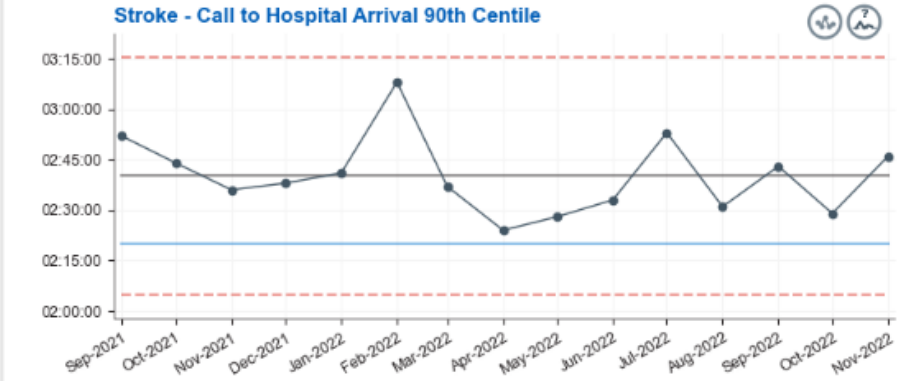
QUALITY IMPROVEMENT

Impact on Patient Care – Stroke



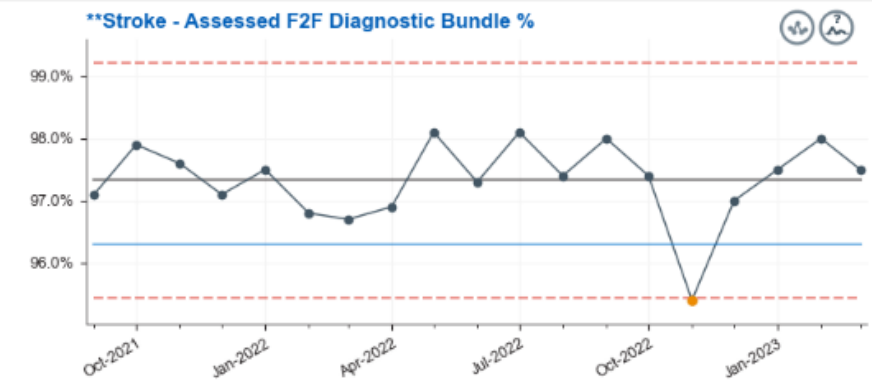
M-8

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.



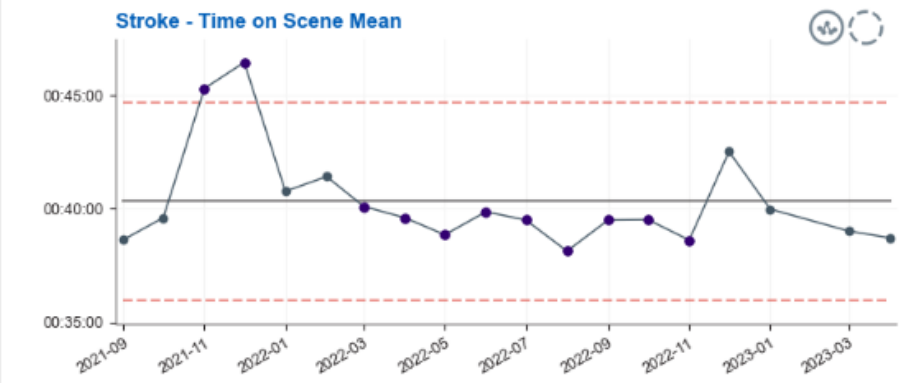
M-9

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

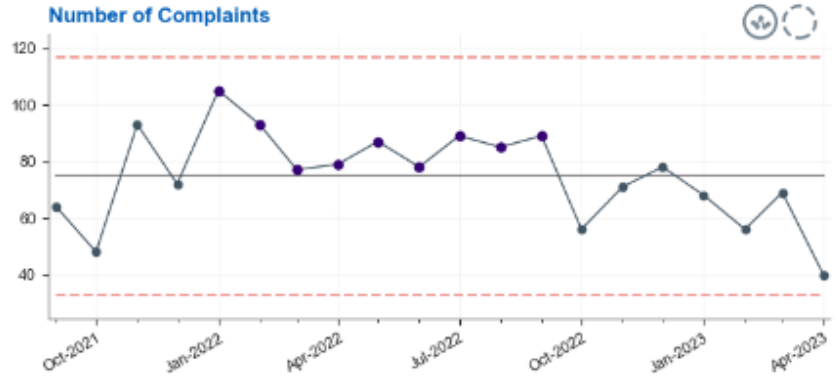
Stroke – Common cause variation continues. We are not meeting the national targets for Stroke patients due to overall delays in arrival at scene, however, once we arrive with the patient, compliance against the Diagnostic Bundle has largely been above target since August 2021. Whilst there's no special 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

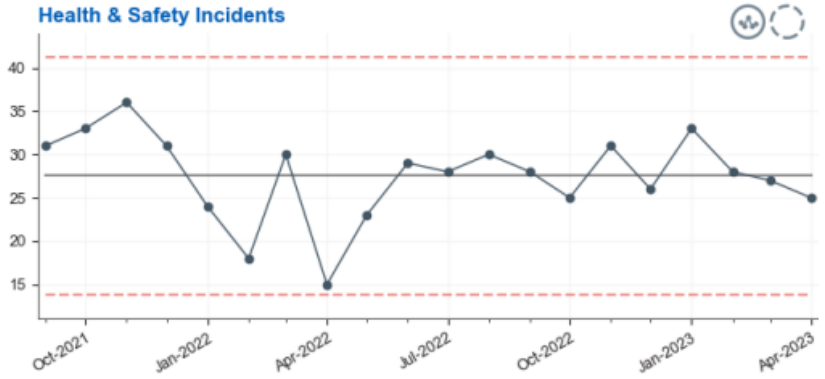
- The number of complaints received within the organisation is within normal variation as is the complaints reporting timeliness and proportion of complaints reporting to crew attitude.
- Crew attitude continues to be a significant theme within complaints. We continue to learn and support individual 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

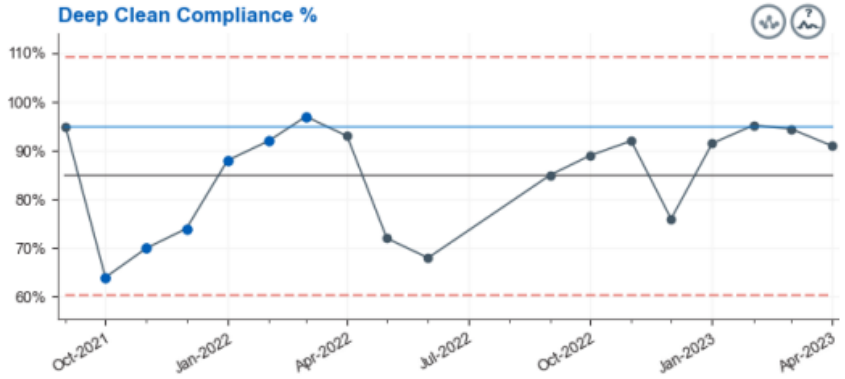
Manual handling incidents reported in March 2023 were 23, again this represents normal variation.

What are we doing

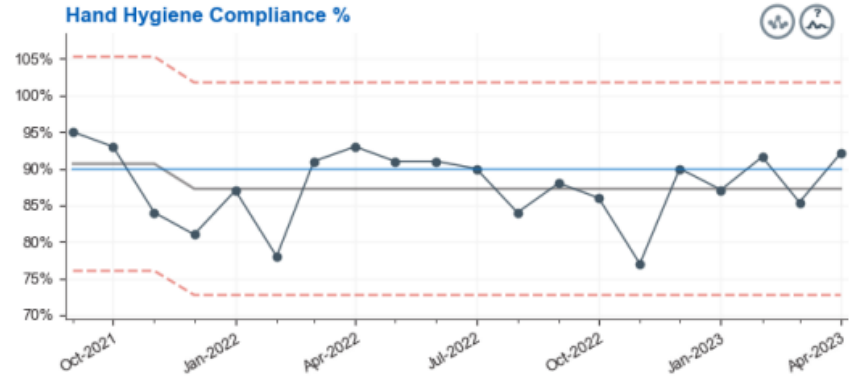
- The regional and Trust Health & Safety group will continue monitoring incident trends. H&S Committee now led by Exec team with H&D Lead to ensure assurance is provided on all regulatory aspects and action plans agreed and acted on.

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.



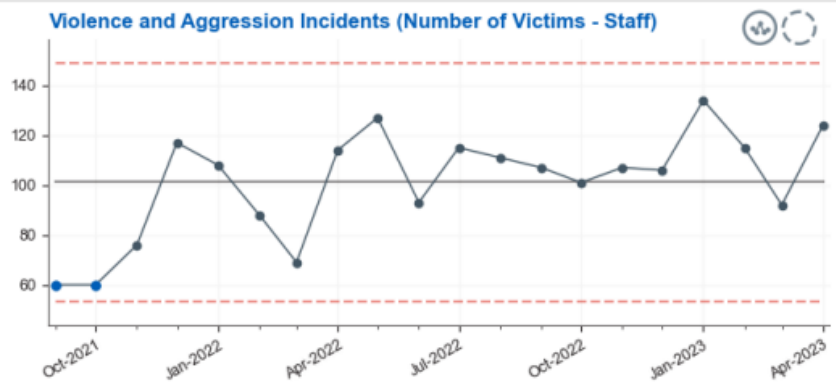
QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 92.1%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

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

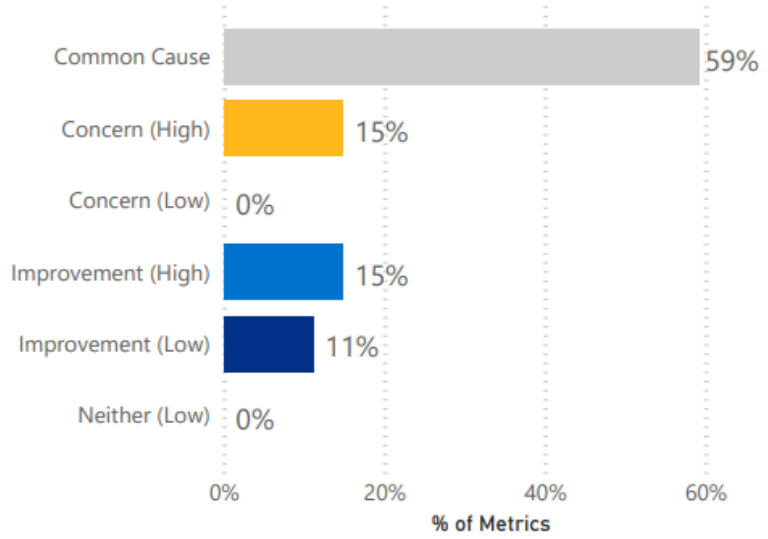
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Bullying & Harrassment Internal Disciplinary Cases	Number of Staff WTE (Excl bank and agency) Sickness Absence % Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Current licence details held for Operational Staff %	
Common 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.

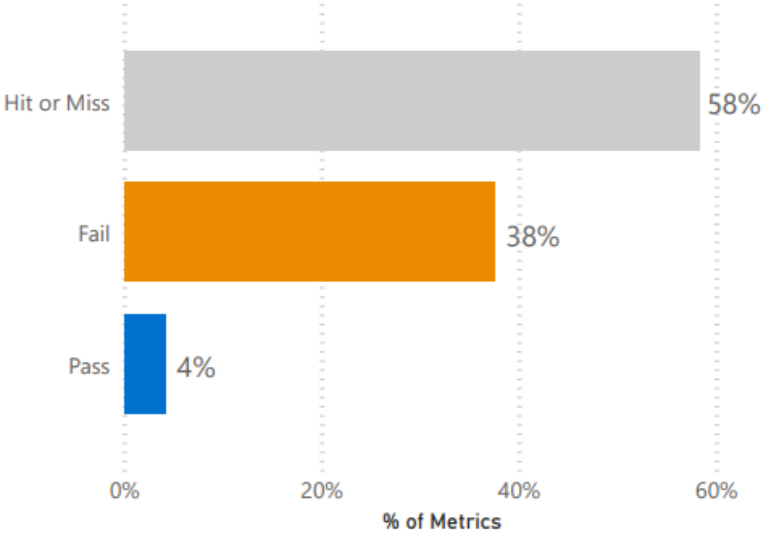
PEOPLE & CULTURE

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%		

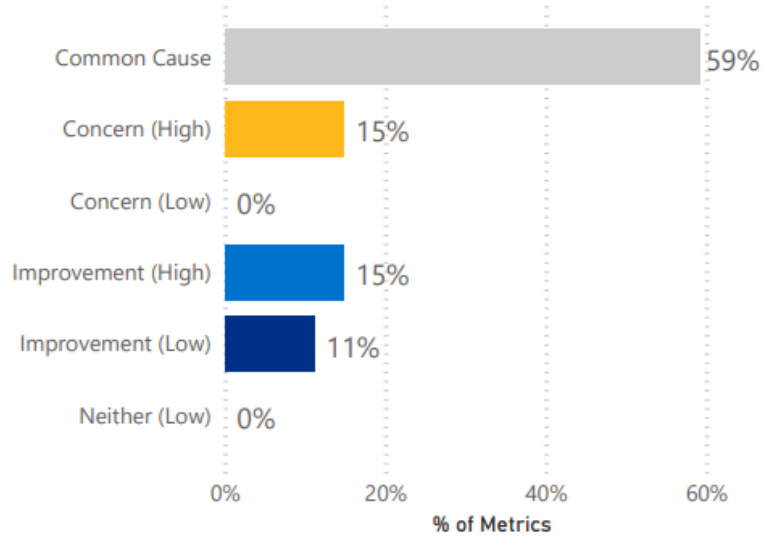
Employee Experience

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%		

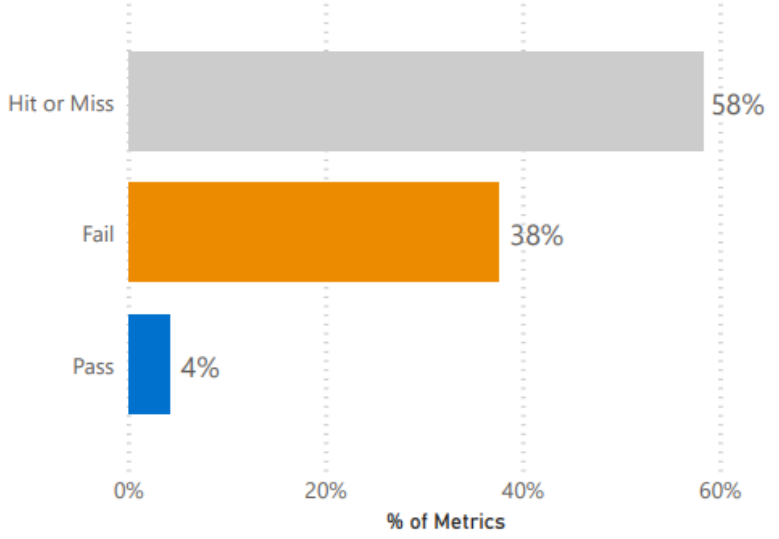
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

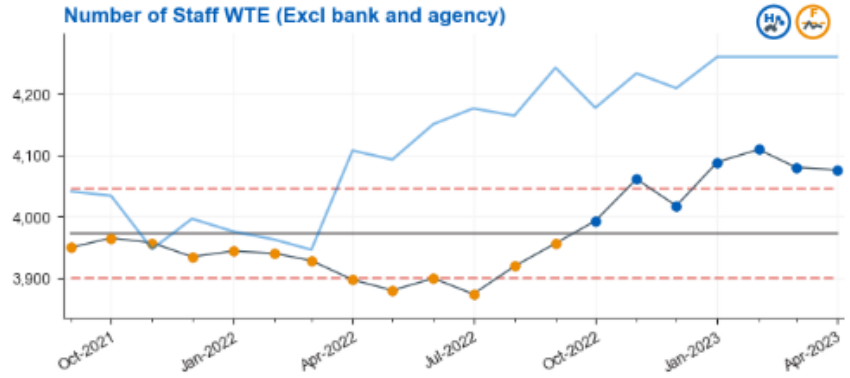
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Apr-2023	7	5	-1.94	10.8	23.54		
Collective Grievances Open	People & Culture	Apr-2023	0	1	-1.63	1.45	4.53		
Count of Grievances Closed	People & Culture	Apr-2023	13	3	-3.09	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		

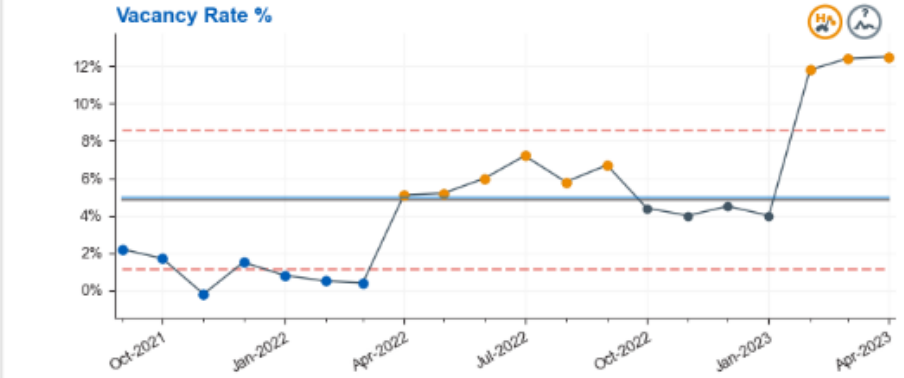
PEOPLE & CULTURE

Workforce (1 of 3)



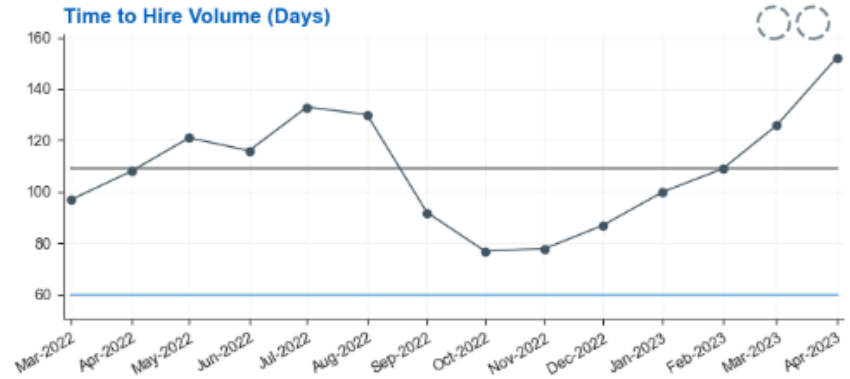
WF-1

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.



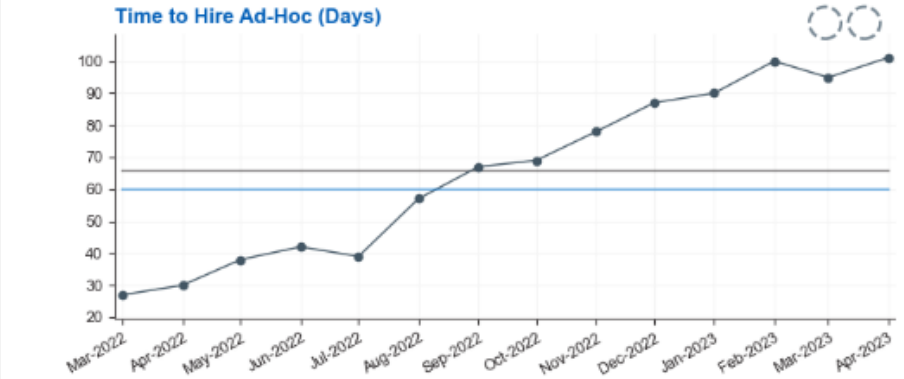
WF-4

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?

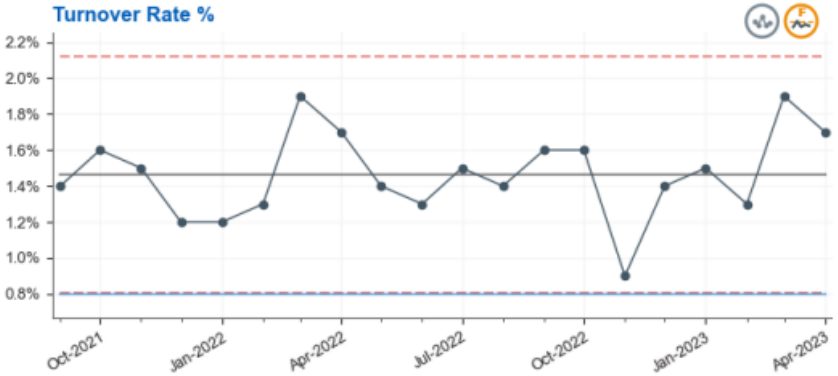
The Recruitment and Onboarding project commenced on 23/05/2023 and aims to streamline our onboarding process using the DMAIC methodology. The project will focus on time to hire, readiness of new hires and drop-off rates.
The project will cater to four main cohorts: permanent cohort, ad-hoc, international 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.

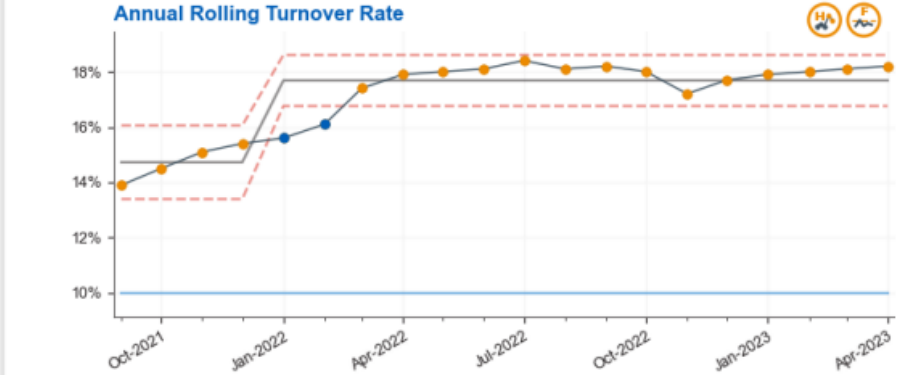
The project has been set with a 3-6 month delivery time so will work at pace to complete.

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.

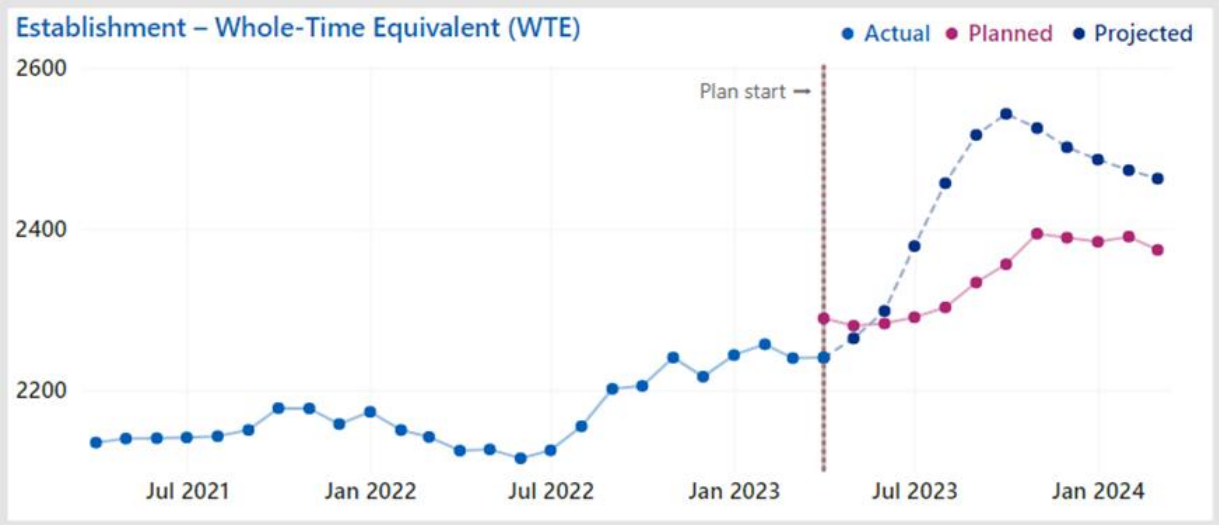
EOC Retention (Culture Change) Moorhouse Report – This programme of work looks to address the 50% turnover in EOC and 111, which is almost double that of other Trusts. 25% of the total turnover related to failure of probation.
Nine quick wins, identified as part of the Culture Change work, have been 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)

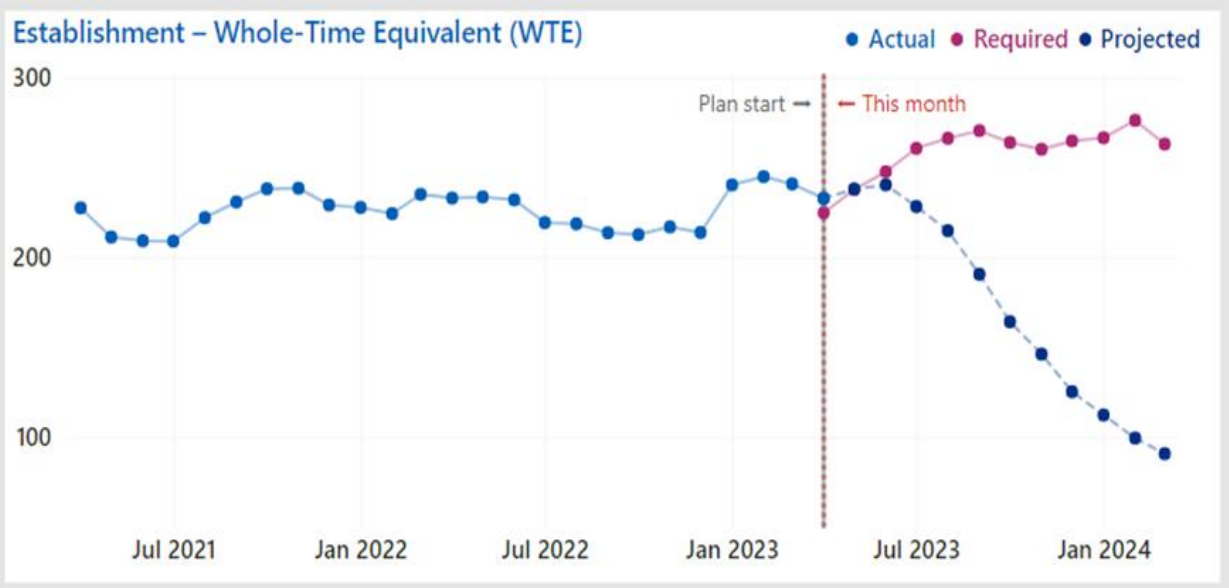
(999 Frontline)



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.

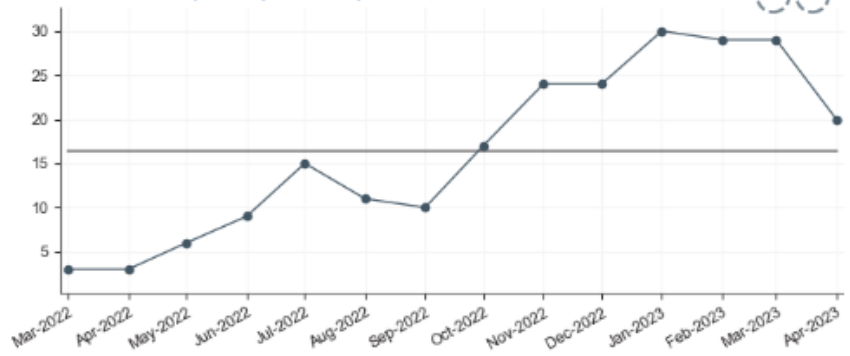
Mitigating actions – EOC EMA
Attrition is planned at 72.3% across 23/24. The attrition plan has been calculated based on a 2-year average, and an additional 30% attrition from the East EOC that has been phased from Sept 23 to March 24 with the move from Coxheath to Medway is currently planned.
This plan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

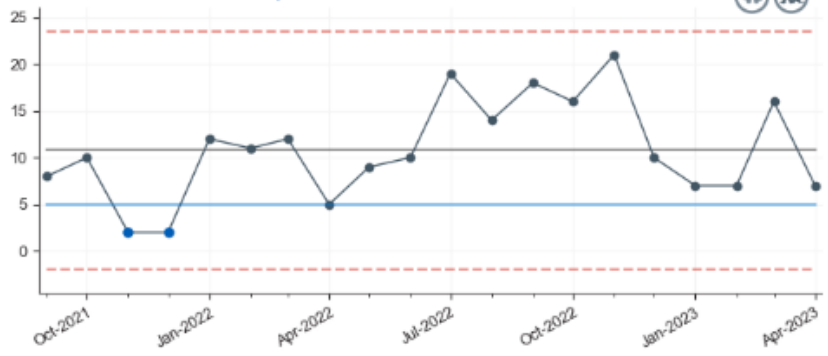


QS-27

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.

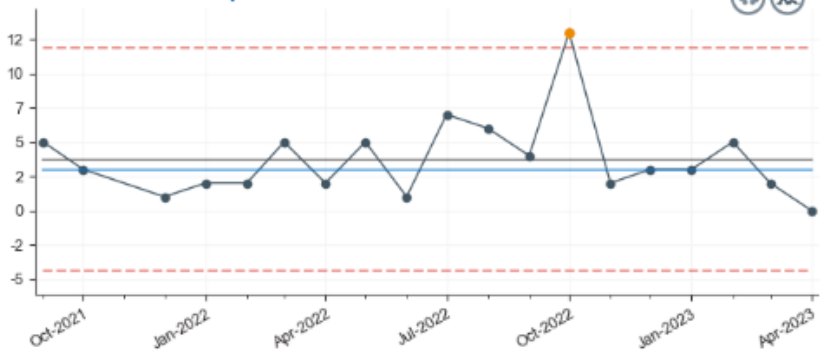
Individual Grievances Open



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.

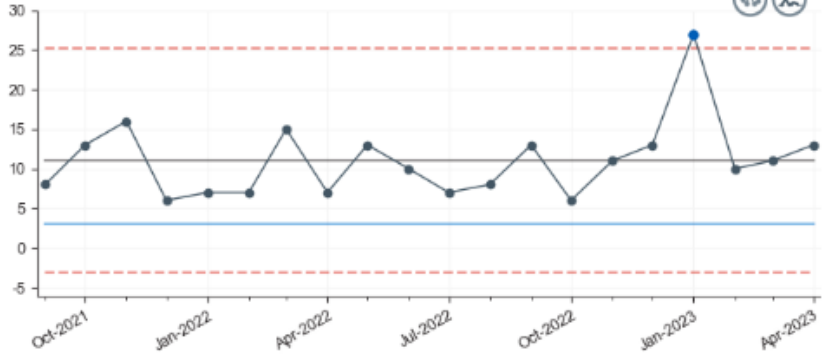
Count of Until it Stops Cases



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.

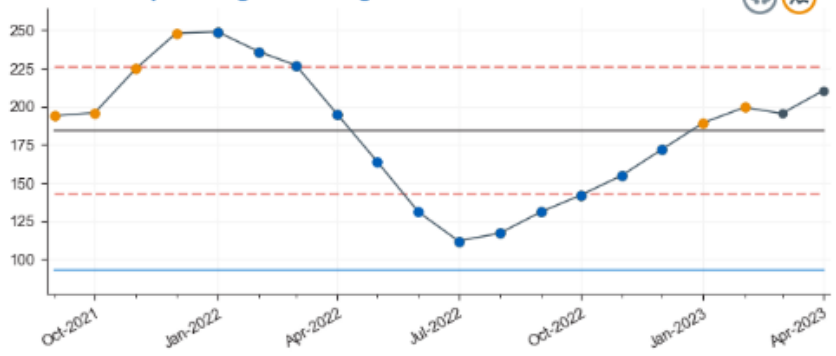
Count of Grievances Closed



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.

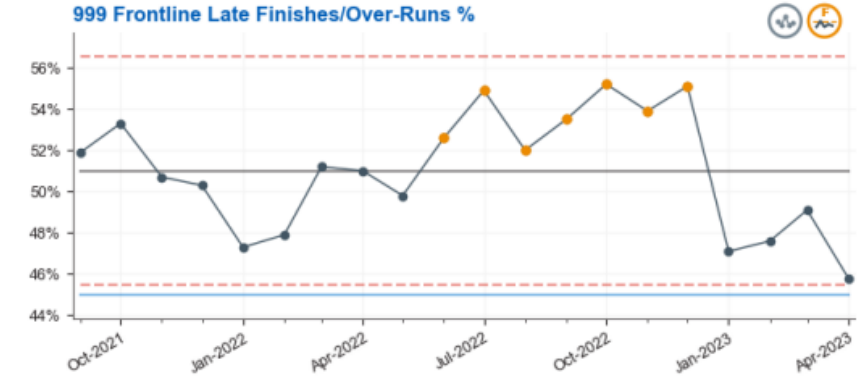
Until it stops Grievances:- The Trust will continue to prioritise train our colleagues and managers on expected behaviours and engage with colleagues who experience these poor behaviours in a supportive manner, ensuring our Managers use the HR policies to ensure a fair investigation and hearing takes 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.

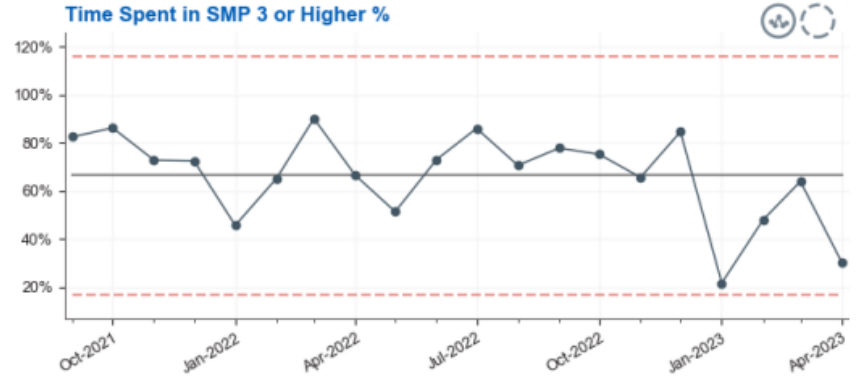
We will continue to emphasise early informal resolution over formal routes; the introduction to the new ER structure will also support training to support the average time to conclude a grievance.

PEOPLE & CULTURE

Employee Experience

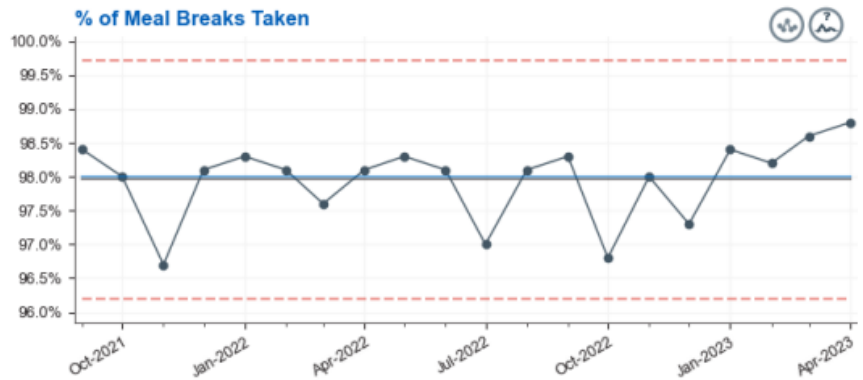


999-15
Dept: Operations 999
IP: People & Culture
Latest: 45.8%
Target: 45%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



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

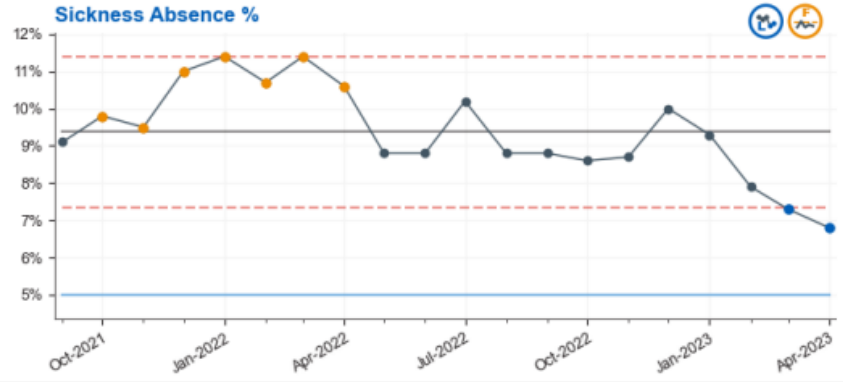
- Late finishes/over-runs for H1 to achieve a sustained Trust-level 45% and during this time, using the performance & quality framework, to develop improvement trajectories for % of over-runs and duration of over-run on an individual dispatch desk basis. This approach follows the paper presented to WWC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

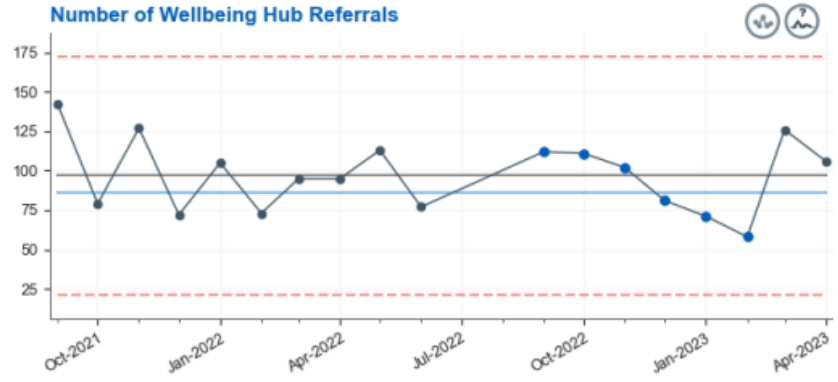
- The development of the IQR through an Operations performance and quality management framework has advanced, with the intention to drill down data to dispatch desk. A monthly cycle of review and challenge is being incorporated with involvement from all directorates.

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.

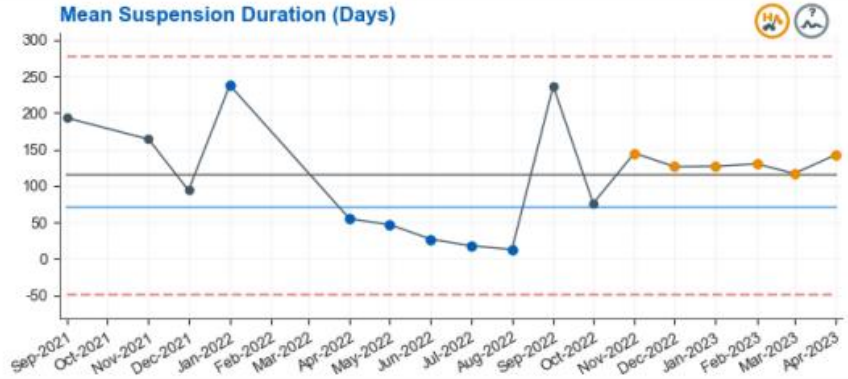
With the additional funding from NHS Charities that we mentioned in April, we have now successfully recruited the two FTC mental health wellbeing practitioners for EOC/111 and Medway. Both will start in the next couple of weeks.

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?

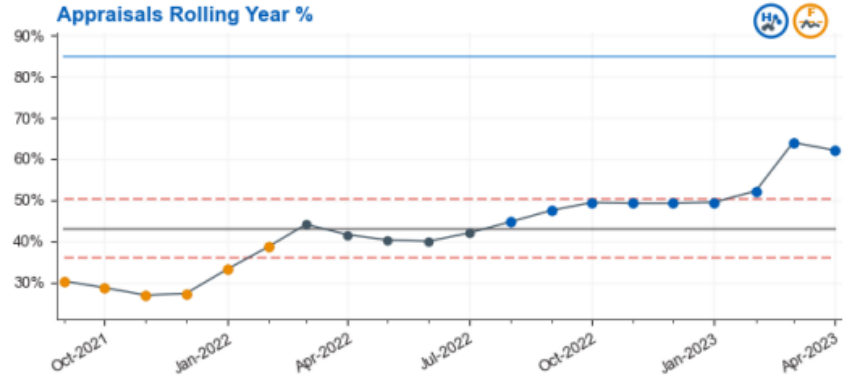
Suspensions: cases continue to be reviewed on a weekly basis by the HRBP Team with the Executive Directors of HR & OD and Operations.

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

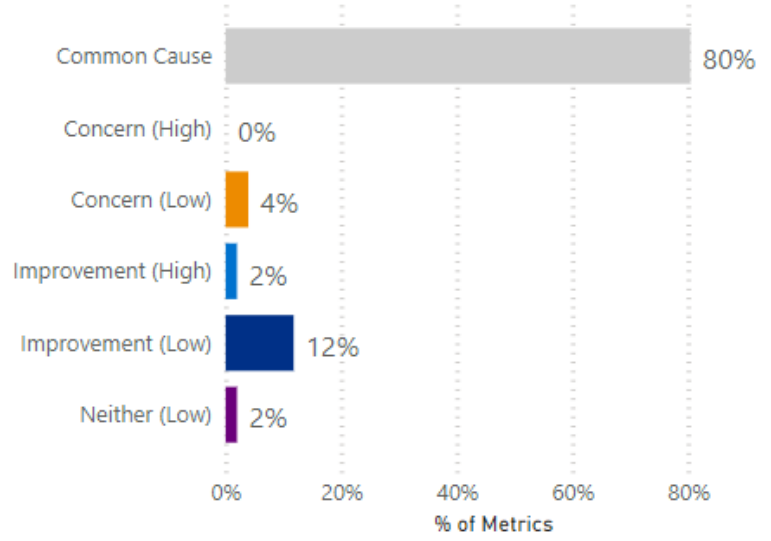
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %	Clinical Contact %		JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as a Proportion of Provided Hours... Number of Hours Lost at Hospital Handover Duplicate Calls % 999 Referrals
Common Cause	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.

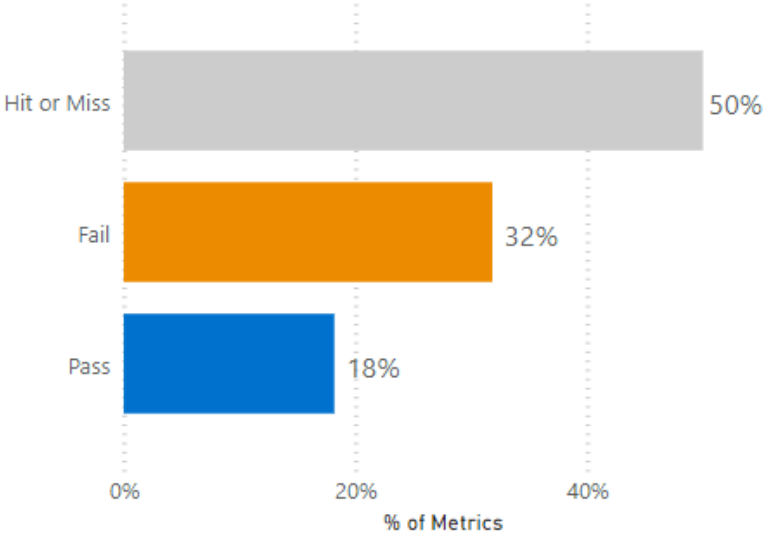
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

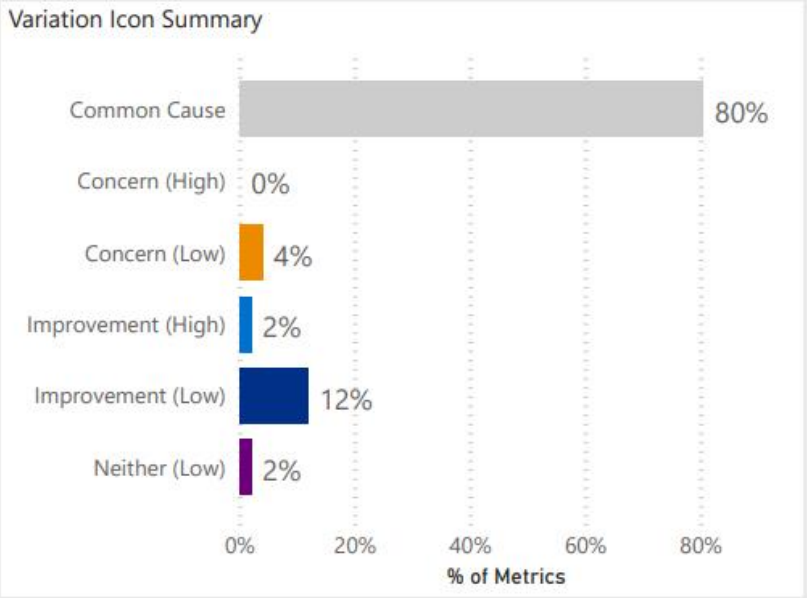
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Apr-2023	01:58:54			00:41:24			
Section 136 Mean Response Time	Responsive Care	Apr-2023	00:21:38		00:12:40	00:26:59	00:41:19		
Cat 1 Mean	Responsive Care	Apr-2023	00:08:22	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		

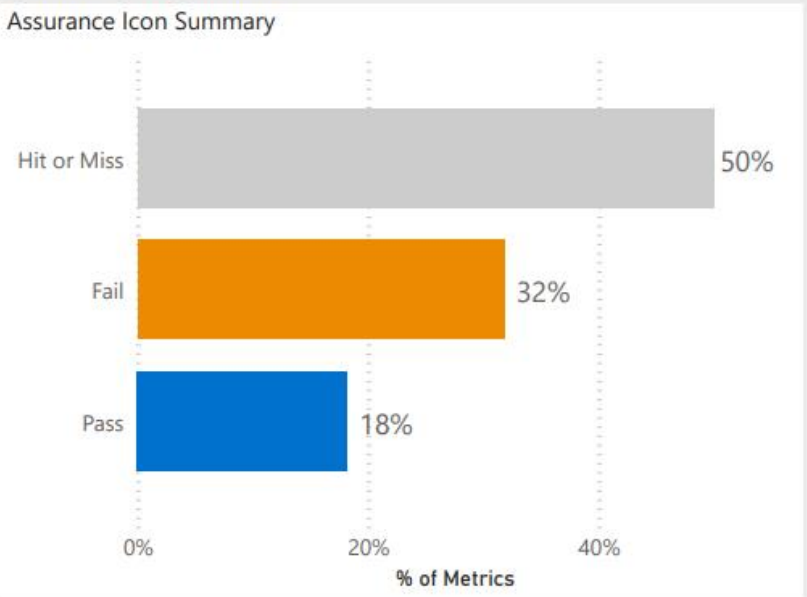
Emergency Operations Centres (EOC)

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

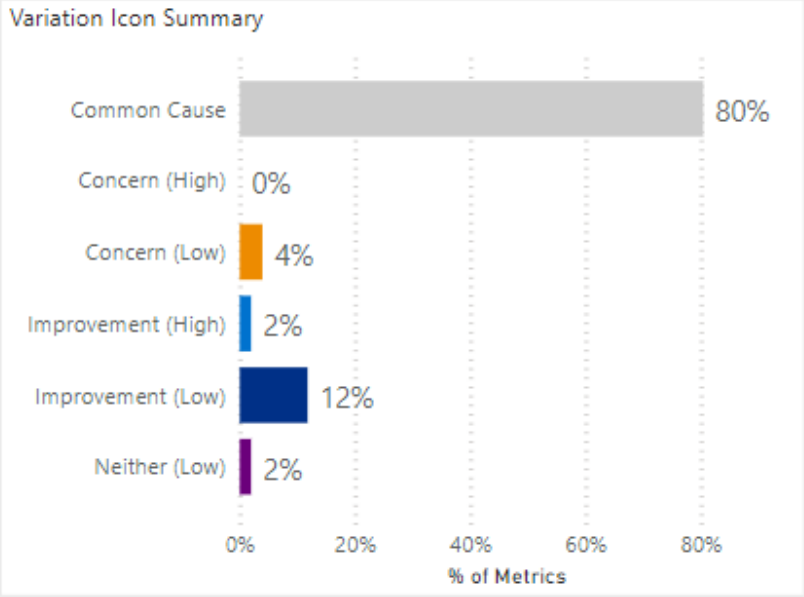
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Apr-2023	92.2%	100%	83.1%	90.3%	97.49%		
Provided Bank Hours %	Responsive Care	Dec-2022	0.7%		0.36%	0.7%	1.04%		
Provided Overtime Hours %	Responsive Care	Dec-2022	7.7%		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		

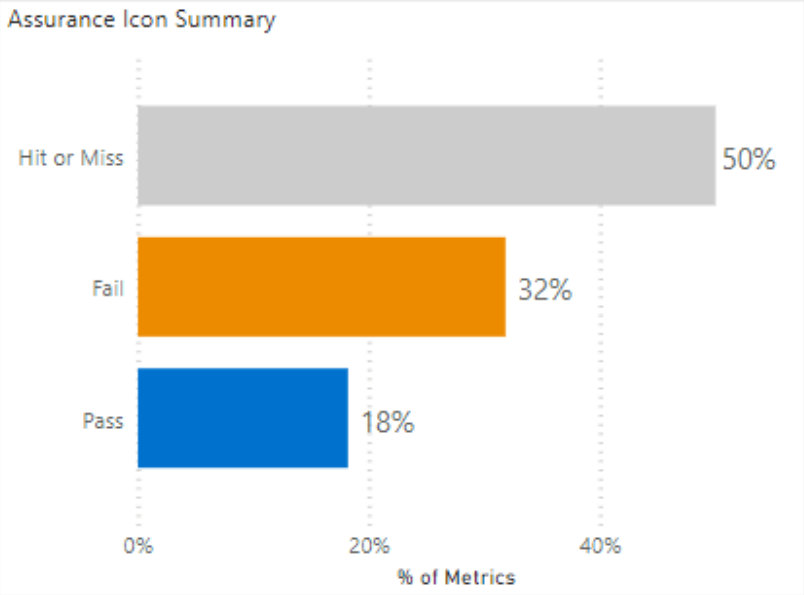
111

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

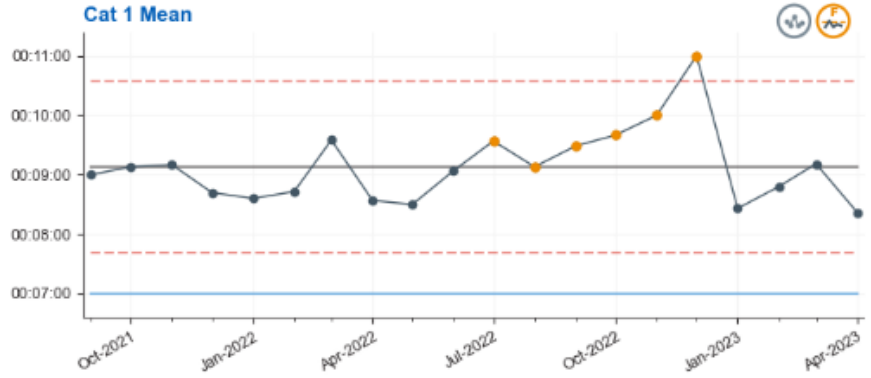
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Apr-2023	01:17:35		01:16:21	01:18:07	01:19:54		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Apr-2023	01:50:39		01:51:07	01:55:59	02:00:51		
Responses 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%		

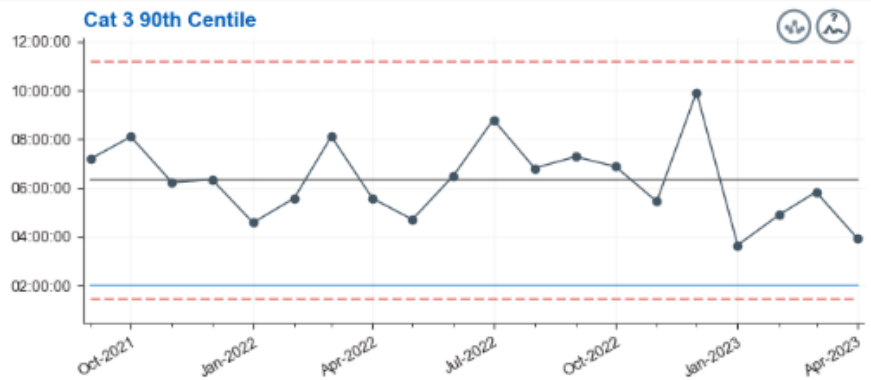
RESPONSIVE CARE

Response Times

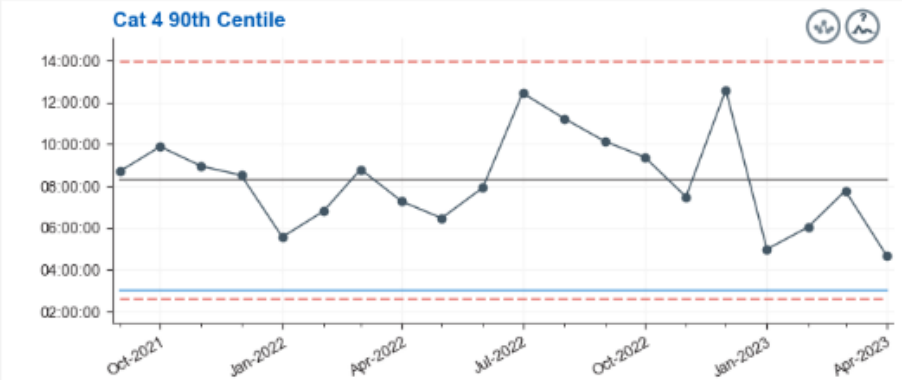


999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:22
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

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.

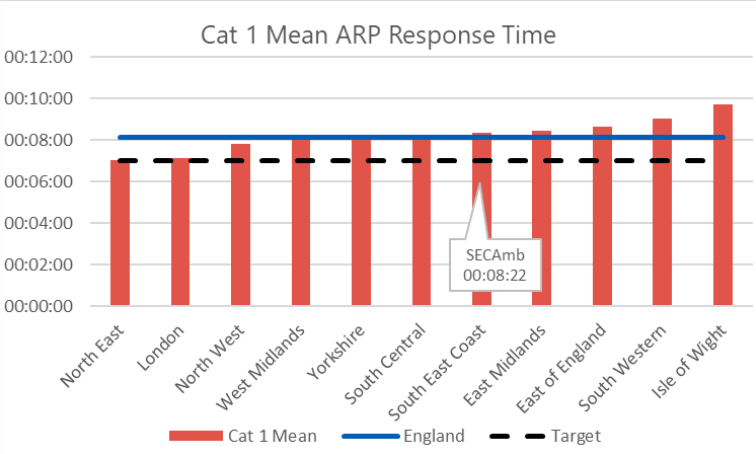
Summary

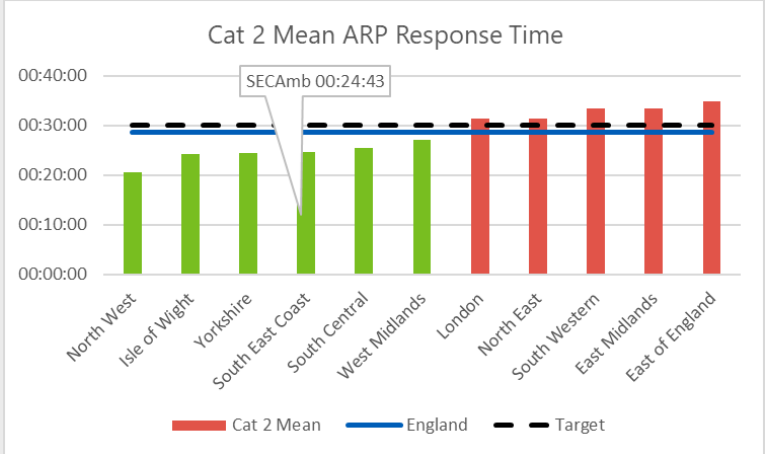
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The overall improvement during Jan-Apr has been due to an improved balance between demand and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

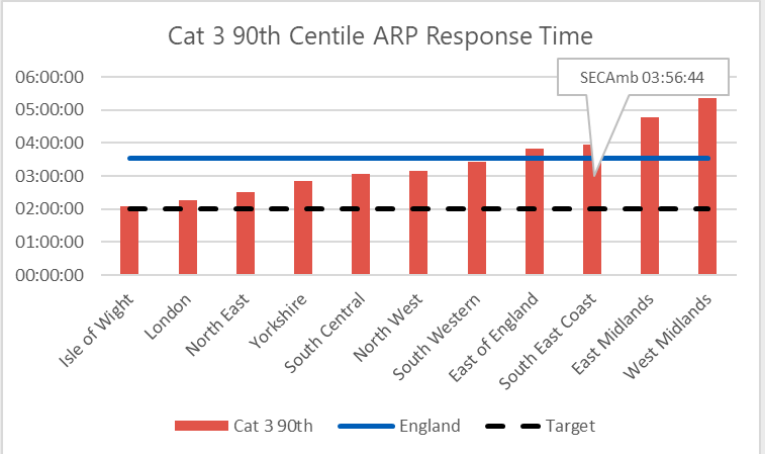
What actions are we taking?

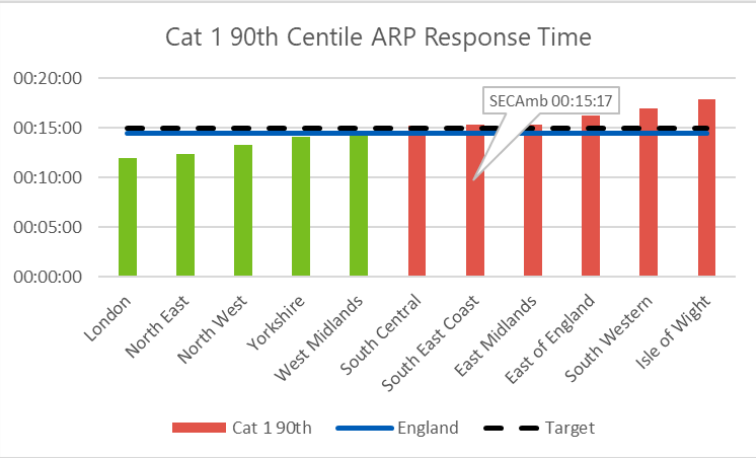
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (95.1% for April - consistent with the previous 3 months).
- Introduction of C3 & C4 Clinical Validation in 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.

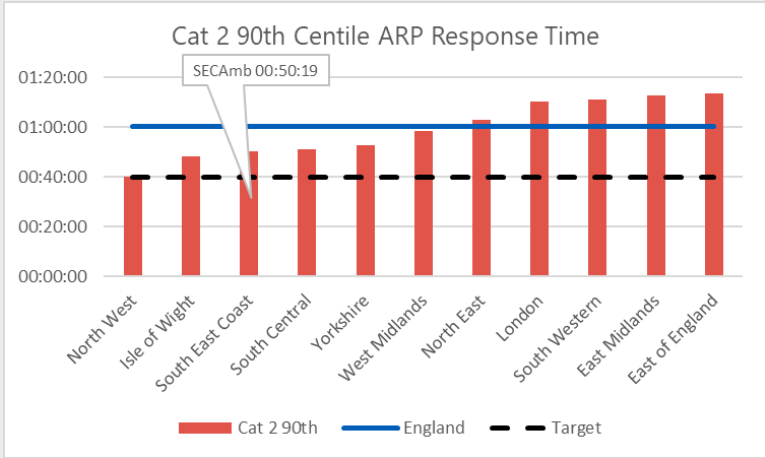
ARP Response Time Benchmarking (April 2023)

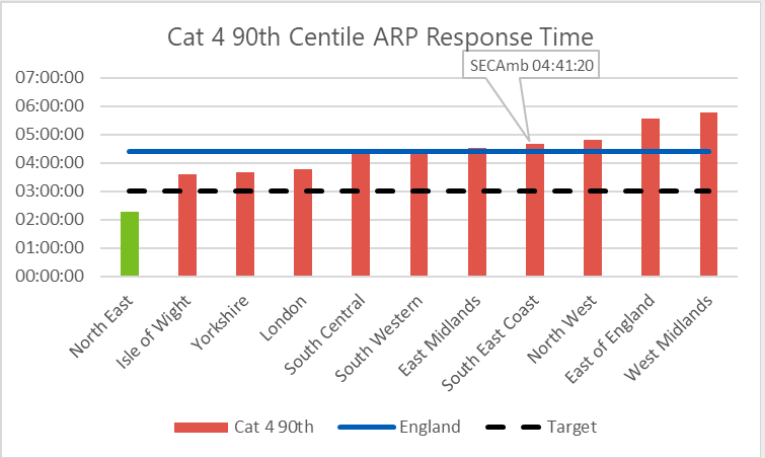










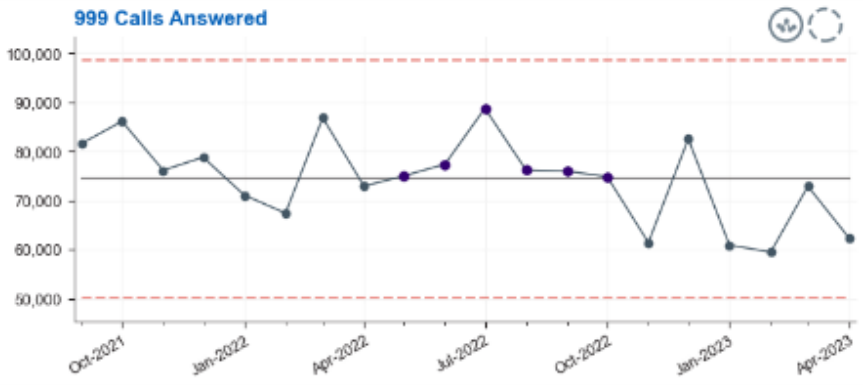


Summary

- 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

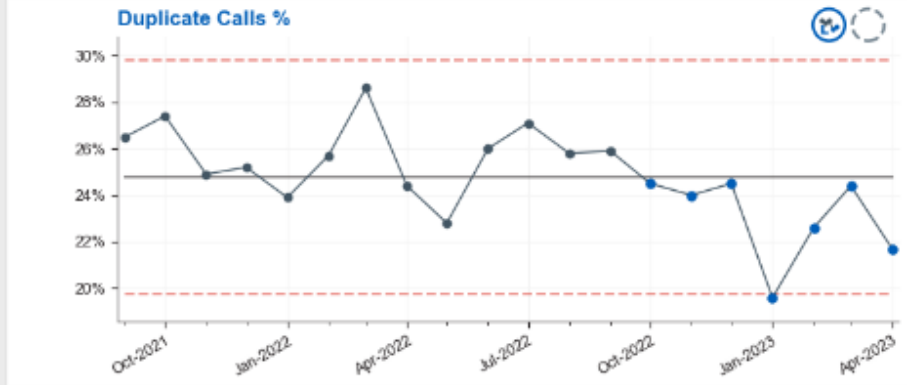
EOC Emergency Medical Advisors



999-10

Dept: Operations 999
IP: Responsive Care
Latest: 62305

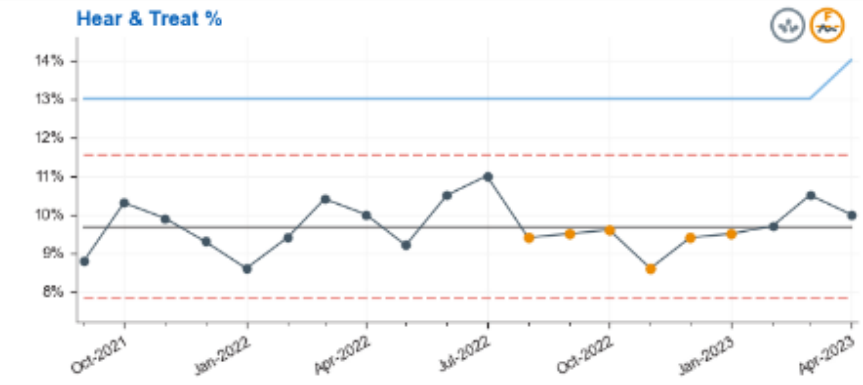
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.



999-33

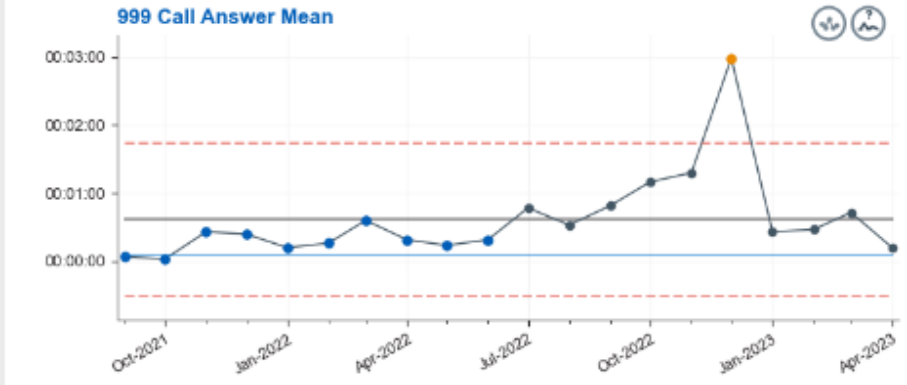
Dept: Operations 999
IP: Responsive Care
Latest: 21.7%

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

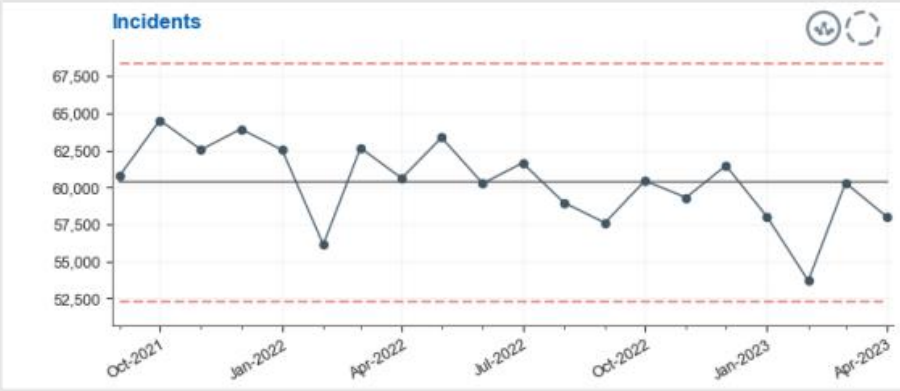
- Call answer mean time has shown improvement in the past two months, underpinned by better staffing and reducing call volumes – this metric is strongly aligned to the EMA resourcing levels over the same period.
- Over the duration of the past 9 months, there have been a more recent decrease in the number 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

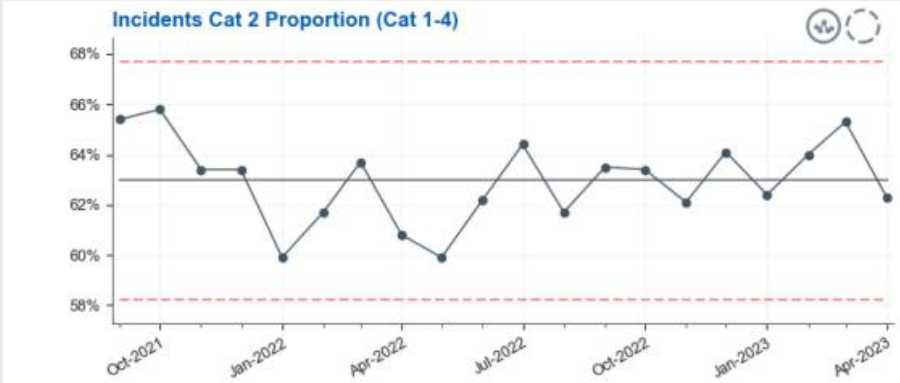
Utilisation



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

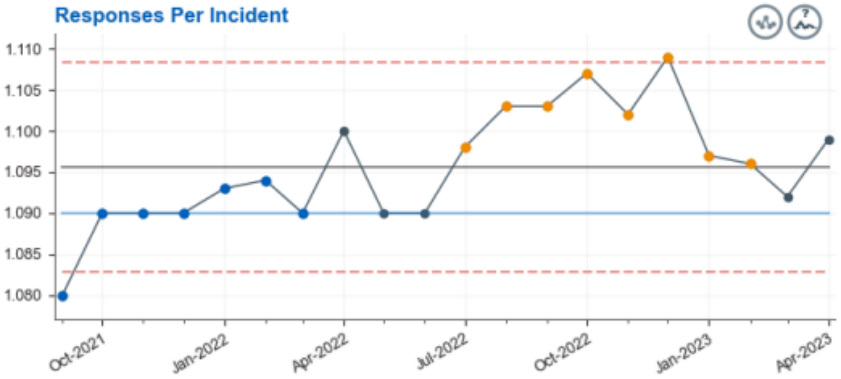
- From the Trust's 111 service, there is a very high revalidation rate for all calls being proposed to be passed to 999 (consistently above 95%) which is resulting in the reduced ambulance referral rate from 111 in Kent and Sussex.
- From the above, since May 2021, there has been very significant fluctuations 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?

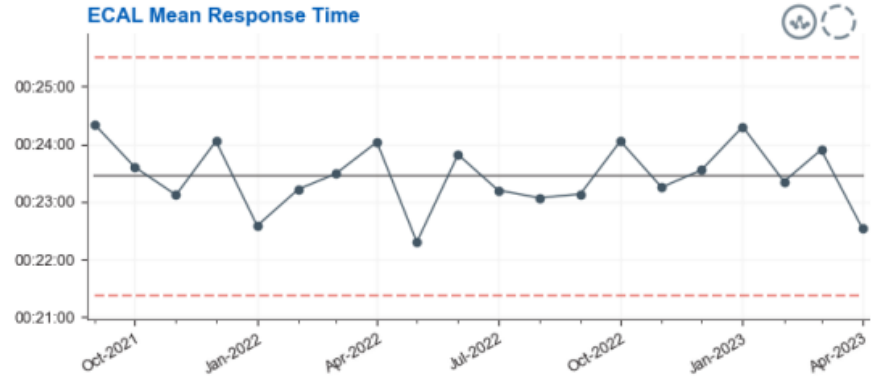
- Continued effective clinical validation of non-emergency ambulance calls from Kent, Medway and Sussex's 111 service, significantly above the contractual requirements to protect 999 - (95.5% for Feb)
- Continued focus on optimising resources through abstraction management and optimisation of overtime 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

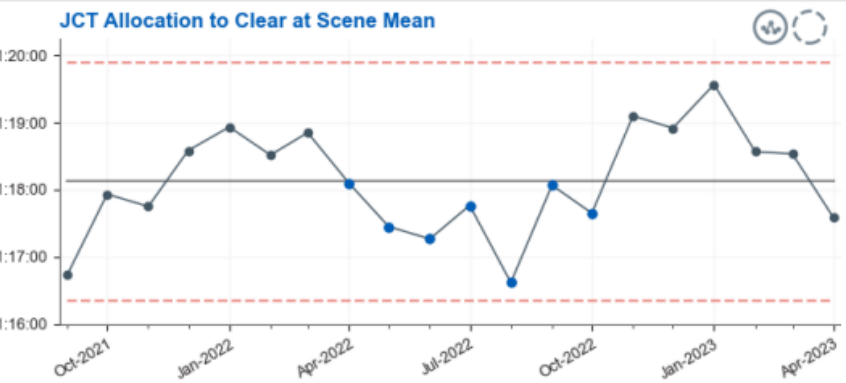


999-17
Dept: Operations 999
IP: Responsive Care
Latest: 1.1
Target: 1.09
Common cause variation, no significant change. This process will not consistently hit or miss the target.



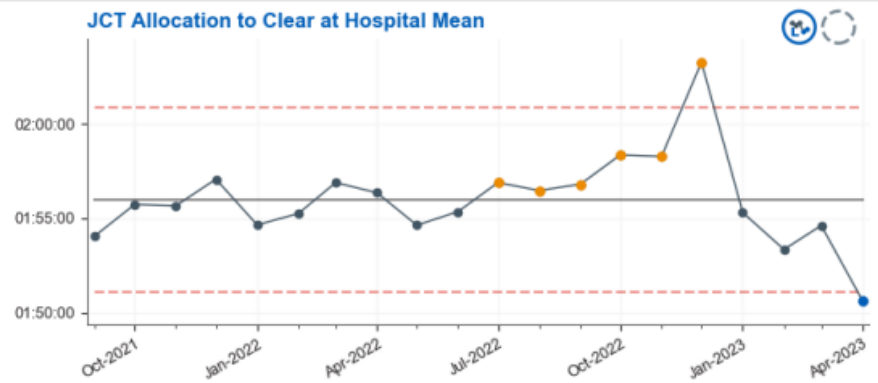
999-13
Dept: Operations 999
IP: Responsive Care
Latest: 00:22:32

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.

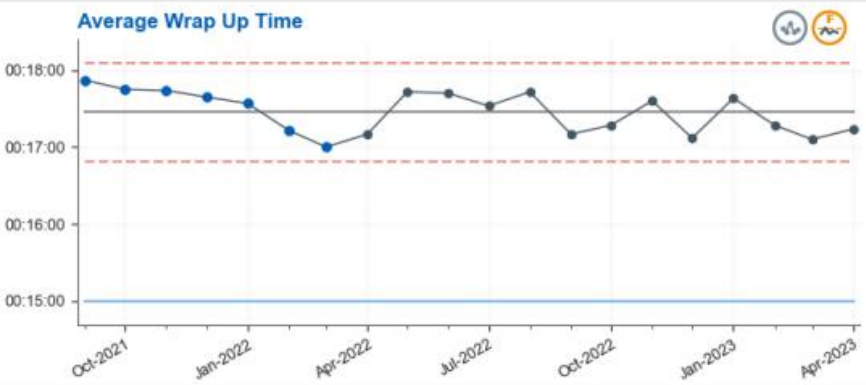
999-9

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

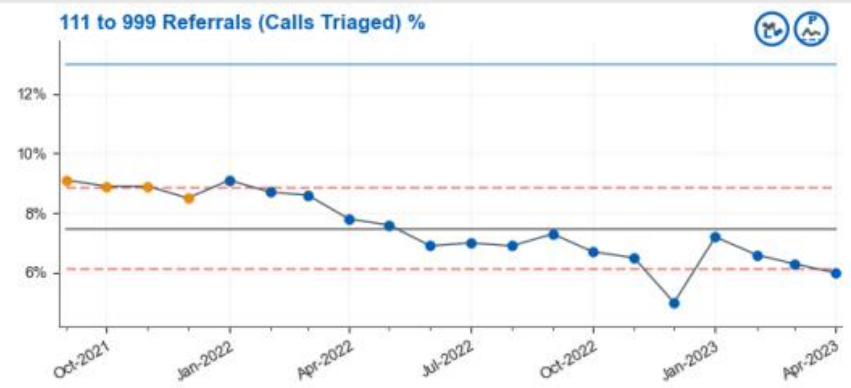
Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.

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

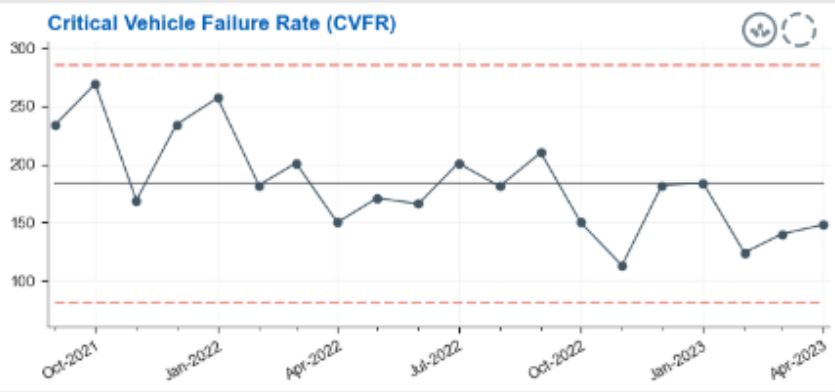
- The service's operational responsiveness remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned call.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment challenges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

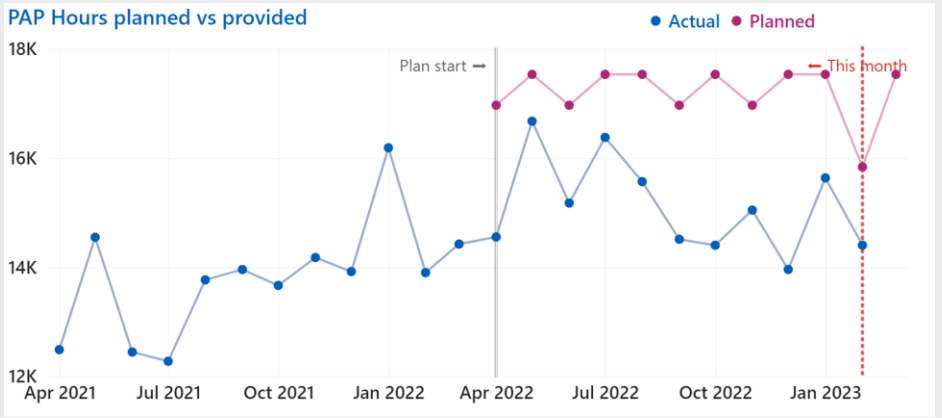
Support Services
Fleet and Private Ambulance Providers

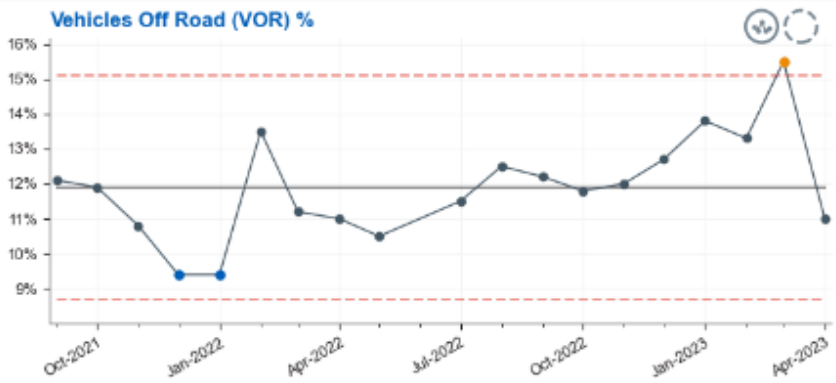


FL-12

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?

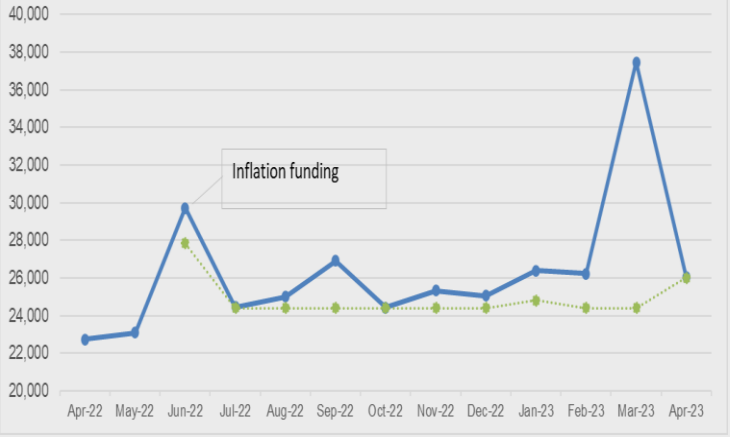
1. A robust cost savings plan is being developed in order to ensure that the £9m savings plan can be delivered. Progress on this is slower than expected and will be reviewed further at the Finance and Investment Committee.
2. Monthly Executive lead directorate meetings are continuing to ensure that each 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

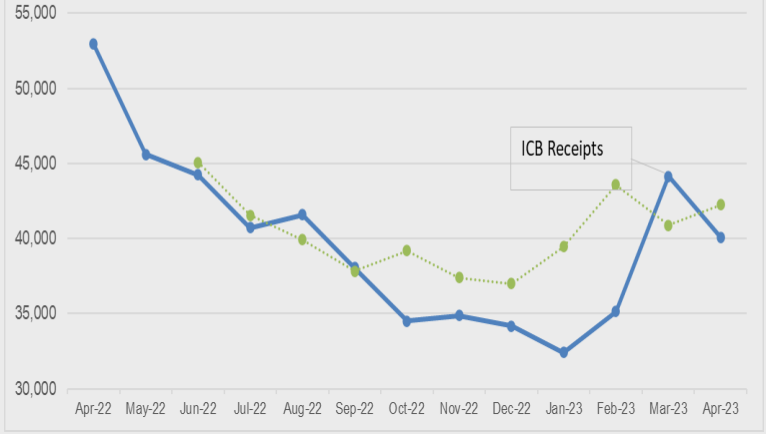
Delivered Against Plan

Actual Plan

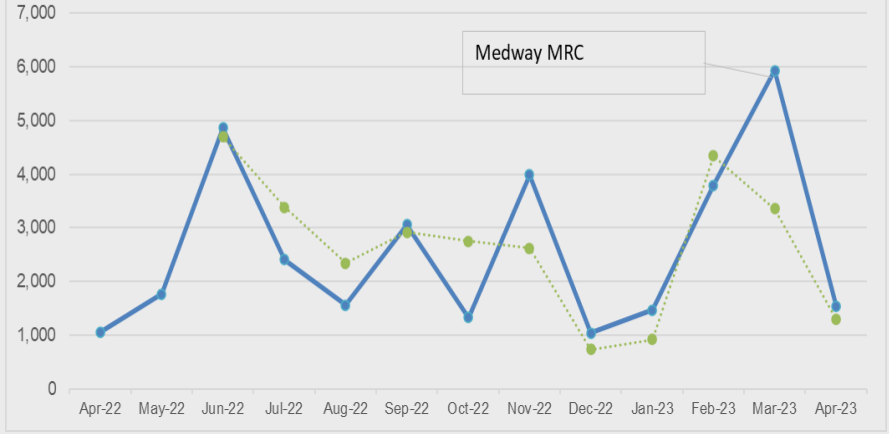
Income £000s



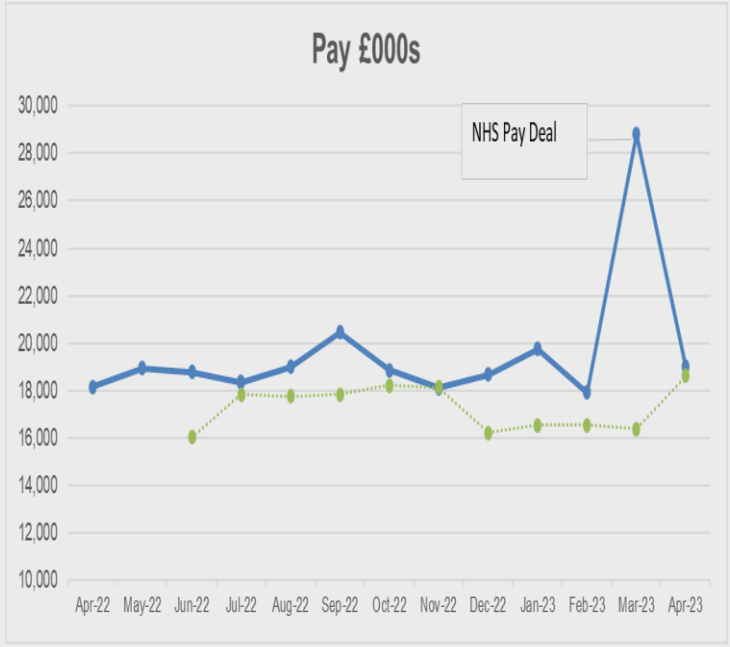
Cash £000s



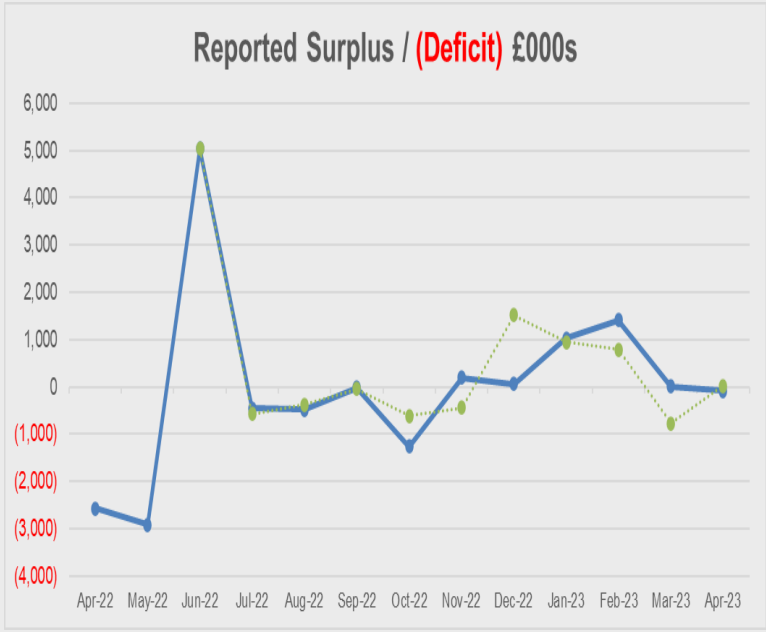
Capital Expenditure £000s



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

Southeast Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee Escalation Report

Overview of issues covered at the meeting 15.03.2023

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

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

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

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

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

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

The findings and recommendations continue to be considered in the planning and delivery of the committee meetings. Below is a summary of progress to-date.

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

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

South East Coast Ambulance Service NHS 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	Appraisals > 85%	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.

Goal 2		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	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 & Partnerships
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 develop innovative and sustainable models of care

Risk ref	Thematic Risk Title	Oversight Committee	Strategic Goal(s) Impacted					Initial risk	Current Risk (Current Position)								Change	Target score	Target date
			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	Tbc
255	*Workforce Plan*	PC	-	-	1-3	1		20				16	16	16	16	16	⇔	08	April 24
348	*Culture & Leadership*	PC	-	1-3	-	-		16					16	16	16	16	⇔	08	Tbc
16	*Financial Sustainability*	FIC	-	-	-	3		16	12	12	12	16	16	16	12	12	⇔	08	April 24

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	Assurance
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.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
See P&C Objectives in section 1			

	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 Likelihood 5)
	Current Risk Score	**16** (Consequence 4 x Likelihood 4)
	Risk Treatment **(tolerate, treat, transfer, terminate)**	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)	**Integrated Quality Report Metrics for Assurance**	**Variation**	**Assurance**
Workforce Plan Agreed	**WF-1** "Number of Staff WTE"		
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-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)

- 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.

Integrated Quality Reports Metrics for Assurance	Variation	Assurance
WF-1 "Number of Staff WTE"		
F-9 "Income (£000s) YTD"	NA	NA
F-10 "Operating Expenditure (£000s) YTD"	NA	NA
F-6 "Surplus/Deficit (£000s) Month	NA	NA

Gaps in Control

Sources of Assurance: Positive (+) or Negative (-)	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) to achieve that plan. The plan is based on delivering Category 2 mean performance of 30 minutes. In accordance with the guidance this is expected to improve to the 18 minute target in future years, which presents a risk either to financial sustainability or performance if further 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	
Sustainability & Partnerships Programme within the Improvement Journey established	Chief Finance Officer	Ongoing	Programme now in operation and delivering in line with the S&P plan.

	BAF Risk ID 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**	**Assurance**
	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 Pharmacist
Actions: Prescribing drugs only when adequate knowledge of patient's health is established and satisfaction gained that the drugs serve the patient's needs. 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. Including measures such as increasing staffing levels, providing additional training and support to staff, and implementing processes and technologies to improve the efficiency of incident response. Regularly reviewing and updating the Trust's Major Incident Plan and NHS EPRR Framework to ensure that they are in line with 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 assessing the Trust's incident response capabilities and making adjustments as needed may help ensure that the Trust is able to respond effectively to EPRR incidents. **Board Oversight**: Audit & Risk Committee – see Board Report in December with assurance obtained following the EPRR Core Standards rating of 'substantial compliance'.					
136	**Process of tagging medicines pouches is not working effectively**	15	15	03	Chief Pharmacist

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 paramedics on how to correctly complete paperwork following their daily assurance checks. Implementing quality control measures - regular audits and checks to identify 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 Planning
Actions: Reviewing investment plans to allocate funds towards meeting decarbonisation targets. Reviewing operating model and clinical strategy to ensure 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 and follow the guidance provided by NHS England to reduce their carbon footprint. Green Plan is in development. **Board Oversight:** Finance and Investment Committee. Last reviewed in March – see April's Board Escalation Report.					
34	**Sustainability in the Medicines Governance Team**	12	**16**	08	Chief Pharmacist

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 increasing demand. Including regular reviews and adjustments of stock levels based on demand patterns, and implementing processes to ensure timely replenishment of 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 medicines 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 Paramedic
Actions: Exploring alternative funding source. Prioritising the most critical deliverables of the Clinical Education and Training Strategy. Engaging with stakeholders to communicate the importance of the strategy and its potential impact on the Trust's workforce plans and staff satisfaction. Developing contingency plans in case the strategy cannot be fully implemented. Phase 1 of the revised business case due to be considered by EMB on 31 May 2023.					

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 controls to ensure that only authorised personnel can access HR data. Providing training and support to HR staff on how to properly handle and process data subject 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 legal 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 Journey reports provided in 22/23. This change reflects the Board's transition from regulatory focus to strategic focus. Our 23/24 strategic themes, goals, and objectives aim to enhance patient care quality, workplace culture, sustainability, and overall performance, thus supporting our NOF requirements 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 the meeting on June 1, 2023.

RSP ref.	Requirement description - The trust must:	Position Statement	SECAmb Progress View
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.	
RSP-L5	Evidence of improved transparency and timeliness of reporting and information sharing with ICB partners. The level of desired transparency will be agreed between the ICB partners	Since its launch in July 2022, the Improvement Journey plans and reporting have efficiently tracked progress, creating a registry of evidence, minutes, TOR, shared with CQC, system partners, and external auditors as necessary. We're also planning to increase Regional and system colleagues' participation in our weekly steering group meetings.	

	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 resourced.	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 us and psicological safety needs further work. Given the ongoing cultural aspects, we rate our current status as Amber/Red.	
RSP-P1	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	We acknowledge the lag between immediate efforts and visible results in staff surveys. Although the upcoming survey in March 2024 may not reflect imminent changes, our ongoing initiatives are focused on boosting staff engagement beyond the propsective RSP exit date. Despite being labeled as 'red' due to its link with the staff survey, we expect	

		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.	
RSP-F2	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.	As above	

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

Low Moderate High Extreme

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

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

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

Appendix 2 - SPC Icon Description

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

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

SECAMB Board

Finance and Investment Committee (FIC) Escalation Report

Overview of issues covered at the meeting on 30.03.2023.

Item	Purpose	Link to BAF Risk
Operating Plan 2023/24	To review and approve the final submission of the 2023/2024 plan, due to be submitted to NHSE on 30 March 2023.	Risk 16 – Financial Sustainability
The committee reviewed the plan, which followed the draft that was considered at the extraordinary meeting of the Trust Board earlier in the month. The main headline is that with a planned £4.5m deficit, the funding will ensure a 34-minute C2 mean. The Board is aware that, recognising the challenges in the sector post COVID where no ambulance service is achieving ARP, there is an interim national target of 30-minutes C2 mean. The committee supports the plan, which includes significant internal efficiencies, and agrees that it is the best that can be reasonably achieved within the funding from commissioners. The discussions with commissioners will be ongoing to ensure clarity on funding from next year, as the executive is clear that to ensure ARP standards are met beyond 2024/25 additional funding will be required. The committee also reviewed the constrained capital investment plan and while it is satisfied that we appear to be prioritising the right areas, it has asked for further detail on the unconstrained capital plan to test the implications of not investing in the other areas. In summary, the committee supported the submission of the plan. It acknowledges this effectively means we are not being commissioned to achieve ARP, but against the background of recent years (of non-achievement) it is a plan that aims to ensure a trajectory of improvement over time. There are two specific areas for the Board's consideration, set out in the escalation section below.		
Financial Performance- M11	To seek assurance that there is robust budget management to ensure we meet our financial plan.	Risk 16 – Financial Sustainability
At Month 11 the committee is confident the Trust will achieve a year-end breakeven position. It reflected that despite the various challenges, the Trust has met its financial plan every year since 2017. Noting the planned deficit this year to further improve the performance trajectory / patient quality, the Trust Board will in due course need to take a view on the likely medium to long term financial position in the context of quality. This will need to explore the strategic solutions in probable event that sufficient funding is not available.		
In-Year Savings – Quality Impact	to seek assurance that the financial savings have not had a	N/A

	detrimental impact on quality/patient safety.	
As requested previously the committee received an assurance paper setting out the impact on quality, from the savings made to close the £8.9m gap identified in Q3. The committee is assured that there has been no significant adverse impact on quality and by the governance that underpinned the recovery plan; the paper set out how the savings were made which the committee reflected were more efficiencies, than savings.		
Acquisitions and Disposals	To seek assurance on the governance and oversight related to how property is valued, and marketed and is aligned to the Estates Strategy.	N/A
A helpful paper was considered providing the status of our current property disposals. The total anticipated sales income is circa £11.2m and the committee sought assurance with the process for ensuring the right people are involved in deciding what can be sold. Noting that this aligns with the Board approved estates strategy, the committee reinforced the need to ensure we dispose of properties we no longer need, to help our cash position and what is available to invest in capital projects.		
Green Plan	to seek assurance that all elements of sustainability are being captured as part of the plan.	N/A
A detailed presentation was provided by the consultants we have procured to support the development of our Green Plan, which is essentially our strategy to reduce emissions to net zero. There is still much to consider, including how we ensure alignment with our ICBs and how it will be funded.		
111 Single Virtual Contact Centre (SVCC)	to seek assurance that SECAmb is appropriately funded to ensure compliance with the expectations of NHS England regarding operational implementation of SVCC.	Risk 17 – Integration of 111 / EOC
The committee is assured that the executive has properly engaged with this initiative. However, we do not have the funding to enable us to meet the threshold for SVCC. An options paper is being developed to set out the implications and next steps. A discussion is needed by the Board to determine how 111 CAS aligns with the Trust's strategic direction. In the meantime, a part 2 discussion is needed to ensure clarity on what we are communicating externally about SVCC.		
DCA Replacement Programme 2023/24	For approval / recommendation to Board.	N/A
An options paper and related business case were considered together. This is on the Part 2 agenda and the committee recommends the Board approves the 57 new DCAs, which ensures compliance with the national specification and aligns with our own Fleet Strategy. This will give the headroom to then work up a new strategy from 2024/25.		
Specific Escalation(s) for Board Action	In the context of the operating plan for 2023/24 and the constrained finances / need to be more efficient, the Board needs time to explore the strategic approach to skill mix and implications for our operating model. The committee suggests this is included in the Board development plan for 2023/24.	

	The Board needs to determine how 111 CAS aligns with the Trust's strategic direction, especially as we are nearing the end of the current contract. The committee suggests this is included in the Board Development Plan for 2023/24.

In Q3 2022/23 the Trust's Improvement Director undertook a **Board Effectiveness Review**, which included a review of this committee. The findings and recommendations continue to be considered in the planning and delivery of the committee meetings. Below is a summary of progress to-date.

Recommendations	**Progress to-date**
All authors to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	Ongoing – each agenda item is now clearer about the purpose and assurance questions.
To ensure the cycle of business is explicit to the whole membership and any omissions are recorded and carried forward	The COB is included for each meeting and used to inform the planning for each meeting. It will be reviewed and updated in March, ahead of the Board annual review in April.
Consider how the BAF (specifically any financial risks) can structurally link to the work of the committee	Each agenda item cross references to the relevant BAF risk(s) and the BAF is used, along with the IQR, Improvement Journey, and COB when planning for each agenda.
The Exec team need to consider where the joining up of finance, performance and quality occurs and how this reports into the governance stream.	Work is ongoing to revise the executive management governance framework. A proposal was discussed at the March leadership team meeting, with a plan to start implementation in Q1.
Consideration needs to be given as to how the financial detail can be presented so that it is clear to existing and new committee members.	The finance report has been revised to make it clearer; positive feedback was provided at the FIC meeting in January and Board meeting in February, related to the clarity of the report.
Check air ambulance contract monitoring is captured on the risk register and consider how discussions that are risk based are cross referenced against the risk register.	Reference to this risk was captured in the FIC report to Board in December. At its meeting in March it was told that discussions with commissioners are ongoing. The Trust and commissioners are reaching out to our peers to check how others contract (we are aware of similar arrangements) to make it more comparable. The expectation is that this will be resolved by June 2023.
Consider where strategies are published and how all Board members are updated on delivery and how accountability is demonstrated to the public.	All enabling strategies are received by the Trust Board for approval and published as part of the papers. The current enabling strategies will be included in the Board section of the website.
Ensure the executive team understand the reason for the patient level costing and why this is higher than the benchmarked services in the report.	A session to be scheduled with EMB in Q1.

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.

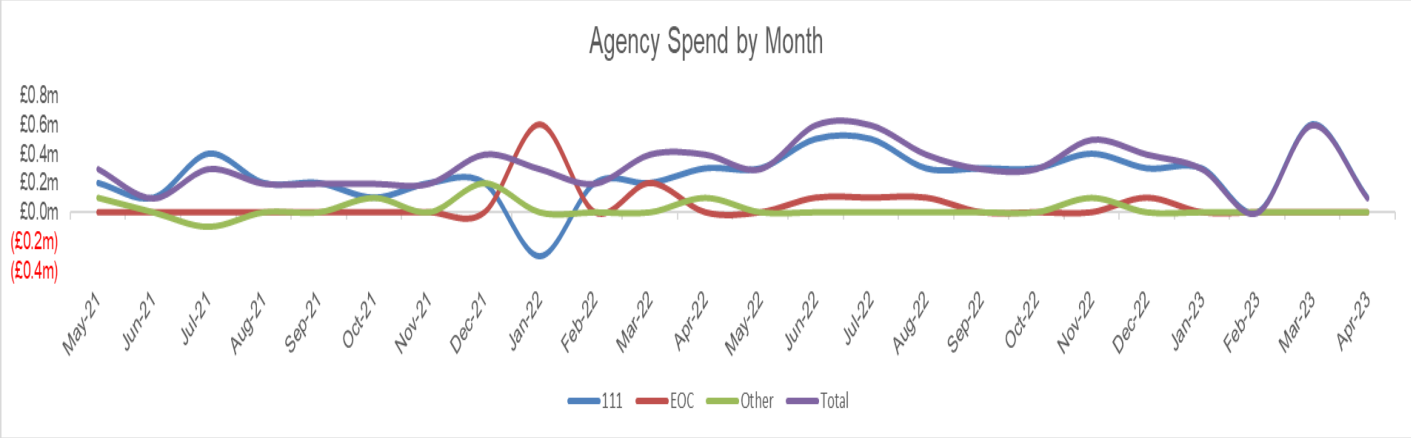
- Progress has been slower than expected but there are still 20 further schemes being reviewed and developed as part of the focus on identifying further £2.6m schemes and to develop a pipeline of sustainable schemes for 2023/24 and beyond. We therefore expect to identify £9m of efficiency projects. A 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

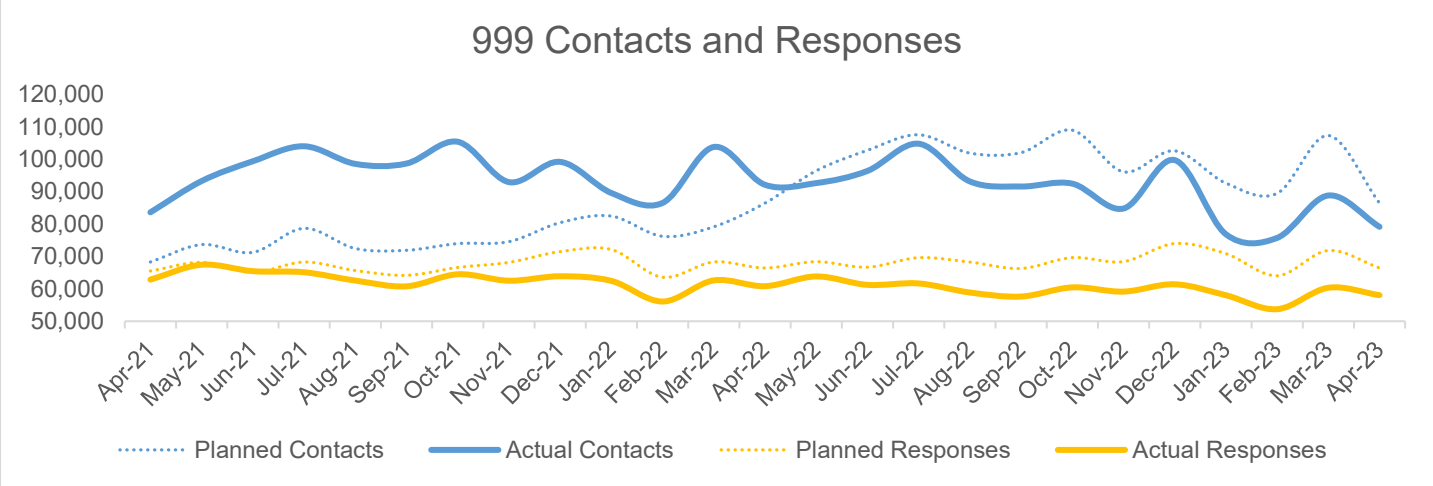
- The table above shows those risks to achieving this year's financial target.

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:

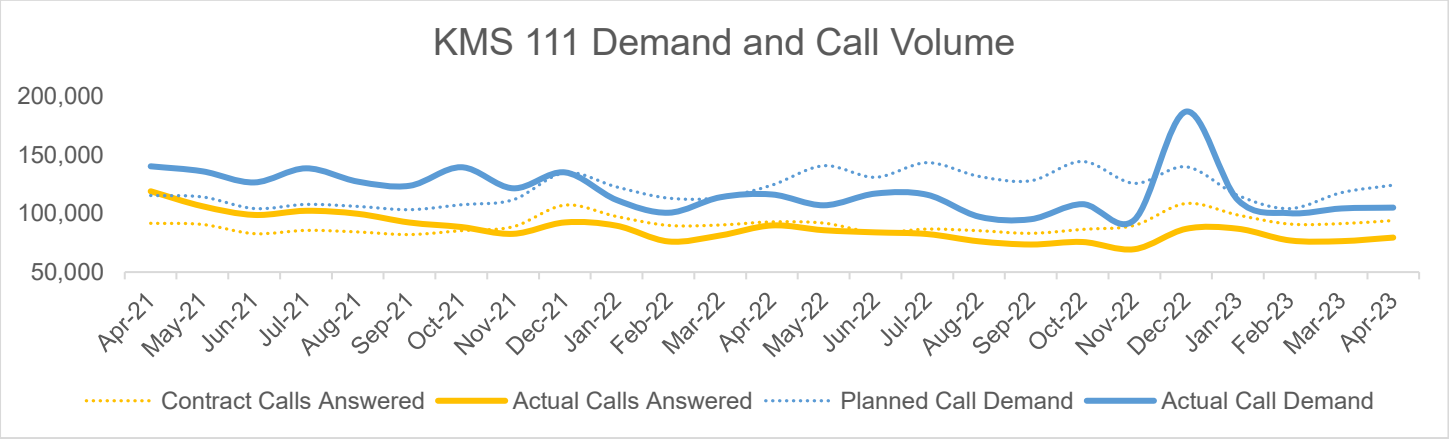


999 contacts (demand) is 14.1 percent down against the last year, with response activity 3.3 percent lower.

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.

Southeast Coast Ambulance Service NHS Foundation Trust

WWC Escalation Report to the Board

Overview of issues covered at the meeting 16.02.2023

Item	Purpose	Link to BAF Risk
Before the main agenda began the following issues were raised under Executive Escalation: 1. Crawley College – Marking Update. The CMO updated that while there are still some gaps in assurance related to the backlog, improvement has been demonstrated. This is supported by a decrease in the number of complaints. 2. Medway Move – Impact on our People. The HR Director updated that the EOC 111 moves are more complex (than Medway Ambulance Station) and is impacted by the delay in the move to September-time. This is unsettling for staff and the executive is ensuring a individualised approach to the staff affected; the policy has been amended to provide relocation costs to help avoid redundancies and support welfare. The next three agenda items related to specific gaps in assurance identified by the Board in December.		
EOC Staff Retention	Following the Board's concern in December related to the 40% annual turnover, to seek assurance that there are robust solutions being put in place to achieve the stated 10% improvement by May 2023. And to ensure clarity on the timeframe for the culture action plan.	Risk 13 – Retention Risk 348 – Culture
The committee welcomed the executive's acceptance that the steps to-date have not worked. This has led to seeking external support to ensure the right level of capacity and capability and a paper was provided setting this out. The committee sought assurance that this new approach will be different and therefore produce better outcomes and is assured with the methodology being used which has been tested elsewhere. The is realisation however that there is no silver bullet and while the external support will help, it will require continued ownership of management. Measuring the impact will be difficult as there are so many different factors, but metrics such as call answer performance, retention and sickness will help the committee determine impact. In light of this the committee is assured with the commitment from the executive but not yet assured it will deliver the change needed, including the 10% improvement in turnover reported in the IQR.		
East Kent Maternity Review	To seek assurance that there is a process in place to ensure we use the lessons from the various	Risk 348 – Culture

	culture-related issues arising from this review.	
Following up from the Board discussion in December, the committee explored how we are using the lessons from this external review to inform our approach to people and culture. It is pleased by the good cross-directorate working, reinforcing that culture is a matter for us all, not just the HR dept. The recommendations will be used to inform the People and Culture Strategy and the committee asked that there is specific mapping so it is clear how this is being embedded.		
International Recruitment	To seek assurance that we are using the learning from previous international recruitment that resulted in high turnover.	Risk 255 – Recruitment Risk – Retention
The Board asked the committee to seek assurance that we are ensuring robust induction, training and support to the international recruits to ensure they are welcomed and supported in the transition to the UK and to SECAmb. Using the learning from when we did this 4-5 years ago when a high number of recruits left within the first 12 months. The executive set out a much more personalised approach being applied this time, where we are involving each individual and their families. The committee is assured by this and in particular how the Trust values are being demonstrated. In 6-12 months the committee will know what impact this has had from the data related to attrition.		
Health & Wellbeing: Sickness Management	To seek assurance the plan to better manage sickness is robust and is being implemented effectively.	Risk 13 – Retention
The approach to sickness management was explored with some assurance about more in person support. The executive is seeking to establish benchmarking of ambulance sickness data and is setting up a session to learn from West Midlands Ambulance Service who have managed to achieve low levels of sickness absence. In addition, there are targeted action plans being developed by HR and OUMs at the seven OUs with the highest persistent sickness. The committee is not fully assured but supports the steps being taken. It has asked for clearer timescales so it can hold the executive to account for delivery. The committee explored how this data triangulates, e.g. does highest sickness correlate with grievances etc. Currently there is no robust quality and performance management framework that ensures this type of systemic triangulation. However, the executive are prioritising this and aim to implement a new framework in Q1.		
Health & Wellbeing: Shift Over Runs	To seek assurance enough is being done to mitigate the high number of shift overruns, acknowledging	Risk 13 – Retention

	the link to staff wellbeing and high sickness.	
The committee received a paper setting out some of the measures in place to manage overruns and asked the executive to ensure it better communicates this so staff understand the steps being taken to address this difficult and longstanding issue. The IQR currently shows a target of 5% and the committee challenged whether this realistic when it has been significantly higher than this for several years. A workshop is being held which will include a review of the target, and the outputs of this will be considered by the committee in April.		
Workforce Plan	To seek assurance that the plan is robust and how we are ensuring the adequate capacity to support delivery, e.g. the clinical education business case.	Risk 255 – Recruitment
There was a detailed review of the workforce plan, with the gap in field ops of circa 100 WTE being rolled into next year. The funding issues for next year were explored with a range between an increase of 371 WTE (assurance was sought that clinical education could support this) to allowing recruitment to shrink if there is insufficient funding. The discussions with commissioners are ongoing and the committee discussed in this context the need to take a strategic view on skill mix and adapting our operating model, for example to provide more remote support; this links to the operating model BAF risk. The committee is clear that whatever direction the Board takes in thinking through the implications of any changes to our operating model on our workforce, linked to funding and the UEC Recovery Plan, we must continue to ensure all groups of staff are valued and are supported to contribute most efficiently and effectively to service provision.		
Culture & Leadership Programme	To seek assurance the plan is being delivered in accordance with the agreed timeframe.	Risk 348 – Culture & Leadership
The committee noted that this programme has been paused, to focus on the development of the People & Culture Strategy. It will then return to this to ensure it closely aligns with the strategy. The committee supported this on the basis that what is important is that we agree the right priorities and actions, to allow a more simplified narrative and approach.		
External HR Review Actions – ER / WB Cases	To seek assurance that there is clarity about each of the open cases and effective plans to conclude each one, including assurance on the business case to increase capacity given the high number of cases.	Risk 348 – Culture & Leadership

The committee will have the HR review as a standing item, with focus on a subset of the actions. The focus of this meeting was ER cases and a paper was received confirming the progress to date. There is still a high number of cases which needs continued attention and focus to ensure a more normalised position is eventually achieved. An external HR Director supported a review of the most complex cases and there is now a clear plan to resolve each one over the next 4-6 weeks. The committee acknowledged the issues with capacity to manage the high number of cases; there are 172 open cases with resource to manage at any one time about 15 and so a business case is being developed to increase capacity temporarily. On a positive note the average time to resolve cases is reducing and the average suspension is now 60 days from 200.

The committee reinforced the importance of ensuring local managers are supported to deal with issues more effectively to reduce the numbers escalating. The committee will be seeking additional assurance to demonstrate this is improving.

Staff Networks	To receive updates from the Chairs of the Pride and Enable Staff Networks	N/A

Informative updates were provided from the Chairs of both the Pride and Enable Networks. Both doing really good work although re-building from the impacts of the pandemic.

The committee challenged the executive to help provide more support to staff networks, and ensure they are better integrated.

Specific Escalation(s) for Board Action	There are no specific escalations for the Board to take action on. However, the Board is asked to note two things: 1. Acknowledging the pressures everyone is under, and concern expressed by the executive about the time they have to prepare paper, the committee reinforced the need for timely paper; several papers for this meeting were late. 2. While the committee reflected that the curiosity and challenge was good, holding to account is hampered due to inconsistent articulation of timeframes / trajectories. There is too much emphasis on planning and so as we move in to more delivery in the next period, the committee will be expecting greater clarity on trajectories for improvement and how the impact will be measured.

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.

Southeast Coast Ambulance Service NHS Foundation Trust

People Committee Escalation Report to the Board

Overview of issues covered at the meeting 27.03.2023

This was an extraordinary meeting and as part of the review of its TOR, the committee proposes to the Board that it is renamed the People Committee.

Item	Purpose	Link to BAF Risk
People & Culture Strategy	To review the progress with the development of the People & Culture Strategy	Risk 348 – Culture & Leadership

An update was received setting out how the strategy was being developed with the support of the HR Director from Sussex Community NHS FT. A number of engagement sessions were held throughout March across each directorate and touching all the levels of the organisation. At the same time, a values 'check in' has been undertaken and it will be supported by a new Comms and Engagement Strategy that will be coming to Board in April.

One of the main drivers for the People & Culture Strategy is to have a clear framework that sets out what we need to prioritise to improve staff experience and how the various initiatives will align. The committee really supports this aim so all the work is more coordinated and it reinforced the need for a clear, focussed and realistic delivery plan, so there is clear accountability for the delivery of the change that is needed.

Training Priorities	To provide the oversight and delivery plan of the proposed programme for the training & development programme for the Operations Directorate for 2023/24	Risk 15 - ETD

The Training Plan helped to demonstrate good cross-directorate working. It is the first time we have developed a training plan across operations and corporate services that is costed. The committee will oversee delivery as a standing agenda item.

The committee explored one of the main aspects of the related BAF risk re abstraction and some of the feedback from the staff survey about time given to access training. Assurance was sought that provision has been made for abstraction; five days that is included in the budget.

There are however aspects of training that is not in the plan, such as conflict resolution and restraint; MH first aid; and neurodiversity awareness training. The executive is picking this up and how it might be funded with commissioners to see if it can be added to the plan in the future, if not this year.

The committee feels that this is really positive as we have taken a risk-based approach and listened to staff feedback about the importance of training. Including from corporate staff who have fed back that their

training is not always prioritised; there is some work ongoing in corporate services to help establish what additional professional training might be needed, e.g. CPD. Taken together with the training plan for operational staff, this will constitute a training needs analysis for all staff.

Inclusion Annual Reports ▪ Gender Pay Gap ▪ Annual Diversity Report ▪ EDS 2022 verbal	To seek assurance that the Trust is taking positive action to ensure equality.	N/A

Gender Pay Gap / Diversity Report

These reports were considered together. This first provides a comparison on the pay of male and female employees and shows the difference in the average earnings (mean and median). The gender pay audit is different to equal pay, which looks at the pay differences between men and women carrying out the same jobs, similar jobs or work of equal value. Any potential equal pay issues are addressed by adherence to Agenda for Change terms and conditions and pay framework, and a robust and objective job evaluation process.

The main findings included the following:

- Our female workforce grew by 1.47% from previous year.
- There are still more males than females in all bands from Band 7 upwards.
- Our Mean Pay Gap increased from 9.98% to 10.92%
- Our Median Pay Gap decreased from 11.09% to 10.89%
- There is an over-representation of females by 30.14% in lower pay quartiles.

The committee asked for further assurance on promotion opportunities for women and BAME staff as this is going in the right direction. It feels that more targeted intervention is needed to be included in the equalities action plan. It will ensure regular review of the plan to ensure progress is made.

SECAmb currently has one equality objective, which was published in 2017, and is currently being reviewed: *'The Trust will improve the diversity of the workforce to make it more representative of the population we serve'.* When the new CEO starts an equality objective will be set for each executive director.

EDS

A verbal update was provided outlining a new approach this year with a soft launch. The full report will then be published in 2024. The executive is gathering evidence internally which is showing us 'under-developed' across most of the domains. Despite this we remain compliant and the integrated equality action plan will be reviewed by the committee at its meeting in May.

Specific Escalation(s) for Board Action	There are no specific escalations from this meeting. However, the Board is asked to a agree the change to People Committee.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	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

Membership Development Committee Report

1. Introduction

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

1.2. In this report, we focus on membership updates and summaries of the top items from the MDC meetings and those that report into the MDC (Employee Experience and Engagement, Community Resilience, Culture Programming and Wellness Plans).

2. Membership update

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

2.2. Current public membership by constituency (as of 1st June 2023) is 9217. Break down data provided as follows.

Constituency	Members	% of Membership	Base	% of Area	Index
Total Membership	**9302**	**100.00**	**14133282**	**100.00**	
Lower East SECAmb	1829	19.66	857528	6.07	324
Lower West SECAmb	1430	15.37	879351	6.22	247
Upper East SECAmb	3322	35.71	6333281	44.81	80
Upper West SECAmb	2208	23.74	6063122	42.90	55
Out of Trust Area	513	5.52	0	0.00	0

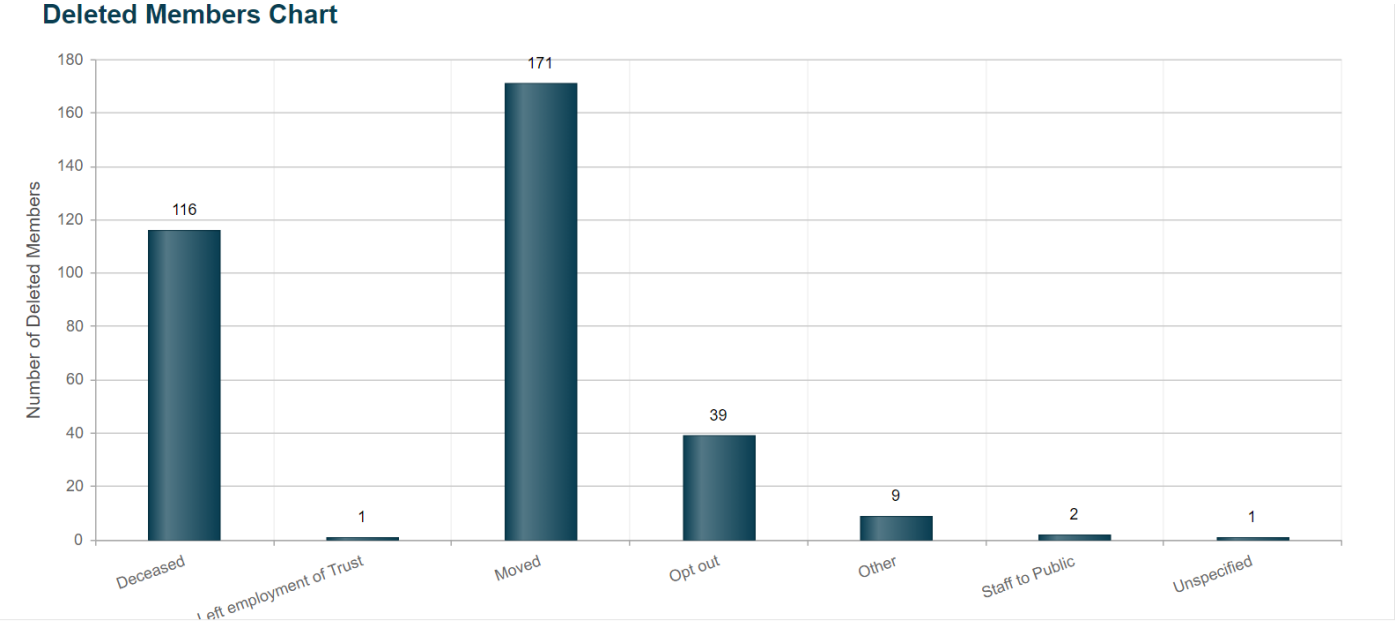
Key: % of membership = Percentage of members within the constituency. Base = Population of people within each constituency. % of Area = Total percentage of members within the constituency which have not joined. Index = A figure indicating how represented the membership by using the percentage of membership and the number from base population.

3. Membership history report

The table below shows the number of memberships that have been deleted since 1st June 2022 to 1st June 2023.

Category or Consituency	Deleted (excluded from PR)
Total Membership	**675**
Public Constituencies	**339**
Out of Trust Area	3
Lower East SECAmb	82
Lower West SECAmb	45
Upper East SECAmb	114
Upper West SECAmb	95

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



4. **Membership recruitment update**

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

- To attend local events that the governors have researched at the beginning of 2023, this is to include a large footfall event such as Brooklands and the South of England Show.
- Attend as many events as possible with a Blue Light vehicles, to help interaction with the public. Open invites to CFR's, paramedics, EOC and recruitment.
- Continue with the presence on social media, adding a sharable post to LinkedIn, Twitter, and Facebook.
- Look at possibly attending winter events if this didn't clash with the winter high season.

5. Membership Engagement Update

- The next newsletter is out slightly later and now due to go out beginning of July. This is to include the next governors election, Going green – including the trial of fully-electric SRVs and requesting memebers email addresses so the newsletters can be emailed to svae on postage costs and save the date for the AMM in September. There will also be features including Therapy Dogs and Neurodiversity.
- The following members newsletter will be due out in September/October and any suggestions for content for future editions are more than welcomed.
- We have moved back to in person formal Council meetings which are held majority in Nexus House. The public, members and staff members are welcome to join to observe these meetings and ask questions at the end.
- Thanks to those Governors who observed the recent Board meetings. The feedback has been extremely vaulable
- We will continue to advertise these meetings to members. Recordings of the meetings are availiable on our website.

- We have moved the GDC and MDC to in person and on the same day to encourage more attendance. The first meeting took place on the 18th May and had a good turn out of presenters and Governors.

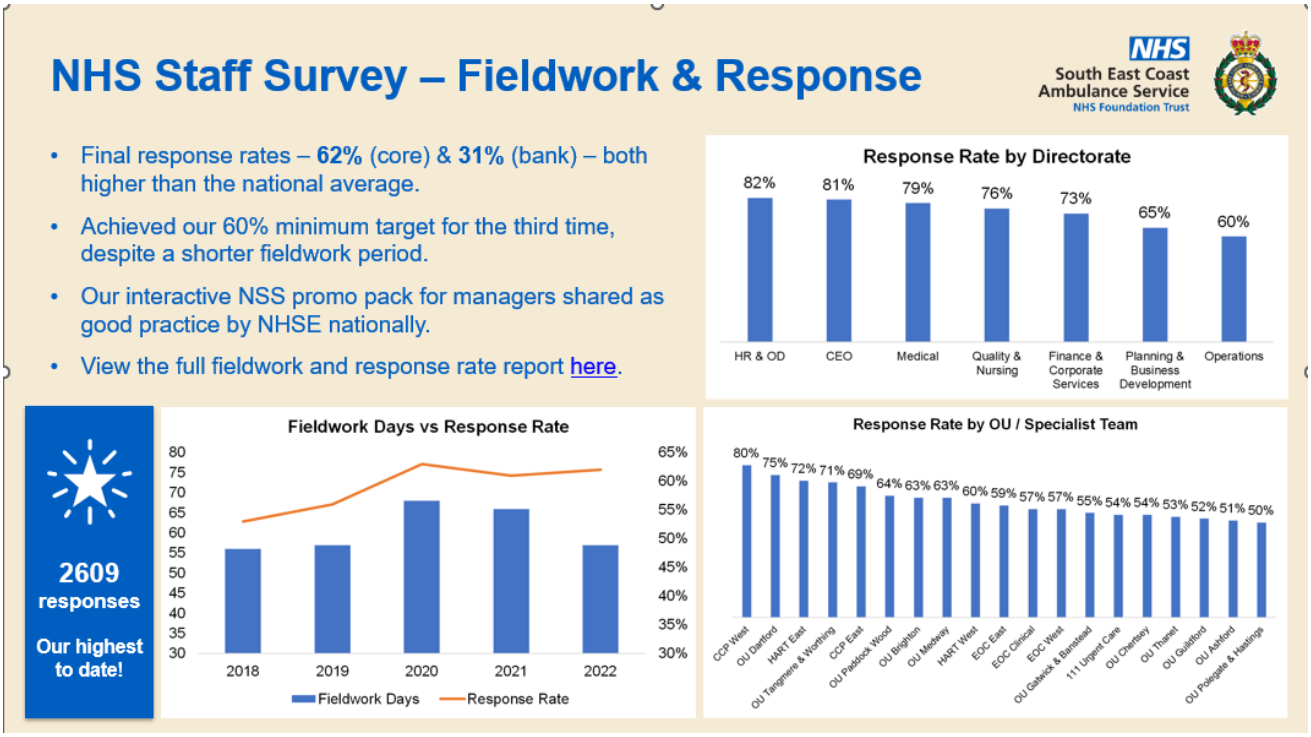
6. Culture Transformation.

Tina Ivanov is the Director of Culture Transformation; she has been with SECAmb since March this year and wanted to give an update on the work that is being done. When Tina spoke to teams locally, it was noted that they are some good practices going on but there is lot of complexity when addresses cultural change. There are many things you must influence, and you have to influence all at once. The way we look at this is made up of many different things, product of the values, the purpose of the organisation, the environment in which we work, the way we talk to each other, the way we interact with the hierarchy and the structures, the polices, the procedures, the values and the motivations that each of us bring every day to work, the list could go on. When we talk about culture, it isn't just about how we talk and treat each other, many of the programs have started and really focused on addressing the behaviours which are valuable, needed and have an impact. Tina has started to work with the executive and more broadly across the Trust about supporting the ongoing transformation, going forward we need to get the foundations right, build that trust with our people and set the standards through activities like updating our policies, confirming our Leadership model, and engaging in our strategy development. We need to keep providing education, but we need to enhance the structures around that so that it complements better ways of working. It's not just about relying on the individual behaving differently, it's a huge piece of work, culture change can take a good five years to really change. The first year will be about making inroads and continuing to focus on the big picture, our people and culture strategy has been signed off by the boards. There is a delivery plan underway, but we recognize that we need to prioritize the most critical actions first and ensure that we deliver those rather than just trying to do everything and putting in into a plan on a just to say it will all be done, the reality is we will be spread far to thin so we really need to check what needs to do be done first then what will be next and then what follows on from that, in order to show those measures that say what kind of change we will see and the transformation that will follow and from there we can build a better way of working and start to bring out the pride in the workplace again.

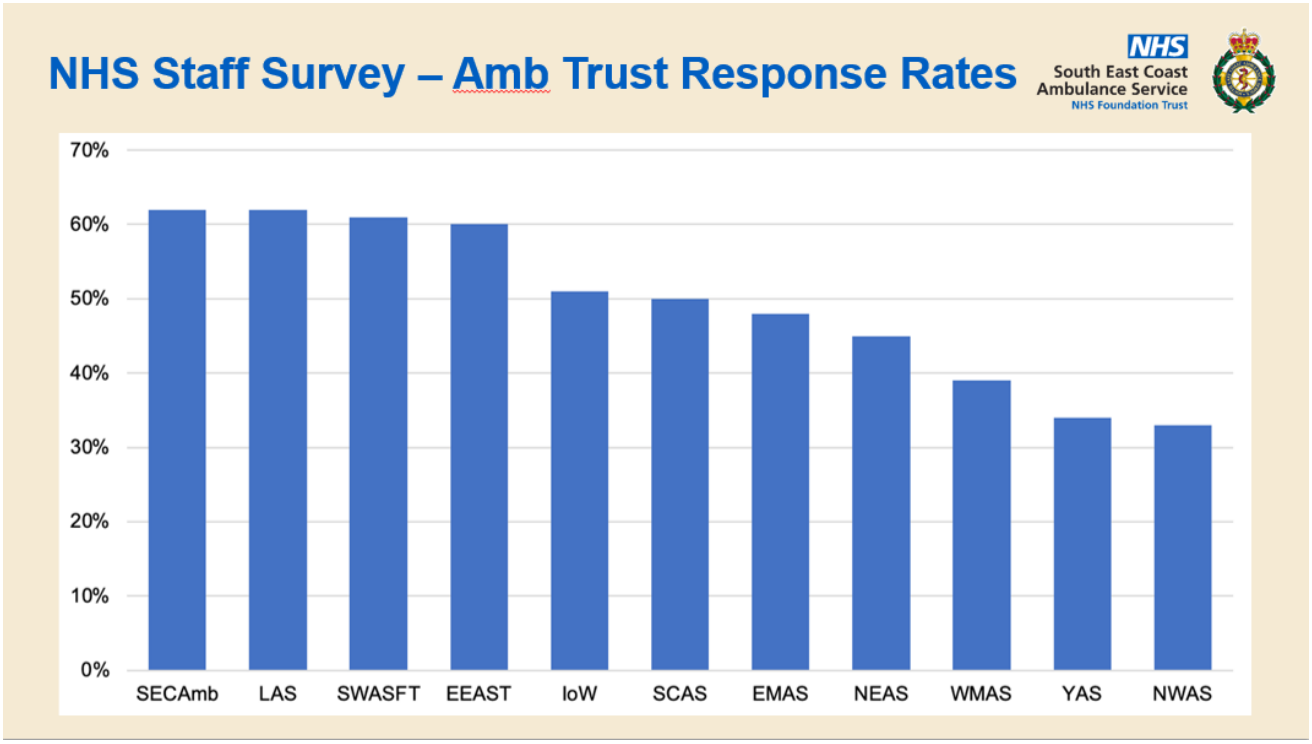
7. **Employee Experience & Engagement Manager**

7.1 Emma Saunders attended MDC via Teams, giving updates of what had been discussed in the previous MDC.

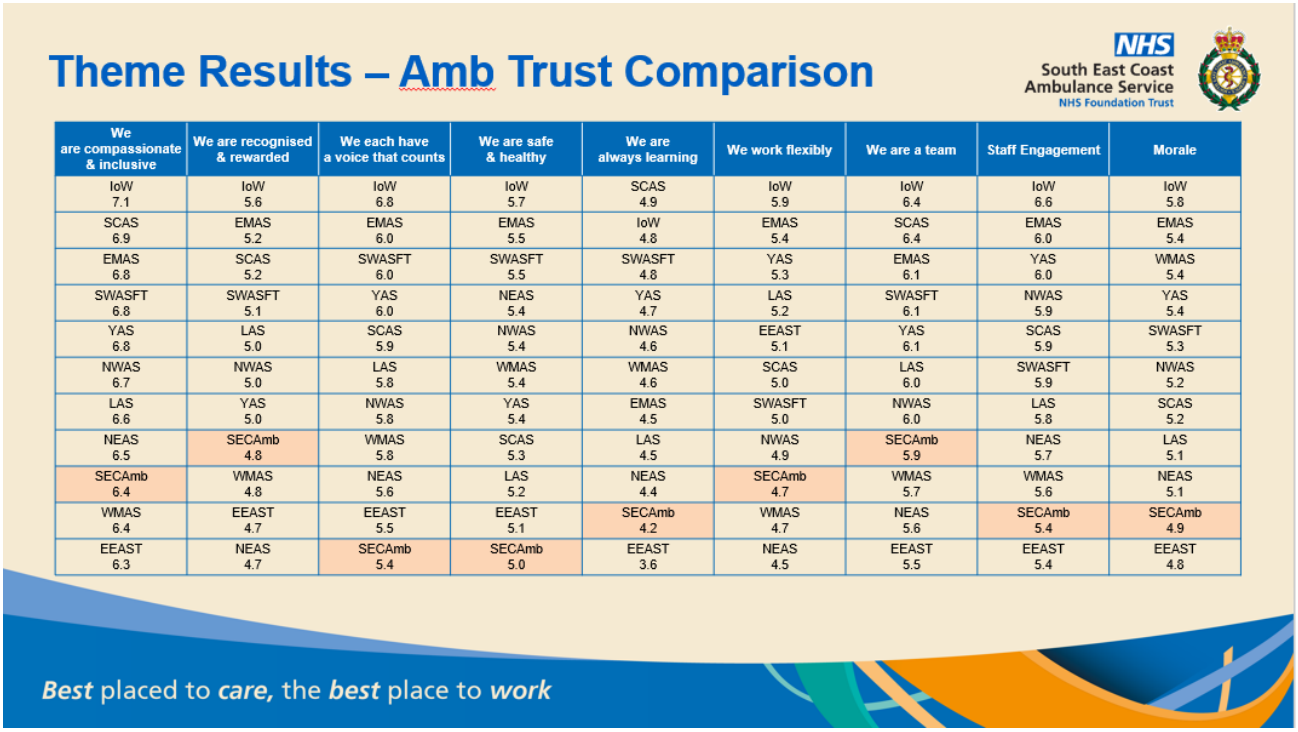
The Staff Survey, Emma presented slides to show more information on the results. There was a really good result on our response rate, we achieved 62% of our core staff and 31% for our bank staff. This may not sound great for bank staff, but it was the first year that the bank workers were invited to complete their survey and both of our response rates were higher that the national average. We achieved our minimum 60% target for the third time in SECAmb history of the staff survey, despite a shorter field work period. Emma's team developed an interactive NHS staff survey promo pack for managers to help them answer questions, myth bust and to promote the survey locally and that was shared as a good practice by NHSE nationally. We had a total of 2609 responses our highest to date.



The graph at the bottom of the page titled Fieldwork Days vs Response rate, you will notice that the response rate (orange line) continues to remain high despite the number of fieldwork days dropping in the last couple of years. The Response Rate by Directorate graph shows the response rates by directorate, for operational staff the response rate was 60%, the highest rate was HR and OD which was 82%. The last graph shows operation broken down into their individual dispatch desks and the lowest response rate was 50%, which is still in line with the national average, the highest rate was 80% which was the CCP West team. The slide below shows how this compares with the other ambulance Trusts across England.

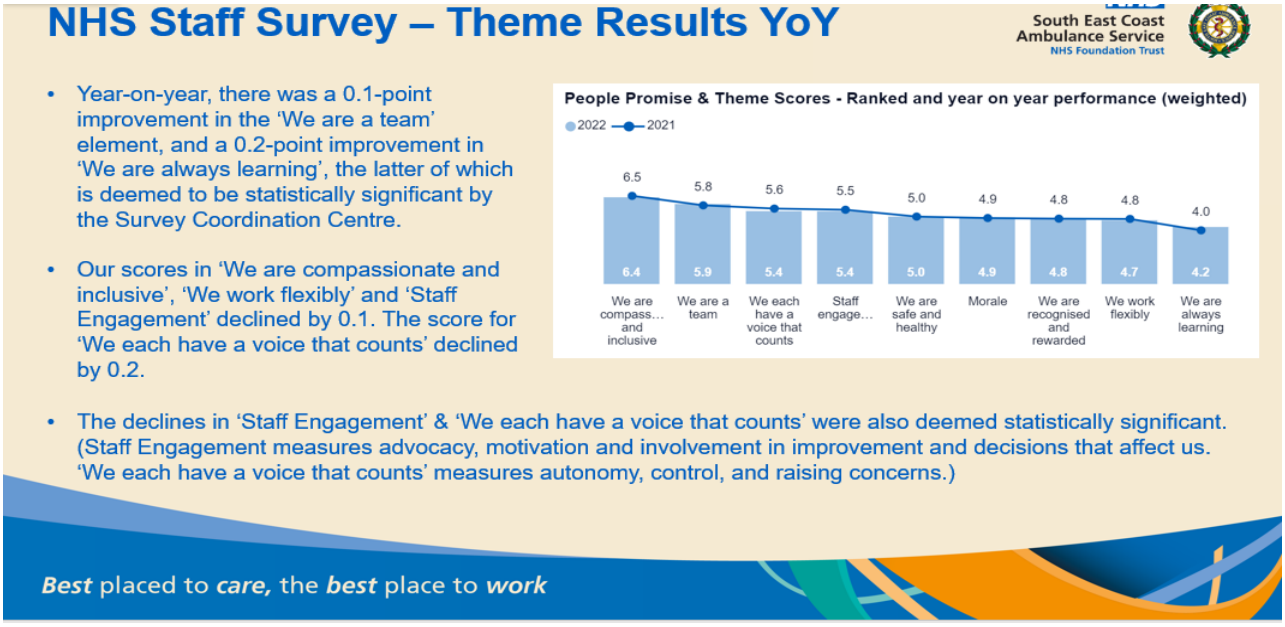


We are at the top, equal with London Ambulance Service (LAS) and the lowest response rate was in the 30s and that was North West Ambulance Service (NWAS).
The next slide highlights where SECAmb scored for each of the seven people promise themes against other ambulance Trusts, SECAmb did score below average across all the themes.

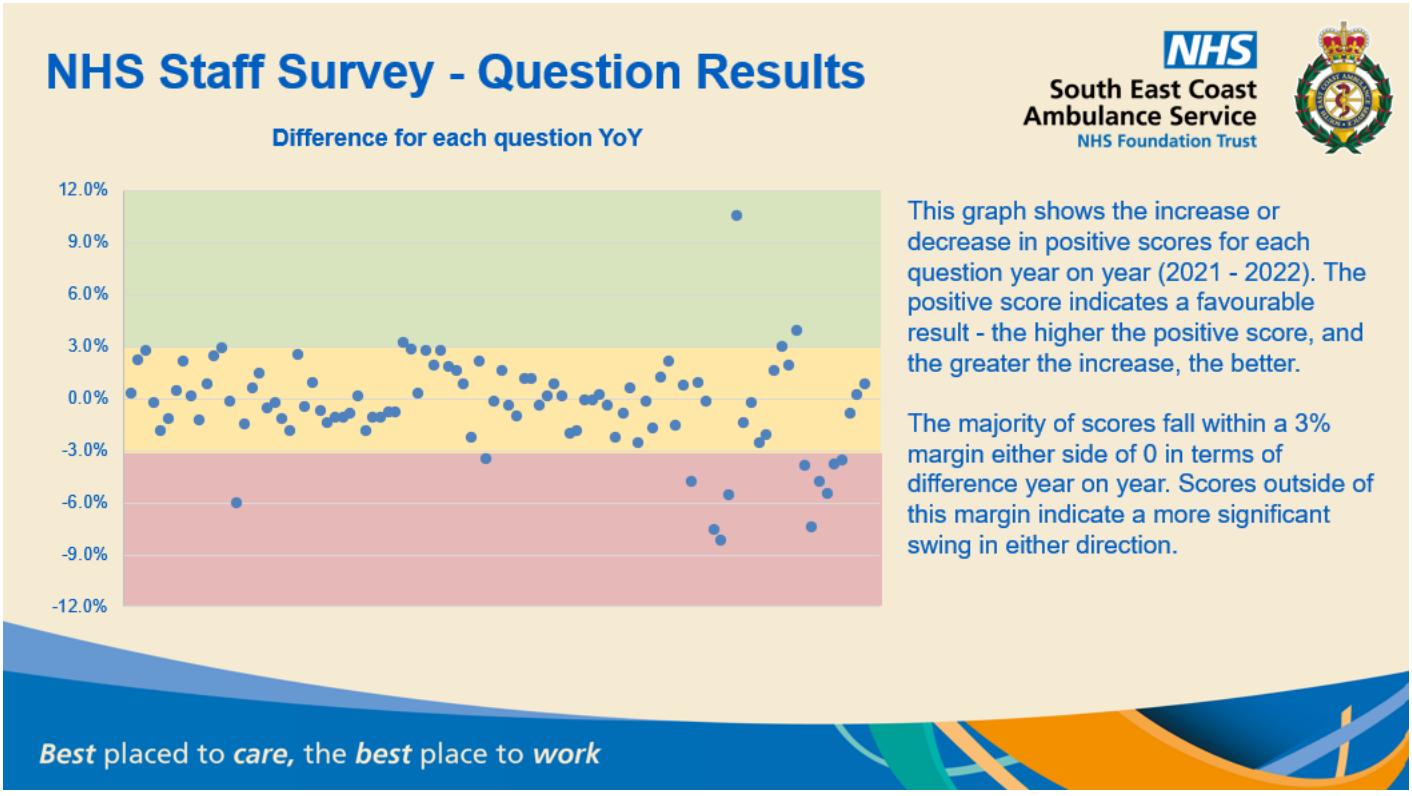


We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
IoW 7.1	IoW 5.6	IoW 6.8	IoW 5.7	SCAS 4.9	IoW 5.9	IoW 6.4	IoW 6.6	IoW 5.8
SCAS 6.9	EMAS 5.2	EMAS 6.0	EMAS 5.5	IoW 4.8	EMAS 5.4	SCAS 6.4	EMAS 6.0	EMAS 5.4
EMAS 6.8	SCAS 5.2	SWASFT 6.0	SWASFT 5.5	SWASFT 4.8	YAS 5.3	EMAS 6.1	YAS 6.0	WMAS 5.4
SWASFT 6.8	SWASFT 5.1	YAS 6.0	NEAS 5.4	YAS 4.7	LAS 5.2	SWASFT 6.1	NWAS 5.9	YAS 5.4
YAS 6.8	LAS 5.0	SCAS 5.9	NWAS 5.4	NWAS 4.6	EEAST 5.1	YAS 6.1	SCAS 5.9	SWASFT 5.3
NWAS 6.7	NWAS 5.0	LAS 5.8	WMAS 5.4	WMAS 4.6	SCAS 5.0	LAS 6.0	SWASFT 5.9	NWAS 5.2
LAS 6.6	YAS 5.0	NWAS 5.8	YAS 5.4	EMAS 4.5	SWASFT 5.0	NWAS 6.0	LAS 5.8	SCAS 5.2
NEAS 6.5	SECAmb 4.8	WMAS 5.8	SCAS 5.3	LAS 4.5	NWAS 4.9	SECAmb 5.9	NEAS 5.7	LAS 5.1
SECAmb 6.4	WMAS 4.8	NEAS 5.6	LAS 5.2	NEAS 4.4	SECAmb 4.7	WMAS 5.7	WMAS 5.6	NEAS 5.1
WMAS 6.4	EEAST 4.7	EEAST 5.5	EEAST 5.1	SECAmb 4.2	WMAS 4.7	NEAS 5.6	SECAmb 5.4	SECAmb 4.9
EEAST 6.3	NEAS 4.7	SECAmb 5.4	SECAmb 5.0	EEAST 3.6	NEAS 4.5	EEAST 5.5	EEAST 5.4	EEAST 4.8

The year-on-year results, as you can see below, we improved by 0.1 on ‘we are a team’ and 0.2 improvement on ‘we are always listening’, regional 0.2 was the highest increase. 0.2 improvement on ‘we are always learning’ was deemed to be statistically significant by the Survey Coordination Centre. Our scores in ‘we are compassionate and inclusive’, ’we work flexibly’ and ‘staff engagement’ declined by 0.1 and the score for each have a voice that counts declined by 0.2. The declines in staff engagement and we each have a voice were deemed to be statistically significant. The staff engagement measures advocacy, motivation and involvement in decisions and changes that affect us, and we each have a voice that counts measures, autonomy. Control and raising concerns.



This graph is showing the increase or decrease in positive scores for each of the questions within the survey 2021 versus 2022. You can see that the majority of questions sit in either they've improved by, declined by 3% margin and that is not deemed as significant. Although there have been a number that have improved and a number that have declined, it is by such a small amount it is not deemed significant by the Survey Coordination Centre but the dots that sit in the green and the red area are deemed to be more significant.



When we narrow those dots down, we can see what they represent. We can see that appraisals have improved by 10.5%, able to access the right learning and development

improved by 3.9% and immediate manager encourages me at work is improved by 3.2%. When it comes to the ones that have declined more significantly, the vast majority are around feeling safe to speak up, raising concerns and the level of pay – which is no surprise given the backdrop of industrial action that's been going on.

NHS Staff Survey - Question Results

NHS South East Coast Ambulance Service NHS Foundation Trust

These questions fall outside of the -3% to +3% window, suggesting that the scores may indicate a more significant change in these areas.

To access a heatmap and see the results for all questions, click here (please open in the desktop app rather than online to enable all features).

Question	% Change
In the last 12 months, have you had an appraisal? (Yes).	10.5%
I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	3.9%
My immediate manager encourages me at work (Agree/Strongly agree).	3.2%
I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	3.0%

Question	% Change
I am confident that my organisation would address my concern (about unsafe clinical practice) (Agree/Strongly agree).	- 8.2%
I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	- 7.6%
My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	- 7.4%
My level of pay (Satisfied/Very satisfied).	- 6.0%
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	- 5.6%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	- 5.5%
I would recommend my organisation as a place to work (Agree/Strongly agree).	- 4.8%
On what grounds have you experienced discrimination? Disability (No).	- 4.8%
Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	- 3.9%
I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	- 3.8%
If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	- 3.6%
My organisation takes positive action on health and well-being (Agree/Strongly agree).	- 3.5%

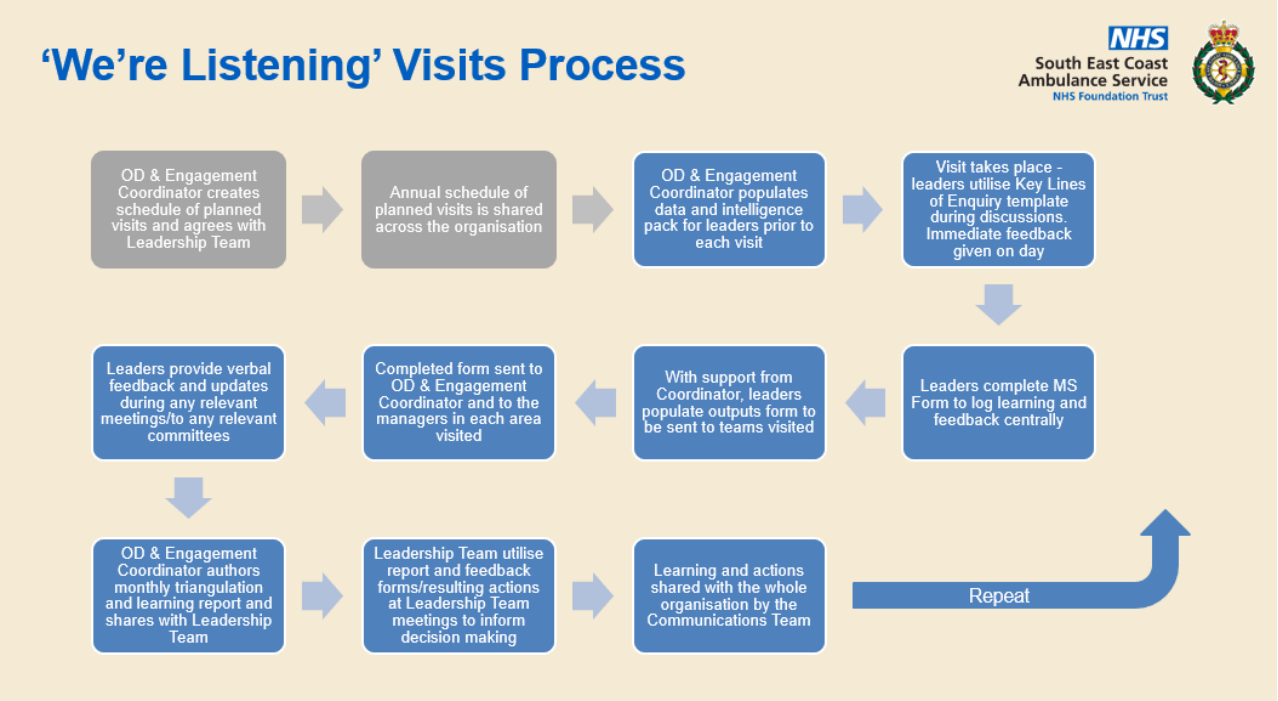
7.2 The National Quarterly Pulse Survey

The team are still working on the results as these have only just come in. The most recent survey was open from April and closed on the 1 May 2023. The idea of the National Quarterly Pulse Survey is to measure employee engagement through levels of advocacy, motivation, and involvement. Using the same questions that are in the staff survey, but it also measures colleagues' mood and other core metrics around health and welling team support and how well-informed colleagues feel about important changes. Emma is in the process of finalizing the results, they will be shared once they have been showed to the Leadership Team. The scores are relatively similar to the NHS staff survey, however when looking at SECAmb scores year on year in the national quarterly pulse survey from April 22 to April 23, the scores are showing a small improvement across all the metrics but that is against a backdrop of a natural average that is worsening and it's worsening every wave of the national quarterly pulse survey. In addition, with the national quarterly pulse survey, SECAmb had the highest response rate, we had 812 responses in the four weeks it is open, this is the highest SECAmb has had and above the national average.

7.3 'We're Listening' Leadership Visits'

Since the last MDC there was a process being shaped and introduced in January. Since Then we have had to revisit it due to some inefficiencies that came about, and parts of the process weren't very effective. The new process was signed off by the Leadership Team for rollout 17th May, the principles are that the leaders go see, ask why, show respect and we are listening. The visits offer an opportunity for the executives, non-executives and other senior leaders to leave their daily routine and see where the real work happens and build relationships with staff based on mutual trust, they are also a vehicle for this Trust to improve knowledge, decision making, identification of improvement opportunities and they

provide another listening channel for employees. Currently the plan that we have developed every area of the Trust will receive four planned visits per year, every area will get a visit from a senior leader at least once a quarter, they will be meaningful visits.
The table below shows the 'We're Listening' Visits Process



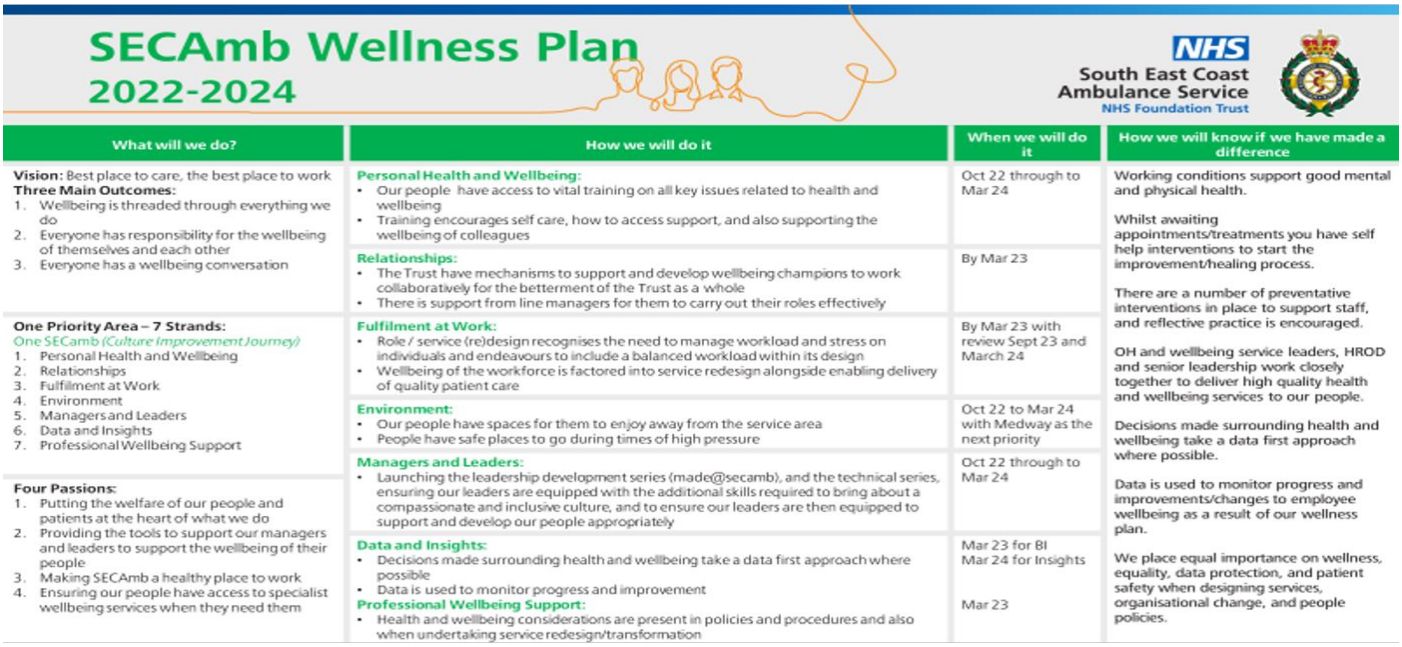
A schedule has been created of planned visits and that is an annual schedule, we will be able to look at any point and staff will be able to see what senior leaders are visiting. This will be shared with all the organisation as soon as this is finalised the engagement coordinator will populate a data and intelligence pack for the leaders prior the visit.

8. Health and Wellness

Assistant Director of Wellness and HR Excellence and Trust Lead for Retention Health and Wellbeing, Ian Jeffreys gave a presentation on Wellbeing and Wellness.

8.1 When we refer people into the wellbeing hub for treatment, mental health support, occupational health, we refer to that as wellbeing more recently we've started to use the terminology Wellness which is the more holistic piece and this is not just the hubs responsibility for what it does, but also a line managers responsibility for a colleague's health and wellbeing doing the wellbeing conversations as part of the appraisal process, doing good quality return to works, making sure the support plans are in place are doing the kind of reasonable adjustment support when colleagues need it, then right the way through to the Trust Board, Executive Management Board's responsibilities for overarching Wellness that we within the Trust and that includes things like supporting Ian. Going forward you will start to hear us talk more Wellness rather than Wellbeing. We have aligned ourselves with the NHS wellbeing framework and our focus is obviously being on ensuring that we support the welfare of our colleagues and then in turn they provide better high-quality patient care. We have a wellbeing hub which is a well-established model that we've had now within the trust for 5 years that has had an investment of £1.17 million that we spend very carefully on different health interventions. A significant chunk of that, some £500,000 per year, goes on the Occupational health services we have in the team just eight and a half a full-time

equivalent colleagues providing all of the different services that we've got that we have on average around 1200 interactions with colleagues each month. But more recently that's increased to 1700, we're seeing a lot more in terms of mental health challenges. Through the different interactions that we have with people that we typically have 60 referrals that are where managers are referring colleagues for support that we have 50 physiotherapy referrals and we have 15 TRIM, TRIM is our specialist trauma. We have in the past done value for money exercises investment to the trust, £1.17 million or £1.25 million as it used to be, we've had quite a significant budget cut this year. We were almost 10% sickness when we started this new plan that we're working on now and which was our highest level, we're now 8.76, still a long way off target, but starting to see some green shoots coming through from the work that we're doing. We've been doing a lot of work as a Trust around bullying and harassment, Sexual safety also starting to see quite a bit around the low self-esteem. We're seeing a lot about Imposter syndrome a particularly amongst our manager population where that they don't feel like they're doing a particularly good job, even though in many cases they are. We are also working closely with the Trusts, wider mental health team and that's predominantly patient focused, they help with providing our specialist trauma and management Service. This is where our colleagues have had to potentially deal with some really horrendous things such as multiple roadside collisions and they need that kind of specialist intervention. We can cover everything from addictions, bereavement, domestic abuse, finance - we've been doing a lot more around financial wellbeing recently. We've got a lot of interventions that we've done recently to kind of build on, on our Wellness plan. We had a fantastic campaign that was executive LED called The Your Mind Matters Campaign. It was very much around raising the awareness, reducing the stigma associated with mental health, which sadly still exists these days, and then sign posting people to the different interventions that we have available to us, every colleague was also issued with the Pocket card as well, which gave them information and particularly what to do and where to go in a crisis situation. We've been lucky to have some investments through NHSE, they gave us £100,000 to utilise on 2 fixed term wellbeing practitioners that we now have recruited, and these people are in our EOC and 111, that have got our highest sickness and highest turnover rates, providing direct support to colleagues so they don't need to have that referral to the hub that they can that immediate support. A new development is the Wellbeing Champions in the Trust, this is a colleague with more depth knowledge of the Wellbeing hub services and they can signpost and support both managers and colleagues. The table below shows the Wellness Plan.



SECAmb Wellness Plan
2022-2024

NHS South East Coast Ambulance Service NHS Foundation Trust

What will we do?	How we will do it	When we will do it	How we will know if we have made a difference
Vision: Best place to care, the best place to work **Three Main Outcomes:** 1. Wellbeing is threaded through everything we do 2. Everyone has responsibility for the wellbeing of themselves and each other 3. Everyone has a wellbeing conversation	**Personal Health and Wellbeing:** • Our people have access to vital training on all key issues related to health and wellbeing • Training encourages self care, how to access support, and also supporting the wellbeing of colleagues	Oct 22 through to Mar 24	Working conditions support good mental and physical health. Whilst awaiting appointments/treatments you have self help interventions to start the improvement/healing process. There are a number of preventative interventions in place to support staff, and reflective practice is encouraged. OH and wellbeing service leaders, HROD and senior leadership work closely together to deliver high quality health and wellbeing services to our people. Decisions made surrounding health and wellbeing take a data first approach where possible. Data is used to monitor progress and improvements/changes to employee wellbeing as a result of our wellness plan. We place equal importance on wellness, equality, data protection, and patient safety when designing services, organisational change, and people policies.
	Relationships: • The Trust have mechanisms to support and develop wellbeing champions to work collaboratively for the betterment of the Trust as a whole • There is support from line managers for them to carry out their roles effectively	By Mar 23	
One Priority Area – 7 Strands: One SECamb *(Culture Improvement Journey)* 1. Personal Health and Wellbeing 2. Relationships 3. Fulfilment at Work 4. Environment 5. Managers and Leaders 6. Data and Insights 7. Professional Wellbeing Support	**Fulfilment at Work:** • Role / service (re)design recognises the need to manage workload and stress on individuals and endeavours to include a balanced workload within its design • Wellbeing of the workforce is factored into service redesign alongside enabling delivery of quality patient care	By Mar 23 with review Sept 23 and March 24	
	Environment: • Our people have spaces for them to enjoy away from the service area • People have safe places to go during times of high pressure	Oct 22 to Mar 24 with Medway as the next priority	
Four Passions: 1. Putting the welfare of our people and patients at the heart of what we do 2. Providing the tools to support our managers and leaders to support the wellbeing of their people 3. Making SECAmb a healthy place to work 4. Ensuring our people have access to specialist wellbeing services when they need them	**Managers and Leaders:** • Launching the leadership development series (made@secamb), and the technical series, ensuring our leaders are equipped with the additional skills required to bring about a compassionate and inclusive culture, and to ensure our leaders are then equipped to support and develop our people appropriately	Oct 22 through to Mar 24	
	Data and Insights: • Decisions made surrounding health and wellbeing take a data first approach where possible • Data is used to monitor progress and improvement	Mar 23 for BI Mar 24 for Insights	
	Professional Wellbeing Support: • Health and wellbeing considerations are present in policies and procedures and also when undertaking service redesign/transformation	Mar 23	

8.2 New Services

Offering One is for a Sickness Management solution - Goodshape - This is an approach aimed at transforming the way we manage the health and wellbeing of our colleagues. When a colleague is sick, they could phone a nurse specialist via a dedicated number. The nurse specialist can take the details of the absence, starting the return-to-work process for managers, and signpost the colleague to appropriate resources to support their wellbeing and speed up recovery. Goodshape also undertake analysis of trends allowing us to provide additional support to areas of the Trust where, for example, the data suggests we have more muscoskeletal injuries, or higher than average respiratory illness.
Offering Two for Financial Wellbeing - HASTE - This is an approach that aims to educate and support colleagues in all aspects of financial wellbeing, particularly beneficial where colleagues are struggling. Haste also offers a solution that will allow colleagues to draw down on their overtime and unsocial earnings (capped) for a nominal transaction fee (£1.99).
Offering Three for an Employee Assistance Programme - TBD - This is an approach that provides around-the-clock mental health support for our colleagues and their immediate family. It's a vital employee benefit that helps in difficult times. Whether it's personal or professional challenges, EAP provides a safe space to talk through it all.

Offering Four is for internal Occupational Health Service provision.

Finally, considering recent tragic events, we are working on ensuring Suicide Pre and Postvention aligns to best practice, including Mental Health First Aid and Applied Suicide Intervention Skills Training. We have a robust process, measured around AACE best practice, for Suicide Postvention. A process that we have sadly had to implement three times in the last few months.

9 Community Resilience Update

- Dave Wells gave an update on volunteers and the developments that have taken place over the last few months but also what has been achieved over the last couple of years. The Community Resilience team have come on leaps and bounds; all volunteers have their own SECAmb email address. This gives the volunteers access to SECAmb systems, such as Sharepoint, but most importantly updates regarding our clinical

updates and skills and most importantly makes the volunteers feel part of the organisation, included and inclusive. In more recent years, the introduction of uniform has been put in place, whereas before there was no uniform just an issue of a Hi-Viz vest and an expectance to arrive in jeans and T-shirt. As a corporation SECAmb have identified our volunteers, in the last two years a new training programme, First Responder on scene has been introduced. This is a Level three nationally recognised qualification, which most other Trusts across the country are using to train and educate their volunteer workforce, this is also an incentive as it gives the volunteers a Health and Safety First Aid at work allocation. Recently the scope of practice has been extended for the volunteers, giving them new skills such Laryngeal Mask Airways (LMA) for the emergency responders to help protect the airway, Blood Monitoring (BM) Capability, they can now do critical haemorrhage management. They have NPR, nasopharyngeal Airways, which is another airway adjunct which helps protect and keep the airways open and Glucose Gel, which is a food substance that is used for patients who are having a hypoglycaemic attack. There is currently a roll out of training across the Trust for the CFRs, there is now 140 of the volunteers trained up for the Falls Project which is going very well. We are now seeing an impact on numbers of patients that the CFRs are attending, the plan is to extend this to the new CFRs that start in the Trust and have it as part of the terms and conditions coming on board with us that they attend all categories of calls so that they can be trained in managing falling patients as well. This has all been signed off and gone through the correct governance, there is a model of care in place that allows the volunteer to assist the patient off the floor with clinical advice and then stand down from the incident after calling the clinician back and the clinician will make the decision as to whether they discharge from scene or whether or not an ambulance will attend for further oversight.

About a year ago we were lucky enough to secure half a million pound from NHS Charities together as a grant. That money was used to uplift the Community Resilience Team, this was chosen because if we want to increase our numbers, we have to have the team in place to be able to support them and make sure they are engaged with and make sure they get the correct training that is needed to support. With the money three band six community resilience leads were recruited, making a total of 5 leads. This gives one community resilience lead to every two operating units in the Trust, which is making a big difference. Complaints have come down, one of the main reasons being because there wasn't enough engagement, now there is. The training has increased and our visibility as an organisation has increased by attending their team meetings, which has proved that we take them seriously. Another part of the money was to bring onboard a band seven manager to look after the Emergency responder scheme and the Falls training, they are now in post and working on those two projects. The other part of the £500,000 was a two-year trial to trial the Emergency Responder project. This is whereby we give them the same skill set as a CFR, but we also include the Blue Light Driver Training. They go through the nationally accredited training just like our ambulance personal do to be able to drive on blue lights. The reason this has been done is that there are two areas of the Trust that we struggle on, which is meeting are C1 and C2 performance. It was decided to put them on the insular Romney March and the A272 between the Hampshire boarder and Billingshurst in West Sussex, these where we were missing performances. This showed that the overall mean time for performance in the Romney Marsh went down, instead of the average time being approx. 20 minutes, it was knocked down to 8 minutes. We are hoping to see some

benefits around patient outcome from that. The Tangmere model is being moved to Horsham, this is because the areas we trialled, and thought were going to get the best benefit from haven't shown any benefit. This could be that the performance and demand in the Trust is down anyway at the moment, compared to what it was during COVID and Christmas, but we are going to try in Horsham and Billingshurst because these are the areas where we are missing a large number of C1 mean performances. If after three months that isn't working, then we will re-evaluate again. So far there are 24 people trained up on the Blue Light Driving.

We have now taken onboard the welfare volunteers within our team, we have four welfare vehicles that are on order with the Trust, that project was started by Angela Rayner, we are hoping to take delivery of the vehicles by the beginning of Summer. We can then get them out with drinks and snacks to help support our staff.
The next big thing will be the National Mobilisation App (NMA) so we can get in place for all our volunteers, at the moment the Dispatching volunteers can be challenging. We currently have a mixture of methods that are being used, some have got Data only Airwave handsets and the others have a Nokia phone that we supply them with and they receive a text message or a phone call to alert them to an incident. This is not a productive or efficient way for dispatching. The NMA itself is a mobile phone, it works on an Android platform and is basically an app on a phone. It allows the dispatcher to drag and drop the incident, just like they do in an ambulance. Once the job is on the way, they acknowledge they've received it – the app alerts them even if it's on silent, and then it tracks them and will map the incident to the postcode that is put in by the dispatcher so they don't have to worry about setting their SAT NAVs up when they get into their vehicles. The app will also book them on scene once they are outside the front door of the property. We are waiting on the relevant documentation to go through the government processes, we also have a few more trials but they seem to be beneficial so far.

SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST

Council of Governors

Nominations Committee Report

22 June 2023

1. Introduction

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

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

2. CEO recruitment

2.1. Recruitment for the substantive CEO position was successful with the appointment of Simon Weldon, CEO SECAmb.

3. NED Appraisals

3.1. NomCom has formally reviewed the NED appraisal process and contributed to the NED appraisals. NED appraisals were reviewed during the last meeting including the Chair's appraisal and objectives. To be ratified at the Council of Governors Part 2 meeting this afternoon.

4. Recommendation

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

David Astley
Chair (on behalf of the Nominations Committee)

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor Development Committee

22 June 2023

1. Introduction

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

1.2. The duties of the GDC are to:

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

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

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

1.5. The GDC met online on 8 March 2023 (MS Teams) and 18 May 2023 (in person). The minutes of these meetings are provided for the Council as an appendix to this paper.

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

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

2. Items of note

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

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

2.3. The Council of Governor Self-Assessment was in February 2023 and completed. Report to be circulated at the next meeting.

2.4. It was suggested that all future meetings be in-person meeting on the same day as MDC.

3. Recommendations:

3.1. The Council is asked to:

3.1.1. Note this report; and

3.1.2. Read the minutes provided.

3.2. All Governors are invited to join the next meeting of the Committee on **TBD.**

Julie Harris (On behalf of the GDC)
Assistant Company Secretary

See below for the minutes of the GDC meetings

Appendix GDC Minutes

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 8th March 2023

Present:

Leigh Westwood	(LW)	Lower East Public Governor & Lead Governor
David Romaine	(DR)	Lower East Public Governor
Andrew Latham	(AL)	Lower West Public Governor
Martin Brand	(MB)	Upper West Public Governor
Julie Harris	(JH)	Assistant Company Secretary
Lisa Bell	(LB)	Appointed Governor
Peter Shore	(PS)	Upper West Public Governor
Amanda Cool	(AC)	Upper East Public Governor

Apologies

Kirsty Booth	(KB)	Non-Operational Staff Governor (Chair)
Linda Caine	(LC)	Upper East Public Governor
Harvey Nash	(HN)	Lower West Public Governor
Angela Glynn	(AG)	Appointed Governor
Brian Chester	(BC)	Upper West Public Governor

Minute taker (from recording):

Jodie Simper (JS) Corporate Governance and Membership Manager

Item No.	Item
Introduction and matters arising	
112/22	**Welcome and introductions** LW welcomed everyone to the meeting.
113/22	**Apologies for Absence**

	As above
114/22	**Declarations of interests** None
115/22	**Minutes of the Meeting 20.10.22 & Action Log and Matters Arising** Minutes have been taken as an accurate record of the above noted meeting Action Log - The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed. Matters Arising – JH mentioned there are new members of the Corporate Governance team who are undergoing training specially on Minute taking. AL asked if a 'meetings' SECAmb email address to be used for meeting invites to stop the numerous amounts of invites being sent for one reason or another. JH agreed this was a good idea and will speak to IT to see if this is possible. PS mentioned if there was a specific quorum for the committee, 8 – 10 of either appointed or elected governors the committee would possibly get a higher attendance. **ACTION**: JH & JS to coordinate with IT for meetings invite email address
Main business	
116/22	**Feedback from 23 February 2023 Council Meeting** - **Part One** - **Discuss the New Format** - **Printout requirements** LW apologised to MB for not replying to his feedback email and invited MB to tell the committee what he suggested on his email. MB discussed the email sent and advised more structure is needed in the meetings, not all points were covered in terms of seeking assurance. LB believes that the meeting needs a combination of some structure and then an informal discussion. Is it possible to have an email account for one point of contact, to put their point across and to give the chair time to discuss. DR mentioned condensing the items, there was a lot of information throughout the day, and it was easy to lose focus. Maybe having a few good points to concentrate on, as there is lots going on around the Trust, structure is good if all the relevant information is given. LB reflected on the comments around structure and the opportunity for the governors to effectively set the agenda. Is there scope with the meeting frequency and the cycle to identify what are the more pressing issues for the next meeting. If the governors want something around staff

	engagement, do we dedicate more to that particular subject rather then cramming it all in to lots of papers and verbal updates. AL mentioned the purpose of the governors is to hold to account the non-executive directors, in their role and to make sure the right decisions are being made. A bit more holding to account is the sort of discussion that would be a benefit. MB suggested some tool to help with keeping the focus on the range of committee papers and the range of themes. Using the tool during the pre-meet to capture points to talk about by the committee. JH confirmed the clear areas of focus are priorities quarterly and the draft specific assurance questions against identified errors. Using the pre meet timeline to align the themes with the talking points out of the report and pen some specific assurance questions. Governors agreed. JH asked the preference on the papers for the actual meeting, would governors prefer actual paper handouts or keep things digital and use laptops/Ipads. MB explained how paper handouts were his preferred option to make notes and turn papers and compare different pages at the same time. DR agreed paper was easier to negative through the pages. LW asked JH if it was possible to print out papers for governors that preferred the paper option. JH advised it is possible to print out and advised the pre meet could be the time to ask for the paper option, with the hope of having more governors join the meeting. **ACTION: Use the Pre-meeting to align themes and talk points. Confirm the number of governors wishing to have papers printed out for the meeting.**
117/22	**Joint CoG/Board meeting – 27 April 2023** - **Input for agenda** JH confirmed this is not a public meeting, it is a joint CoG and board. The agenda is made by Peter Lee (PL) with the input of the GDC, the priority discussions could happen here. MB mentioned the items that were not covered before could now be covered, priorities for the next financial year. LW agreed finance is certainly a topic to dive into. AL agreed that the 18 million deficit needs to be a topic. LB asked for the new CEO, when appointed, to speak about their plan for the first 100 days at SECAmb, what is their vision. DR would like to hear about retention, is there a program or an initiative to try and encourage people to stay. AL agreed with DR's comment on retention and would also like to hear about people management. LB added to DR's comment of retention, having greater visibility around the whole workforce planning, attrition rates in terms of direction of travel, financial challenges.

	JH summarised the points to pass to PL – priorities for next financial year, financing forecast for 2023/24, efficiency and workforce planning, business continuity, first 100 days of the new CEO, a direct presentation attrition and retention program, initiative to find out the underlying causes. LB asked for the understanding of what is happening with the bullying, inappropriate sexual behaviours campaign, how is the work being measured, are we seeing more complaints coming through, what is the profile of those internal complaints and behaviours. LW agreed this topic would be beneficial. **ACTION: JH to pass items to PL for Joint CoG & Board**
Standing agenda items	
118/22	**Governor training and development requirements:** - For discussion regarding priorities - Training and development opportunities for discussion - Observation opportunities with 111/999/Field Ops - Observing and reporting on NED committee meetings JH advised that JS will share the new governor training and development opportunities coming up on Friday. There hasn't been a lot of up take on the observation opportunity with the 9's,1's and the field Ops. If there is any governor training or development courses, we haven't shared with you, please do share with us and we will see about providing the training to you. PS mentioned in the Governor handbook that newly appointed governors receive a one to one meeting with the Chair, Lead and/or Deputy Lead Governor and the option to be given a mentor from the existing Governors. Is this still in place? **ACTION: JH & JS to look into one to one meetings with Chair, Lead & Deputy Governor and mentors for newly appointed governors.** **JS to share governor training and development opportunities**
118/22	**Topic ideas for Part 3 (Governor Development Session)** JH asked for topic ideas for the governor's development session which is held after the formal CoG. Items that have been picked up from today's meeting is Emergency Preparedness, Resilience and Response (EPRR) with Dave Williams and finance, where does the money come from. JH mentioned the Clinical Advisory group and explained it's role and asked if the MDC would be interested in hearing from them. It was agreed to ask them to do a small presentation.

	MB asked to have a few future meetings regarding the Improvement Journey, in terms of what is happening and how is it going, especially with a new CEO how will it be going forward PS mentioned it would be useful to have a run down on the staff structure of the Trust, for example, a basic description of the number of paramedics, technicians, call handlers, what their bandings are and what the supervisory/management structure is. **ACTION: JH to look into topics for development session** **JH & JS look into staffing structures of the Trust.**
PART 2 – Other business	
119/22	**Any other business** None
120/22	**Review of meeting effectiveness** All agreed the meeting was useful and ran in plenty of time. **The next GDC meeting takes place on 18 May 2023 at 1000 in person at Crawley HQ on the same day as MDC. Lunch will be provided**

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 18th May 2023

Present:

Leigh Westwood	(LW)	Lower East Public Governor, Lead Governor and Chair
Brian Chester	(BC)	Upper West Public Governor
David Romaine	(DR)	Lower East Public Governor
Andrew Latham	(AL)	Lower West Public Governor
Martin Brand	(MB)	Upper West Public Governor
Julie Harris	(JH)	Assistant Company Secretary
Ann Osler	(AO)	Upper West Public Governor
Sam Bowden	(SB)	Operational Staff Governor
Harvey Nash	(HN)	Lower West Public Governor
Peter Shore	(PS)	Upper West Public Governor

Attendance Online:

Linda Caine	(LC)	Upper East Public Governor
Amanda Cool	(AC)	Upper East Public Governor
Nicholas Harrison	(NH)	Operational Staff Governor

Apologies

Kirsty Booth	(KB)	Non-Operational Staff Governor (Chair)
Colin Hall	(CH)	Upper East SECAmb Public Governor
Angela Glynn	(AG)	Appointed Governor
Lisa Bell	(LB)	Appointed Governor
Mark Rist	(MR)	Appointed Governor

Minute taker:

Jodie Simper (JS) Corporate Governance and Membership Manager

Item No.	Item
Introduction and matters arising	
121/23	**Welcome and Introductions** LW welcomed everyone to the meeting.

122/23	**Apologies for Absence** As above
123/23	**Declarations of interests** None
124/23	**Minutes of the Meeting 8 March 2023** Minutes reviewed and discussed the format of minutes are not to be verbatim and need to be sent to the Chair to be reviewed within a week of the meeting.
124b/23	**Action Log and Matters Arising** The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.
Main business	
125/23	**Feedback from 23rd February Council Meeting** LW confirmed the feedback is for the Council Meeting on the 23rd February and not the 2nd March as stated on the Agenda HN wanted confirmation of the procedure of the Pre-meet, timing and practicality. The governors discussed previous Pre-meets, how they were held via Teams making it easier for governors to attend and on a different day to the Council meeting allowing the NEDs the opportunity to gather the information they may wish to respond with. JH mentioned for any governors that are unable to attend the Pre-meet, they are able to submit comments in writing which will be presented at the meeting to be discussed and then shared with the NEDs. BC suggested that the Pre-meet needs to be put in the diary early to avoid clashes with other commitments. BC advised that the original Pre-meets were discussions for the Governors only, with no disrespect to the staff here. This gave more freedom of speech in debates; the Lead Governor then gave a summary of the meeting. HN asked when the papers should be out before a meeting. JS confirmed a week before the meeting the papers should be sent out. DA confirmed the papers should be out at least 7 days before the meeting to give everyone the chance to read them and ask the most meaningful question based on the papers. DA suggested a Pre-meet several days before would be helpful, it doesn't need to be detailed questions it could be themes or a mixture to give my colleagues a chance to reasonably prepare the answers. There needs to be spontaneous discussions and debate. Governors are in agreement with the Pre-meet being a few days before and ensuring the papers are out a week before.

	DA mentioned that the questions need to be out around 3 working days due to NEDs having other prior commitments and needing time to prepare. LW confirmed themed questions that come from the pre meet will be drafted up, sent to the governors for approval and then submitted to the NEDs so they know what the Governors are focusing on. JH agreed with LW, this process has been on trial for this year. The Tuesday before the Thursday CoG there is a pre-meet. The Governors are invited to come and do a summary document, JH then forwards to the NEDs by the end of play on the Tuesday. Giving the NEDs 48 hours to digest and be ready for the debate or discussion. MB asked if this gives the NEDs time to get in touch with people within the Trust to get the information, they need to report back to us. JH advised that the questions and themes stem from the papers which stem from Board papers that have been submitted previously to the Board so they should already know the answers. DA agreed with JH, two working days before the meeting is fine, JH would escalate to DA if the right responses were not getting received. Governors agreed on Pre-meet timings. LW asked the Governors on their view of having the corporate staff in the pre meetings, do the Governors wish to change the format so it is just the Governors in attendance. The Governors discussed the format of attendance to the Pre-meets. If it was to be governors only then papers would need to be out sooner and there would be a pressure for this to work. It was agreed that the Governors feel comfortable having discussions in front of the staff and that we are all there to help SECAmb. DA wanted to assure the governors that the Governors team are very committed to service in the Council of Governors and making sure the spirit of the CoG is carried forward. If there was anything the Governors wanted to discuss without the team there, the Governors just need to ask them to step out for five minutes. They are all very professional and have no problem doing so. Governors held a discussion on the format and mapping of meeting and felt that the NEDs were not held accountable. If the meeting was to have themes, then the NEDs that are involved in the themes need to attend the meeting. **ACTION: Ask Paul Brocklehurst to update on IT failure.** **Sort page numbering and agenda item numbers**
126/23	**Council of Governor Meeting – 22nd June 23 – Input for agenda** HN mentioned that Attrition, Retention and Appraisals needs to be on the agenda with a look at staff morale. AO agreed with HN but asked who was responsible for looking into attrition and retention and who is in charge of appraisals are these reported back to the Governors. JH confirmed Yvette Bryan (YB) oversees appraisals and a request for a presentation from her. Ali Mohammed is recruitment. Governors and DA had a discussion on staff morale, management and the different levels of management, staff sickness and returning to work, adding these items under a heading of Culture to

	the agenda. There needs to be training for the middle management, so staff see they are being supported and an understanding of where the finances come from. The results of the CQC and what has been done to improve the Trust. LW confirmed all the governors are in agreement to have the following in the agenda. • Financial forecast • Attrition, retention, sickness, appraisals, and staff morale • People and culture strategy development • IT failure update • Staff survey results
127/23	**Governor Training and Development Requirements** JS provided an update on training available to the Governors, including the NHS Providers Governors Conference on the 23 May. Two governors are attending at the moment but there is still space available if anyone else wanted to join. There is also another opportunity to attend the conference on the 11 July. Make Ready Centre visit booking system is open at the end of May, JS will share details of this when it is live. If governors wish to attend a Make Ready Centre before this date, then they are to contact JS and she will contact the unit direct to book a date and time. JS mentioned that LC mentioned about booking a visit to the Medway centre with the Governors of that constituency. Each Governor should visit the units in their area. Observing NEDs committee meetings, the dates were sent out but there are still spaces available on some committees. AL mentioned about the meeting invites, when someone leaves the Trust it gets confusing when someone new comes in and takes over the meetings by sending another invite. AL suggested a universal meeting email address that can send invites out so that it doesn't matter if someone in the team leaves. JS advised that talks have been had with IT regarding a meeting address but will chase this up again. HN mentioned that SECAmb use Sharepoint as do the family courts which causes confusing with IT systems. SECAmb IT are stopping the governors doing their job and needs to be held to account. PS asked for a management structure. The governors had a discussion on feedbacking on the NEDs committees and the procedure of observing. **ACTION: JS to send out the dates available for the NEDs committee meetings** **Chase IT for a universal meeting email address** **JS to send out a management Structure.** **JS to send Feedback form to AL –** sent at the end of meeting.
128/23	**Topic Ideas for Part 3 (Governor Development Session)** JH explained the structure of the Governor Development sessions and asked what the Governors would like to know about SECAmb. It will be an armchair discussion, informal with anybody form the Trust that the Governors would be interested in hearing from. The governors would be interested in hearing about finance.

	JH mentioned SECAmb have a new CFO, they start next month, and a new deputy CFO. Timing might be short as they are new. BC asked due to discussions today could the morale of staff be the initial part 3 and the next part 3 be finance, giving the new CFO and deputy time to settle in. AL suggested AM could talk about the People Plan. JH suggested the People Plan be presented in the CoG in Part One and then in Part three, TI and YB who are involved with the staff to come and talk about the People Plan. LW suggested that Finance goes to Part Three and then Cultural can be moved to Part One. JH mentioned the COVID Incident Report is out next week, this has to be presented to NHS E and is about the emergency preparedness, this could be an interesting topic for the future. MB advised that the last audit report mentioned if an incident happened like in Manchester, SECAmb wouldn't be ready for it but there was no mentioned of why we wouldn't be ready. JH advised this could be an armchair discussion with Dave Williams.
PART 2 – Other business	
129/23	**AOB** DR mentioned for the SECAmb to be most effective the calls need to be cut down. Speaking to the frontline staff the number of calls that they are expected to attend has risen and they are being hassled by the dispatcher to move on. DR believes it doesn't matter how much finance or IT fine tuning is done it isn't going to help. AL agreed with DR and believes there has been a failure in the Trust to deliver the Hear and Treat which takes calls out of the system. JH suggested a conversation around risk appetite in every committee and every situation.
130/23	**Review of meeting effectiveness** The meeting was deemed to have been effective. JH asked the governors if they like the new in person meeting with the MDC running after lunch. Governors agreed in person meetings are most effective but have the option of online for those that are unable to make it in person, Hybrid. It was confirmed that GDC and MDC will now run on the same day, with an extra MDC to match the four GDC, with a Hybrid option. **The next GDC meeting date is to be confirmed**

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Governor Activities and Queries

22 June 2023

1. Governor activities

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

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

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

Date	Activity	Governor
26.01.23	New Governor Induction	Harvey Nash Peter Shore Leigh Westwood Sam Bowden Colin Hall Barbara Wallis
30.01.23	Governors Support Meeting	Leigh Westwood
21.01.23	NHS GovernWell Training – Accountability	Christopher Burton
01.04.23	Godalming Spring Festival – Public Membership recruitment, engagement	Martin Brand Ann Osler Sam Bowden
02.04.23	Brighton Marathon – Public Membership recruitment, engagement	David Romaine
15.04.23	The English Festival, Gillingham, Medway - Public Membership recruitment, engagement	Linda Caine Colin Hall Christopher Burton
22.04.23	Spring Live!, Ardingly - Public Membership recruitment, engagement	Harvey Nash David Romaine Sam Bowden

23.05.23	NHS Providers Governor Focus Conference 2023, London	Kirsty Booth Nicholas Harrison
09.06.23	South of England South - Public Membership recruitment, engagement	David Romaine
10.06.23	South of England Show - Public Membership recruitment, engagement	Angela Glynn David Romaine Brian Chester
11.06.23	South of England Show - Public Membership recruitment, engagement	Harvey Nash Angela Glynn

2. Governor Enquiries and Information Requests

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

Recommendations

2.2. The Council is asked to note this report.

2.3. Governors are reminded to please complete the online form after undertaking any activity in their role as a Governor so that work can be captured.

Leigh Westwood
Lead Governor