South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

03 August 2023
10.00-13.15

Trust HQ
Nexus House, Crawley

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
30/23	10.00	Welcome and Apologies for absence		-	DA
31/23	10.01	Declarations of interest		To Note	DA
32/23	10.02	Minutes of the previous meeting: 01 June 2023		Decision	DA
33/23	10.03	Matters arising (Action log)		Decision	PL
34/23	10.05	Chair's Report		Information	DA
		Board TOR		Decision	PL
35/23	10.15	Audit & Risk Committee Report		Information	MW
36/23	10.25	Chief Executive's Report		Information	MS
Strategy					
37/23	Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report**		
People & Culture – *Everyone is listened to, respected and well supported*					
38/23	10.40	**Improving Culture**	Board Story		MD
			NHS Long Term Workforce Plan		AM
			People & Culture Strategy Delivery Plan		AM
			Comms & Engagement Strategy - Delivery		JC
			People Committee Report		SS
	11.40	**Break**			
Quality Improvement – *We listen, we learn and improve*					
39/23	11.50	**Keeping patients safe**	Quality Improvement Strategy		MD
			Quality & Patient Safety Committee Report		TQ
Responsive Care – *Delivering modern healthcare for our patients*					
40/23	12.20	**Operational Performance & Efficiency**			EW
Sustainability & Partnerships – *Developing partnerships to collectively design and develop innovative and sustainable models of care*					
41/23	12.45		Finance Report		SS

		Achieving Sustainability / Working with Partners	FIC Report	HG
			Strategy Steering Committee Report / TOR	MP
			Partnerships Report	DR
Board Effectiveness				
42/23	13.10	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
43/23	13.15	Any other business		DA

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

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 01 June 2023

Trust HQ, Nexus House

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Simon Weldon	(SW)	Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
Charles Porter	(CP)	Chief Finance Officer
David Ruiz-Celada	(DR)	Executive Director of Planning & Business Development
Emma Williams	(EW)	Executive Director of Operations
Max Puller	(MP)	Independent Non-Executive Director
Margaret Dalziel	(MD)	Interim Executive Director of Quality & Nursing
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Rachel Oaten	(RO)	Chief Medical Officer
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

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

Chairman's introductions

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

16/23 Apologies for absence

Howard Goodbourn	(HG)	Independent Non-Executive Director
Liz Sharp	(LS)	Independent Non-Executive Director

17/23 Declarations of conflicts of interest

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

18/23 Minutes of the meeting held in public 06.04.2023

The minutes were approved as a true and accurate record.

19/23 Action Log [10.03-10.04]

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

20/23 Chair's Report [10.04–10.13]
DA used his report to set the context for the meeting reinforcing the revised approach to the BAF, the actions taken in response to the board effectiveness review, and recent focus on the approach to developing a new strategy, engaging with key stakeholders including the Council of Governors.

DA noted the need to continue talking and listening to our people to ensure the actions being taken in line with our people and culture priorities are having the right impact.

Board Committee TOR / COB
PL then outlined the revision to the Board Assurance Framework, which now includes progress against the in-year priorities and risks to their achievement. This is the first version and so is a work in progress and the strategic risk section in particular will be subject to change in light of the development of our approach to risk appetite; the next Board session is in July. The aim is to help shape the focus of the Board and its committees, as reflected in the committee annual plans, which have also been revised. These along with the terms of reference are before the Board as part of the annual review.

Save for TQ acknowledging the need to include within QPSC a review of the efficiency programme quality impact assessments, the committee TOR and annual plans were approved by the Board.

21/23 Audit & Risk Committee Report [10.13–10.20]
MW updated on the last meeting which was the year end meeting considering the annual report and accounts; these are important accountability documents, which set out how the trust discharges its duties. MW confirmed that there were a good set of financial statements which were in accordance with reports to the Board over the past year. They are still subject to final audit and the committee will meet again on 15 June to formally approve the Annual Report & Accounts on behalf of the Board. KPMG have to-date, not indicated any major issues to bring to the Board's attention. On the value for money judgment, work is underway and this will be influenced by the CQC inspection findings, in particular related to well-led.

MW then referred to the annual governance statement which demonstrates the way we have managed resources and the extent to which we have in place a sound control environment. It is informed by the formal opinion provided by the Head of Internal Audit; there are four possible opinions; a sliding scale with two positive and two negative. We have been provided the third (negative) opinion, reflecting the work still required to embed the improvements and maintain our internal controls. MW confirmed that the committee is however confident that action is being taken by management to address the identified weakness in controls e.g. procurement, policy management and ensuring our risk processes are more embedded.

MW reinforced the need for the executive to take the Internal Audit plan more seriously, so each review is owned and the actions acted upon effectively. The CEO provided assurance to the committee that this is in hand.

In summary, MW felt overall there is a good set of accounts, the improvement includes the areas the Board is aware of.

DA thanked MW for this update.

SW acknowledged the points made and will come back with a plan re policies to the July committee meeting. SW also confirmed that he has taken then opportunity to review the Internal Audit plan to ensure it is aligned with the strategic objectives.

22/23 Chief Executive's Report [10.20–10.27]
SW firstly thanked everyone for their welcome. He noted that while there are challenges, he has been struck by the progress in meeting them. He has met very many staff over recent weeks who have inspired him to ensure we can be the best we can be.

SW is in the process of listening and expects to come back to the Board in August with his priorities as it is important he is transparent about his personal focus.

Lastly, SW confirmed that the organisation has completed the business planning cycle, a requirement of each provider, and submitted the operation plan that has been accepted by NHSE. It is regarded as being robust and of good quality. He thanked the team for their efforts.

CG asked about how we intend to mark NHS 75. SW explained that we held an all staff webinar seeking their views on priorities, which we submitted to NHSE. The feedback included being very proud of the NHS, including the Windrush generation's contribution and priorities for change to ensure the NHS is protected. There was also recognition about the issues in the wider social care system. It was a really good debate. In terms of celebration, we will be represented in the July service.

DA added that the video of webinar has been shared and suggested people watch it if they haven't already.

23/23 Primary Board Papers
As reflected by DA in his Chair's Report to the Board, the primary board papers will be used as reference documents to inform the areas of focus within the agenda.

24/23 Keeping Patients Safe [10.27-11.25]
This item was framed by the Board Story, which RO introduced. She explained that we are in a fortunate position to have a Consultant Midwife who is influencing national policy change in the ambulance service and working internally to ensure good care. This story focusses on a colleague who needed help in the delivery of their baby and also how we are talking health inequalities.

Following the video being played the Board reflected on the work to improve maternity care, noting the high number of babies delivered, which is similar to a small maternity unit. The issues in maternity care in the news recently highlight the need to keep this high on the agenda within AACE and our ICBs. The Board expressed disappointed that we did not get as part of the system a share of funding arising from the Ockenden review. TQ asked if we have pushed back on this. RO responded that we asked other ambulance services and none have received additional funding. We have escalated this highlighting the risks in pre-hospital care.

DA asked that we formally acknowledge this disappointment and through the appropriate channels ensure our voice is heard.

SW paid tribute to Dawn Kerslake, Consultant Midwife, for her work. We have good level of specialist expertise here and our new strategy will require direct conversations with commissioners; if they value the service, they will need to invest in it. SW will be taking this forward in to those conversations and noted that the onus is on us to show the complexity and what we can provide, then challenge commissioners on what is funded so any gaps are clear.

CG explored the point in the video about ethnic minority mothers who have statistically poorer outcomes, with our training leading the way to mitigate this inequality.

SS asked whether we are looking at a health inequalities strategy / plan, as this is likely to relate to other services too. RO outlined some of the work, which will form part of the considerations as we develop the new strategy. MD added that we have training in maternity as one of the priorities in our Quality Account and also CQUIN.

The Board noted the learning from this story and through the work of Dawn, how we helped to amend NHS pathways to ensure more appropriate categorisation.

On behalf of the Board DA sent his best wishes to Coral and her family. He thanked her for sharing her experience with the Board. There is a process in place where the executive are doing what it can to ensure we have the right funding for these services and address the related health inequalities.

MD then summarised her cover paper, highlighting progress with the priorities listed, which are covered in detail in the BAF. She noted the blip confirmed in the IQR related to complaints, response is down to 86%. There is a QI intervention to correct this and the challenge will then be to embed the process and sustain improvement. Similarly, with risk management, as per the updated from the Audit & Risk Committee; interventions by directorate will ensure risk processes and culture are more embedded.

MD referred to the role of the Quality Assurance Framework and compliance visits. A dashboard has now been developed to ensure these are informed by the right data. EW added that four dispatch desks are testing the process before wider roll out and an EOC dashboard is also being developed. MD agreed and this moves us to a more local based quality assurance framework, supported by PSIRF.

In terms of the quality assurance visits, these started in April and have been really well received by the teams. They are co-designed with good input cross-directorate. Actions plans follow the feedback, which includes corporate services and how we can improve the support to operational delivery. The QAV plan is set for the year and we have invited ICB and external partners to join once it is more established. DA asked that we invite Governors too.

SS referred to risk management and some specific risks within the paper related to ER cases and medicines management; in light of the related metrics in the IQR SS asked if the risk score is being reduced too soon. RO responded on the medicines risks and confirmed the recent full review of all medicines risks, with the Chief Pharmacist and her team. There is good assurance with a number of these risks in light of improving capacity. The Chief Pharmacist is comfortable these risks are reducing.

With regards the reduction for the ER risk (361) AM was not able to confirm the detail behind this but agreed to take this away.

SS then referred to FTSU and the reported detriment, asking how we are seeking the learning. MD responded that we are dealing with this on case by case basis, to understand the detail better. She has met with the FTSU Guardian and there are planned sessions to get this shared understanding with the leadership team. MD added that we don't yet have a strong learning foundation, hence why this is one of our priorities. We are working to ensure people feel safe to speak up. The dashboard shows detriment has increased in the last three months we need to understand this better; we are focussed on it. The Board noted that this is already an action agreed last time to be picked up by the audit committee.

SW explained that with regards the concept of embedding, as CEO he is confident in the amount of work going on, but when we link this to the discussion later re RSP, the key word is embedding and how will we judge something is embedded. The Board will need to continually consider this when assessing its level of assurance.

On medicines, SW felt that the issue at Paddock Wood is less about variation in performance but more about whether we have a strategically fit for purpose facility. Work is ongoing, but this is unlikely to be straight forward given the challenging estate.

MW built on the concept of embedding. He reflected that 18 months ago we had the incident with the paramedics in Kent (operation carp). When he went to Thanet recently staff there felt that the issues arising from this incident is captured in training, but they were less clear about the way we have communicated learning. TQ confirmed that following the request by the audit committee, the quality committee is scheduled to review the impact of the learning at its next meeting. RO added that we still monitor the actions, but acknowledges we don't share with staff well enough when improvements are made. MW felt that this goes to the issue of whether lessons are embedded; OUs should know about big cases like this and be able to explain what has been learnt.

TQ asked if the executive is happy that we are working at pace on the quality agenda. MD is confident in the work we are doing which has been focussed on getting basics right / backlogs etc. The next step will be to ensure a better learning framework; we are not alone here as after reaching out to others to see what they have in place they are also struggling. MD reinforced that we are delivering not just planning. But we need learning to be more systemic; this is part of the focus for the coming year, as set out in the BAF.

PB challenged the optimistic reflected in the RAG rating in the BAF. SW responded that his observations so far is that we need to define more clearly what we are trying to achieve. We probably have too much on the go, driven by external pressures. He is therefore trying to encourage a debate on what the core essentials re delivery are. Also, we have in the past over promised without having resources to deliver. So we are exploring now the resources we have to ensure we can deliver against our promises.

DA thanked MD and RO for their report and for clarity on how the executive is approaching quality and joining up the work across the organisation. It is positive we are holding each other to account via the QA framework, including corporate services. We must not overpromise and ensure we have the resources that are needed to deliver our stated priorities.

<u>QPSC Report</u>
TQ outlined the outputs of the last meeting, much of which has been covered. He reinforced the positive escalation re the QI role in improving complaints management, and work to ensure consistently good papers.

[Break 11.25 – 11.35]

25/23 Improving Culture / People & Culture Strategy [11.35-12.45]
AM highlighted from his report the following:

- The industrial action position which is reflected in the reduction in risk.
- Workforce planning risk and the QI project re on-boarding
- The ambulance data confirming we are not an outlier on sickness or retention, but improvements still need to be made.
- The impact of the ICB closing the wellbeing hubs they had set up during COVID. This has left us with a capacity gap, which we are in discussion with the ICB about as we have been disproportionately impacted.
- Stat Man training target was achieved at the end of March, but more work on appraisals as reported to the recent People Committee.

- People & Culture strategy and related in-year priorities. AM set out the priorities and the rationale for these.
- ACAS mediation – following an initial meeting last week the plan / timeline is to be agreed in the next few days.

In the context of the numbers failing probation in EOC; low appraisals completion; high sickness; low retention lower; sexual safety training below 85%; increase in FTSU concerns, SS asked if the pace of change is enough in the context of the P&C strategy delivery plan priorities. AM reinforced that the priorities in the plan are for year one and have been assessed as having the biggest impact and being achievable within the available resources. He did however acknowledge there is much to get through. SS asked the whole executive if they agree these are realistic and achievable priorities. EW reflected that the challenge is some are so interdependent they can't be separated. Ideally, you'd do less, but so many are linked we need to move on them together.

DA noted that there is an action here for us all to take. He challenged whether we are all working collectively to resolve these issues. EW responded that we are doing training with managers to support them lead better. This is done in collaboration with HR. AM added that we put time and effort as an executive to ensure these are seen as joint problems. The language is important as people issues are sometimes seen as HR issues which isn't the case. We are moving away from a blame culture, but there is definitely work still to do to embed, as discussed earlier.

MW asked about the quality of our communication related to the strategy, to ensure we embed trust. We need to be honest with our people about what is trying to be achieved. MW felt the strategy addresses some of these issues, but is not assured we are communicating clearly enough. AM responded that the comms strategy is aligned to this strategy and our corporate objectives, but accepted it is work in progress. JC added that we have talked broadly but not specifically as we haven't had the plan, until now. This is the plan to respond to the staff survey feedback.

MD added that while this is the trust wide response to the staff survey, directorates are doing work locally too to address more local issues.

MP reflected that 'you said we did' works if we have currency of data, but the time-lag of the staff survey doesn't help as at best we are responding to data months old. So what we need to focus on now is how we anchor this strategy on all insights not just the annual staff survey.

SW picked up a few points. Firstly, we have a set priorities and part of the discipline is holding to what we believe in and commit to them. It is likely that the staff survey results this year will be same as last, so we must be in this for the longer term. It will not be delivered if we carry on with same operational delivery model; we are therefore opening the conversation with the executive team about too much looking up, which creates a log jam. We need to bring the OUM layer into the conversation to help them be agents of change. So everybody will have to change in this process. On comms, SW hears the point and acknowledges our internal comms plan needs further work as lots of good things are happening out there and comms will be critical to tell our story of success.

PB asked if we can we measure the implications of being 8-10% down on establishment figures. DR responded that we do measure this impact and use PAPs and overtime to close the gaps while the workforce plan delivers.

DA summarised that this has been a really good discussion on such an important matter; we are now getting to the heart of the issues and how we do things around here. Our people feel good about the care they give

and so what we need is for them to feel good about the organisation. The Board is assured by the executive focus in this.

The Board approved the strategy and will hold the executive to account for delivery, ensuring we do what we promise.

FTSU Guardian Report

Kim Blakeburn joined to provide her bi-annual report to the Board. She outlined the key issues, reinforcing the purpose is to give an overview of the development of FTSU service and information about the themes / hotspots. The themes and hotspots remain relatively consistent. There have been three main improvements:

- Two new deputy FTSUG are now in post. This has made a big difference in supporting teams more locally to manage the concerns coming through.
- 93-day process now in place along with managers toolkits, which is helping to ensure closure in a timelier way.
- Significant improvement in data comparing with other providers. Working with the data team we have created a FTSU dashboard to help us work proactively where areas most need it.
- We are also looking to establish ambassadors as per the NGO recommendation.

CG referred to the 16% increase in cases and asked what is driving this. Kim responded that while the increase is high compared with our peers, it is not a particular concern as it doesn't relate to poor culture necessarily; it could be a sign of people feeling able to speak up / have a route available to raise concerns. With regard to the types of issues, these are mainly related to behaviours and interpersonal relationships. CG followed up by asking Kim's view on the P&C plan and whether it will deliver the change needed. Kim responded that evidence of change e.g. how we are addressing concerns and how senior leaders are encouraging others locally to respond to concerns, is definitely improving. There are green shoots. The capacity of team working alongside local teams has helped this.

TQ asked how we use the intelligence in our assurance / leadership visits to ensure issues are dealt with locally. MD responded that prior to visits we use data from across the trust including FTSU. This informs the approach / areas of exploration / what we need to test in the visits. So when we do visits, we have a sense of what the picture is, which we then explore to get to the truth. EW added that the new quality and performance management framework will test this too.

DA reflected that the Board needs assurance on how management is supporting hotpots make improvement and we are hearing this is now starting to happen.

MP flagged that the most pressing sub theme relates to leadership and asked if this because it is a catch all category and what is behind this increase. Kim responded that there was a misconception that people were raising issues via line managers, but they were just not getting a response they needed. Or in some cases the response made matter worse. DA asked how we manage instances where the response is appropriate and the person just doesn't like the answer. Kim accepts there are some cases like this but not very many; we do clarify where we confirm the initial response is reasonable.

AM is pleased to see the progress in FTSU. As the quality of reporting gets better there is a way to analyse ER and FTSU cases and report against protected characteristics. AM will work with Kim on this. It will help highlight any particular groups less able to speak up.

DR reflected that at heart of this is ensuring psychological safety to speak up. It is good to hear from the team that they are focussing not just on hot spots but areas not raising concerns, so we can understanding the silence.

SS asked how achievable it will be to increase training which is running at under 40%, to 85% in one year. Kim responded that it is mandatory and is confident we can deliver it. It is online training that will be put on ESR; it was low last year because it came in year late.

SW welcomed the report. Clearly one of things we will be judged on is progress over the year in this area. So is it a good thing for more concerns as it shows people are speaking up. However, we need clarity about what where we want it to go, e.g. at what point does the increase become a concern?

DA asked about the numbers of cases in the finance team. CP confirmed that there have been three meetings with FTSU to understand the issues better, which has led to action to resolve. It helps to show how FTSU is working. Some of this is basic management, not necessarily culture related.

DA thanked Kim for this helpful update which has informed a good discussion and triangulation of issues. The challenge for us all is to support a culture of speaking up safely and openly. The Board is pleased with the good progress demonstrated.

<u>People Committee Report</u>
SS summarised her report from the last meeting. The committee is assured there is shared ownership by the executive team on people and culture.

Clinical education has not been mentioned today, but this is core to what we do and so the committee was disappointed with the lack of progress with the business case. However, there is now a plan in place and RO updated that following EMB yesterday the reframed business case was approved.

26/23 Operational Performance & Efficiency [12.45-13.05]
EW summarised the key aspects from her report linking to the IQR and BAF risks, explaining the SVCC omission relates to the gap in funding providing the required staffing levels. SCAS are in a similar place so we not going live in the southeast due to commissioning. The Board noted the conversation it needs to have in due course about the implications of commissioning intentions and our future strategy.

EW also updated that we have started the EPRR core standards cycle linked to HART and are working to ensure appropriate funding for HART; in discussion with commissioners about this as reported last time.

PB asked how we can deliver our operational plan with the current gap in WTE. EW responded that there are some positive factors such as better handover times but accepted it will be a challenge. We have delivered well against the C2 mean in the recent past. DR added that we did not hit targets last year and the workforce plan fell short and H&T did not hit the target either. But the difference this year, using the learning from last, is we are over recruiting to plan for attrition; also we have more realistic efficiencies re-focusing on getting more value from clinical time rather than driving people harder. DR felt we have a more realistic plan, but we need to keep eye on progress as per the BAF.

DA noted that ARP is clinically validated and so while we can't achieve C2 18 minutes we must achieve at least 30 minutes as the interim position agreed nationally, but then improve from next year and beyond. This is why the discussions with commissioners related to funding and the development of our new strategy is so important.

SS noted that the IQR confirms H&T is reducing. EW agreed but the trend nationally is everyone saw a decrease; there will be fluctuation but EW is assured with the plan to sustain the actions to drive the 14% target.

SS asked about Police taking steps to stop attending to mental health patients. EW explained that Surrey and Sussex are likely to follow the Met Police as this is seen more a health than a Police issue. We are planning to hold a workshop to run through the implications which will include commissioners as it won't all fall to the ambulance service. TQ reflected that the assurance point is this is not in our gift to fix alone and so who are we engaging with. DA had asked SW to raise at AACE. It seems to have caught us all in ambulance service by surprise. We are still in the discovery phase about what has been agreed and how it will be handled; we are all alarmed and it is top of the national agenda in the ambulance sector.

CG asked about impact of new rotas. EW responded this should smooth gaps between demand and resources and realigning to peaks during the day. In terms of volunteers we are increasing numbers and with dispatchers ensuring desks staffed frequently to ensure better utilisation.

DA summarised that the Board understands the risks to operational delivery and notes the plans in place to mitigate and deliver our objectives as set out in the BAF.

27/23 Achieving Sustainability / Working with Partners [13.05-13.21]

Strategy Development

DR updated on the work since the joint Board COG last month to inform the specification for securing an external partner; this is about securing our future responding to the range of feedback from our people about needing clarity on the future of SECAmb. More in part 2 due to commercial sensitivity.

Partnerships Report

The Board noted this report which helps set out our situational awareness related to our place in the system. This will link to development of our strategy. The report summarises the joint forward plans – our presence is not very high which is indicative of where we might be seen by the system. That said, we are painted as a partner in prevention and managing flow and other pathways. So we can use this in our engagement and development of our strategy. So timing is good.

A patient flow group has been established supported by QI, linked to a number of objectives in the BAF.

Finance Report

CP highlighted the financial position, we are slightly under plan but CP is comfortable it is close to budget, at the same time as delivering strong performance ahead of 30 min C2 mean. There is work to ensure robust efficiency programmes, but we are not yet where we want to be with detailed schemes. We are not far off (£6.4m from £9m) but we must ensure a sustainable process, which is partly why we are slower than ideal. .

MW expressed concern about the efficiency programme which needs ongoing scrutiny. In this context, he asked that we review the investments in MRCs in recent years to establish the extent to which the stated value for money improvements have been delivered. SW suggested we use Medway, the most recent investment, to do what MW suggests. He added that more strategically, our current finance model will not be sustainable beyond this year so it is essential we talk about a new model in due course to test what we can offer versus what we are funded for. For example, we value our specialist staff but we need commissioners to confirm their intention so inform our strategy for the future.

28/23 Review of Board Effectiveness [13.21-13.25]

Our Leadership Way:

- Compassion
  Example of compassion about our patients and staff; we started about being compassionate with ourselves related to how we prioritise and don't take on too much. Wellbeing hub issues too reflect focus on compassion.
- Curiosity

Good triangulated questions across BAF IQR and other papers.

- Collaboration
  Referred to the work with staff / engagement. Working as an executive team is coming through. Also with the health economy e.g. ICB NHSE.

29/23 AOB

None

There being no further business, the Chair closed the meeting at 13.25.

DA then asked if there were any questions from the public in attendance, related to today's agenda. No questions.

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
15.12.2022	70 22a	QPSC to seek assurance on the implementation and effectiveness of the Falls Programme.	PL	29.06.2023	QPS	C	Considered by the committee in June, see escalation report
15.12.2022	70 22c	As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.	DR	Q4 2023/24	Board	IP	July Update: While this was initially planned for Q1 it is suggested that we defer this until early next year, as a better time to do this will be once we have developed our clinically focused Trust strategy as this should revolve around patient outcomes. We will in any event need to refresh the IQR then so it will be sensible to do it all at once.
15.12.2022	70 22e	The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.	SW	Q2 2023/24	Board	IP	
15.12.2022	71 22g	WWC reported to the Board in December that the Board has good visibility of aspects of Culture and Leadership but has less visibility on Staff Health and Wellbeing. It suggested that at its meeting on 2 February the Board receives a paper setting out the vision and approach to ensuring the wellbeing of our people.	AM	03.08.2023	Board	C	06.04.2023: This is deferred to the meeting on 1 June 01.06.2023: Deferred to 3 August 2023. This is on the agenda see item 38-23 (NHS long term workforce plan).
02.02.2023	84 22	WWC to review the root cases of RIDDOR report; the actions we have taken in response; and how we benchmark with our peers	RN	29.06.2023	People Committee	C	06.04.2023: On agenda for 20 April - will be included in the Board report on 1 June. 01.06.2023: The paper was deferred to June; it is on the agenda for the meeting on 29 June - see escalation report (2 Aug Board agenda)
06.04.2023	10 23	The Board has noted the special cause variation in the IQR related to NHSP audits. It has asked QPSC to follow this up, to understand the reasons and what corrective action is necessary. There is also a cultural issue here related to the support we provide staff who are audited, e.g. ensuring it is a learning tool, not punitive.	EW	24.08.2023	QPSC	IP	Added to COB
06.04.2023	11 23a	AUC to explore the reasons why staff are perceiving detriment as a result of speaking up and seek assurance that the processes in place will mitigate this.	MD	21.09.2023	AUC	IP	20.07.2023: A panel has been set up between FTSU, Director of Q&N, Deputy Director of Operations, Deputy Director of HR and Director of Strategic Planning to go through highlight of cases, captured on the FTSU dashboard, where detriment has been put forward by the person raising the concern. The aim is to explore the options then available to us to address this situation in a systematic way and we will report back on what that process will be. Until we explore this area in an experiential way, we will not be clear on the best way to address it.
06.04.2023	11 23b	As part of the development of the IQR, SPC charts don't work well for rolling targets and so need to present this data in a more helpful way for the Board. Stat Man Training and Appraisals, two examples identified by the Board in April.	DR	TBC	Board	C	Stat & Mand - Will now be a line chart. It was agreed SPC wasn't appropriate for this one, as it would be unlikely to ever hit the target except in March due to the nature of the data. Appraisals - Because the process changed to appraisals now being done monthly based on start date, this is one that should be able to be shown Rolling and have meaning in the SPC format. See IQR August that explains this. Rolling annual turnover – most board reports have this so unlikely to change.
06.04.2023	11 23c	As part of the development of the People and Culture Delivery Plan, clear metrics / dashboard to be established that demonstrates impact on culture.	AM	03.08.2023	Board	IP	To be picked up under the People & Culture item on the agenda
06.04.2023	11 23d	Update to Board each quarter on the delivery of the comms and engagement strategy and the impact it is having.	JC	03.08.2023	Board	C	First update scheduled for August - see agenda

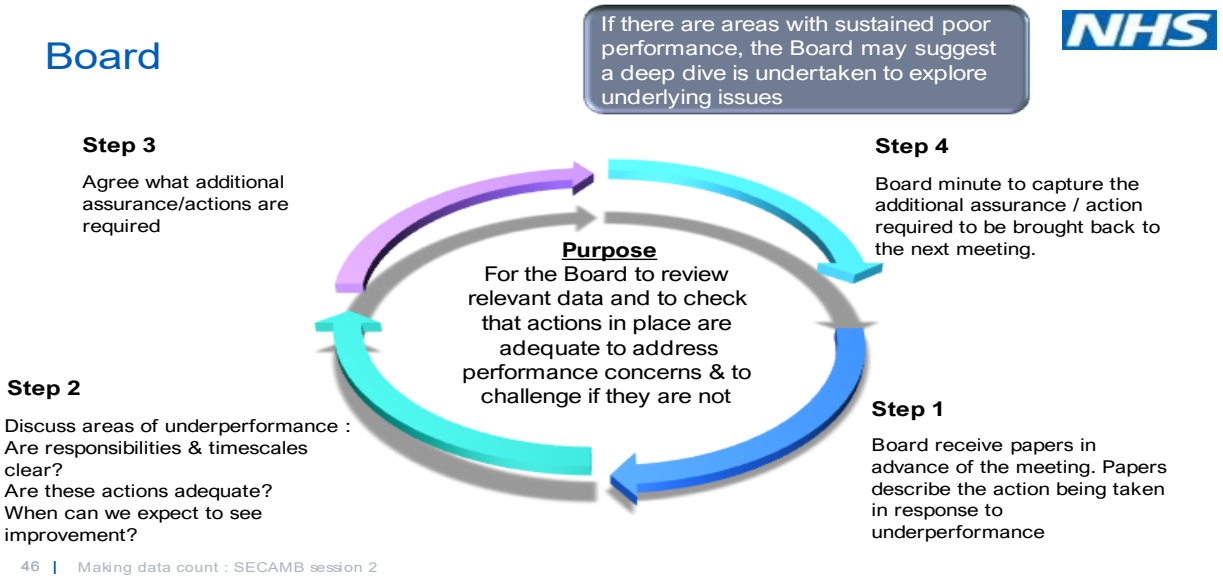
Key

- Not yet due
- Due
- Overdue
- Closed

		Item No	34-23
Name of meeting	Trust Board		
Date	03.08.2023		
Name of paper	Chair Board Report		
Report Author	David Astley, Chairman		

Board Meeting / Effectiveness

This is the second meeting since the revision to the Board Assurance Framework (BAF), which helps provide the Board with greater clarity on progress against the organisational objectives and the main risks to their achievement. The BAF together with the Integrated Quality Report are the Board's primary documents used to inform the Assurance Cycle and where there are gaps in assurance. This meeting will include (step 4) follow up, as captured in the Action Log and set out in the relevant Committee Escalation Report.



Since the last meeting of the Board the NHS Long Term Workforce Plan has been published. We have reflected the importance of this on today's agenda with a focus on staff wellbeing and retention.

I was really pleased to see the first cohort of staff graduate from the apprenticeship programme. This is delivered in partnership with the University of Cumbria, and is over a two-year period, as opposed to three years via the traditional undergraduate route [First SECAmb staff graduate from new Paramedic Apprentice Programme - NHS South East Coast Ambulance Service]

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 – Appendix 1.

Board Development

We covered three areas at our most recent Board development meeting in July.

1. Risk Appetite

The session facilitated by NHS Providers helped the Board to explore how it might adopt a different approach to risk management, with a focus on risk appetite and risk tolerance to enable a more rounded assessment of risk. The Executive Director of Quality & Nursing, and Company Secretary are following this up and will bring back a proposal to the next Board meeting in October.

2. Clinical Leadership

It was great to hear from our people about how they view clinical leadership. This will help inform our approach to the development of a new, clinically led, Trust strategy. Establishing a new strategy that ensures a sustainable future is the Board's number one priority.

3. Board Connectivity

We invited circa 20 of our operational managers to engage in a conversation about some of the challenges being faced and how we can work together to increase meaningful autonomy. This was a start of an ongoing conversation that will continue in September. The feedback included:

- A willingness for greater responsibility and accountability at local level
- A sense that autonomy already exists but the support and process to make it work is lacking
- A need for improved working relationships with other teams
- The link to supporting clinical leadership and development
- Work is needed to better define the role, and the roles within the supporting structures
- A need for investment in support services and infrastructure
- Simplifying the governance

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.

The Council of Governors last met in June when it explored the progress with the development of the Trust strategy, which it acknowledges will be critical to the future sustainability of SECAmb. Its areas of focus related to quality and performance is closely aligned with the focus of the Board and included the risks to delivering the efficiency programme and potential impact of this in terms of quality. There was significant focus on People & Culture and how we are supporting the wellbeing of our people and getting the basics right, such as management of ER cases, supervision and appraisals. These are all issues that the Board will be reviewing at this meeting.

This years' Annual Members Meeting is on Thursday 14 September 2023, at The Orchards Event Venue, New Road, West Malling, Kent, ME19 6BH. It will be an opportunity to not only reflect on the past year but to look ahead to how our stakeholders will be able to help shape SECAmb's future. Further details can be found on our website.

Engagement

I continue to undertake leadership visits, to hear from staff about what is working well and where there are challenges.

I attended a briefing with the NHS Chair and top team on the expectations for winter planning.

I have also attended meetings of the NHS Providers Board. I am the NED representative for Ambulance Trusts in England. NHS Providers represents the interests of NHS Trusts to Government, Regulators and the media. The Chief Executive of NHS Providers, Sit Julian Hartley is to visit SECAmb on 5th September to be briefed on our work.

As well as the usual round of Trust and NHS meetings I and the CEO met with the Surrey County Council Adults Health and Select Committee. The Councillor members actively support our work and represent the interests of their electorate. Our Partnership Team led by Matt Webb work hard to maintain strategic and operational contact with all the Councils we serve as well as ICB and other NHS partners.

Appendix 1

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 have been drafted (Appendix 2) for the Board's approval.
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.
Individual authors, the Chair and the Secretary to ensure papers adequately	This is ongoing, to ensure continuous improvement.

address the need to assess, monitor and drives improvements.	
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.

South East Coast Ambulance Service
NHS Foundation Trust

		Item No	34-23
Name of meeting	**Trust Board**		
Date	03.08.2023		
Name of paper	**Trust Board Terms of Reference**		
Author name and role	Peter Lee, Company Secretary		
One of the recommendations from the Board Effectiveness Review was to have Terms of Reference for the Board. Historically, the Trust has the Trust relied on the Standing Orders to provide a framework for the Board. These were deemed to lack the same clarity and, as they sit elsewhere, are less accessible to the Board membership. These draft TOR, which are consistent with the Constitution / Standing Orders, aim to provide improved clarity. They have been reviewed by the Audit Committee.			
Recommendation	For approval.		

South East Coast Ambulance Service NHS Foundation Trust

South East Coast Ambulance Service NHS Foundation Trust

Trust Board of Directors

Terms of Reference

1 Constitution

1.1 Established in accordance with South East Coast Ambulance Service NHS Foundation Trust (SECAamb) Constitution and Standing Orders, the Board of Directors is responsible for exercising all the powers of the Trust on its behalf. The Trust Board may delegate some of powers to a Committee of the Board or to an Executive Director.

1.2 The Board of Directors, in its capacity as Corporate Trustee, takes responsibility for the overall management and governance of charitable funds and any related fund-raising activity.

2 Purpose

2.1 The Board of Directors is collectively responsible for ensuring the quality and safety of the services, education, training and research delivered by the trust, and applying the principles and standards of integrated governance set out by NHS England, the Care Quality Commission and other relevant NHS bodies.

2.2 And for promoting the long-term sustainability of SECAmb as part of the ICS and wider healthcare system in England, generating value for all patients, service users, the public and members.

3 Membership

3.1 The membership of the Trust Board comprises:

- Independent Non-Executive Director Chair
- Seven Independent Non-Executive Directors, to include the Deputy Chair and Senior Independent Director
- Chief Executive Officer
- Chief Finance Officer
- Chief Medical Officer
- Executive Director of Quality & Nursing
- Executive Director of Operations
- Executive Director of Human Resources & Organisational Development
- Executive Director of Planning & Transformation

3.2 Members of the Board will each be entitled to cast a single vote on matters before it. Every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question.

3.3 No business shall be transacted at a Board of Directors' meeting unless at least two Executive Directors and two Non-Executive Directors are present.

4 Attendance

4.1 The Trust Secretary will have a standing invitation to the meeting of the Trust Board of Directors.

4.2 Other officers of the Trust and other individuals may be invited to attend meetings or part of meeting as required by the Chair and/or the Board for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter.

5 Meeting Frequency

5.1 Ordinary meetings of the Board will be held in public, at least bi-monthly. Dates will be scheduled on an annual basis.

5.2 As set out in the Constitution, additional meetings will held in private when business needs to be transacted which is confidential in nature.

6 Duties

6.1 Leadership and Culture

6.1.1 Ensure that there is a clear vision and strategy for the Trust which people understand and that it is implemented within a framework of effective control.

6.1.2 Set Trust values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with them.

6.1.3 Promote a patient-centered culture of openness, transparency and candour.

6.1.4 Ensure workforce policies and practices are consistent with the trust's values and support its long-term sustainability.

6.1.5 Ensure that SECAMB is an attractive employer through the development of an effective workforce strategy, overseeing its implementation and operation.

6.1.7 Implement an effective Board and Committee structure and clear lines of accountability and reporting throughout the organisation.

6.1.8 Ensure that there are appropriately constituted appointment arrangements for senior posts such as Executive Directors.

6.2 Strategy

6.2.1 Establish the trust's vision, values and strategy, ensuring alignment with the Integrated Care System(s) strategy. Ensuring decision-making complies with the triple aim of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

6.2.2 Set and maintain the Trust's Strategy, ensuring that the necessary financial, physical and human resources are in place to meet its objectives. Including how it will deliver against the NHS plan for delivering Net Zero.

6.2.3 Responsible for ensuring effective workforce planning aimed at delivering high quality of care.

6.2.4 Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

6.3 Quality and Performance

6.3.1 Ensure that the Trust's quality responsibilities for clinical effectiveness, patient safety and patient experience are achieved.

6.3.2 Monitor and review management performance to ensure the Trust's objectives. are met and identify opportunities for improving the delivery of high quality services

6.3.3 Monitor feedback relating to the experiences of people who use the services of the Trust and the processes for proactive engagement. Ensure that there are sound processes and mechanisms in place to encourage effective patient and carer involvement with regard to the review of quality of services provided and the development of new services.

6.3.4 Ensure that that the Trust engages with all stakeholders, including patients and staff on quality issues.

6.3.5 Ensure that there are sound processes in place to ensure compliance with, and awareness of, equality, diversity and inclusion standards

6.3.6 Ensure that the organisation promotes clinical research.

6.4 Finance

6.4.1 Ensure the Trust operates effectively, efficiently and economically to secure the continuing financial viability of the organisation

6.4.2 Ensure effective financial stewardship through effective value for money, financial. control and financial planning and strategy

6.5 Governance

6.5.1 Ensure compliance with relevant principles, systems and standards of good

corporate governance and has regard to contemporary guidance, and appropriate codes of conduct, accountability, openness and transparency

6.5.2 Ensure that the Trust complies with the requirements of its License, governance and assurance obligations in the delivery of safe, clinically effective services

6.5.3 Agree the schedules of matters reserved for decision by the Board of Directors

6.5.4 Ensure proper management of, and compliance, with, statutory requirements of the Trust and, ensures the statutory duties of the Trust are effectively discharged.

6.5.5 Oversee the effective management of the Trust Charitable Funds and ensure good governance and legal compliance in the areas of fundraising.

6.6 Risk Management and Internal Control

6.6.1 Establish a framework of effective controls that enable risk to be assessed and managed.

6.6.2 Determine the nature and extent of the risk it is willing to take in achieving its strategic objectives

6.6.3 Ensure that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements in line with the requirements of the Provider License

6.6.4 Ensure an effective system of integrated governance, risk management and internal controls across the whole of the Trust's clinical and corporate activities

6.7 Communication and Engagement.

6.7.1 Ensure relationships are maintained with the Trust's stakeholders, regulators, public, members, governors, staff and patients.

6.7.2 Meet its engagement obligations in respect of the Council of Governors and members and ensure that the Governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

6.7.3 Ensure the effective dissemination of information on organisational strategies and plans, providing a mechanism for feedback.

6.7.4 Hold an annual meeting of its members which is open to the public.

6.7.5 Approve and publish the Trust's Annual Report and Accounts, Quality Accounts and other statutory submissions

7 Reporting

7.1 The approved minutes and papers from all meetings held in public will be published on the Trust website.

7.2 The Board will receive escalation reports from each of its established Committees, after each meeting.

8 Review

8.1 The Board shall undertake a self-assessment on an annual basis and consider its effectiveness at the end of each meeting.

8.2 The Board shall review its Terms of Reference at least once a year.

Version	1.0 Draft
Author	Company Secretary
Approved by	Trust Board of Directors
Approval Date	
Next Review Date	

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	35-23

Name of meeting	Trust Board
Date	3 August 2023
Name of paper	Audit & Risk Committee Escalation Report – 20 July 2023
Author	Michael Whitehouse, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 20.07.2023.

Internal Audit Progress Report

There was good assurance on the Data Security and Protection Toolkit. This is a mandated framework for all NHS providers and the conclusion is that we have by in large all things we should have in place to ensure good data security and information governance.

There is however still a gap in assurance related to our IT resilience, as reported previously to the Board and the committee welcomed the external review that is about to start.

The committee also reviewed the outcome of a review it requested related to purchasing and procurement. Some internal control issues have been identified related to the process of receipting good and services, which management are addressing. The Committee expressed some concern over this and whether it presented a control weakness and asked the Chief Finance Officer to form an overall assessment of the financial control environment and report back to the Committee in December.

The Internal Audit Plan for the year was amended following a review by the CEO, to ensure it aligned more closely with the priorities. The committee supported these amendments.

Counter Fraud

While overall our Local Counter Fraud Specialist is reasonably assured with the controls in place (SECAmb achieved an overall rating of Green re the Counter Fraud Functional Standards Return), the committee remains concerned with some aspects, in particular related to timesheet recording and working while sick. The executive has been asked to provide further assurance at the next meeting in September.

Risk Management

The committee has increasing assurance with the progress for embedding our risk management processes. The risk report received was much improved and the committee noted a real step-change in how this helped to focus the discussion on the underlying systemic risks.

There was a discussion about the recent Board workshop and the committee looks forward to reviewing the proposal for a new approach to risk appetite.

Policy Management
Good progress has been made in reducing the backlog of overdue policies. However, work is needed to rationalise the policies in place to ensure they are fit for purpose and support delivery of our objectives. The committee will continue to monitor this until it is fully assured that the design of this internal control is embedded and operating effectively.
Other matters
The committee received a paper related to Digital Support and the work to undertake a review of our resilience. It also noted the changes to the Provider License, and supported the Board Terms of Reference, which it recommends to the Board for approval.

Specific Escalation(s) for Board Action	The committee does not require specific intervention from the Board at this time, but asks it to note the areas of concern that the committee will keep under close review.

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

Item No	36-23

Name of meeting	Trust Board
Date	03.08.2023
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 June and July 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:

- Close monitoring of our financial plan for the year and the progress of our Efficiencies Programme
- Driving the process to develop a new Trust Strategy
- Scrutiny of our Culture Programme and the progress being made

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**
We were pleased to welcome our new Chief Finance Officer Saba Sadiq to SECAmb, who joined us on 3 July 2023. It's great to have her on board as part of the team.

7 Thank you to Charles Porter for his support as Interim Chief Finance Officer during May and June ahead of Saba's arrival.

8 **Priorities**
As the Board meets, I will have completed just over 100 days in post. It is right that at this point, I reflect on what I have heard and set out my priorities for delivery. I

think it is important to contextualise these priorities with two points. First, whilst these are my priorities, they are based on the feedback I have heard from wide engagement (see below) I have done in the organisation and with partners. Clear messages emerge from that engagement and are reflected in my objectives. I have also tested these objectives with colleagues, and they have been endorsed.

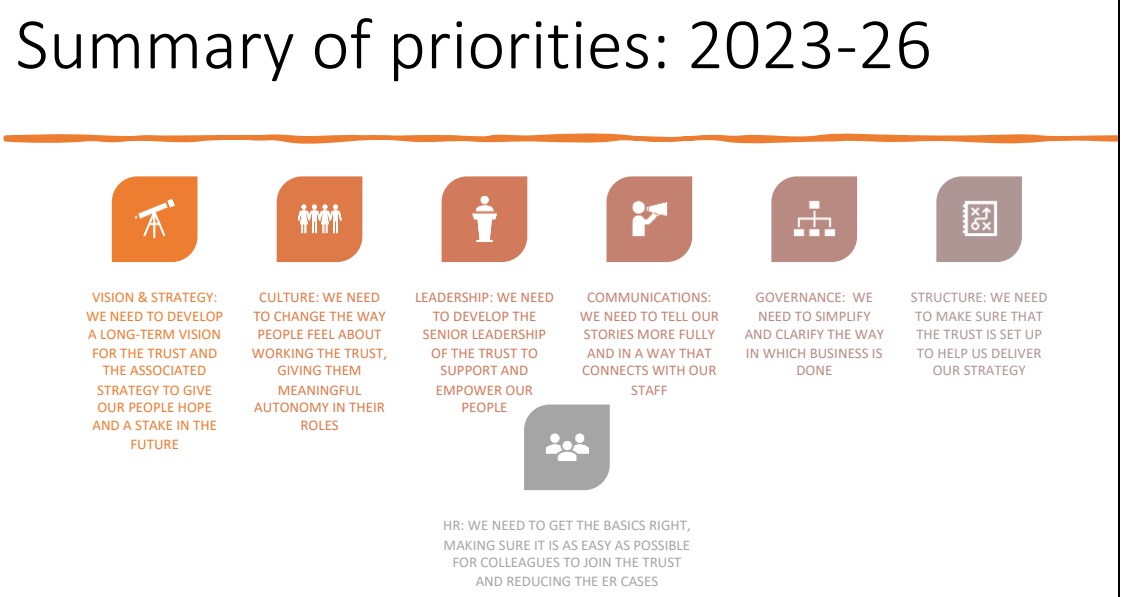
9

Secondly, although what I set out here today has a necessary linkage to the need to make progress in our Recovery Support Programme (RSP) trajectory, the nature of these objectives is that they will take time to deliver. I recognise – and I know the whole Board does – that the cultural change that we are embarked on takes several years to deliver. It is essential to be both ambitious in our aspirations and realistic about delivering progress that is sustainable.

10

So today, I set out seven priorities that I believe that will deliver the sustainable changes SECAMB needs:

11



12

Beneath each of these priorities is an analysis of current state and an associated set of deliverables and outcomes. Work is underway now in each of these areas:

- We have appointed a partner and will begin work on our strategy in August
- We have begun the process of developing our teams with a particular focus on developing local autonomy
- We have agreed a leadership development programme which we expect to roll out from September
- We will invest further in our comms function to make sure we reach all our colleagues consistently with news that is relevant to them
- We have made improvements in our BAF and approaches to risk management
- In September, I will complete a review of our senior structures to make sure the Trust is positioned to implement its strategy effectively

	• We have invested in our ER team so that we can bring down the number of cases we have
13	In summary, priorities for this year – absolutely. But equally importantly guide posts for the coming three years.
14	**Engagement** I am continuing my programme of visiting as many of our sites as possible and have continue to enjoy spending time meeting teams and hearing from colleagues about what is important to them.
15	During June and July, I have visited Chertsey, Banstead, Tongham, Guildford, Medway, Thanet, Sheppey, Thameside and Dartford and intend to continue this approach. These visits have been a source of invaluable feedback and insight into the opportunities and challenges SECAmb faces. It was an especial pleasure to be present at the reopening of Chertsey, almost a year to the day after the flood. Huge thanks must go to Jo Crerar for her leadership during this time.
16	I have also continued to spend time with a number of our key regional and national system partners including amongst others, the Chief Constable of Sussex Police, St John's Ambulance and Wes Streeting MP, as well as attending meetings of the Surrey Heartlands Delivery Oversight Group, the Sussex ICB System Oversight Board and NHS Providers Chair and Chief Executives Network meeting.
17	As a regional provider I was also very pleased to meet with our ICB CEOs together. This was an important conversation as it allowed me to test my emerging priorities with them. I am pleased to say they endorsed the analysis I presented.
18	I am also pleased to have hosted two 'Big Conversations' so far - online sessions, to which all colleagues are invited, and which provide a good opportunity to discuss a key issue. The sessions so far have focussed on our aspirations and hopes for the NHS in the future (as part of the NHS 75 events) and, most recently, the development of our Trust strategy.
19	Both sessions have been well attended, with good contributions from a wide range of colleagues. The 'Big Conversations' will continue on a monthly basis, with future topics including speaking up, leadership and how we are getting things right for our people.
20	**Investment in TRiM (Trauma Risk Management)** I am pleased to share that as part of our commitment to getting things right for our people and to support their wellbeing, we are investing £40,000 per year over two years into our TRiM support for colleagues across the Trust.
21	TRiM helps to identify risks for people who may suffer poor mental health following traumatic experiences. SECAmb is considered nationally to be one of the NHS Trusts who has been most successful in its implementation, however we have previously expected colleagues to train and provide TRiM on a voluntary basis.

22	Providing specific funding will enable us to build on and embed our previous success and develop a sustainable, long-term approach for TRiM provision.
23	**IT Resilience** Following issues with the resilience of our Computer Aided Dispatch (CAD) system during June, we have commissioned an external review of our IT infrastructure which will begin shortly.
24	The review, which should take three months to undertake, will consider our operational response to CAD outages and the resilience of our infrastructure, as well as any resource and investment implications for us to address.
25	**Increasing use of body worn cameras** I welcome the fact that, in June, we agreed to extend the availability of body worn cameras for frontline crews as we continue to explore the use of the devices and their impact on reducing violence and aggression towards our teams.
26	The cameras, which are for voluntary use by colleagues, will be available across all our reporting sites and are aimed at reducing occurrences of violence and aggression towards ambulance crews. They can also capture evidence to hold individuals responsible for their actions alongside vehicle and building CCTV.
27	The cameras are just one way in which we are looking to reduce violence and aggression towards our people. Other work includes support and advice provided to colleagues when they are subjected to violence or aggression, review of training and the welfare support that is available.
28	**Development of our new Trust Strategy** One of our three key priorities for the year is to develop a new, clinically driven Trust Strategy, which will shape and frame what we want to achieve as a service during the next five years. We are aiming to develop an initial draft Strategy by December 2023, with final sign off by the Trust Board in February 2024.
29	The development of the Strategy is starting in earnest this month, including engaging an external partner to support us and will use all of the feedback we have received during the pre-engagement phase during May, June and July to help us build and develop.
30	Ensuring there are extensive opportunities for engagement from our people, our partners and our patients is vitally important for us as we move through the process and I look forward to this work continuing at pace during the remainder of the year.
	B. Regional Issues
31	**Go live of new operational centre at Medway** I was very pleased to see both our field operations (on 8 June) and our 111 teams (on 28 June) move into our new, multi-purpose ambulance centre in Gillingham during the month, after many months of preparatory work and investment.

32	The feedback from the teams based at the new centre has been positive so far and, having visited the centre myself, I was incredibly impressed with the facilities, which provide a real improvement on the outdated facilities at previous sites.
33	We remain on track for EOC colleagues, currently based at the Trust's control room in Coxheath, to begin relocating to the new centre later this year and I am very much looking forward to seeing the new centre in full use then. Thank you again to everyone involved in delivering this significant project.
34	**Medicines Distribution Centre** Our Medicines Distribution Centre, based at Paddock Wood, is currently subject to a number of risks and this is of concern not only from a patient safety perspective but also as a suitable place for our colleagues to work from.
35	I am committed to finding a solution quickly, as this is not a position we should tolerate any longer than is necessary.
36	There are a number of options being discussed currently, including the re-location of the Centre and I will provide an update as these progress.
37	**External review of HART/SORT/Resilience** Following some issues raised, I have commissioned an external review into the Resilience and Specialist Operations department, as well as the levels of compliance with national standards in this area.
38	Colleagues will have the opportunity to provide input into the review, the outputs of which will enable us to ensure we have a sustainable and properly funded model.
	C. National Issues
39	**Successful bid for additional national funding** I am very pleased that, working to very tight timescales, we were successful in bidding for £2.5m of additional funding from NHS England to support improvements in Category 2 performance.
40	During the next three months, the additional funding will be used to: • Increase 999 call handling capacity • Increase clinical capacity in the EOCs to support an increase in Hear & Treat • Increase field operations capacity
41	The approach to deliver the operational use of this additional funding is currently being finalised by the Senior Operations Team.
42	**NHS 75** I was proud to see the NHS's 75th anniversary marked and celebrated in a variety of ways across SECAmb and the wider NHS in early July.
43	It was great to see the Trust represented at the special Westminster Abbey service on 5 July and also earlier in the week at a celebration service at Rochester Cathedral.

44	Colleagues appeared in local news features marking the anniversary and it was great to see colleagues from Crawley join in the special NHS parkrun event where they pushed an ambulance trolley around the 5km Tilgate Park course – well done all.
45	It was also fantastic to see the results of a call-to-action from Hastings Operational Team Leader, Neville Bettley, which saw more than 100 local staff and volunteers, past and present, gather for a photo. With a further 156 individuals added to frame the final photo, and more than 4,000 years' service represented, it really brings into focus the numbers of people involved in providing compassionate and expert care in just one small part of our region.
46	I would like to formally place on record my thanks to each and every individual, across the whole of SECAmb, whatever their role, for their continued hard work and dedication over so many years.
47	**National Ambulance LGBT+ Conference/ NHS Confed Expo 2023** On 15 and 16 June, I was delighted to attend the National Ambulance LGBT+ Conference in Manchester, together with a number of colleagues from SECAmb.
48	The theme of this year's Conference was Intersectionality+ and I found the topics covered during the Conference illuminating and thought-provoking. I learnt a great deal and although I think we all still have much to learn, it's clear that our challenge is to understand the complex ways in which someone's identity is made up and how, as we do that, we create a supportive environment for everyone to work in.
49	Congratulations to Tony Faraway from our Pride in SECAmb Staff Network who was recognised during the Conference for his unfailing commitment to keeping the network going during the challenges of the COVID pandemic. Well done Tony.
50	Whilst in Manchester, I was also able to join some sessions at the Confed / Expo, the NHS national conference. This provided a useful opportunity to hear the latest national policy thinking and a chance to hear in person from Steve Barclay, the Secretary of State for Health, who gave an update on the annual NHS mandate, published that week.
51	The big theme overall at this year's Conference was the digital tech agenda. Not only was it a key strand in the presentations from the main speakers, it also dominated the content in the exhibition stands, re-iterating our commitment to ensuring this is a key building block in our emerging Trust Strategy.
52	**NHS Long Term Workforce Plan** On 30 June 2023, NHS England published the first comprehensive workforce plan for the NHS. It focuses on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history.
53	The NHS Long Term Workforce Plan 2023 covers a 15-year assessment of the workforce that will be needed for the future and provides a costed plan of how we develop the current NHS workforce to meet existing and future demand and

	challenges and support the health and wellbeing of the population. Over £2.4 billion has been committed to fund additional education and training places over the next five years, on top of existing funding commitments.
54	The plan sets out the strategic direction for the long term as well as short- to medium-term actions to be undertaken locally, regionally and nationally. Those actions fall into three priority areas: • Train - substantially growing the number of doctors, nurses, allied health professionals and support staff • Retain – embedding the right culture and improving, with better opportunities for career development and improved flexible working options. • Reform - working differently, and delivery training in new ways.
55	This is a key publication and it's imperative that we carefully consider our response to it through the development of our own long term workforce plan as part of the development of our new Trust Strategy.
56	**Visit by Chair of NHS England** On 31 May 2023, we were pleased to host Richard Meddings, the Chair of NHS England for a day at SECAmb. Richard lives in our area and was keen to spend time learning more about how ambulance services work.
57	During his visit he spent time in EOC and in 111 at Crawley before joining a double-crewed ambulance in the Gatwick Operating Unit.
58	I know he really appreciated spending time with us and the openness and honesty of all the colleagues he met so thank you to all those involved.
	D. Escalation to the Board
59	**Operational Performance** The performance of all ambulance services nationally remains challenged and both 999 and 111 demand remains inconsistent, including the impact of industrial action in other parts of the NHS.
60	We continue to work hard to ensure that we provide as responsive a service as possible to our patients and continue to perform reasonably well compared to our peers nationally, although no Trusts are currently achieving the national response time targets.
61	As reported in section C of my report above, we have secured additional national funding to support improvements in our Category 2 performance for the next three months and the plan to make best use of this resources is being developed and led by Emma Williams and the Senior Operational Team.
62	We moved to REAP Level 3 on 16 June 2023 but continue to keep this under close review.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	37-23

Name of meeting	Trust Board
Date	03.08.2023
Name of paper	Board Assurance Framework (BAF) 2023 24
Author	Peter Lee, Company Secretary

This is the second version of the new BAF, which sets out progress with the in-year corporate objectives and related risks, in addition to the longer-term strategic risks. Its aim is to help the Board's assessment of progress against the agreed strategic priorities of the Trust.

At its development meeting in July, the Board agreed in principle to adopting a different approach to risk appetite. A proposal will come back to the Board on 5 October, via the Audit & Risk Committee.

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

Quality Improvement		
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**	
People & Culture		
Goal 1	**Getting our foundations right consistently**	
Goal 2	**Making internal processes effective**	
Goal 3	**Improving the experience of our people**	
Responsive Care		
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**	
Sustainability & Partnerships		
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 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.

Specific aspects of the BAF are highlighted by the relevant Executive Director in the cover paper for each agenda item.

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' in 23/24 Provide QI team support, coaching and facilitation to at least 5 local QI projects in 23/24	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:

The Keeping Patients Safe in the Stack QI project is progressing as expected and is aligned with the project plan. The project team have completed the Define, Measure & Analyse phases of the DMAIC process. Papers are now being completed for approval to implement the identified improvements to achieve the following objective:

- Reduce the number of duplicate calls the service receives.
- Reduce the time spent on closing duplicate calls.
- Reduce time spent on welfare calling.

The aim of these improvements is to reduce non-value adding activity, reducing cognitive burden, and allowing clinicians time to identify and support patients most at risk of harm.

Following review by QPSC in June 2023 and extensive stakeholder engagement, the QI Strategy for 2023-2025 has been completed and has been submitted for sign off by the Board – see separate paper.

The full QI team have now commenced in the Trust and are supporting across the organisation. Year to Date, we have trained 113 colleagues in 'Introduction to QI'. Training evaluation suggests that this is significantly improving people's motivation, confidence, and competence in QI. This is being evidenced in requests for the team to support 7 local QI projects across the Trust.

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	None			

Mitigation

N/A

	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 SLT of the Operations directorate, 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 end of Q2 Regional Incident review groups by end of Q3 Training programme in place for and attended by core facilitators.	Q3
	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 **Green** because

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

Progress to-date:

QI 4:

- ✓ Patient Safety Oversight Group (PSOG) established and TOR with stakeholders for approval (the PSOG is the Central Incident review panel).
- ✓ Trust patient safety priorities identified, and full plan will be presented to Board in Q3. The plan is currently with key stakeholders and will be shared at QPSC in August.
- ✓ National standards for training and competencies established and paper being presented to Education Training and Development Group in August. External provider will be required at a cost to the Trust.
- ✓ Trust wide comms and engagement plan being prepared for launch in September that include webinars, printed materials, and inclusion on the 'Big Conversation'.
- ✓ Agreed on continued BI analyst to support the analysis and identification of learning themes.

- ✓ With an MDT have set out membership and agenda for systems-based Incident review groups that replace centralised SIG. TOR being reviewed

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.

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) Quality & Performance Reviews at dispatch-desk level underway in Q1 – review effectiveness Q4 System-level Quality/Clinical Lead identified and in place by end of Q3 Quality & Clinical Governance Group relaunched in assurance-focused format in September 2023, for formal evaluation in Q4 All five elements in place, connected and functioning by end of Q4	Q4
	QI 8	**A Quality compliance and Engagement 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 by Q3. Quarterly assurance reports to EMB	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:

QI 7:

- Data and KPIs for Field Operations and EOC agreed.
- Field Operations model is live and is already in use by operational teams (in line with plans aiming to go live in June)
- First iteration of the EOC quality report has been developed and made available to EOC teams (in line with plans to follow Field Operations in July)
- Second iteration of the field operations quality report has been developed and expands upon the available metrics.
- Worked in partnership with Partnerships, Quality & Nursing, and Operations team to develop an integrated Governance oversight model across Regional and System levels. The model was approved at EMB in May and has been shared with commissioners through SAM, ICS Quality Collaborative and ICB CEOs.
- Agreed plans now in place for reformatting the Trust-wide Quality & Clinical Governance Group (QCGG) integrating Clinical, Operations and Quality in assurance across the KLOE
- Identification of Quality & Clinical Leads for each System-based QCGG is still to be completed – Exec Directors of Q&N, Medical and Ops aligned to achieve this. This does not affect the timelines to plan **but is a potential risk.**
- Workshop held with key internal stakeholders to develop the QAF with successful outcome of progressing each element, and gaining agreement on Clinical and Quality governance leadership, and the model for system-based groups linked to PSIRF IRGs.

QI 8:

- Four successful visits have now taken place since commencement in April to Banstead, Chertsey, Thanet, and Worthing with very positive evaluations from staff and visitors alike.

Two-way feedback delivered within two weeks to OUs for further dissemination and setting of corrective actions that then feed back into monthly Q&P reviews.

- Further co-design changes made to the format of the QA&EV receiving positive evaluation from all staff and visitors.
- Full year's programme plans now out with Directorates, commissioners and to be shared with Council of Governors to identify visiting groups in advance.
- 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.
- Members of the team to visit each unit on QA&EV have primarily come from Q&N directorate – more robust plans being established now to identify staff from across all Directorates, interested commissioners and members of the CoG in order to identify cross-section of teams well in advance of each visit.
- The model for feedback to corporate functions in a systematic way is delayed due to transition of leadership but is being developed now.

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. BI have dedicated 2 WTE of senior analyst resource solely to this work.				
		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 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. Work with Directorate BSM to identify a cohort of 6-7 visitors for each of the visit days in advance.				

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	Q3
	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 developed and new space created on Staff Zone.

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

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. – to commence in Q2.

In Year Risks to achieving the objectives					
Goal 2		**Risk Description**	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	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
PC12 - First mediation meeting held in June.

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 approved and recruitment of team commenced				
		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 21mins 28secs (June).
- RC2: Call answering mean 33 secs (June).
- RC3: Mean activity on own dispatch desk 100.1%, with a maximum variation of 22.4%, down from >50% in the previous report.

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 (88.15% hourly compliance).
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 18sec (137.5 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	Hear 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	TBC	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 6.2% to 19.2%).
- 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.
    - Reduction in RPI through CCD review of resource allocation versus likely clinical need, particularly for C1 calls
    - 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
    - Improved efficiency by reducing scene time where there is a CCP present (exception – cardiac arrest, EoL, entrapped
- 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.

In Year Risks to achieving the objectives					
Goal 2		**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
	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 4.3% with variation from 3.0% to 5.9%
  - LSO performance has shown an improvement on Jan-Mar due to better balance of demand v resourcing.
- RC8: EOC and the MRC have now successfully moved to the new Medway site. EOC still on track to move in September.
- **RC9 (rated green)**: 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.
- NHSE Procurement through the national fleet group has developed a procurement framework which will give Ambulance providers a broader range of choice of suppliers, vehicle builds (van and box), and also give us a route to procure zero-emissions DCAs. This is due to complete in October 23, in time for our fleet strategy refresh due in November 23 which will include a preferred vehicle following our engagement with colleagues. Further update to be provided at the December 23 Board once the process has finalised, in time for orders being placed by end of Q4 in line with our normal replacement cycle.

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	4x1 = 4	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. (Update August) NHSE have confirmed there will be an expanded selection of available fleet to procure through the national procurement framework, and we now do not expect to require derogation from our commissioners to secure the fleet that is fit for purpose for our people and our patients.			

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 (Update August) The scope for the Clinical and Quality Strategy has been included as part of SP2 and the development of a clinically led Trust-wide strategy.	~~Q2~~ Q4
	SP 1	**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 **Green** 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. Previously this was reported Amber, pending the procurement process and resources being in place to deliver in time. We have now indicated a preferred bidder following an engaging and inclusive selection process and expect to complete contract award by end of July.

The programme has been revised at the advice of the core team and stakeholders involved in the tender evaluations to finalise in February, with an initial draft in December, to allow for possible challenges through the winter period and ensure quality engagement can be done through the programme.

Progress to date:

- Extensive engagement has been completed with multiple key stakeholder groups. All of their input has been incorporated into the tender specification, and we have written back to all groups explaining the preferred bidder selection and the strengths of the programme we are planning in line with their inputs.
- Key Groups engaged so far:
    - Councill of Governors
    - Board
    - Senior Management Groups
    - All directorates (pending finance which is scheduled)
    - Volunteers
    - OUMs (Field Ops and EOC)
    - Staff Networks
    - Trade Unions
- ICBs (lead and associates)

Programme to start at the end of July with a draft for December 23 and final approval February 24.

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	3X2=6	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	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

In year progress with the achievement of the Strategic Goal is **GREEN.** The new governance arrangements have been shared and approved by EMB and the system. 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 (patient flow group).
- 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:

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?

- Review of the governance model and align internal and external governance to ICS, around Quality and Patient Safety. This includes a review of the contract review meetings, strategic commissioning board, and SAM arrangements.
- Go live of the new model

SP5:

- No plans in Q1
- Plans in Q2 and Q3 are to develop the long term workforce plan as an output of the Strategy development, working back from the patient needs and the target operating model.

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

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

In Year Risks to achieving the objectives	Goal 2	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
	SP3	There is a risk we can effectively measure improvements due to data limitations	4X3=12	4X3=12	4X2=8
	Mitigation				
	The current data remains a limitation. Current datasets show very low utilisation levels, and provide us with a baseline starting point - UCR is <1% of outcomes - 40-50% of our total Hear and Treat are referrals to alternative non-ED pathways - Only 10% of our S&T activity is to alternative pathways. The working group is mitigating this by working closely in alignment with the Ambulance Dataset (ADS) programme which should provide better patient flow end to end data by September. In the meantime, we will provide further assurances to Board by integrating the details from the Community Dataset into our IQR by system, so that the Board have visibility of the performance at a granular level.			
		Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	SP4	There is a risk that the governance of the system does not support SECAmb in delivering it's objectives	4x4 = 16	4x3 = 12	4x2 = 8
	Mitigation				
	A proposal for the updated governance model has been developed between the lead ICB and our partnerships team. This has been delayed due to uncertainty around the move from Surrey Heartlands to Sussex, and the work is not progressing with the assumption that the move will not happen soon. Parts of the model have gone live, and we will be adopting further changes in Q2, starting with SAM, and then progressively re-establishing the Strategic Commissioning Board as a mechanism to engage system partners in the Strategy development. Full alignment to the external governance model can only happen once our operating structure has aligned to Kent, Surrey (+Frimley), and Sussex. A timeframe for this has now been set to end of Q4, as this will be a key output of our strategy to ensure we are aligned to our ICBs in the best way to deliver the emerging vision for the organisation.			
		Risk Description	**Initial Score**	**Current Score**	**Target Score**

			C + L	C + L	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
The Green Plan has been completed and presented at FIC in July 23. Key interventions for de-carbonisation this year are included in the plan and in Q2 we will be establishing the internal governance oversight required to ensure we deliver the plans in line with approved plan. There remain significant risk due to the un-funded nature of the plan, and we will be incorporating the expenditure and investment required to support our de-carbonisation targets as part of the 5-year financial modelling associated with the strategy

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 (reviewed at FIC in July). 63% 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			May 22	Aug 22	Sep 22	Dec 22	Feb 22	Apr 23	June 23	Aug 23			
14	*Operating Model*	QPSC	-	-	1-3	1-3		20	16	16	20	20	20	20	20	20	⇔	08	Mar 24
255	*Workforce Plan*	PC	-	-	1-3	1		20			16	16	16	16	16	16	⇔	08	April 24
348	*Culture & Leadership*	PC	-	1-3	-	-		16				16	16	16	16	16	⇔	08	Tbc
16	*Financial Sustainability*	FIC	-	-	-	3		16	12	12	16	16	16	12	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 The People and Culture Strategy makes a commitment to reduce TTH and onboarding to achieve the 60 days target as one of a number of priority areas identified for people and cultural change.	**WF-1** "Number of Staff WTE"		
	WF-3 "Time to hire"		
	999-12 "999 Frontline Hours Provided %"		

Gaps in Control
Funding for international recruitment ends in Sept 2023 Clinical Education Resourcing

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

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**
A Quality Improvement project to improve TTH and onboarding	Director of HR	TBC	Commenced on 23 May 2023.
Clinical Education resourcing plan for 2023/24	Chief Medical Officer	TBC	Phase 1 agreed by 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:** **March 2024**

Underlying Cause / Source of Risk: Our operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need, and there is a risk that 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**
The current model: •Does not support clarification as to what the function of an ambulance service is in the post-Covid environment, including its role/interaction with the UEC pathway. •Does not meet contractual (ARP) response times with the current workforce – any increase in staffing levels is not realistically deliverable in the current financial envelope and considering the wider workforce economy in the South-East. •Cannot respond to the need for differentiated care to different patient groups/needs. •Does not allow the Trust to provide a clear direction to our people in terms of career development and workplan delivery, causing morale and well-being issues. The focus for the 2023-24 financial year is on the four IQR metrics listed to the right (with hospital handover time used in addition to hours lost). A plan for delivering these metrics has been developed and submitted to NHSE and commissioners.	**999-1** 999 Call answer mean		
	999-9 Hear and Treat		
	999-4 C2 mean		
	999-24 Hours lost at hospital handover		

Gaps in Control
Strategy in development

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
In-year delivery plan (+) Strategy development (+) Delivery of actions associated with the additional monies award Aug-Oct may support further bids for extra recurrent budget as part of the National Ambulance uplift (+)	Longer term recurrent overall budget right-sized to meet the organisational need in light of strategic, regional and national ambulance service requirements (-)

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

Trust strategy under development – following the completion of this a delivery plan will be drawn up that will fully address this BAF risk going forward. This will include a clear purpose for the service, a target clinical delivery model to meet that purpose, and associated workforce and delivery plan (5yr horizon) to deliver that vision.	Exec. Dir. Strategy & Transformation	Q4	Initial scoping underway ahead of formal appointment of consultancy partner to assist in the development of the Trust strategy. Programme due to start by end of July and extensive pre-engagement completed.
In year actions related to the UEC Recovery Plan, focusing on the KPIs listed above.	Exec. Dir. of Operations	Q4	Call answer remains challenged due to significant ongoing staffing issues. Delivery against plan for the other metrics are on track.
As of 21/07/23, the Trust was successful in bidding for an additional £2.5m for use during Aug-Oct, focusing on call answering, EOC Clinical and Field Operations provision.	Exec. Dir. of Operations	End Oct 2023	Plan implementation commencing 24/07/23.

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. Review in June in the context of EPS – see Escalation Report					
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 June 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 July - see Board Escalation Report. Related Board Seminar scheduled for 3 August 2023 too.					
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 June Board Escalation Report.					

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 July evaluation against the RSP exit criteria is provided below, and it's now an agreed position with our lead ICB and NHS SE Regional team. A target date for exiting is now set to the 31st of March 2024, and will also be contingent to a clear strategy which will focus on achieving long-term sustainability for the Trust.

RSP ref.	Requirement description - The trust must:	Position Statement	SECAmb Progress View (July)	Change
RSP-L1	Interim CEO appointed and the Trust's Board-level leadership seen as stable.	**Achieved**: Substantive CEO in place. Interim arrangements in place. **Plan to exit**: Development of a Trust-wide strategy will create a clear vision which will support SECAmb become more resilient to changes at Board and Executive level. Executive structure to be reviewed in Q3/4 to support delivery of the new Strategy.		↓
RSP-L2	Clear lines of responsibility and accountability for individual executives.	**Achieved**: Portfolios re-arranged in Q4 to support interim executive arrangements. **Plan to exit:** As above 01. In addition, executive development plan is a priority for 23/24 to support resiliency and clarity of individual roles and accountabilities, as well as strengthening unitary team approach.		↓
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.	**Achieved:** Annual plan and objectives have clear SMART objectives and milestone deliverables that are embedded within a new BAF that drives the cycle of business for the Board. **Plan to exit:** Further work required to fully embed strategic risks (which will emerge from the strategic planning process in Q3/4), and evidence that the Board is dynamically managing risk. This is being supported in the Board Development plan with a facilitated session by NHS providers on 6 July.		=
RSP-L4	Improved communication and engagement channels between the frontline and the Board, inclusive of	**Achieved:** Improvements in communication channels and accessibility for our people. Development of a Communications and Engagement Strategy with external support. Embedding leadership visits, quality and performance management and quality assurance visits have now gone all live.		↑

	routes of escalation for risks and concerns.	**Plan to exit:** Embed improvements, resource appropriately to support impact to frontline, and further development of a clear identity and brand for the organisation as part of the strategy development. Resourcing plan due in Q2. Embedding of quality assurance frameworks.		
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 and SECAmb as part of the improvement journey evidence framework to avoid duplication	**Achieved:** Arrangements for evidence and data sharing in place since July 2022. **Plan to exit:** Increase further transparency with system partners by aligning key areas of focus for the remaining 9 months with a joint forward plan and invite support from system SMEs into internal weekly steering group.		=
RSP-L6	External Well-Led review co-commissioned and all key recommendations acted on effectively.	**Achieved:** Review of Board effectiveness and Well-Led conducted by NHSE Improvement Director in Q4 22/23. All actions and recommendations have been adopted and are being monitored at the relevant committee and Board and are part of the Board Development Plan for 23/24.		↓
RSP-L7	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	**Plan to exit:** Embedding of recommendations, sharing of the development plan with system partners for visibility and input, and agreeing external WLR timeframes closer to the planned exit date of March 24.		↓
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.	**Achieved:** Robust plan in place with clear mechanism for oversight of progress through weekly steering group, and collation of evidence and alignment with internal Quality Compliance Assurance. **Plan to exit:** Embed Quality Compliance Assurance as Must-Do's get delivered to ensure future risks and issues can be identified through the risk and quality governance of the organisation as part of "BAU"		=
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.	**Complete:** Quarterly milestone plan for each RSP and Must-Do is in place. There is a clear understanding of the deliverables and measurables, and a weekly internal steering group that oversees progress and supports teams delivering improvements across different areas. This is attended by the executive team and there are bi-monthly updates to the Board and System partners.		↑
RSP-Q2	Improved Board oversight and clarity on safety and quality metrics, ensuring there is good triangulation	**Achieved:** Significantly improved internal reporting to Board through re-vamped integrated quality reporting across quality, people, performance and finance. Place-level		=

	between demand and capacity issues driving ARP challenges, and the impact on patients and staff.	(service line) integrated quality reporting developed to support new Quality and Performance management framework and Quality Compliance visits. **Plan to exit:** Embed full quality assurance cycle by Q3		
RSP-Q3	Trust F2SU policy/process has received board assurance and oversight and has been appropriately resourced.	**Achieved:** FTSU team has grown from 1 to 3, extensive internal training and engagement (including Board), and Speak up Policy in consultation stage in line with National FTSUG guidance. Significant improvement to access to data, being used to understand hotspot areas and take action. **Plan to exit:** Impact of actions taken not yet felt and psychological safety to Speak Up is a key area of focus in the Culture Improvement plan and People Strategy. Significant leadership development of first line and middle management planned for this year to support our people in resolving concerns locally.		=
RSP-P1	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	**Achieved:** Significant step up in leadership visibility and increased response levels to Pulse Surveys. However, no impact observed due poor 22/23 results. **Plan to exit:** Culture Improvement plan includes targeted action to address c. 40 specific issues identified by our people and aligned to the new People and Culture Strategy. Focus on a renewed clinically led Trust-wide strategy and significant engagement through that process expected to support improvement, providing our people a clear story of who we are and where we want to go.		=
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.	**Achieved:** Workforce plan for core services clearly understood by skill mix, and included in our plan for 23/24 as part of the UEC Recovery programme. Plan is on-track for field operations for recruitment and training, however, there remain risks in Call Centres due to a site move and retention challenges, impacting call handling times. **Plan to exit:** System review of WF plan for 23/24 will inform what the deliverables of a long-term workforce plan looks like as a result of the wider organisational strategy, contributing to a system workforce strategy and in line with the NHS workforce strategy.		=
RSP-P3	Trust career development and career pathways strengthened in line with the Board-approved clinical education strategy.	**Achieved:** Since BRAGG agreed, phase 1 of our Clinical Education investment programme has been approved. **Plan to exit:** Challenges to support clear career pathways step from the lack of a vision for the workforce. Phase 2 of the investment is expected to match the needs of the workforce plan once it's developed by Q4 as part of the Trust-wide strategy.		=
RSP-P4	Trust not an outlier with ambulance service peers for staff retention or sickness absence.	**Achieved:** Sickness levels significantly decreased from 11% to 7% Y-o-Y.		↑

		Plan to exit: Benchmark data is being developed by our BI team working with national Model Ambulance NHSE team for more robust comparator data.		
RSP-P5	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	**Achieved:** HR reporting improved with clear understanding of ER caseload and challenges. Re-structure underway to create dedicated ER case management team. **Plan to exit:** Red rating remains as Trust has excessive >190 open ER cases and will continue to do so until the trend is reverse.		=
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.	**Achieved:** External review completed, most actions and recommendations completed. Trust plans to break-even in 23/24 and plan agreed and signed off with commissioners and scrutinised by NHSE. Trajectories met for the last 2 quarters. **Plan to exit:** Efficiencies and improvements required on Cat 2 Performance gap and £9m efficiency programme required to deliver plan.		=
RSP-F2	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.			=
RSP-F3	Trust can evidence delivery of financial trajectories for at least two most recent quarters.			↑

Appendix 1 - Risk Scoring

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

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

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

	No or minimal impact of statutory guidance		Issue of statutory notice		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.

Appendix 3 – BRAGG Rating Definitions (for RSP – using National Criteria)

BRAGG Rating definitions

	For Exit Criteria - Exit Criteria achieved and embedded **For Risk** – Only to be used once risk has been mitigated
	For Exit Criteria - Off track with high risk of inability to meet exit criteria by planned date **For Risk** – High impact on the delivery of the project which requires
	For Exit Criteria - Emerging risk of inability, or no clear evidence of ability, to meet exit criteria by the planned exit date. **Note - If used for 2 quarters consecutively need to have clear explanation on why it has not moved to either Red or Green** **For Risk** – Moderate impact on the delivery of the project
	For Exit Criteria - On track, and with clear evidence, to meet the exit criteria by the planned exit date **For Risk –** Low impact on the delivery of the project
	For Exit Criteria - Resources just deployed; too early to tell - **can be used for only 1 quarter** **For Risk** – Not applicable

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – August 2023

Reporting Period: May & June 2023

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

Contents

Improving Quality of Information to Board – August 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. The **Data Strategy** development has begun but the timing of it's completion is now aligned to the Trust-wide strategy to ensure alignment.
- **Update August:** We have now updated an initial cover page under "Annual Plan" to provide the Board with performance against in-year objectives at a glance. This is under development but >80% of the KPIs are available and therefore included in this version to support improving the quality of the discussion.
- In addition, we now have incorporated medicines governance key reporting such as PGD compliance (CQC Must Do), and stock levels, as part of the Continuous Improvement of the report.

Alignment Framework

Improvement Journey **[see comment]**

Quality Improvement

We listen, we learn and improve

Responsive Care

Delivering moderns healthcare

People & Culture

Everyone is listened to, respected and well supported

Sustainability & Partnerships

Developing partnerships to collectively design and develop innovative and sustainable models of care

IQR Themes	QUALITY IMPROVEMENT	RESPONSIVE CARE	PEOPLE & CULTURE	SUSTAINABILITY & PARTNERSHIPS
	- *SI, Incidents and Harm* - *Patient care – Cardiac* - *Patient care - Stroke* - *Medicines Management* - *Safeguarding* - *Safety in the workplace* - *Patient Experience*	- *Ambulance Quality Indicators* - *Call Handling EOC* - *Utilisation* - *999 Frontline Efficiency* - *Supporting the system* - *111 Operation* - *Support Services*	- *Employee Experience* - *Culture* - *Workforce* - *Wellbeing* - *Development*	- *Delivery against Plan*

Icon Descriptions

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

Note: This is a new page from August Board to provide the Board with progress against in-year KPIs at a glance. Whilst it's under development, most KPIs for the year can be found below. The "Mean" still relates to the last 15 periods as per NHSE's Make Data Count SPC methodology.

Quality Improvment

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
CFR Attendances	Jun-2023	787		1289.65		
Harm Incidents per 1000 Incidents	Jun-2023	1.61		1.3		
Count of No Harm Incidents	Jun-2023	1088		1104.4		
Count of Low Harm Incidents	Jun-2023	171		168.95		
Count of Moderate Harm Incidents	Jun-2023	4		6.5		
Count of Severe & Death Harm Incidents	Jun-2023	0		1.6		

People & Culture

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Sickness Absence %	Jun-2023	6.9%	5%	9.11%		
Statutory & Mandatory Training Rolling Year %	Jun-2023	74.9%	85%	72.27%		
Appraisals Rolling Year %	Jun-2023	58.1%	85%	60.17%		
Freedom to Speak Up: Total Open Cases	Jun-2023	16		16.31		
Freedom to Speak up: Cases Opened in Month	Jun-2023	3	3	9.1		
Freedom to Speak up: Cases Closed in Month	Jun-2023	8		8.2		
Time to Hire - Volume (Days)	Jun-2023	110.67	60	112.97		
Time to Hire - Ad-Hoc (Days)	Jun-2023	92.29	60	70.71		

Responsive Care

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Hear & Treat %	Jun-2023	10%	14%	9.72%		
999 Frontline Late Finishes/Over-Runs %	Jun-2023	46.7%	45%	50.4%		
Average Late Finish/Over-Run Time	Jun-2023	00:38:00		00:40:27		
999 Call Answer Mean	Jun-2023	00:00:33	00:00:05	00:00:39		
Cat 2 Mean	Jun-2023	00:31:09	00:30:00	00:33:15		

Sustainability & Partnerships

Metric	Latest Date	Value	Target	Mean	Variation	Assurance

***Integration of KPIs for S&P not completed due to priority being on quality reporting.*

Financial reporting is not currently integrated into our data systems and therefore reported separately. A timeframe for integration has not been agreed and it's not in the plan for 23/24.

Details can be found in the S&P section below in this report and in the Finance Report.

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Quality Improvement

QUALITY IMPROVEMENT

Summary

June 2023

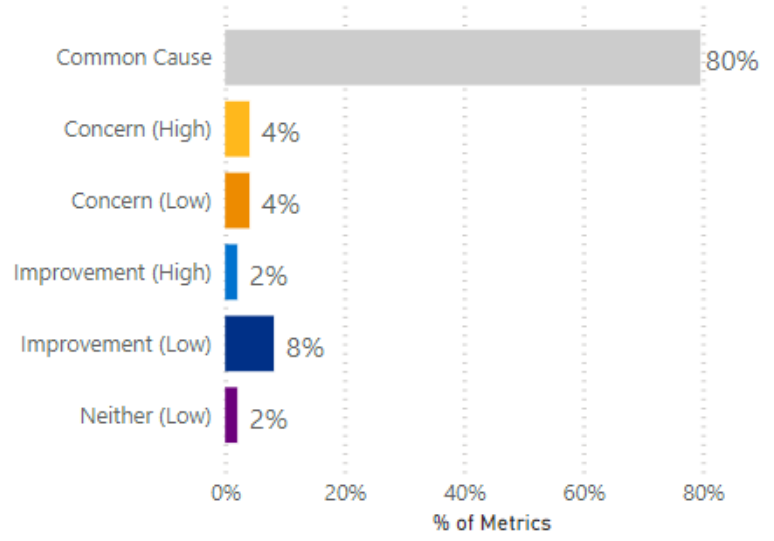
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Medicines Management % of Audits Completed		Count of Moderate Harm Incidents Complaints per 1000 999 Calls Answered Complaints relating to privacy and respect % Outstanding Actions Relating to SIs, Outside of Timescales
Common Cause		Acute ST-Elevation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

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.

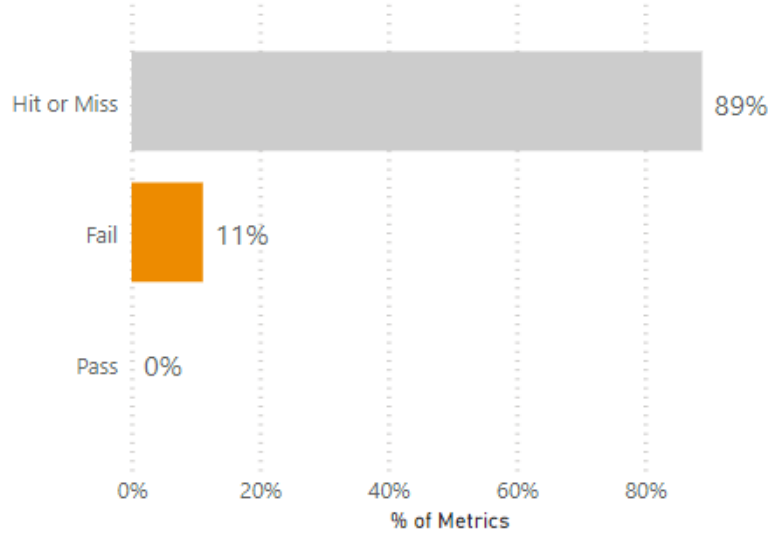
QUALITY IMPROVEMENT

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	Jun-2023	214		87.23	155.55	223.87		
Number of CD Breakages	Quality Improvement	Jun-2023	28	0	6.95	20.95	34.95		
Number of Datix Incidents	Quality Improvement	Jun-2023	1279		947.5	1420	1892.5		
Number of Incidents Reported as SIs	Quality Improvement	Jun-2023	4		-4.77	4.75	14.27		
Duty of Candour Compliance %	Quality Improvement	Jun-2023	100%	100%	62.14%	87.26%	112.39%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Jun-2023	125		55.93	106.75	157.57		
Number of RIDDOR Reports	Quality Improvement	Jun-2023	11		-1.17	11.15	23.47		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Jun-2023	22		25.32	52.9	80.48		
Health & Safety Incidents	Quality Improvement	Jun-2023	27		11.22	27.6	43.98		

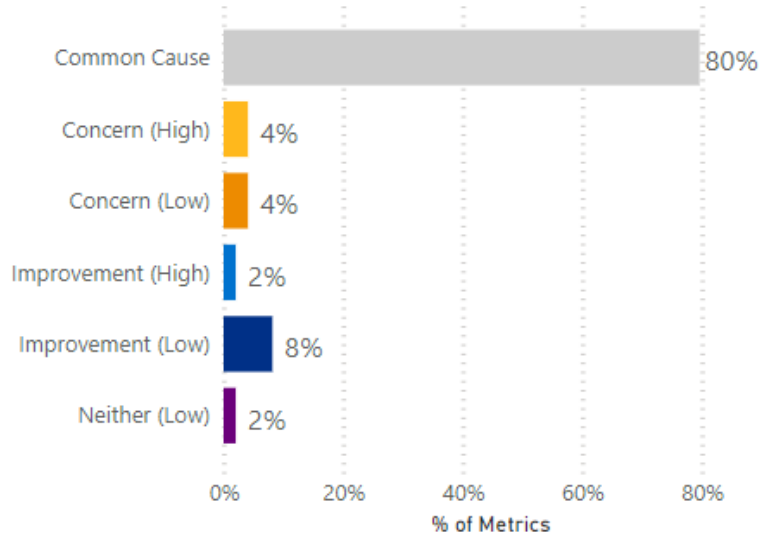
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Jun-2023	0%		-0.07%	0.02%	0.1%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Jun-2023	56%		44.1%	65.1%	86.1%		
Complaints Reporting Timeliness %	Quality Improvement	Jun-2023	96%	95%	27.79%	71.47%	115.15%		
Number of Complaints	Quality Improvement	Jun-2023	48		30.73	75.95	121.17		
Complaints per 1000 999 Calls Answered	Quality Improvement	Jun-2023	0.66		-189.29	104.24	397.78		
Number of Compliments	Quality Improvement	Jun-2023	144		66.29	163.61	260.94		

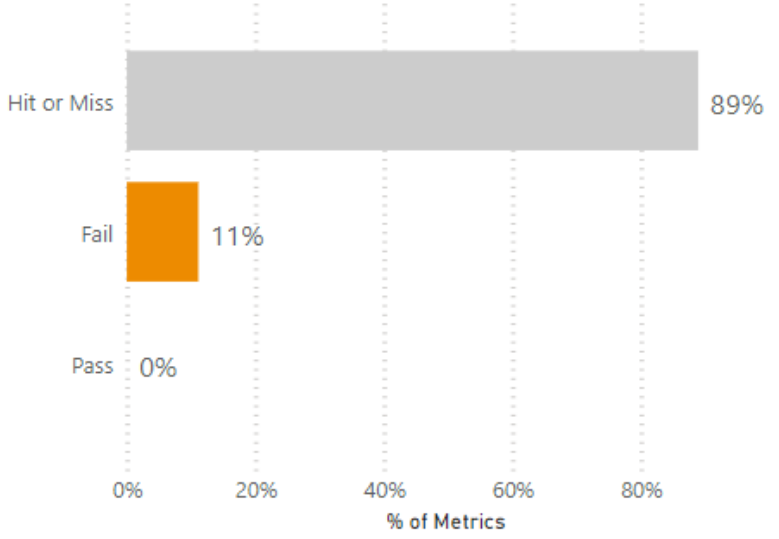
QUALITY IMPROVEMENT

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	May-2023	50%	45.1%	28.03%	48.35%	68.67%		
**Cardiac ROSC ALL %	Quality Improvement	May-2023	28.2%	23.8%	18.14%	26.02%	33.89%		
**Sepsis Care Bundle %	Quality Improvement	May-2023	84.1%	85%	81.52%	86.28%	91.04%		
**Cardiac Survival Utstein %	Quality Improvement	Mar-2023	6.4%	25.6%	6.79%	23.88%	40.97%		
**Cardiac Survival ALL %	Quality Improvement	Mar-2023	15.4%	9.6%	0%	13.86%	27.73%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	May-2023	68.7%	76.8%	60.22%	72.66%	85.11%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	May-2023	66.4%	64.7%	62.83%	73.3%	83.77%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Feb-2023	02:35:00	02:22:00	02:09:23	02:34:34	02:59:45		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Feb-2023	04:04:00	03:14:00	02:55:26	03:39:56	04:24:27		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Feb-2023	01:29:00	01:29:00	01:23:00	01:40:34	01:58:07		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Feb-2023	02:20:00	02:20:00	01:51:40	02:37:04	03:22:28		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	May-2023	97.8%	96.3%	95.54%	97.34%	99.14%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	May-2023	93.6%	93.8%	84.96%	93.03%	101.09%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	May-2023	77.3%	77.9%	65.85%	78.18%	90.5%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Jun-2023	105.6%		78.23%	102.42%	126.61%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Jun-2023	86.6%	100%	75.28%	85.45%	95.61%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Jun-2023	100.5%	100%	75.67%	91.03%	106.38%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Jun-2023	92.6%	100%	86.94%	98.51%	110.07%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Jun-2023	53.3%		11.78%	62.33%	112.88%		

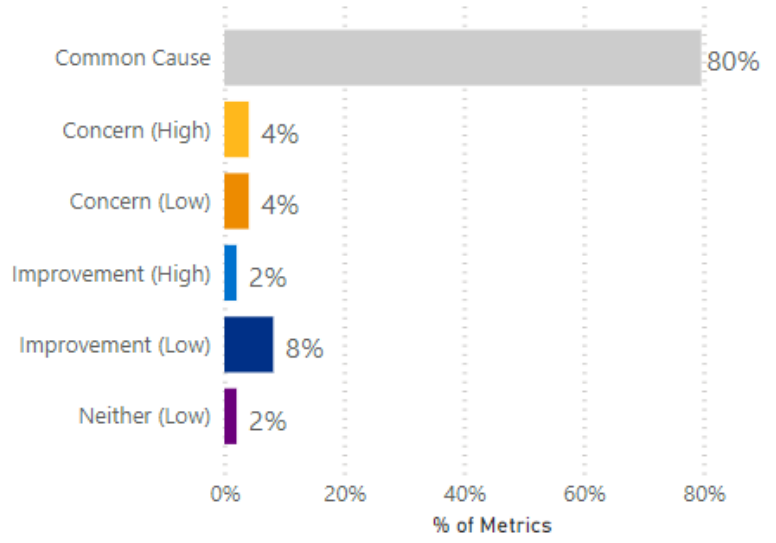
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Jun-2023	85.3%	90%	73.37%	87.27%	101.18%		
Deep Clean Compliance %	Quality Improvement	Apr-2023	91%	95%	64.34%	85.51%	106.69%		

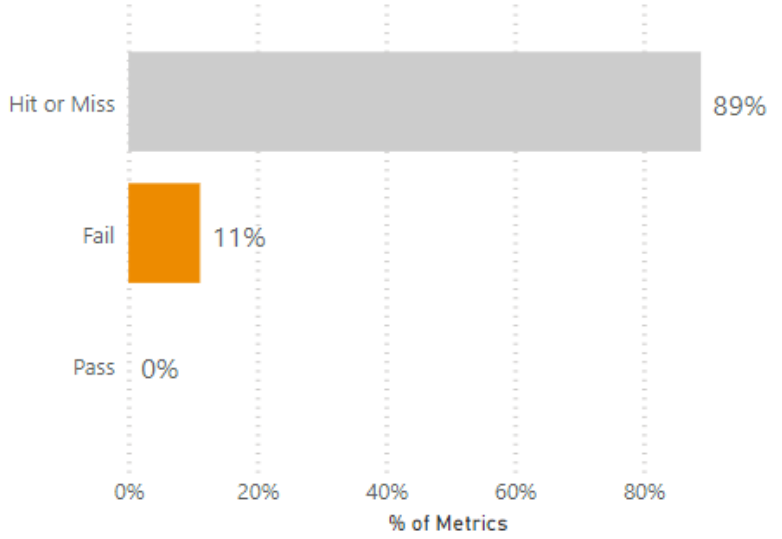
QUALITY IMPROVEMENT

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



Health & Safety

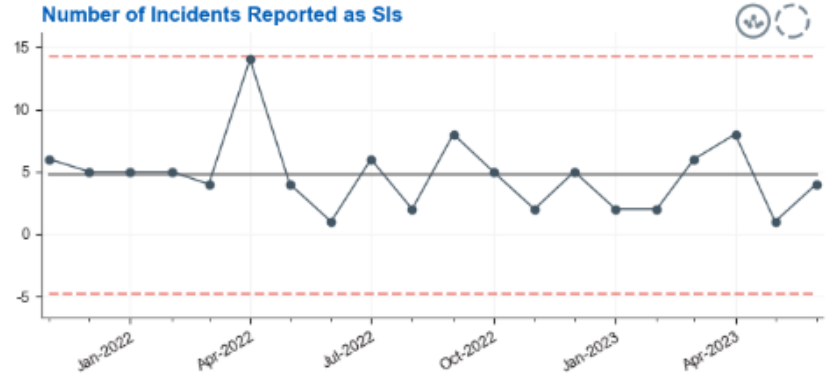
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Jun-2023	67.1%	85%	74.35%	80.04%	85.73%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Jun-2023	44.2%	85%		59.26%			
Manual Handling Incidents	Quality Improvement	Jun-2023	32		12.31	27.85	43.39		
Organisational Risks Outstanding Review %	Quality Improvement	Feb-2023	38%	30%	-0.68%	42.23%	85.15%		

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	10.71	39.44	68.17		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Feb-2023	25	0	-23.49	72.63	168.74		
Medicines Management % of Audits Completed	Quality Improvement	Jun-2023	97.1%	100%	75.19%	88.98%	102.77%		
PGD Compliance %	Quality Improvement	May-2023	79.1%	100%		73.23%			
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Jun-2023	82%	100%		48.5%			

QUALITY IMPROVEMENT

SIs, Incidents, & Duty of Candour

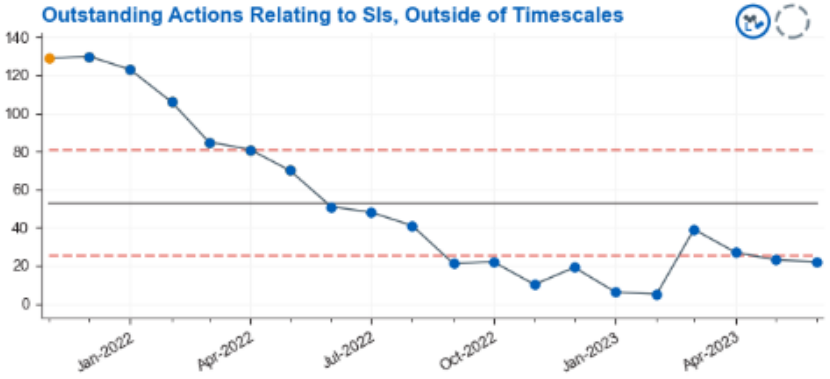


QS-2
Dept: Quality & Safety
IP: Quality Improvement
Latest: 4

Common cause variation, no significant change.

QS-1
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1279

Common cause variation, no significant change.



QS-17
Dept: Quality & Safety
IP: Quality Improvement
Latest: 22

Special cause of an improving nature where the measure is significantly LOWER.

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 four 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 ensure feedback to individuals / team and organisational wide learning.
- Work has begun on the implementation of PSIRF and building the new incident module on DCIQ.

(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: 9.52

Special cause of a concerning nature where the measure is significantly HIGHER.

QS-29

Dept: Quality & Safety

IP: Quality Improvement

Latest: 1.61

Common cause variation, no significant change.

Summary

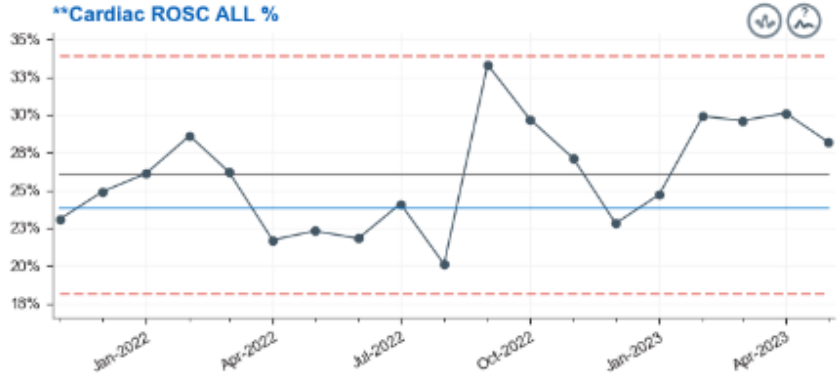
- The BI has changed the way they report on the number of no-harm incidents per 1000 jobs recorded.
- Prior the incidents reported were only measured against jobs where crews attended or a resource was dispatched to. This did not account for all calls received through 111 or calls where a resource was not sent or stood down
- Just over 1300 no-harm incidents were reported in April measured against 125000 jobs reported to the Trust, therefore creating an average of 9.52 incidents reported per 1000 jobs
- This is a slight increase in April to incidents reported and on further investigation found to be because of the bank holiday weekend where 111 reported an additional 150 incidents concerning CPCS pharmacies

What actions are we taking?

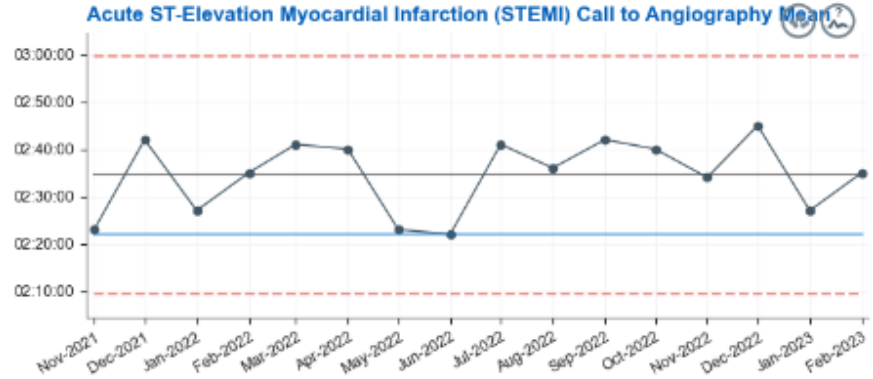
- To develop a robust mechanism of meaningful feedback to individuals / team and organisational wide learning.
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support continuous improvement.
- Continue to monitor Grade of Harm in relation to the Trend or Theme of incident that is being reported and raise concerns or arising issues with all OUs when completing the initial checks

QUALITY IMPROVEMENT

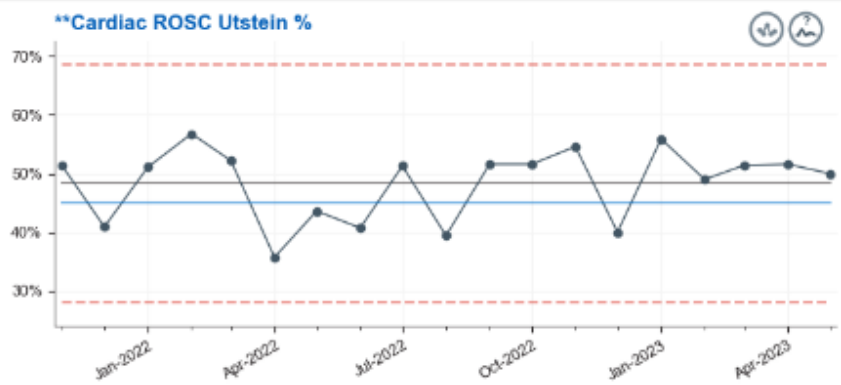
Impact on Patient Care - Cardiac



M-2
Dept: Medical
IP: Quality Improvement
Latest: 28.2%
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: 02:35:00
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: 50%
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: 66.4%
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, albeit with a mean to date above target. The annual Cardiac Arrest Report is published during Q4 reporting a validated retrospective 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: 214

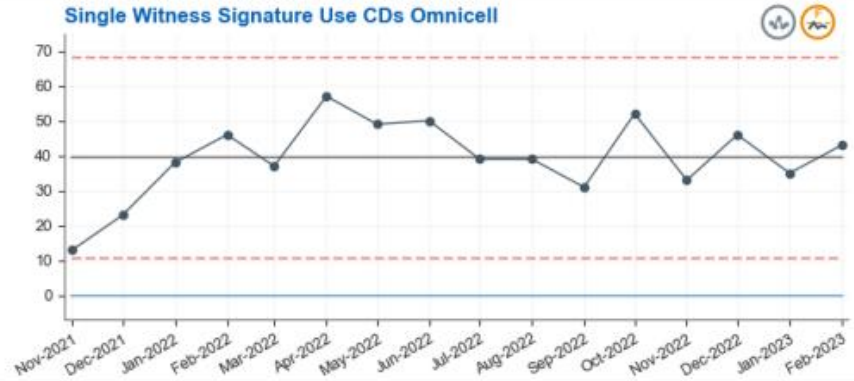
Special cause of a concerning nature where the measure is significantly HIGHER.

MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 97.1%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 28
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.

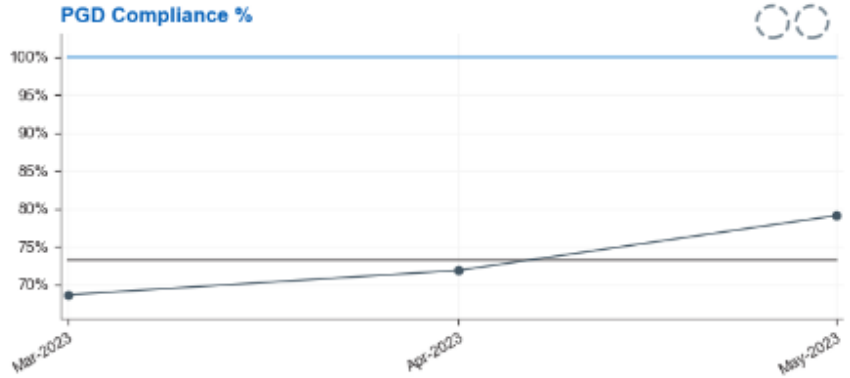
Summary

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. These audits are also discussed in medicines lead subgroup. 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. Training has commenced (July 2023) for OTLs on CD governance and activity. Single witness signatures are discussed as part of this training.

What actions are we taking?

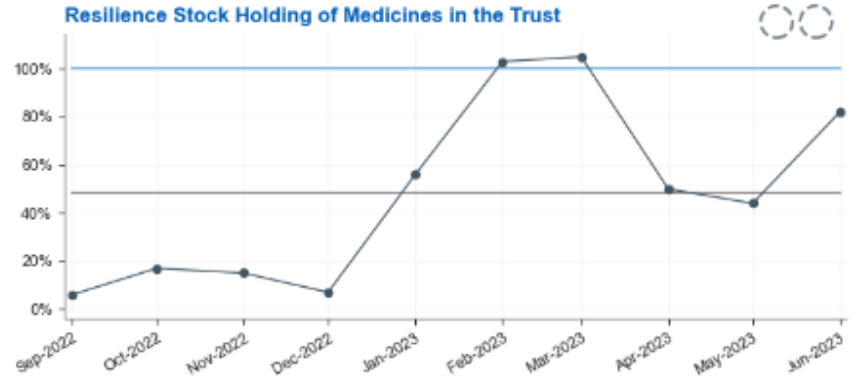
Medicines team have met with Power BI team and software developers to move forward with medicines data and presentation on central platforms. PGD workplan and CQC 'must dos' all progressing forward. OTL report moving onto central dashboard.
Medicines Safety Officer (MSO) role being advertised for medicines team. This post holder will focus on patient safety and medicines incidents and learning.

QUALITY IMPROVEMENT Medicines Management (2 of 2)



MM-8

Dept: Medicines Management
IP: Quality Improvement
Latest: 79.1%
Target: 100%
Special cause or common cause cannot be given as there are an insufficient number of points.



MM-9

Dept: Medicines Management
IP: Quality Improvement
Latest: 82%
Target: 100%
Special cause or common cause cannot be given as there are an insufficient number of points.

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. Medicines team currently recruiting to vacancy to ensure sustainability in medicines pouch packing.

Patient Group Direction (PGD) Compliance in line with MD11 has continued to increase and further engagement with ops and specialist teams underway.

What actions are we taking?

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

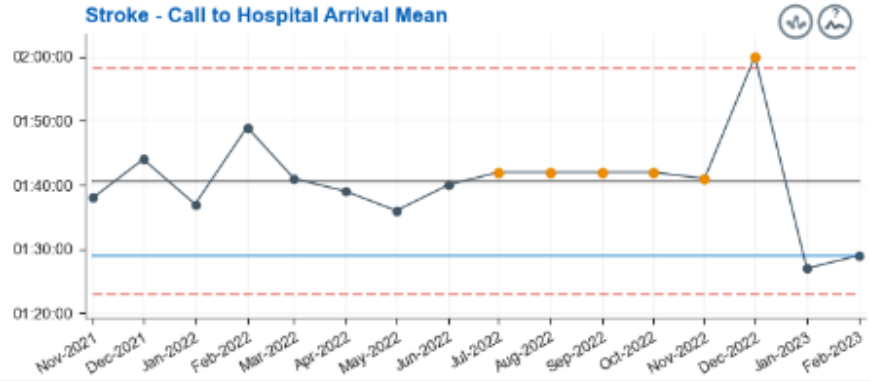
PGD report down to practitioner level being shared with OUMs monthly. Targeting OUs and cohorts of under-compliance, with a target to achieve >95% by end of Q2.

PGD compliance standing agenda item for discussion at PGD working group. Medicines leads across the Trust supporting in increasing compliance. Agenda item at last Medicines Governance Group data still being cleansed and not linked to ESR currently.

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

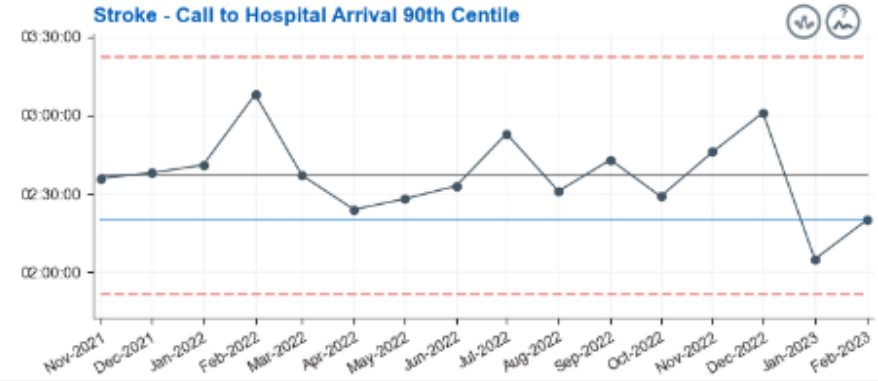
QUALITY IMPROVEMENT

Impact on Patient Care – Stroke



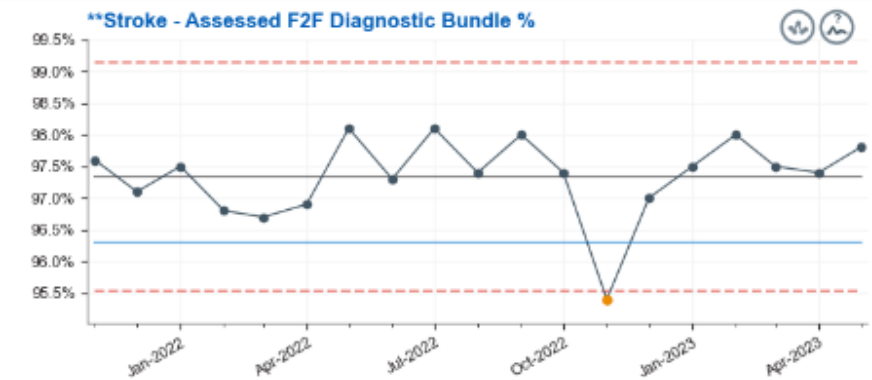
M-8

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



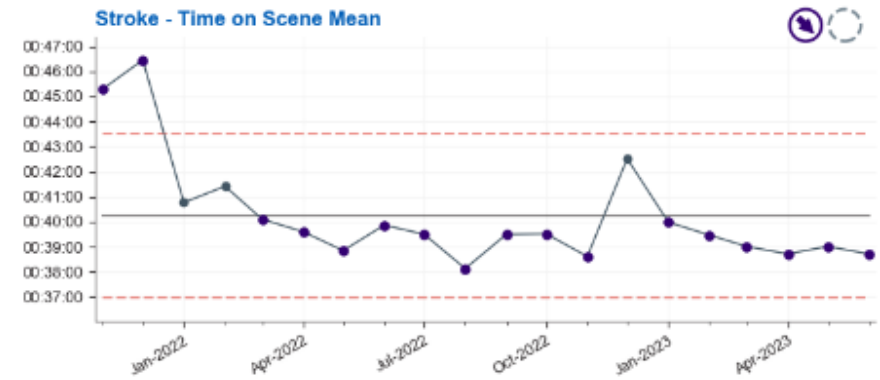
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:20:00
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: 97.8%
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

Special cause variation where DOWN is neither improvement or concern

Summary

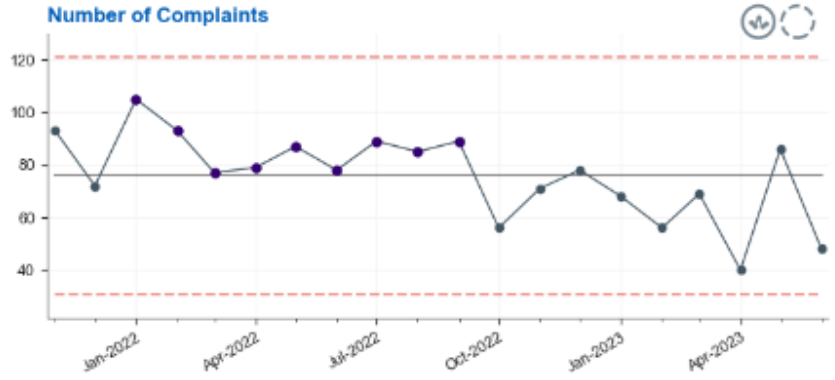
Stroke – Common cause variation continues. We are not meeting the national targets for Stroke patients due to overall delays in arrival at scene, however, once we arrive with the patient, compliance against the Diagnostic Bundle has largely been above target since August 2021. Whilst there's no special 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 time (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: 48

Common cause variation, no significant change.

QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 96%
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: 56%

Common cause variation, no significant change.

Summary

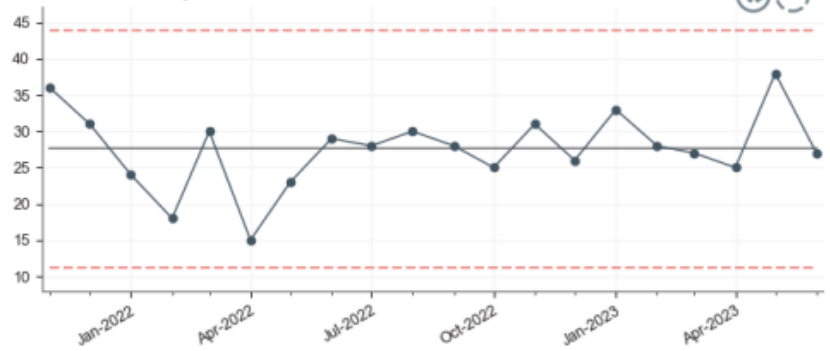
- No significant variation.
- The timeliness for complaint responses exceeded target at 96% responded to within timescale in June. This is following a review of the process by the team and increased engagement with operational teams.
- The number of complaints received within the organisation is within 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 continue to respond to at least 95% of complaints within timescale going forward.
- 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.

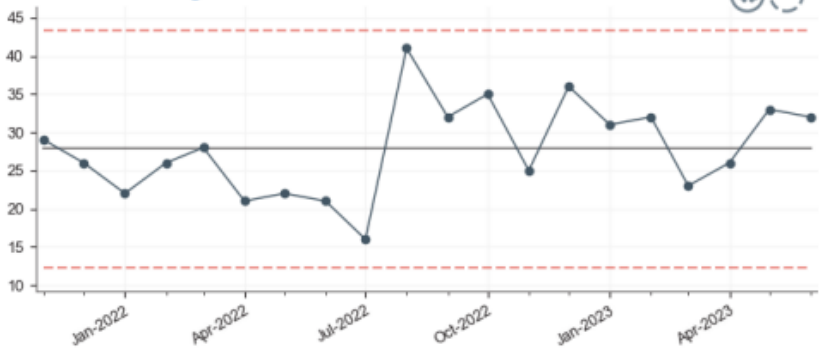
QUALITY IMPROVEMENT

Safety in the Workplace (1 of 3)



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 27

Common cause variation, no significant change.



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

Common cause variation, no significant change.

Health & Safety Incidents

No significant variation.

During May 2023 (38) Health and Safety incidents were reported.

The 3 occupations which reported the greatest number of Health & Safety incidents for May are listed below:
- Paramedics (7)
- ECSW (5)
- Ambulance Technicians (5)

The main sub-categories for the incidents reported were:
Slips, Trips and Falls, cuts and abrasions and struck by objects/equipment.

During June 2023 (27) Health and Safety incidents were reported.

The 3 occupations which reported the greatest number of Health & Safety incidents for April are listed below:
- ECSW (5)
- Paramedics (4)
- Ambulance Technicians (4)

The main sub-categories for the incidents reported were:
Slips, Trips and Falls, cuts and abrasions and struck by objects/equipment.

What are we doing
The regional and Trust Health & Safety group will continue monitoring incident trends.

Manual Handling Incidents

No significant variation

Manual handling incidents reported in May 2023 were 33.

The 3 occupations which reported the greatest number of Manual Handling incidents for May are listed below:
- Paramedics (14)
- ECSW (6)
- Ambulance Technicians (4)

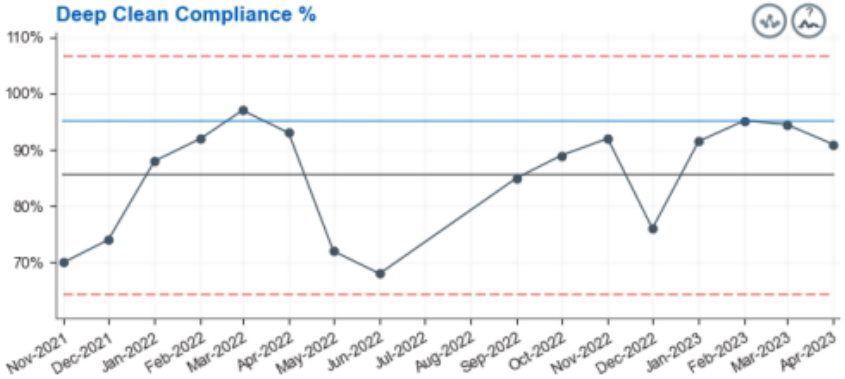
Manual handling incidents reported in June 2023 were 32.

The 3 occupations which reported the greatest number of Manual Handling incidents for June are listed below:
- Paramedics (11)
- ECSW (8)
- Ambulance Technicians (3)

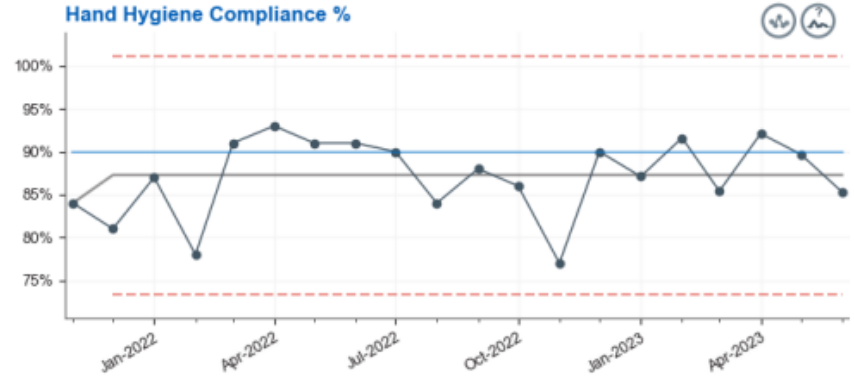
What are we doing
The regional and Trust Health & Safety group will continue monitoring incident trends. The H&S group is led by an Executive Director with the H&S Lead to ensure assurance is provided on all regulatory aspects and action plans agreed and acted on.

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: 85.3%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Hand Hygiene Compliance

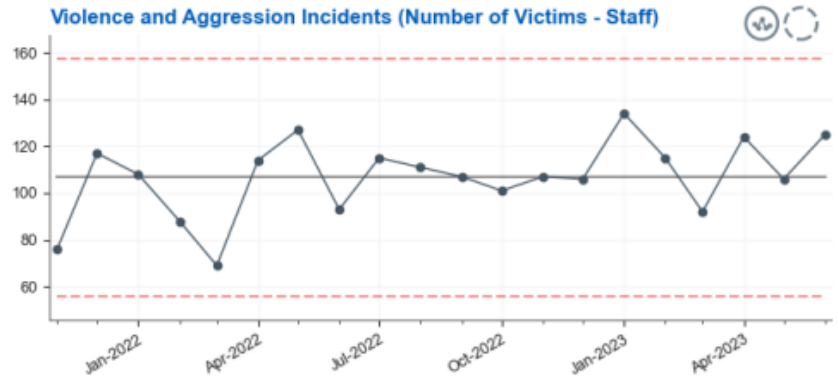
The data for hand hygiene compliance is showing normal variation. We note that there is unwarranted variation in the process, and we are not consistently meeting the 90% target. In acknowledgement of this, the IPC team are currently undertaking the following actions with a view to improving hand hygiene compliance across the Trust.

What actions are we taking?

- Planning meeting to discuss contributary factors for compliance with hand hygiene audits to be held on 31.07.23.
- IPC team working to engage IPC champions for each OU/EOC/111 to develop better relationships, communication, and knowledge to support more devolved effective local IPC management.
- IPC team to undertake a robust review of SCAS CQC report and our own previous CQC report in relation to IPC and complete self-assessment / gap analysis and associated action plan for improvement.

QUALITY IMPROVEMENT

Safety in the Workplace (3 of 3)



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 125

Common cause variation, no significant change.

Violence & Aggression

No significant variation.

Staff reported 106 violence and aggression related incidents in May 2023.
The sub-categories of these incidents are shown below:

- 34 verbal abuse
- 28 Anti-Social Behaviour
- 24 assaults

Staff reported 125 violence and aggression related incidents in June 2023.
The sub-categories of these incidents are shown below:

- 43 verbal abuse
- 36 Anti-Social Behaviour
- 30 assaults

What actions are we taking?

- Trust approval for a permanent Violence Reduction Support Officer
- 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.
- BWC licences approved by the Trust for 2 further years. Expansion complete to 23 reporting sites.
- 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. Relevant policies have been approved.
- Staff completing Level 3 and 4 Violence Reduction and Prevention courses.

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 use and 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

June 2023

Pass | Hit and Miss | Fail | No Target

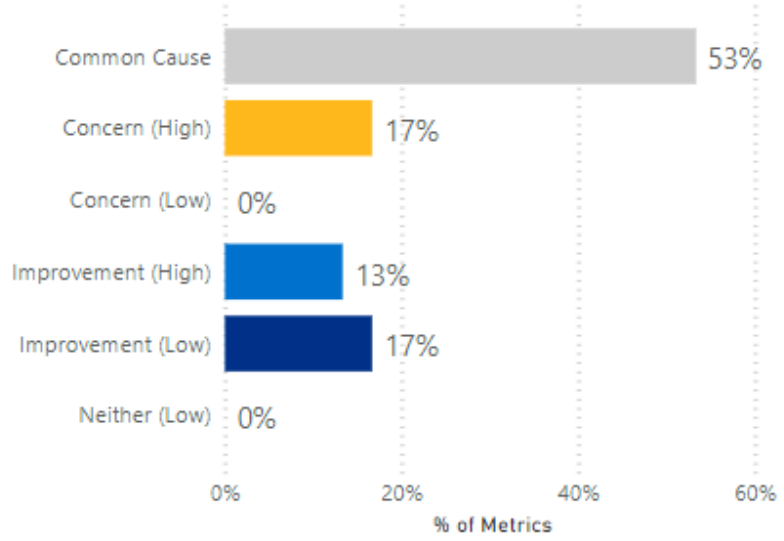
Special Cause Improvement		Disciplinary Cases % of Meal Breaks Taken Freedom to Speak up: Cases Opened in Month	Number of Staff WTE (Excl bank and agency) Sickness Absence % Statutory & Mandatory Training Rolling Year % 999 Frontline Late Finishes/Over-Runs % Current licence details held for Operational Staff %	Average Late Finish/Over-Run Time
Common Cause	DBS Compliance %	Vacancy Rate % Turnover Rate % Individual Grievances Open Count of Grievances Closed Suspension Closures Number of Wellbeing Hub Referrals	Appraisals Rolling Year % Time to Hire - Volume (Days)	Freedom to Speak Up: Total Open Cases
Special Cause Concern		Mean Suspension Duration (Days) Time to Hire - Ad-Hoc (Days) Grievances Mean Case Length (Days)	Until it Stops Average Case Length 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.

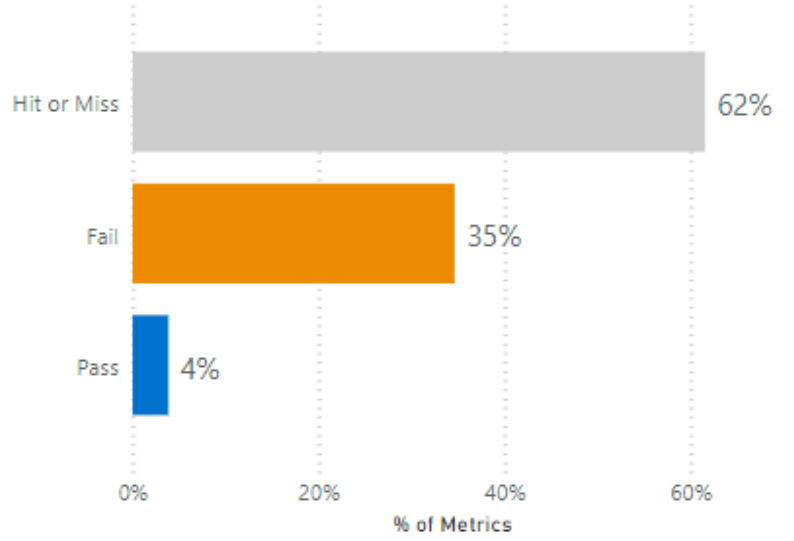
PEOPLE & CULTURE

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	Jun-2023	4080.16	4260	3913.26	3986.15	4059.04		
Vacancy Rate %	People & Culture	Jun-2023	2.6%	5%	0.06%	4.88%	9.7%		
Turnover Rate %	People & Culture	Jun-2023	2%	0.8%	0.64%	1.47%	2.3%		
Annual Rolling Turnover Rate	People & Culture	Jun-2023	18.7%	10%	16.73%	17.74%	18.76%		
Sickness Absence %	People & Culture	Jun-2023	6.9%	5%	7.15%	9.11%	11.07%		
DBS Compliance %	People & Culture	Jun-2023	100%	90%	100%	100%	100%		
Current licence details held for Operational Staff %	People & Culture	Jun-2023	97.6%	100%	89.65%	94.72%	99.78%		
Time to Hire - Volume (Days)	People & Culture	Jun-2023	110.67	60	67.63	112.97	158.31		
Time to Hire - Ad-Hoc (Days)	People & Culture	Jun-2023	92.29	60	46.73	70.71	94.69		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Jun-2023	74.9%	85%	61.56%	72.27%	82.98%		
Appraisals Rolling Year %	People & Culture	Jun-2023	58.1%	85%	54.85%	60.17%	65.49%		

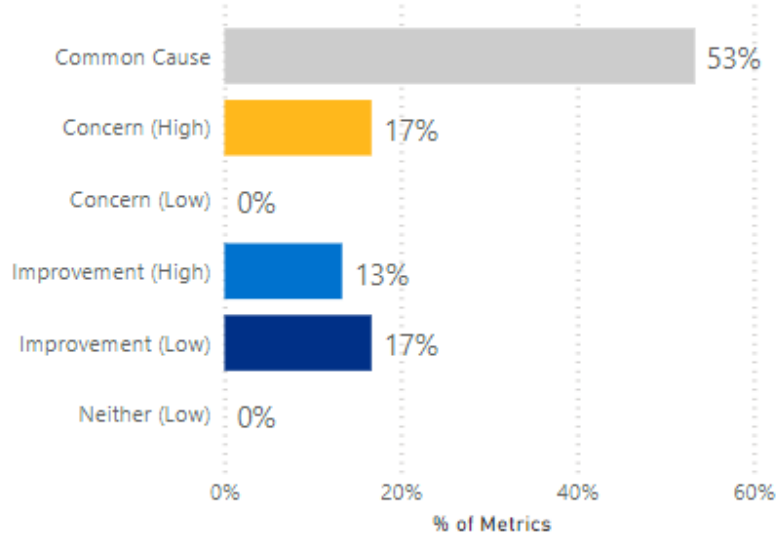
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Jun-2023	46.7%	45%	45.27%	50.4%	55.52%		
Average Late Finish/Over-Run Time	People & Culture	Jun-2023	00:38:00		00:35:58	00:40:27	00:44:56		
% of Meal Breaks Taken	People & Culture	Jun-2023	98.6%	98%	96.46%	98.01%	99.56%		
% of Meal Breaks Outside of Window	People & Culture	Jun-2023	54.1%		28.17%	55.77%	83.36%		

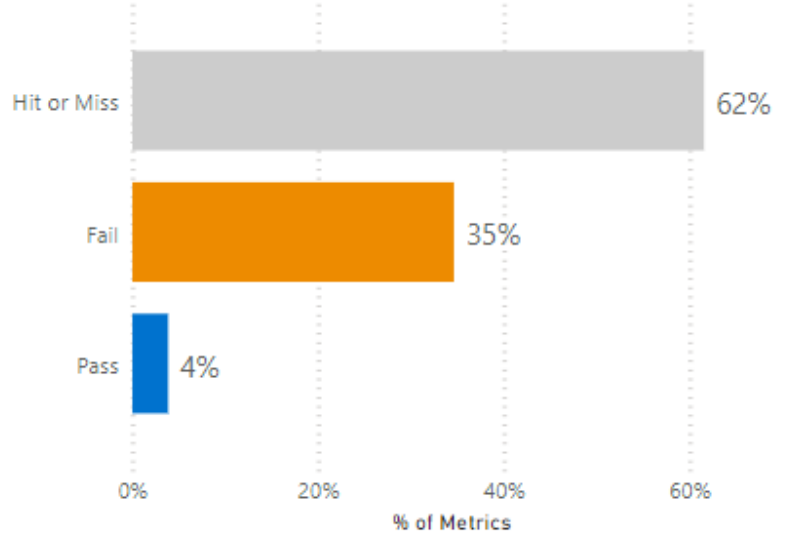
PEOPLE & CULTURE

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	Jun-2023	18	5	-1.68	11.2	24.08		
Collective Grievances Open	People & Culture	Jun-2023	2	1	-1.62	1.6	4.82		
Count of Grievances Closed	People & Culture	Jun-2023	12	3	-1.91	11.25	24.41		
Grievances Mean Case Length (Days)	People & Culture	Jun-2023	170.05	93	30.52	91.85	153.19		
Bullying & Harrassment Internal	People & Culture	Jun-2023	3	2	-4.05	2.25	8.55		
Disciplinary Cases	People & Culture	Jun-2023	0	3	-0.88	3.6	8.08		
Freedom to Speak Up: Total Open Cases	People & Culture	Jun-2023	16		6.91	16.31	25.71		
Freedom to Speak up: Cases Opened in Month	People & Culture	Jun-2023	3	3	-2.52	9.1	20.72		
Freedom to Speak up: Cases Closed in Month	People & Culture	Jun-2023	8		-6.22	8.2	22.62		
Policies & Procedures Outstanding Review %	People & Culture	Feb-2023	73.1%	0%		51.06%			
Count of Until it Stops Cases	People & Culture	Jun-2023	0	3	-4.71	3.42	11.55		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Jun-2023	124	86	36.88	98.06	159.24		

PEOPLE & CULTURE

Workforce (1 of 3)

WF-1

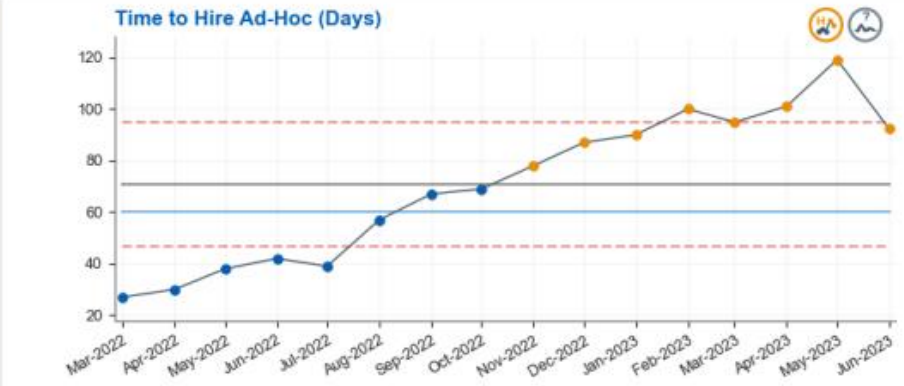
Dept: Workforce HR
IP: People & Culture
Latest: 4080.16
Target: 4260
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

WF-4

Dept: Workforce HR
IP: People & Culture
Latest: 2.6%
Target: 5%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

WF-43

Dept: Workforce HR
IP: People & Culture
Latest: 110.67
Target: 60
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-51

Dept: Workforce HR
IP: People & Culture
Latest: 92.29
Target: 60
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

- 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 will now be split further in future with EOC/111 separate from frontline roles, and the ability to comment on specific role TTH.
- 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

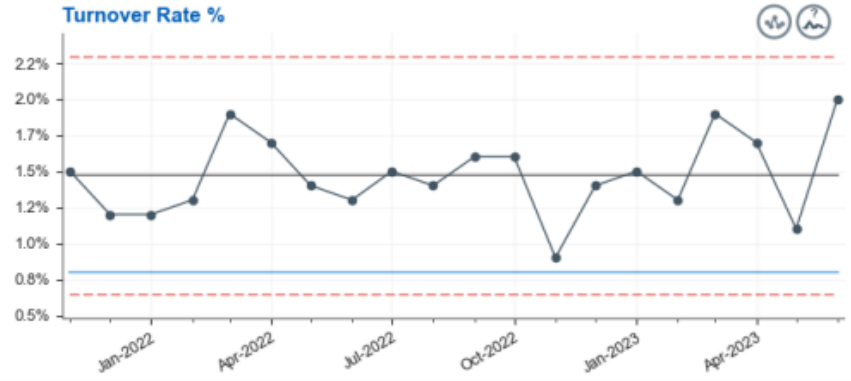
What actions are we taking?

The Recruitment and Onboarding project commenced on 23/05/2023 and aims to streamline our onboarding process using the DMAIC methodology. The project has focus on time to hire, readiness of new hires and drop-off rates.
The project caters 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.

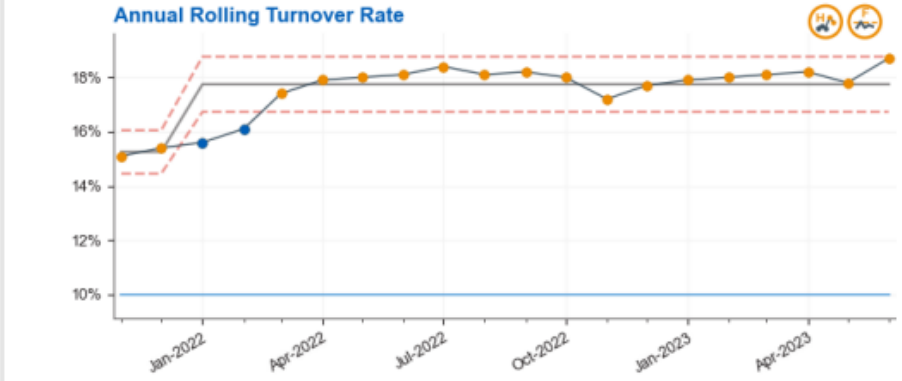
Data has been extracted on the end-to-end recruitment process from initial identification of a vacancy to when the individual is sat ready to work. The team now need to both prove the concept of approach to the project and allow analysis of the data to see where the blockages may be and subsequently provide solutions to reduce the overall time to recruit. Certain cohorts such as NQPs will have no room to reduce the TTH as the campaigns are in line with university end of course dates. Attraction and targeted recruitment of NQPs starts months in advance of hire dates.

PEOPLE & CULTURE

Workforce (2 of 3)



WF-48
Dept: Workforce HR
IP: People & Culture
Latest: 2%
Target: 0.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-7
Dept: Workforce HR
IP: People & Culture
Latest: 18.7%
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.

We are addressing the concerns we reported in the last IQR (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 has shown an improving YoY trend). This forms part of the People and Culture Delivery Plan.

Complexity is added to the data for July and August with the recent Medway relocation (redundancies and leavers). This should stabilise by Nov/Dec one we know the outcomes of those on trial periods (as a result of accepting alternative roles to redundancy)

What actions are we taking?

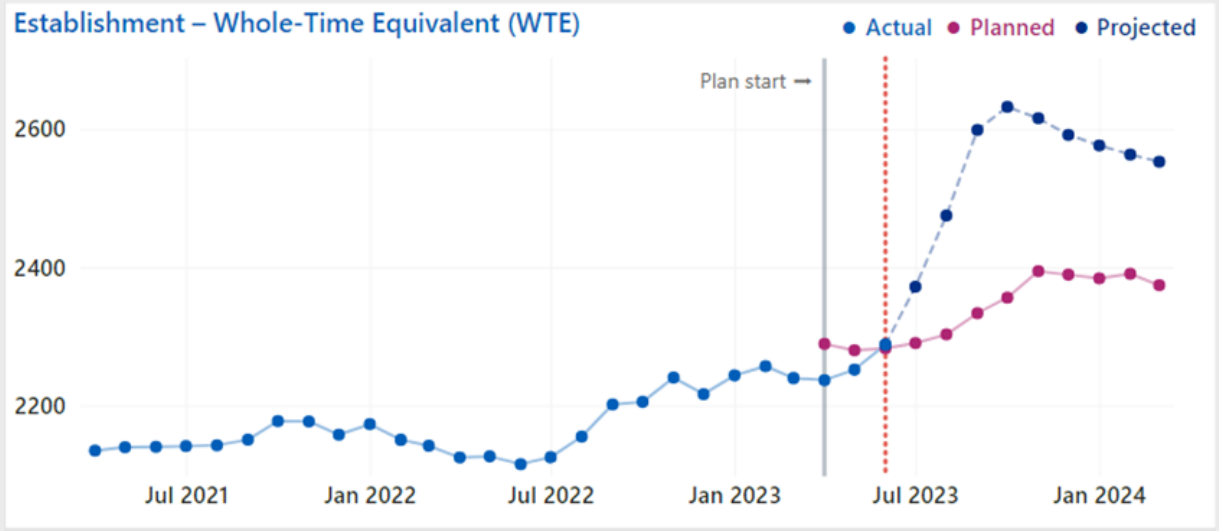
We have reviewed the Retention initiatives from the 2022/24 plan – in the context of the focus on the recently launched NHSE Long Term Workforce Plan and NHSE EDI Improvement Plan, we believe that the entire range of measures to improve retention now require fundamental review.

As a Trust we took a positive stance to awarding the non-consolidated pay element to the 19 colleagues who were on career breaks, recognising their contribution during COVID, and their role in supporting the NHS recovery.

PEOPLE & CULTURE

Workforce (3 of 3)

(999 Frontline)

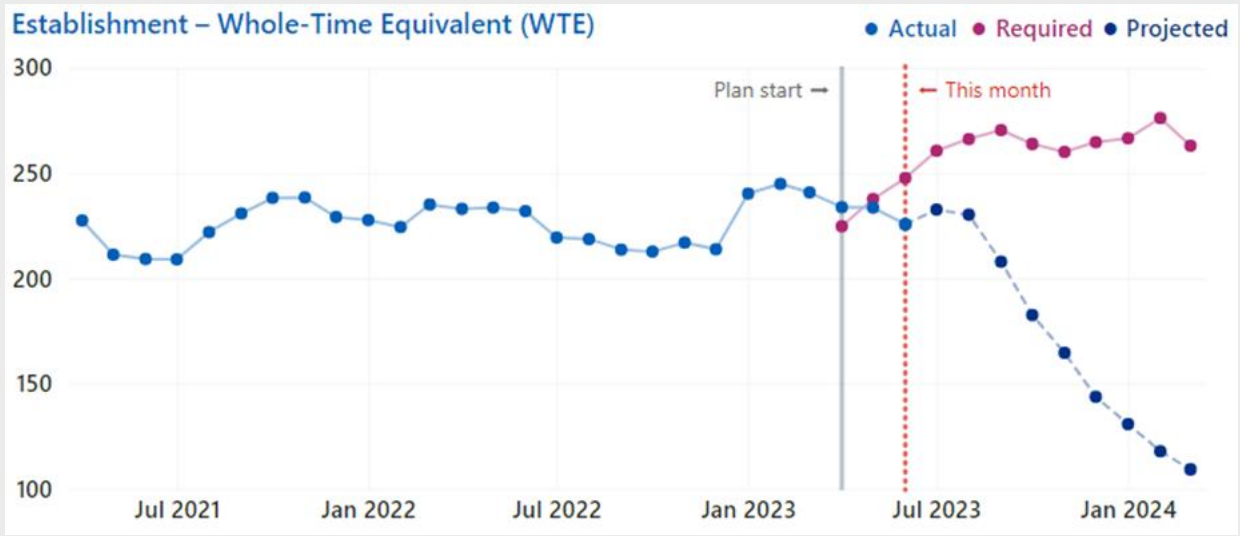


Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
June's data shows an increase in WTE slightly ahead of the workforce plan (5.6FTE) Attrition was lower than planned which has helped this number.
NQP recruitment continues with a strong position for 23/24 and more confirmed 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
The workforce plan for 23/24 factors in the gaps in workforce, and recruitment is well under way to support this. The plan factors in a higher turnover rate that is inline with this year's turnover rate, along with an overall recruitment target of 371 WTE.

Additional Information
The chart is currently over-projecting workforce as it has assumed that new recruits account for 1 WTE. However, we have a cohort of 100 new ECSWs that will be joining us that will only account for 30 WTE as they will be on part-time contracts whilst they complete their university course. This has resulted in a 70 WTE over projection which will be corrected in the system for the next report

(EOC EMA)



Summary – EOC EMA
EMA establishment for June showed a reduction of FTEs with a difference of -21.9 to plan. New starters were lower than planned with a difference of 12.00FTE less.
The Trust continues to focus on recruitment and training to bridge this gap.

Mitigating actions – EOC EMA
EMA recruitment has been increased with focus on courses being filled to capacity. The compliance team resource has been increased to ensure that candidates are cleared in a timely manner and contact with them is consistent, to minimise dropouts. This is in place for both frontline and contact centre roles. Extra resource has also been sourced from the CSU to help recruit to the new Gillingham site in anticipation of an increase in attrition when the full move over is completed, due to redundancy, or staff that have agreed to trials not moving to new site. Currently 21 have signed up to a trial for EOC, and 74 for 111.

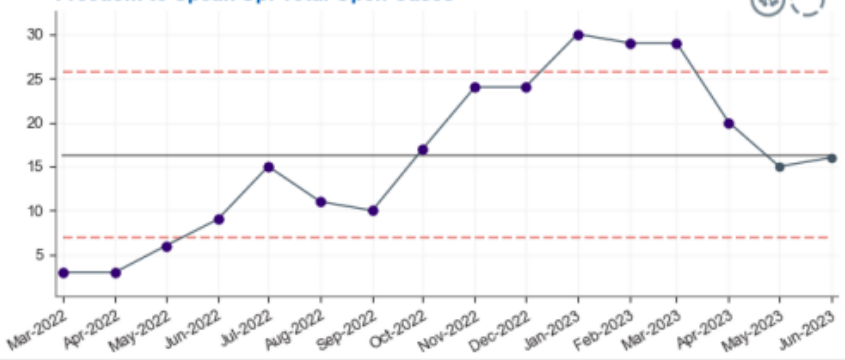
Additional Information
The workforce projection is currently based on confirmed recruits who currently have an offer of employment. As EMA recruitment typically only has a lead time of 2 months, no additional recruitment is factored into the projection beyond this point, which results in the chart only showing attrition. This is not a cause for concern by itself as recruitment drives will continue throughout the year and ensure the gap is filled.

PEOPLE & CULTURE

Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

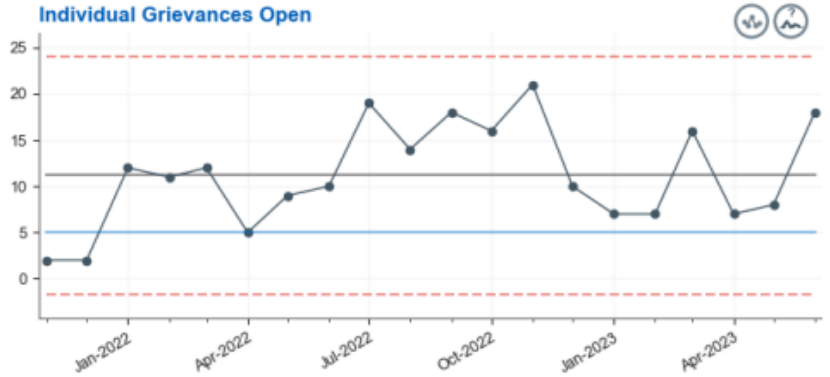
Freedom to Speak Up: Total Open Cases



QS-27
Dept: Quality & Safety
IP: People & Culture
Latest: 16

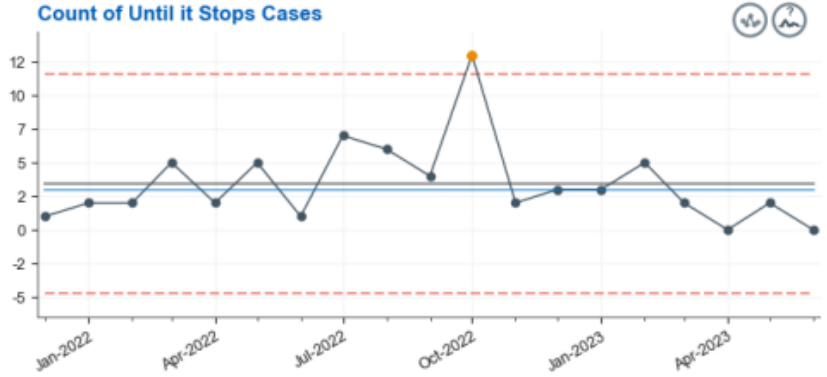
Common cause variation, no significant change.

Individual Grievances Open



WF-10
Dept: Workforce HR
IP: People & Culture
Latest: 18
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Count of Until it Stops Cases

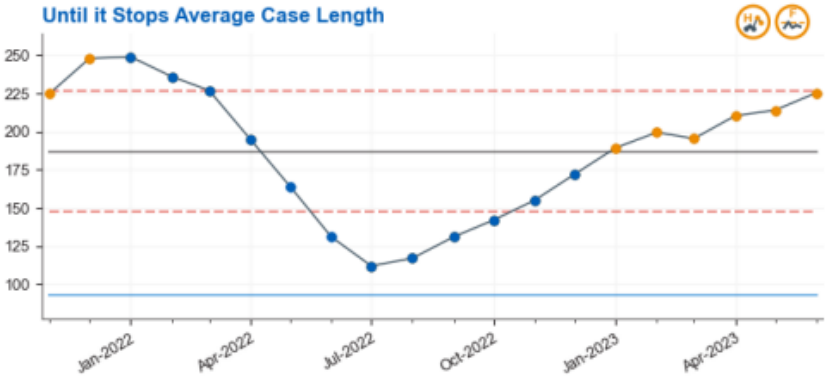


WF-41
Dept: Workforce HR
IP: People & Culture
Latest: 0
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Count of Grievances Closed

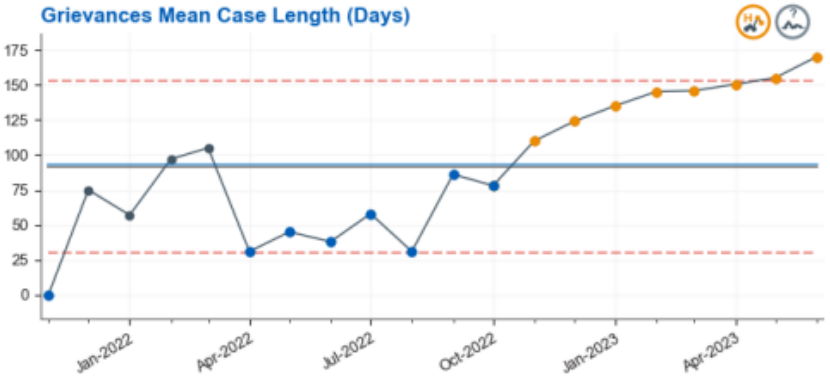
WF-42
Dept: Workforce HR
IP: People & Culture
Latest: 12
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Until it Stops Average Case Length



WF-50
Dept: Workforce HR
IP: People & Culture
Latest: 225.4
Target: 93
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

Grievances Mean Case Length (Days)



WF-44
Dept: Workforce HR
IP: People & Culture
Latest: 170.05
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 behaviour

Actions to implement the recommendations will be undertaken during Q2.

Until it stops Grievances:- The Trust has closed 32 cases over the past 12 months. 9 cases had no case to answer,10 were resolved informally, 13 cases had formal outcomes including dismissal.

21 cases remain open - 2 cases are Sexual Harassment and 19 are Bullying and Harassment these 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 has increased presently due to delays in investigations. This has also identified structural gaps within the HRBP Team due to capacity, management development (skills) gaps and lack of time for managers to complete investigations.

Individual Grievances /Count of Grievances– We have seen an increase in June and July of new grievances, The HR Team are working with managers with increased emphasis on early and informal resolution – this work is led by the Interim Deputy Director of HR.

What actions are we taking?

Culture, Values and behaviours Workshop – A task and finish group led by Emma Williams has been established to guide the development of a one-day workshop focussed on culture, values and behaviours for all staff. We are working with an external supplier "A Kind Life" on the workshop design. To day three co-design sessions have been held. A pilot workshop will be held on 24 July 2023, the workshop design will be finalised following the pilot. The workshops will be rolled out to all staff from October 2023.

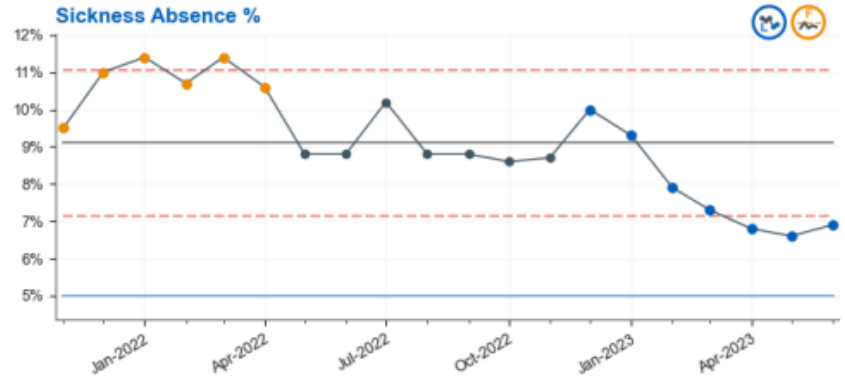
The Trust grievance policy is currently under review with key stakeholders across the Trust. This policy is being designed to support a timely resolution for our colleagues.

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

The Trust has successful recruited to the "Head of ER Role" the new candidate is planning to start with the Trust in October 2023.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 6.9%
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: 124
Target: 86
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

As a Trust we recently signed up to the NHS Improving Attendance Challenge 9.0, completing a self-assessment against the NHS Absence Management Framework.

We have identified a few areas for further improvement, and we are working on addressing these. This will include review of our Managing Health and Attendance Policy.

What actions are we taking?

The Trust continues to address our targeted actions plans, 6 out of the 7 targeted areas have seen a reduction in their absence %, and data to support this was supplied as assurance to the People Committee in July 2023.

We have successfully recruited the two FTC senior mental health practitioners for EOC/111 and Medway. Both have started and are already having a positive impact based on the feedback emails we have been receiving.

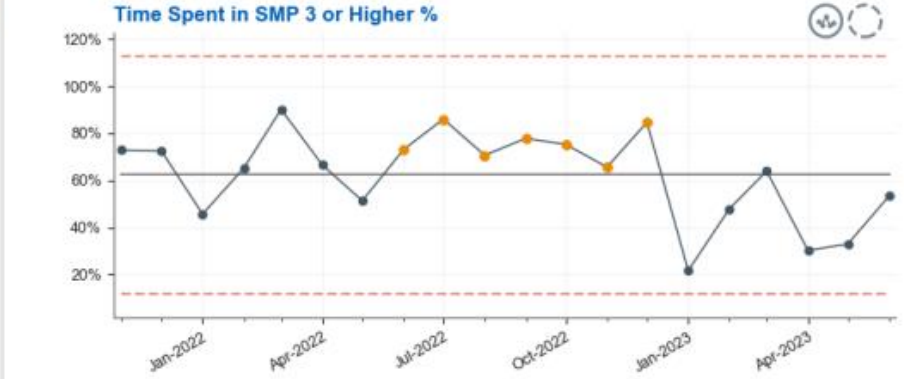
We reported last month that our referral numbers relate to wellbeing hub and physiotherapy but exclude TRiM, alternative duties, and other wellbeing interactions, and that we were working to get these figure combined for a more accurate picture and to allow for more detailed reporting of actions. We have since moved TRiM referrals to Marvel, which will allow for combined reporting by September 2023. We will need to agree a change to the target to reflect the additional reporting metric.

PEOPLE & CULTURE

Employee Experience

999-15

Dept: Operations 999
IP: People & Culture
Latest: 46.7%
Target: 45%
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.



999-14

Dept: Operations 999
IP: Quality Improvement
Latest: 53.3%

Common cause variation, no significant change.

999-27

Dept: Operations 999
IP: People & Culture
Latest: 98.6%
Target: 98%
Special cause of an improving nature where the measure is significantly HIGHER. 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 Suspensions

WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 9
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: 140.78
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: The mean duration of suspensions remains high at 140 days. Three of the seven suspension cases were impacted by Industrial Action in terms of management and union representation capacity to resolve these cases. July update – 4 cases have now been resolved, with a further two booked to be heard formally by the end of July.

Our most frequent reason for suspension remains bullying and harassment.

What actions are we taking?

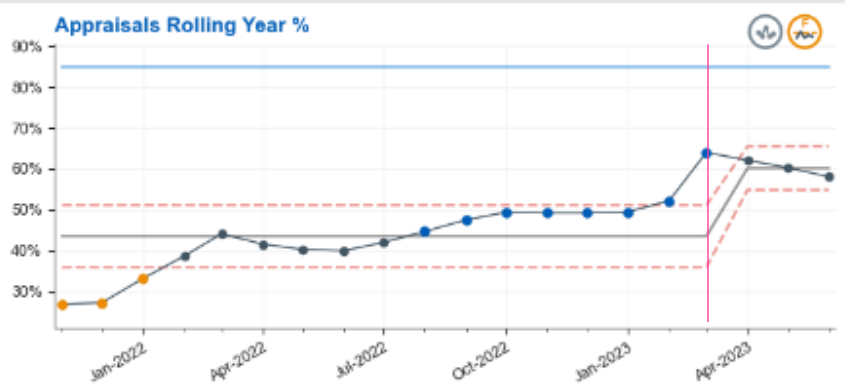
Suspensions: Cases continue to be reviewed on a weekly basis by the HRBP Team with the Executive Directors of HR & OD and Operations.

We are currently reviewing all key employment policies which will include a review of the Disciplinary policy.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 74.9%
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: 58.1%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Fundamentals First Line Managers Programme

Investment in our managers continues through the Fundamentals Programme for first line managers. 165 managers have attended the first 3 days over 13 cohorts. 23 managers did not attend their scheduled cohort.

Appraisals

ESR Appraisal roll out was completed in March 2023.

The Appraisal Task & Finish Group continues to meet regularly. The membership has widened enabling the group to transition into a working group. The group has made the following recommendations following:

- New appraisal training for managers to be designed and rolled to fully equip managers with the skills to hold appraisal, performance and career conversations
- Raise awareness of the appraisal eLearning that is currently available
- As a short term measure circulate a MS Word version of the appraisal form to enable appraisers to easily upload completed appraisals to ESR Appraisal
- Introduce proxy access to allow delegation of appraisal administration to support appraisers

The appraisal working group will monitor the impact of these recommendations as they are rolled out.

What actions are we taking?

Appraisals

Appraisal reports will be submitted to SMG on a fortnightly basis enabling SMG to take appropriate action to address progress toward achieving the Trust's compliance target. The Operations directorate has allocated 2 hours per person for appraisals, scheduling of appraisals in corporate teams is managed by line managers. This will be led at SMG by the Interim Deputy Director of HR & OD.

Statutory & Mandatory Training

Our compliance level has dipped from the end of year performance level and this will be reviewed by SMG to regain performance.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

June 2023

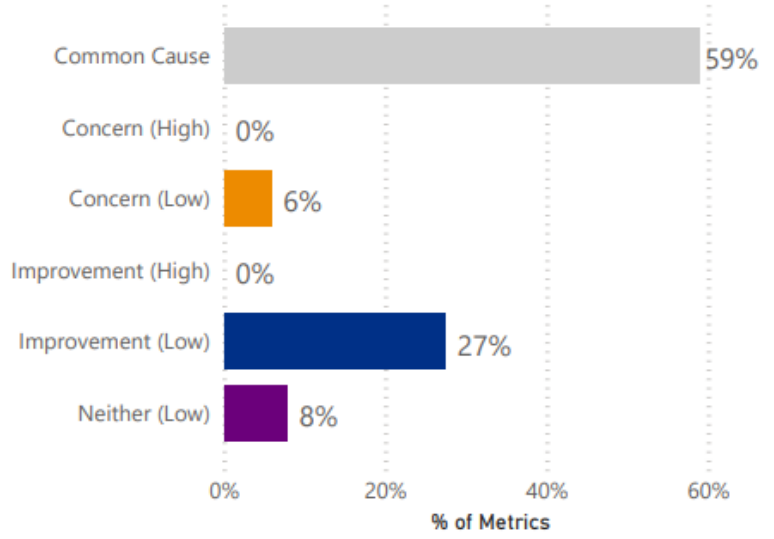
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %	111 Calls Abandoned - (Offered) % Cat 2 Mean Cat 2 90th Centile Cat 3 90th Centile		JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as a Proportion of Provided Hours... Number of Hours Lost at Hospital Handover 999 Referrals HCP 3 Mean HCP 3 90th Centile HCP 4 Mean HCP 4 90th Centile
Common Cause	Cat 1T 90th Centile Cat 1T Mean	A&E Dispositions % 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	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) Duplicate Calls % Incidents
Special Cause Concern	Ambulance Validation %			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.

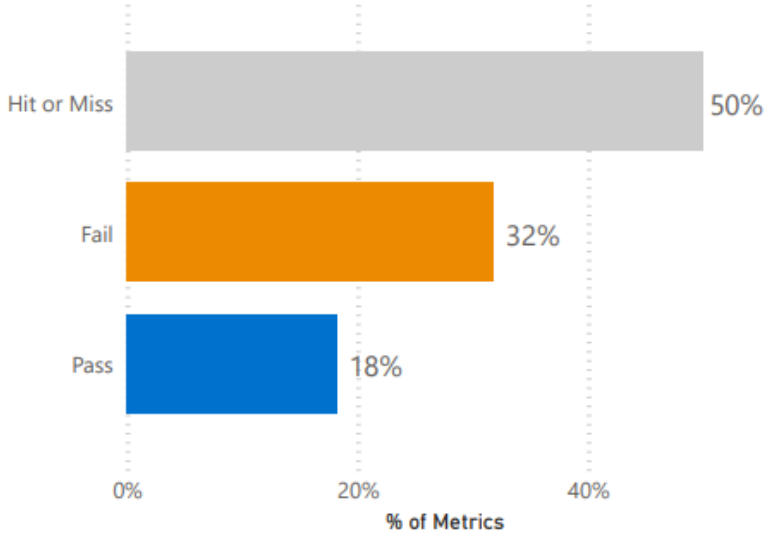
RESPONSIVE CARE

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	Jun-2023							
Section 136 Mean Response Time	Responsive Care	Jun-2023	00:21:35		00:15:25	00:27:26	00:39:27		
Cat 1 Mean	Responsive Care	Jun-2023	00:09:18	00:07:00	00:07:30	00:09:06	00:10:42		
Cat 1 90th Centile	Responsive Care	Jun-2023	00:17:00	00:15:00	00:14:13	00:16:30	00:18:47		
Cat 1T Mean	Responsive Care	Jun-2023	00:10:50	00:19:00	00:09:03	00:10:55	00:12:47		
Cat 1T 90th Centile	Responsive Care	Jun-2023	00:20:18	00:30:00	00:16:56	00:20:04	00:23:11		
Cat 2 Mean	Responsive Care	Jun-2023	00:31:09	00:30:00	00:17:19	00:33:15	00:49:11		
Cat 2 90th Centile	Responsive Care	Jun-2023	01:03:48	00:40:00	00:32:55	01:08:19	01:43:43		
Cat 3 90th Centile	Responsive Care	Jun-2023	05:37:55	02:00:00	01:16:41	06:01:53	10:47:05		
Cat 4 90th Centile	Responsive Care	Jun-2023	08:22:45	03:00:00	02:07:32	08:01:46	13:55:59		
HCP 3 Mean	Responsive Care	Jun-2023	02:27:37		00:56:18	02:47:53	04:39:28		
HCP 3 90th Centile	Responsive Care	Jun-2023	05:48:32		00:48:10	06:29:45	12:11:20		
HCP 4 Mean	Responsive Care	Jun-2023	03:11:58		01:17:46	03:33:19	05:48:53		
HCP 4 90th Centile	Responsive Care	Jun-2023	07:59:26		02:22:46	08:21:34	14:20:21		

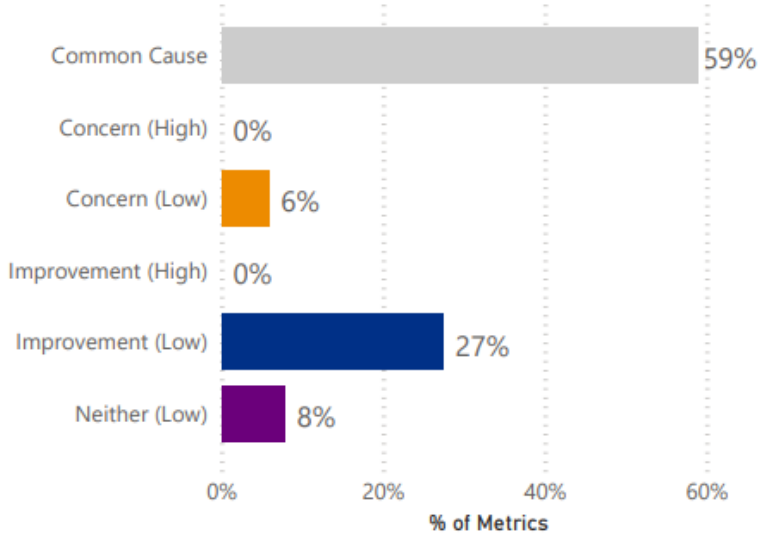
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Jun-2023	24.9%		19.41%	24.43%	29.44%		
999 Calls Answered	Responsive Care	Jun-2023	68260		49603.62	72887.3	96170.98		
999 Call Answer Mean	Responsive Care	Jun-2023	00:00:33	00:00:05	00:00:28	00:00:39	00:01:46		
999 Call Answer 90th Centile	Responsive Care	Jun-2023	00:02:08	00:00:10	00:00:52	00:02:06	00:05:04		

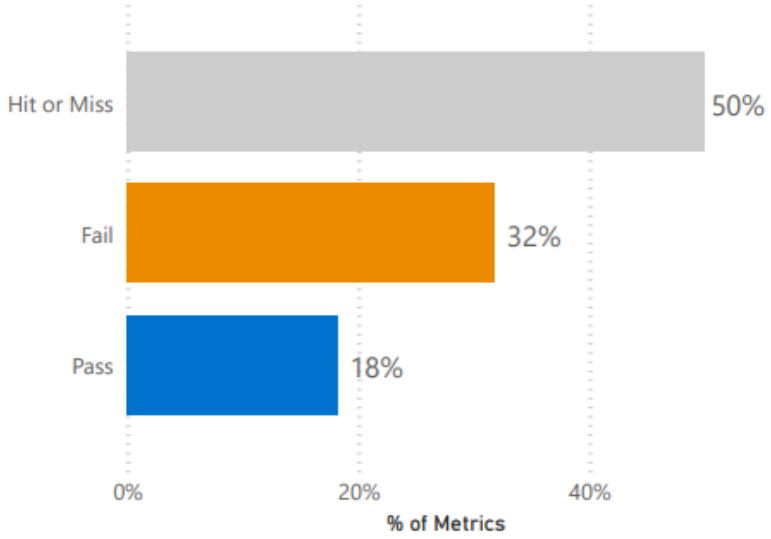
RESPONSIVE CARE

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Utilisation

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Jun-2023	89.2%	100%	83.33%	90.53%	97.73%		
Provided Bank Hours %	Responsive Care	Jun-2023	0.7%		0.57%	0.73%	0.89%		
Provided Overtime Hours %	Responsive Care	Jun-2023	6.6%		6.99%	10.04%	13.09%		
Provided PAP Hours %	Responsive Care	Jun-2023	4.4%		4.66%	5.54%	6.43%		
999 Operational Abstraction Rate %	Responsive Care	Dec-2022	34.5%	28%		35.21%			
999 Remaining Annual Leave FY	Responsive Care	Jun-2023	42.5%			33.68%			
Vehicles Off Road (VOR) %	Responsive Care	Jun-2023	13.3%		8.63%	11.99%	15.34%		
% of DCA vehicles off road (VOR)	Responsive Care	Jun-2023	14.8%		10.39%	12.91%	15.43%		
% of SRV vehicles off road (VOR)	Responsive Care	Jun-2023	3.3%		-6.58%	7.83%	22.24%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Jun-2023	115		77.77	169.05	260.33		
Number of RTCs per 10k miles travelled	Responsive Care	Jun-2023	0.59		0.24	0.69	1.13		
% of planned vehicle services completed	Responsive Care	Jun-2023	65%		56.22%	74.06%	91.89%		
% 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	Jun-2023	63.7%		58%	62.69%	67.38%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Jun-2023	6.3%	13%	5.83%	7.21%	8.58%		
Incidents	Responsive Care	Jun-2023	59238		52018.08	60107	68195.92		

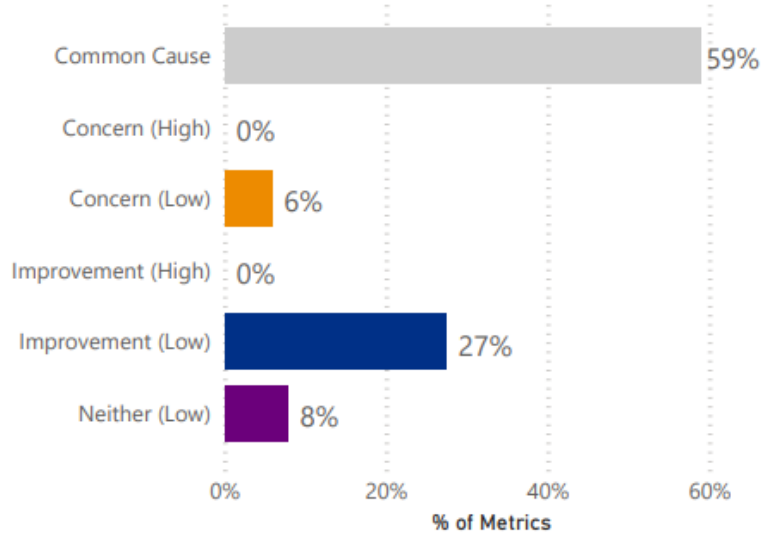
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Jun-2023	84878		69263.74	110336.8	151409.86		
111 Calls Answered in 60 Seconds %	Responsive Care	Jun-2023	45%	95%	-0.16%	32.34%	64.83%		
111 Calls Abandoned - (Offered) %	Responsive Care	Jun-2023	12.6%	5%	1.79%	19.57%	37.35%		
999 Referrals	Responsive Care	Jun-2023	4202		4317.7	5749.9	7182.1		

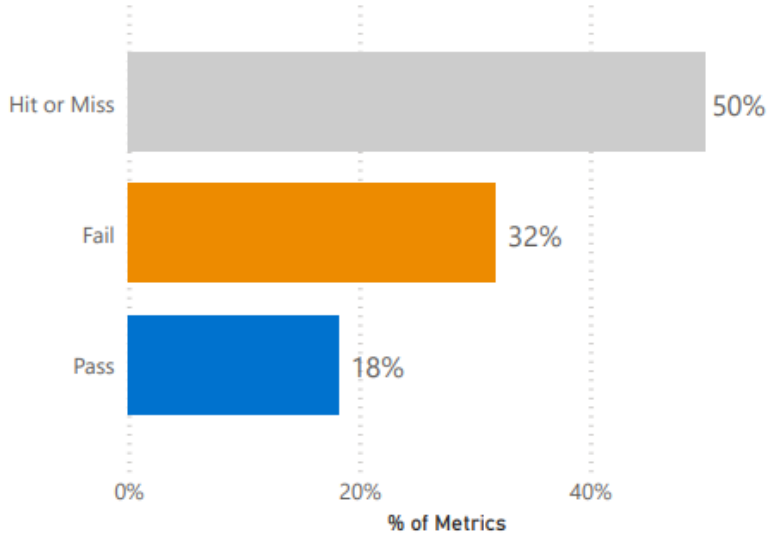
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

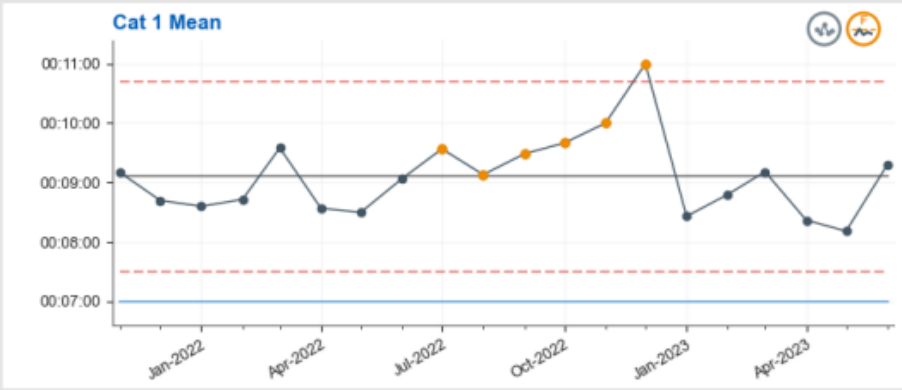
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Jun-2023	01:15:47		01:16:11	01:18:01	01:19:51		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Jun-2023	01:51:01		01:50:48	01:55:33	02:00:19		
Responses Per Incident	Responsive Care	Jun-2023	1.1	1.09	1.08	1.1	1.11		
CFR Attendances	Responsive Care	Jun-2023	787		801.75	1289.65	1777.55		
FFR Attendances	Responsive Care	Jun-2023	148		114.22	225.8	337.38		
ECAL Mean Response Time	Responsive Care	Jun-2023	00:24:28		00:21:15	00:23:25	00:25:35		

111/999 System Impacts

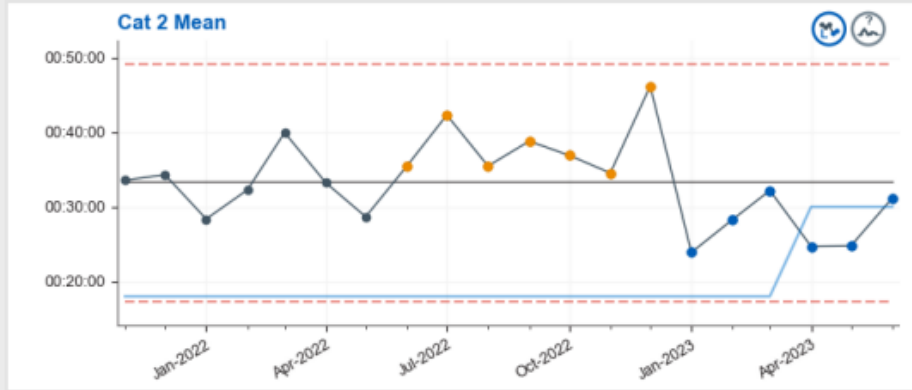
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Jun-2023	10%	14%	8.11%	9.72%	11.33%		
See & Treat %	Responsive Care	Jun-2023	31.5%	35%	30.19%	31.79%	33.38%		
See & Convey %	Responsive Care	Jun-2023	58.4%	55%	56%	58.37%	60.74%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Jun-2023	0.8%		0.73%	1.46%	2.19%		
Number of Hours Lost at Hospital Handover	Responsive Care	Jun-2023	2232.79		2060.46	4028.72	5996.97		
Average Wrap Up Time	Responsive Care	Jun-2023	00:17:16	00:15:00	00:16:44	00:17:24	00:18:05		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Jun-2023	46.9%		44.59%	47.65%	50.7%		
A&E Dispositions %	Responsive Care	Jun-2023	8.6%	9%	6.97%	8.66%	10.35%		
A&E Dispositions	Responsive Care	Jun-2023	5751		5437.96	6880.1	8322.24		
Clinical Contact %	Responsive Care	Jun-2023	49.8%	50%	46.89%	50.91%	54.92%		
Ambulance Validation %	Responsive Care	Jun-2023	91%	85%	93.27%	95.72%	98.17%		

RESPONSIVE CARE

Response Times



999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:09:18
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: 00:31:09
Target: 00:30:00
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

999-5
Dept: Operations 999
IP: Responsive Care
Latest: 05:37:55
Target: 02:00:00
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

999-6
Dept: Operations 999
IP: Responsive Care
Latest: 08:22:45
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

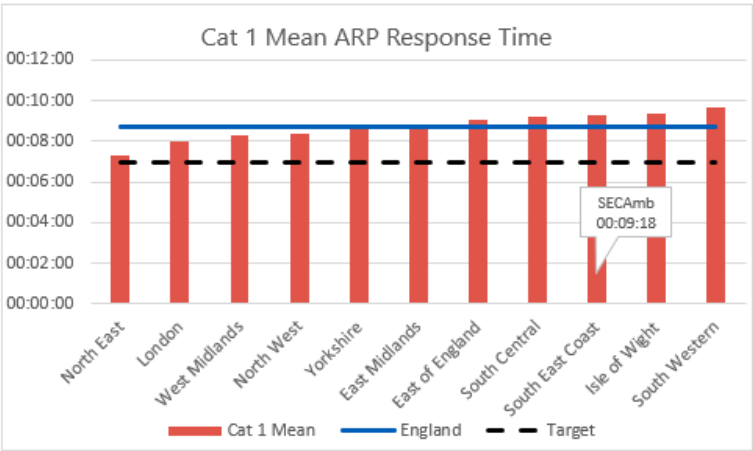
Summary

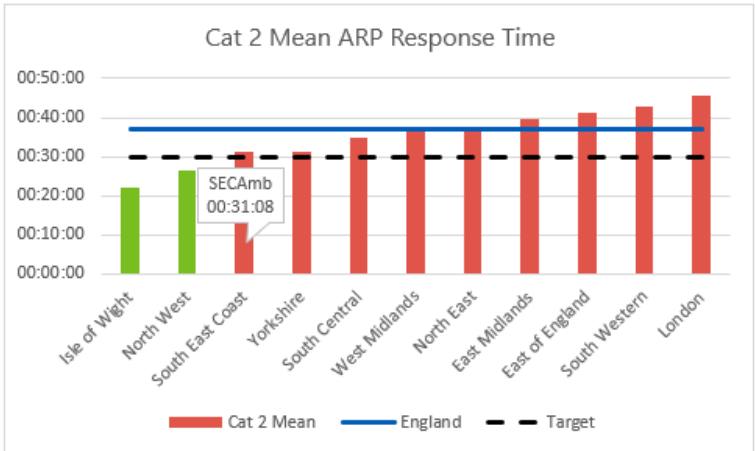
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against the delivery plan – in June 2023, performance was 31mins 8sec, against a national average of 36min 49sec..

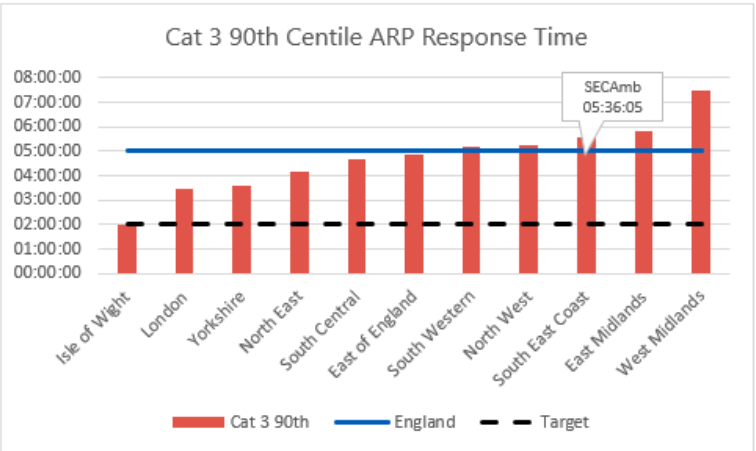
What actions are we taking?

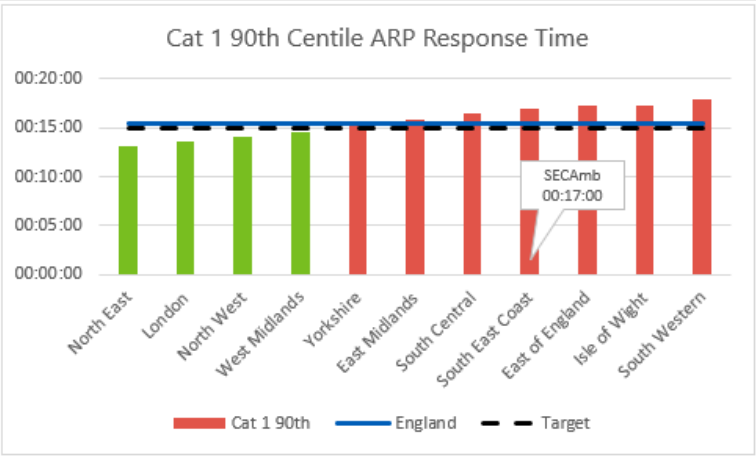
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (92.1% for June - consistent with the previous 3 months).
- C3 & C4 Clinical Validation continues, with focused clinical staffing in EOC to maintain patient safety and support apposite ambulance dispatch
- Focused attention on abstraction management, particularly on sickness 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.

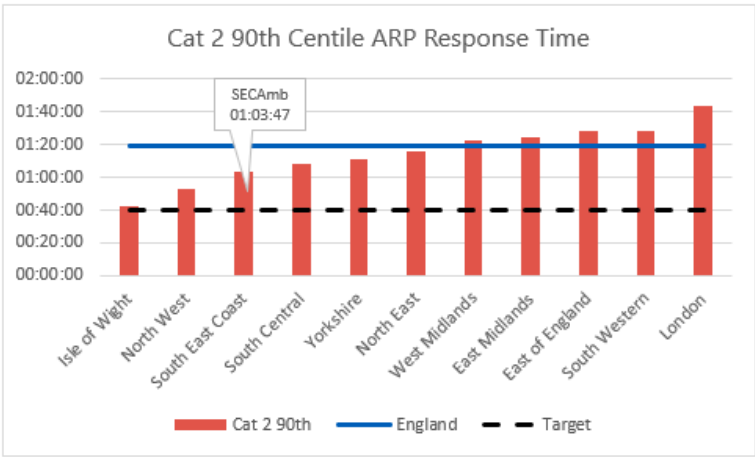
ARP Response Time Benchmarking (June 2023)

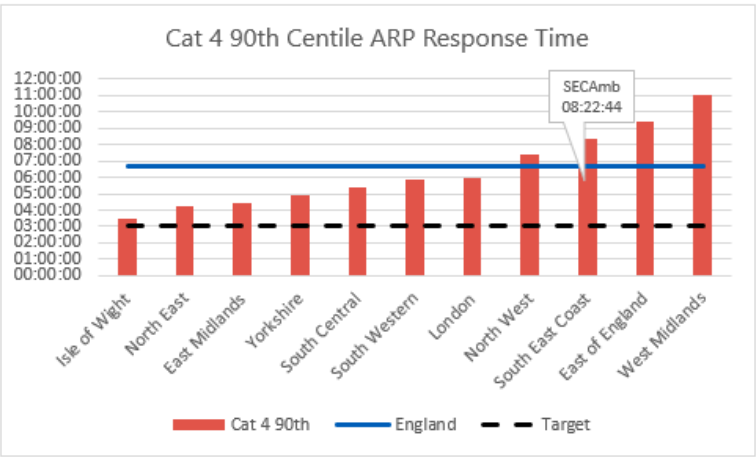












Summary

- C2 mean (a focus for the UEC recovery plan) has increased above 30min (31min 08sec) in June – however still on track against the plan for 2023-24.
- Other ARP metrics continued to be notably under-performing with

RESPONSIVE CARE

EOC Emergency Medical Advisors

999-10
Dept: Operations 999
IP: Responsive Care
Latest: 68260

Special cause variation where DOWN is neither improvement or concern

999-33
Dept: Operations 999
IP: Responsive Care
Latest: 24.9%

Common cause variation, no significant change.

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: 00:00:33
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 continues to fluctuate, underpinned by ongoing staffing challenges, a higher proportion of newer staff who are developing , although noting that there has been a small reduction in ***calls answered*** over the same period.
- ***Hear and Treat*** performance is now stable, above 10% for the previous 2 months (mid-pack in the English ambulance league table), on track with the planned trajectory for this financial year. Recruitment of Paramedics to support remote

What actions are we taking?

- EMA establishment is currently at 230, 21 WTEs below the planned levels for June. 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.
- ***C3 & C4 clinical validation model*** and ***C2 segmentation*** in August – this supported implemented at greater pace/scale with additional monies from NHSE during Aug-Oct.
- The ***Hear and Treat*** trajectory is for 12% by end of Q3 and 14% end of Q4. Additional support through the specialist Paramedics and B6 Paramedics working in local hubs continues to grow.
- The change to the EOC operating model and actions to improve H&T, and the EMA recruitment drive and associated operational efficiencies are reviewed through a formalised governance structure, overseen monthly by the Executive Director of Operations with the senior service leads, using key metrics and highlight reports.

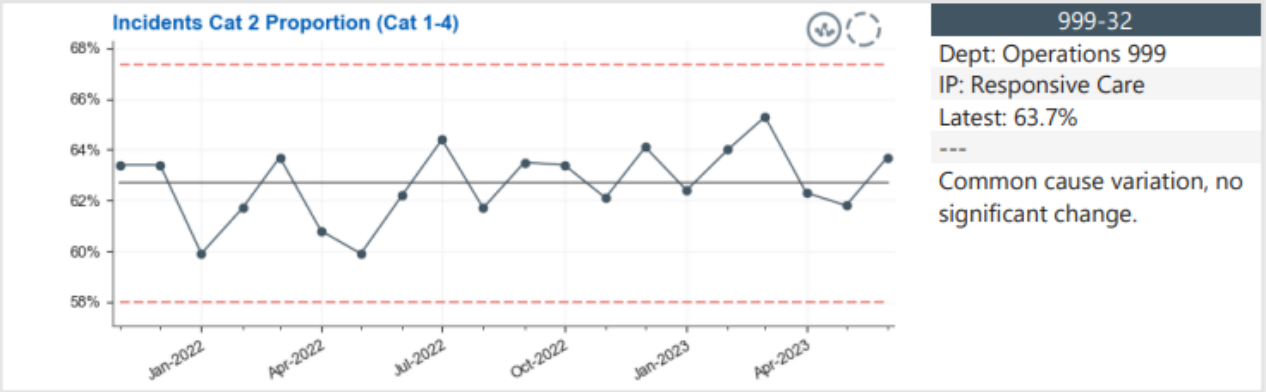
RESPONSIVE CARE

Utilisation

999-10
Dept: Operations 999
IP: Responsive Care
Latest: 59238

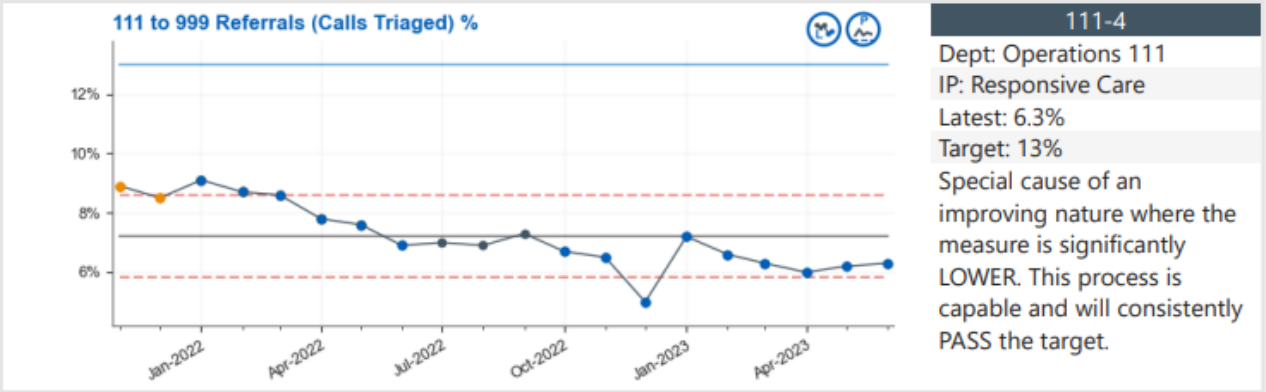
Common cause variation, no significant change.

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 89.2%
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: 63.7%

Common cause variation, no significant change.



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.3%
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 ***validation 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 implementation of the new rotas is expected to improve overall resourcing against requirement across the 24/7 period
- Frontline hours throughout the year have impacted by high ***abstraction levels***, mainly driven through sickness (which has seen some recent improvements) plus the carry-over of additional Covid annual leave. Training continues to be delivered against plan.

What actions are we taking?

- Continued effective ***111 to 999 clinical validation*** of non-emergency ambulance calls from Kent, Medway and Sussex's 111 service, significantly above the contractual requirements to protect 999 - (92.1% for June '23).
- 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: 00:24:28

Common cause variation, no significant change.

999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:15:47

Special cause of an improving nature where the measure is significantly LOWER.

999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:51:01

Special cause of an improving nature where the measure is significantly LOWER.

Summary

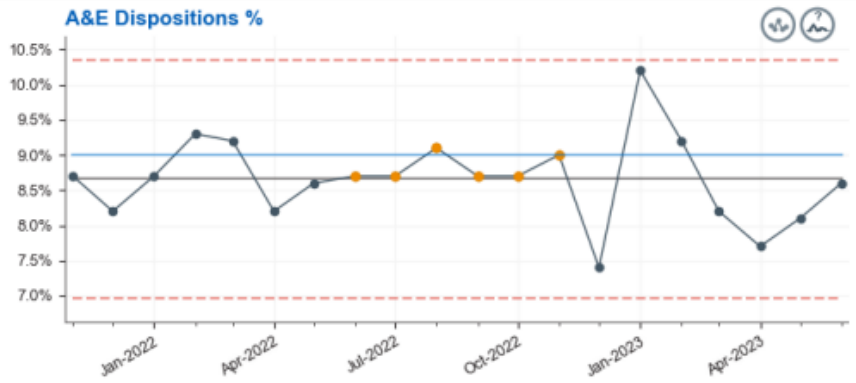
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with a deterioration in April.
- ***Job cycle time*** (JCT) provides a 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 to assist with on-scene decision making and signposting to clinical pathways; also support to work with OOH GP/primary care call-backs.
- Specific work has been undertaken in local dispatch desk areas focusing on hospital handover and on-scene times, which has resulted in the noted improvement in ***job cycle time*** since early 2023.

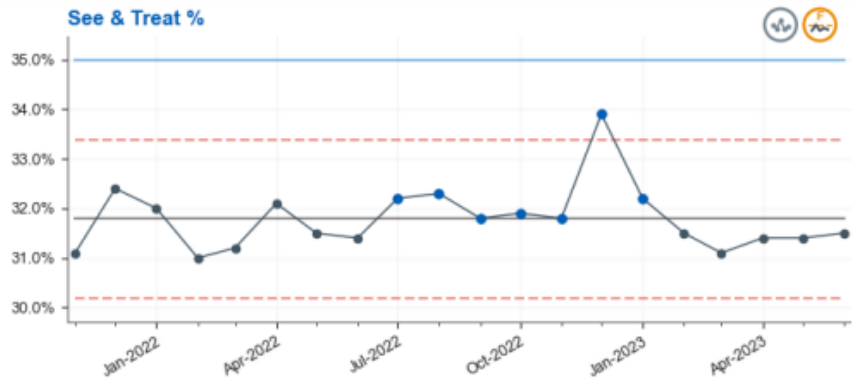
RESPONSIVE CARE

111/999 System Impacts



111-5

Dept: Operations 111
IP: Responsive Care
Latest: 8.6%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



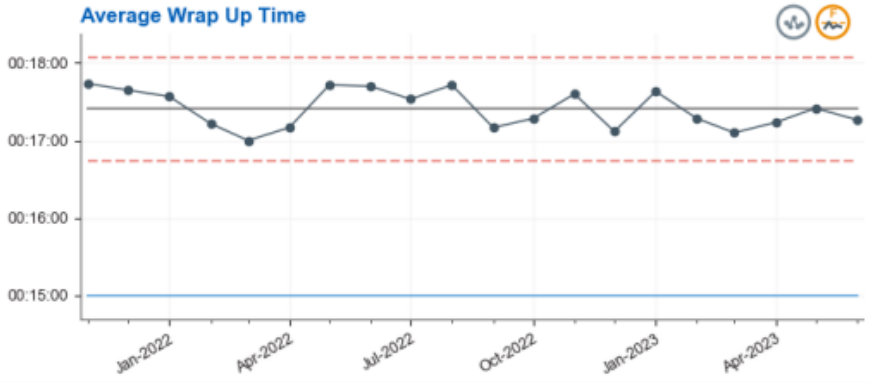
999-9

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

999-24

Dept: Operations 999
IP: Responsive Care
Latest: 2232.79

Special cause of an improving nature where the measure is significantly LOWER.



999-31

Dept: Operations 999
IP: Responsive Care
Latest: 00:17:16
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.33%, noting that there is significant variation between geographical dispatch desk areas heavily influenced by the availability and accessibility 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?

- 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.

RESPONSIVE CARE

111

111-1

Dept: Operations 111
IP: Responsive Care
Latest: 84878

Common cause variation, no significant change.

111-2

Dept: Operations 111
IP: Responsive Care
Latest: 45%
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: 12.6%
Target: 5%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

111-4

Dept: Operations 111
IP: Responsive Care
Latest: 6.3%
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

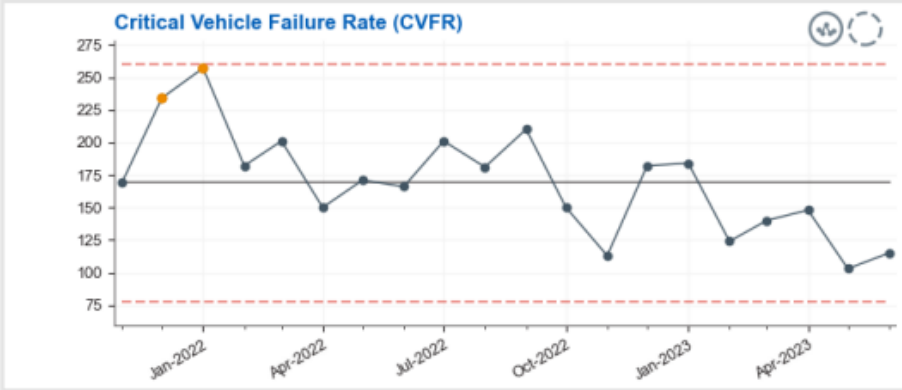
- The service's ***operational responsiveness*** remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned call.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment 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 5 months of 2023 on a 18hrs per day, 7-days a week basis.

RESPONSIVE CARE

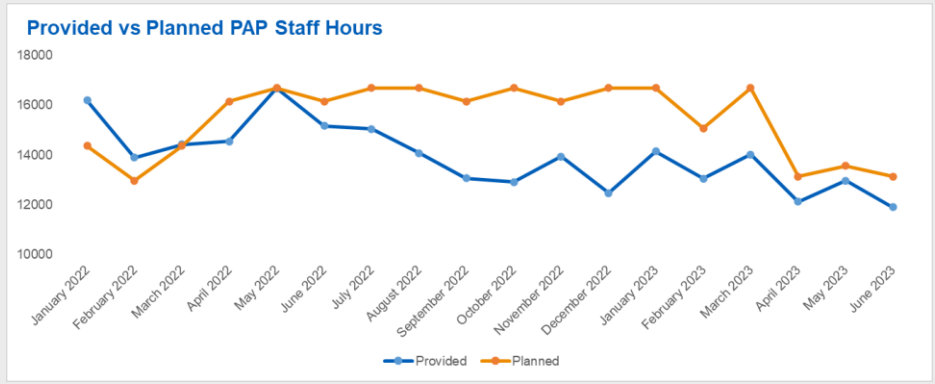
Support Services
Fleet and Private Ambulance Providers

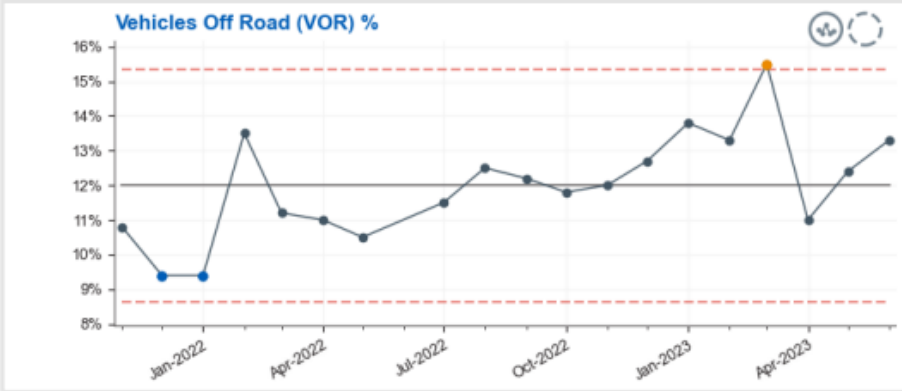


FL-12

Dept: Fleet
IP: Responsive Care
Latest: 115

Common cause variation, no significant change.





FL-13

Dept: Fleet
IP: Responsive Care
Latest: 13.3%

Common cause variation, no significant change.

FL-3

Dept: Fleet
IP: Responsive Care
Latest: 65%

Common cause variation, no significant change.

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.
VOR remains above target of 10% due to the know issues associated with delayed parts for FIAT, and lack of specialist workshops in our patch. In the short term, this is being addressed through the national fleet group. In addition, high vacancies within the VMT team are impacting the capacity we have to address issues within our workshops (vacancies c. 10%). We are doing a review of our recruitment approach to mitigate further eroding of our establishment.

What actions are we taking?

We have been collaboratively working with other Trusts as part of the oversight group for the refresh of the national DCA specification. The proposed draft specification will give Trusts different Lots with more than one conversion option and manufacturer that will also address concerns raised nationally around the current contract and the ability for that supplier to support all Trusts. Work will start to look at the potential implementation of a recruitment retention premium for vehicle maintenance staff to help with recruitment of current vacancies.

Our **PAP** hour provision is now in-line with the 120 WTE capacity contracted for 23/24 and in line with out plans. In addition, we are in discussions with St Johns Ambulance to provide further additional capacity (c- 5/6 shifts a day) from September as part of an effort to strengthen our partnerships in preparation for the winter.

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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

	June 2023			Year to June 2023			Forecast to March 2024		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	£27.4m	£27.6m	£0.2m	£79.4m	£79.9m	£0.4m	£318.3m	£318.7m	£0.4m
Operating Expenditure	(£27.3m)	(£27.2m)	(£0.1m)	(£79.3m)	(£79.7m)	(£0.4m)	(£318.3m)	(£318.7m)	(£0.4m)
Trust Suplus/ (Deficit)	£0.1m	£0.4m	£0.4m	£0.2m	£0.2m	£0.0m	£0.0m	£0.0m	£0.0m
Cash	£0.4m	£0.4m	£0.0m	£0.9m	£0.4m	(£0.4m)	£9.0m	£9.0m	£0.0m
Capital Expenditure	£40.4m	£45.5m	£5.1m	£40.4m	£45.5m	£5.1m	£50.4m	£48.4m	(£2.0m)
Effciency Target	£1.1m	£1.9m	(£0.7m)	£3.7m	£5.6m	(£1.9m)	£25.9m	£25.9m	£0.0m

Summary

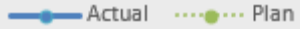
1. The Trust's financial performance is on plan and a surplus of £0.2m is reported for M3 YTD.
2. Financial pressures of £0.4m in operations were partly mitigated by vacancies across the Trust, profit on vehicle disposal and higher than planned interests received on cash in bank.
3. Efficiency Programme has delivered £0.4m worth of savings at M3 YTD (under-delivery of £0.4m).
4. Cash at M3 is £45.5m (12.6% ahead of plan) due to the timing of settling the tax liabilities arising from the pay awards. The Trust is forecasting a cash position at the end of March 2024 of £48.4m, which is £2.0m below plan. This is driven by anticipated pressures in operations.
5. Capital expenditure of £5.6m is £1.2m above plan due to timing of asset purchases, mainly in IT. The Trust is confident that it will deliver its capital departmental expenditure limit (CDEL).

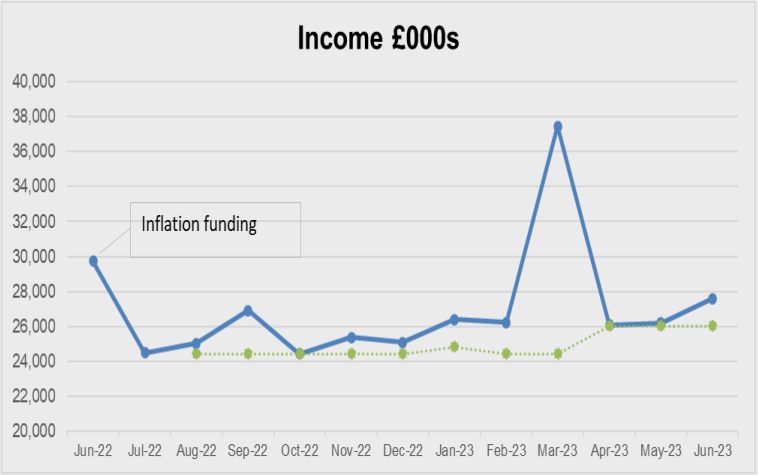
What actions are we taking?

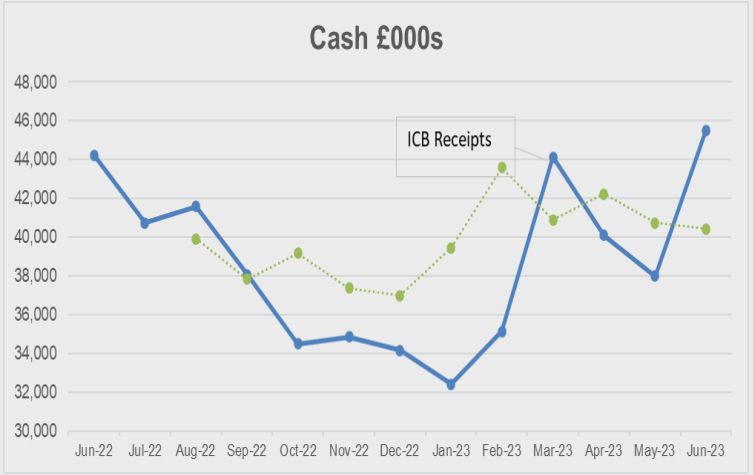
1. The Trust is working with budget holders to ensure that any overspends are brought back into line with the allocated budget allocation.
2. The Senior Management Group is focusing on identifying further efficiencies to support delivery of the efficiency target of £9.0m. This includes progressing the approval of scoped schemes into the delivery phase, developing additional schemes to support the Trust's pipeline and progressing the schemes identified by our people through identification of milestones and quantification of the financial opportunity of each scheme. Regular updates will be provided to the Joint Leadership Team meetings and Finance and Investment Committee
3. Monthly Executive lead directorate meetings are continuing to ensure that each directorate delivers their element of the financial plan e.g., budget and efficiency target.
4. A deep dive has been carried out on the overspend in operations and remedial actions have been identified to mitigate financial risk and to support the delivery of the Trust's financial breakeven plan at year end.

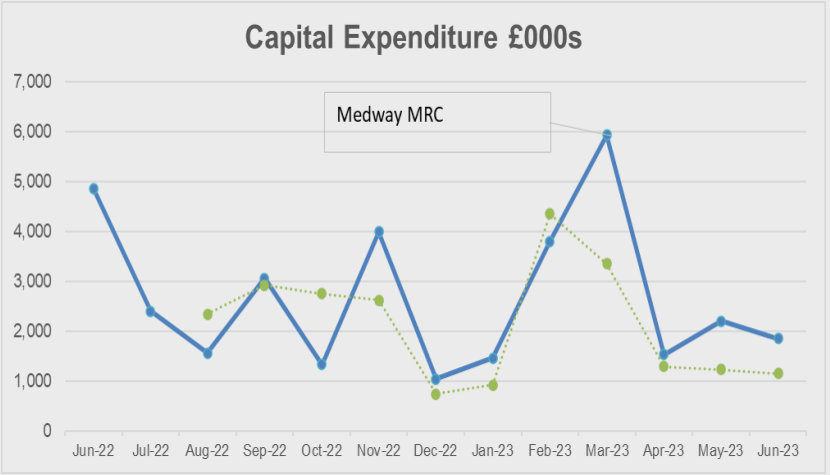
SUSTAINABILITY & PARTNERSHIPS

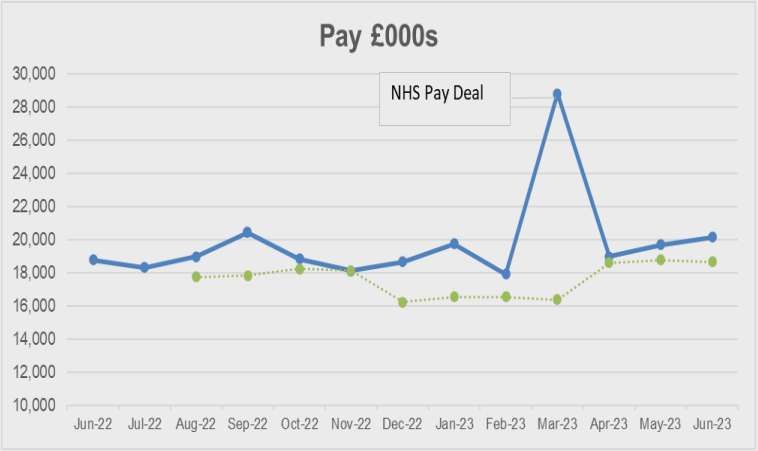
Delivered Against Plan

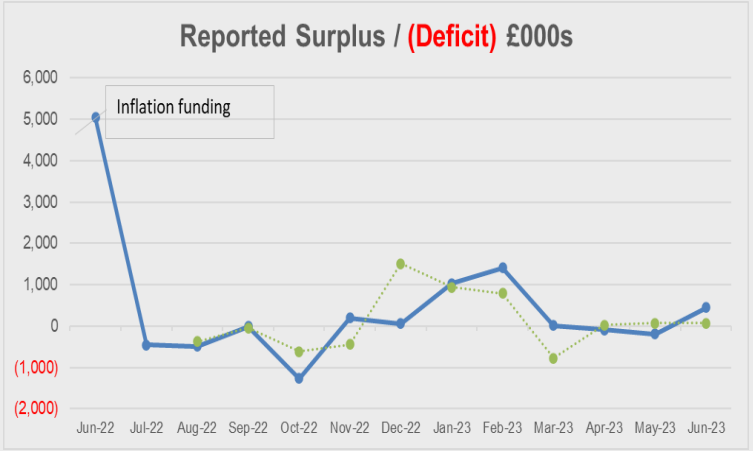












Summary

- The Trust's financial performance is on plan and a surplus of £0.2m is reported for M3 YTD.
- Financial pressures of £0.4m in operations were partly mitigated by vacancies across the Trust, profit on vehicle disposal and higher than planned interests received on cash in bank.
- The main areas to highlight from the graphs are the additional cost and income in M3 2023 relating to the NHS pay deal, ICB cash receipts and Capital expenditure on IT.

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Appendix

Appendix 1: Glossary

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations

F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	38-23

Name of meeting	Trust Board
Date	3 August 2023
Name of paper	People and Culture - Executive Summary to the Board
Strategic Goal	Focus on People and Culture
Lead Director	Ali Mohammed, Executive Director of HR and OD
Primary Board Papers	BAF Risks i. Workforce Plan (255) ii. Retention (13) iii. Culture and Leadership (348) iv. Integrated Quality Report (slides 21-33)
Executive Summary	**Risk Overview** The previous combined risk of retention, culture and leadership has been split into two risks with one now specifically focusing on retention and the other now confirmed as Culture and Leadership (risk 348). The Recruitment risk has now been relabelled as Workforce Plan. The IQR is reflective of the current risks (except for industrial action) through the key metrics set out in the Overview. Industrial action has been paused by most unions now. Some further action may be possible by the RCN and UNITE. Action by the BMA, primarily in hospital partners, continues. The national pay arrangement for Agenda for Change staff was implemented successfully in June 2023. **Workforce Plan** The SPC charts within the IQR now show both 'volume' or cohort and 'ad hoc' recruitment. The former are to fill spaces on both contact centre and field operations planned courses, whilst the latter are to fill vacancies in other positions that arise throughout the year. 371 WTE in staff will be recruited by end of 23/24 with the following breakdown. • 139 NQPs • 87 International Paramedics • 110 ECSWs • 35 AAPs A Quality Improvement project to improve TTH and onboarding commenced in May 2023 and an update is provided in the IQR from the initial meeting.

	The People and Culture Strategy makes a commitment to **reduce Time to Hire (TTH)** and onboarding to achieve the 60 days target as one of a number of priority areas identified for people and cultural change. An update on the work to refine the Trust's **vision for wellbeing** at work is contained with a separate paper to this Board. This will continue to be monitored by the People Committee. **Retention** Staff retention remains a high concern. A focus on **flexible working**, including a policy update to incorporate legislation changes, and a management and colleague guide to flexible working will be the retention priority for Q3. Sickness absence has increased slightly, at 6.99% which is still above our target of 5%. We are **not an outlier** compared to other ambulance Trusts. Monthly scrutiny of action plans at Operations Senior Leadership meetings continue with support from HR Advisors. An attendance management deep dive using the **NHS Attendance Management Challenge Toolkit V9.0** has been undertaken by the HR&OD Team and the findings are currently being assessed. The IQR shows natural variation in the number of wellbeing referrals and so it is likely that this has now reached a stable picture in terms of overall Wellbeing Hub referrals. There is now a capacity gap however as external ICB support has been withdrawn by closure of the three ICB Resilience Hubs. The NHS has launched a new **Long-Term Workforce Plan** and retention is the most immediate section which we will need to pay attention to. This initially is the subject of a separate paper. **Culture and Leadership** The Trust Board agreed a new People and Culture Strategy at its April 2023 meeting. The executive team has worked together to identify Year 1 priorities, actions and KPIs. It will be critical to ensure that the implementation of the strategy is communicated to, seen and felt by all our people particularly as this strategy also now effectively forms our response to the Staff Survey by focusing on actions which our people have asked us to consider in the survey. A **new step in transparency** has been taken by including a **specific area on the Staff Zone where the delivery plan for the strategy is available to all**. An **executive team development programme** is being developed under the leadership of the CEO. The number of suspension cases continues to decrease showing progress both in process terms but also in terms of considering alternatives to suspensions and removing suspensions as soon as practically possible. As a result, we have moved from **c.20** suspensions at the beginning of 2022 to **four** open cases. Importantly, the continuation of the focus on sexual misconduct means that we currently **do not have any** sexual harassment cases within the four suspensions.

	An Improvement Case has been fully approved to increase employee relations capacity by creating a specialist ER team separate to the HR Business Partner team. We have **successfully recruited the new Head of ER** role and they will be starting with the Trust in October 2023.Two specialist ER managers are now being recruited to complete the senior tier within the new team. As updated at the last Board, the next steps on the work with ACAS mediation to improve working relationships with TUs proceeds. A proposal from ACAS was received and agreed to by the Trust and its five recognised unions. The proposal involves two days of the executive team meeting with the GMB and then two days with all five unions. The days with the **GMB will be complete in July** and the wider dates are now being set up. The latest **National Quarterly Pulse Survey** closed on 31 July 2023. The number of responses (as at 25 July 2023) **was 836**. Previously our highest response was 812 in April 2023. A report will be prepared for internal dissemination following the closure of the survey. Concerns raised through the FTSU team remain high with continuing concerns about detriment. The themes appear to be similar to previous months including **bullying and harassment, inappropriate behaviours and safety/wellbeing**.
Recommendations, decisions or actions sought	We continue to face a number of operational and workforce challenges. These are reflected with the BAF and Trust Risk Register and by the scale of the work set out in the strategic objectives and associated delivery plans. The work set out in the People and Culture delivery plan focused initially on those areas within the CQC warning notices but has now importantly moved to address the **deeper issues in respect of culture, leadership and staff experience**. The development and approval of a new People and Culture Strategy is an important and critical step forward in our aspiration to create a better place of work for our people. The **delivery plan** is a key step forward and the visibility given to that delivery plan on an **open space within the Staff Zone** is a major step forward in terms of transparency. It is recommended that the Board **discuss** and **endorse** the actions taken to date and **individually and collectively own and support** the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	38-23

Name of meeting	Trust Board
Date	3 August 2023
Name of paper	NHSE Long Term Workforce Plan
Executive sponsor	Ali Mohammed, Executive Director of HR and OD
Author name and role	Ali Mohammed, Executive Director of HR and OD

NHS England recently launched its long-term workforce plan NHS England » NHS Long Term Workforce Plan

In addition, an update is provided (Appendix 1) of the work we are doing relating to the wellbeing of our colleagues, provide a vision for 'Wellness' for 2023/24, and to provide assurance that the Trust investment is both effective and value for money – as provided in the external VFM review by the University of East Anglia (Appendix 2)

The focus on 'safety and health' in the recently launched NHS England Long Term Workforce Plan is likely to mean increased focus, scrutiny and support to ensure that NHS staff feel that the NHS cares for and about them.

1. Introduction

The publication of the NHSE Long-Term Workforce Plan ('the Plan' provides both an opportunity but also a challenge for SECAmb. We are operating in a fairly constrained labour market in terms of paramedics in particular and face issues with workforce supply, recruitment, retention and staff experience due, in part, to the culture within the Trust.

The Plan sets out a fairly ambitious programme of change and indeed reform to the NHS workforce and divides this into three broad sections – Train, Retain and Reform. The challenge for us will be to ensure that we place our effort and attention on the parts which really matter to our people and place as a provider of urgent and emergency services.

2. Our workforce challenges

As we continue to uphold our commitment to providing exceptional urgent and emergency services to our community, we must address the long-term workforce challenges that lie ahead. In light of the evolving healthcare landscape and growing demands on our services, it is imperative that we develop strategies to tackle the critical aspects of education, workforce supply, recruitment, training, and retention within our organisation.

a. Recruitment

Recruiting and attracting qualified and diverse candidates to join our service is of utmost importance for the continued success of our mission. The demand for skilled and compassionate clinical professionals is on the rise, and we must ensure that we remain competitive in this market.

Strengthening outreach efforts, creating a **stronger employer brand**, demonstrating a clear and tangible commitment to **diversity and inclusion**, targeting our recruitment strategies and **reducing our time to hire** as well as **improving candidate experience** will be critical for the Trust and these are all areas which are highlighted in the Plan, albeit without sufficient attention to the specific needs of the ambulance service.

b. Education and Training

As medical practices and technologies evolve, ongoing training and development are essential for our workforce to stay at the forefront of pre-hospital care. A well-trained

and adaptable team enhances the quality of our services and fosters staff satisfaction.

Key elements to our future workforce strategies will include strengthening our approach to continuous professional development (**CPD**), investing in **management and leadership development for existing and aspiring managers** and continuing to forge new and stronger **strategic partnerships** with reputable healthcare education institutions.

Our approach to **talent management and succession planning** will also need to develop. By identifying and nurturing talent from within our organisation, we can cultivate a robust pipeline of future leaders committed to our values and mission as a service. Strong programmes of **mentoring and coaching** will be essential and we should aim to work in **partnership** with other system, regional and national partners to access the best support to our people.

c. Retention

Retaining our skilled and dedicated workforce is vital for maintaining service excellence and preserving institutional knowledge. Our **People and Culture Strategy** sets out our strategic objectives and it will be important to stay focused to deliver against the strategy. By fostering a supportive and inclusive work culture and environment, we can enhance employee experience and engagement and thereby reduce turnover.

Taking our **employee wellbeing** offering to the next level by more initiatives to prioritise the physical and mental health of our employees and promoting work-life balance, such as more **modern flexible work arrangements** to cater to the diverse needs of our employees.

Recognising and rewarding exceptional performance is crucial in creating a positive and motivating work environment. In addition, it is critical that managers are able to **address poor performance** as this can also have a negative effect to staff morale of others if left unchallenged.

To ensure that our people see a future within our organisation, the development of **clear career pathways and opportunities for professional growth** will be essential. Some of this work will need **strategic partnerships with system partners** to offer opportunities for colleagues to gain and bring back experience from elsewhere in the system. Employees who perceive a clear trajectory for advancement are more likely to stay committed to our organisation for the long term and indeed, **moving elsewhere for better career development/opportunity is the most common reason given in exit interviews for leaving SECAmb**.

Meeting the long-term workforce challenges of recruitment, training, and retention requires a proactive and collaborative approach. By adopting the proposed strategies, we will be better equipped to secure a skilled and diverse workforce, invest in their continuous development, and create a more positive culture and environment where our employees thrive professionally and personally regardless of their background.

3. The NHSE Long-Term Workforce Plan

The Plan sets 'out a strategic direction for the long term, as well as concrete and pragmatic action to be taken locally, regionally and nationally in the short to medium term to address current workforce challenges. Those actions fall into three clear priority areas:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
- **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.' *From the NHSE Long-Term Workforce Plan*

A summary of the Plan can be found at **https://www.england.nhs.uk/long-read/accessible-nhs-long-term-workforce-plan/#summary.**

The Plan is substantial in size and will require all parts of the NHS to work carefully through its content and implications**.** As a provider organisation in the urgent and emergency care service, we will need to engage at the appropriate system, regional and national levels to ensure that we are able to maximise its impact and benefit to our services and people.

What is clear is that many organisations are already responding. Often, this is simply by offering initial analysis or opinion, but there are also questions and suggestions being proffered at this early stage.

A selection of responses can be found at the links below.

Organisation	Link
College of Paramedics	Our response to the NHS Long Term Workforce Plan (collegeofparamedics.co.uk)
NHS Confederation	Ambitious NHS Workforce Plan offers hope to staff working in the NHS | NHS Confederation
British Medical Association	Future of NHS in Government's hands following workforce plan announcement, says BMA - BMA media centre - BMA
Kings Fund	Train, retain, reform: does the NHS Long Term Plan provide a coherent map for the future? | The King's Fund (kingsfund.org.uk)
General Medical Council	GMC response to the NHS Long Term Workforce Plan - GMC (gmc-uk.org)

Conclusion

Staff retention is clearly the area where we can have most immediate and direct impact and is recommended therefore as our initial area of focus. This is therefore the recommended area of initial discussion today at the Board.

Improving staff experience at all stages, addressing staff concerns, becoming more flexible and providing a great working environment and culture as well as proper attention and investment in development and education will be critical steps in our journey to improving staff retention.

Appendix 1

The Vision for Wellness

1. Introduction

1.1 This paper comes at the request of the Trust Board and aims to provide assurance that we are meeting the Wellbeing needs of our colleagues, as defined in the NHS Wellbeing Framework 2022.

1.2 Throughout this paper we use the terms 'Wellbeing' and 'Wellness' interchangeably.

1.3 'Wellbeing' being the term used most by the NHS when referring to the support that we provide to our colleagues through the provision of the Wellbeing Hub (Physiotherapy, Mental Health support, Occupational Health etc).

1.4 'Wellness' being the more holistic terminology that includes a colleague's own responsibility for their health and wellbeing, such as taking any prescribed medication, attending appointments, following treatment/recovery plans etc. The terminology also includes management responsibility for the health and wellbeing of their colleagues through timely referral, quality return to work interviews, accurate recording of absence, and wellbeing conversations.

1.6 Internal assurance is provided via the People Committee through Bi-Annual reports, with Professor Tom Quinn (Non-Executive Director) being the Trust's Wellbeing Guardian.

1.7 Despite a significant number of Wellbeing meetings, both locally and nationally, as well as ambulance specific meetings, there is currently little governance of wellbeing outside of our own internal processes.

1.8 The focus on 'safety and health' in the recently launched NHS England Long Term Workforce Plan is likely to mean increased focus, scrutiny and support to ensure that NHS staff feel that the NHS cares for and about them.

2 NHS Wellbeing Framework Diagnostic Tool

2.1 The NHS Wellbeing Framework Diagnostic Tool was seen as the perfect tool by the newly appointed Associate Director responsible for Wellbeing to assess where we were in our wellbeing provision, and what remained to be done. The later forming the Wellbeing Plan 2022-24 (See Appendix).

2.2 Whilst it was a self-assessment process, we scored well in three of the seven areas, reaching a 'significant progress' rating. These areas included environment, personal health & wellbeing, and managers & leaders.

2.3 More information on the NHS Wellbeing Framework Diagnostic Tool can be found here.

2.4 We scored ourselves as 'low level of progress' on three of the remaining four areas, relationships, data insights, and professional wellbeing support. We have actions to redress these areas and bring them up to 'significant progress' within 12 months.

2.5 In one area we scored ourselves as 'not started'. This related to fulfilment at work. Again, we have a plan to get this up to 'significant progress', although this will take 18 months.

2.6 The self-assessment was a rating for the Trust and not of the Wellbeing Hub. Much of work to do with wellness sits outside of the hub.

2.7 We have taken a coaching approach to supporting and developing managers. Revisiting policies, as appropriate, attending Team meetings and inductions, and developing support materials.

2.8 We are due to complete a re-review in September where we expect to see a positive improvement in the metrics.

2.9 Through external review, the Wellbeing Hub has been assessed as being good value for money. What we now need to do is further enhance our service provision, providing tailored support. In much the same way as we have done for the 1s and 9s.

2.10 We also need to consider the development of new service provisions to meet demand for 2024 onwards.

3. Current Issues

3.1 Aside from the current budget challenges, which affect the whole of the Trust, NHSE have ended funding for the Regional Wellbeing Hubs.

3.2 The Regional Hubs provided mental health support for circ.400 SECAmb colleagues.

3.3 We are now faced with having to find alternative provisions for these colleagues, and at a time when our own Mental Health Practitioners are at capacity.

3.4 To address this, we have developed a business case (invest to save), which includes the procurement of an Employee Assistance Programme, an additional Mental Health Practitioner, and an administrator to take the

paperwork burden of the clinicians and allow them to support more colleagues.

3.5 Whilst there are always improvements to make, and hurdles to overcome, our colleagues really value the Wellbeing provisions provided by the Trust. As a Hub we are receiving multiple compliments every week, and we take pride in celebrating each of them.

4. Wellness Plan 2022-24

4.1 The SECAmb Wellness Plan is designed to be easy to understand, following a simple engagement model consisting of four elements:

a. What Will We Do?
b. How Will We Do It?
c. When Will We Do It?
d. How Will We Know If We Have Made a Difference?

4.2 The plan aligns to our strategic vision of 'Best Place to Care, Best Place to Work.

4.3 The plan has 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

4.4 The plan has seven priority areas which align to the NHS Health and Wellbeing Framework. This is where we have concentrated our actions for 2022-24.

4.5 There are also four things that we are passionate about as a Trust leadership team:

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

4.6 The full Wellness Plan can be found in the appendix.

4.7 As a Wellbeing leadership team, we have taken time to engage with different teams, ensuring they understand the plan and their responsibility for its delivery.

5 The Future of Wellness

5.1 The Health and Wellbeing landscape continues to change, with NHSE devolving progress to ICB level, with a focus on collaboration on shared services.

To this end we are **collaborating with ICB colleagues on a shared internal Occupational Health provision for 2027**.

5.2 We have our **Wellness Plan** that gives us our focus for the next 18 months.

A critical part of our plan is to ensure that we engage with our people further to ensure that our service remain valued and relevant. We will therefore develop a **clear engagement plan** during August 2023 which reaches all parts of the Trust and is consistent with the People and Culture Strategy and the Comms and Engagement Strategy.

We have also just secured our Occupational Health provision for the next three years through Optima, and we are currently looking at **three new provisions to further enhance our offering** and **drive improvement in attendance in line with our strategic objectives.**

5.3 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.

5.4 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 (£1.75).

5.5 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.

5.6 And 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 a number of times in the last year.

Through our **Postvention review process** we have satisfied ourselves that we are doing everything we committed to do, and in a timely manner. What is evident is that we need to do more around **coaching and supporting managers** when health matters are raised during **Wellbeing Conversations**. Managers are saying that they do not feel sufficiently equipped and/or trained to support colleagues in this area.

5.7 We are also working on **aligning the various workflows that feed into alternative duties**, such as Carers Passport, Disability Passport, Temporary and Permanent Redeployment. Our managers are telling us that they lack a clear pathway to determine what support they can give to colleagues. Our managers are also telling us that they are struggling to understand the next steps when presented with either the Carers or Disability Passport.

5.8 Another area of focus will be doing more to support our **Neurodiverse colleagues and build on the charter** that was signed in 2021.

5.9 **Regular updates will be provided as part of the delivery of the Trust's People and Culture Strategy and our response to the NHS Long Term Workforce Plan**.

6.0 Conclusions

6.1 The **NHS Long Term Workforce Plan** will mean that we will need to continue to provide and increase a high-quality health and wellbeing support offering to our people.

6.2 As a Trust, our **Wellbeing provision has been assessed as providing value for money** (external review by the University of East Anglia – Appendix 3).

6.3 We remain the 'go to' Trust for others considering setting up their own Wellbeing offering, and we feed into the **ICB Wellbeing Group**, contributing ideas and initiatives to support other Trusts.

6.4 We have a **robust plan and will engage with our people** to drive ongoing improvements in our service provision.

6.5 We also have a number of **investment initiatives for further enhancement of our health and wellbeing services** for our people.

Wellbeing Plan

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 **In Development**	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. **Good Progress** rrounding health and 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 **Completed**	
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 **Good Progress**	
	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	
	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 **Good Progress**	
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	**Data and Insights:** • Decisions made surrounding health and wellbeing take a data first approach where possible • Data is used to monitor progress and improvement **Completed BI** **Professional Wellbeing Support:** • Health and wellbeing considerations are present in policies and procedures and also when undertaking service redesign/transformation	Mar 23 for BI Mar 24 for Insights Mar 23 **Good Progress**	

2022-24%20Wellness%20POAP.pptx

SECAmb Wellbeing Vision: In line with the NHS Wellbeing Framework 2022, our vision is to support the health and wellbeing of our colleagues, enabling them to provide high quality patient care.

Wellbeing Hub Overview

SECAmb's Wellbeing Hub, and its wellbeing interventions for colleagues, has long been seen as the model to aspire to by other Trusts.

Through a £1.25million annual investment, £1.17million for 23/24, the Wellbeing Hub have been able to provide a one-stop-shop model for all health and wellbeing interventions.

Every month the Wellbeing Hub handles an average of 1,200 interactions, either directly from colleagues or via their line manager. In April 2023 this increased to over 1,700 interactions.

From these interactions we average 60 'Wellbeing' referrals, 50 Physiotherapy referrals, and 15 TRiM referrals each month.

'Wellbeing' referrals typically relate to things such as work-related stress, anxiety, bullying & harassment (psychological impact), low self-esteem, and trauma related.

TRiM is our specialist trauma risk management service. TRiM seeks to provide assistance for managing normal reactions to potentially distressing or traumatic situations and prevent the development of further difficulties.

As well as the 'core' services already mentioned we also provide 50 plus mental health assessments each month, either through our Wellbeing Practitioners or via Regional Hubs. These assessments often then lead on to talk therapies such as Cognitive Behavioural Therapy.

Advice and support on addictions, bereavement, COVID-19, domestic abuse, family & relationships, finances, legal & crime, neurodiversity, physical health, and workplace support as also provided through the Wellbeing Hub.

'Your Mind Matters' Campaign. This was an Executive sponsored campaign focused on Mental Health support for colleagues. SECAmb developed the campaign to help colleagues navigate the help that is available to them, from maintaining good mental health to where to turn to in a crisis. Alongside this we have updated our Wellbeing Zone pages to make our offering clearer and are running targeted campaigns through the next 12 months on the different service we have to offer. We will monitor uptake and impact through our People Analytics Data and report accordingly.

‘Wellbeing Practitioners’ for EOC and 111. Through £100k of NHSE/I funding we have been able to recruit two dedicated Wellbeing Practitioners, on two-year fixed term contracts, to provide direct support to our Urgent and Emergency Care colleagues.

The two EOC’s and 111 represent the highest sickness and highest turnover rates for the Trust. It is hoped that by having dedicated wellbeing resource we can begin to reverse this.

‘Wellbeing Champions / Mental Health First Aiders / Applied Suicide Intervention Skills Trained Colleagues’. Each Operating Unit and Directorate now has at least one each of the above.

Our Wellbeing Champions are colleagues with in-depth knowledge of the Wellbeing Hub services, and they can signpost managers and colleagues to relevant services.

Our Mental Health First Aiders have undergone 1-day certified training and have in-depth knowledge & understanding of mental health and factors that can affect the wellbeing. These include:

- Practical skills in spotting triggers and signs of mental health issues
- Confidence to get involved, reassure and support a colleague who is in distress
- Enhanced interpersonal skills such as non-judgemental, and listening skills

Our Applied Suicide Intervention Skills trained colleagues have undergone a 2-day certified training course and are equipped to intervene where a colleague has suicidal ideations.

Wellbeing Volunteers provide their time in support of our colleagues through the provision of tea, coffee and refreshments via our welfare vehicles and trolleys in times of high demand.

Employee Assistance Programme (Overview)

An Employee Assistance Programme provides around-the-clock mental health support to our workforce and their immediate family. It’s a vital employee benefit that helps our teams make it through difficult times. Whether it's personal or professional challenges, an EAP provides a safe space to talk through it all.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	38-23

Name of meeting	Trust Board
Date	3 August 2023
Name of paper	Culture Transformation Program - Update to the Board
Strategic Goal	Focus on People
Lead Director	Ali Mohammed, Executive Director of HR and OD
Author	Dr Tina Ivanov, Programme Director (Cultural Transformation)
Executive Summary	The People and Culture Strategy Delivery Plan is approved and has commenced. A webinar launching the Strategy was held on 17 July 2023. This was very well attended with good engagement. A commitment was made to hold an update webinar approximately every six weeks. In Year 1, 111 actions have been identified, including the 41 'housekeeping' items. 26 actions are complete, 5 actions are overdue in Q1 and expected to be completed in Q2, 41 actions are in progress and 44 not due to start. Quarter 2 (Q2) continues the delivery of actions, with 39 due. The Programme Director meets with leads regularly and is assured the project remains on track for completion. Leadership programmes for the Executive, Senior Managers and Operation Managers are under development, due to commence in Q2. External support is being sourced for the executive programme, and will inform the content for the other groups. This will also build on the discussions with the Operational Managers at the Board Development day, as the Trust prepares for more distributed leadership, meaningful autonomy and supported cultural change at local level. The Cultural Change communications plan has been agreed, mapping the weekly, monthly and annual activities that will celebrate changes and deliver consistent messages about how we are "Getting Things Right for our People". The plan is supported by a themed campaign, is multi-modal and supports generating conversations so that we hear from our people and engage in dialogue about things that matter. The culture dashboard is under development, utilising current and new metrics as 'groups' to set change thresholds for each of the People and Culture Strategy outcomes. The team had an initial meeting in July, to confirm the 'groups', and will look at setting the proposed threshold to be achieved (the impact of the culture change work), at the next meeting in August. The team is also exploring the ability to measure 'sentiment' from the free text, to assess if how people feel has changed. A draft dashboard will be presented to People Committee in September. It is recognised that the Staff Survey results may not change significantly in the 2023 report, so other methods for understanding the impact is critical.
Recommendations, decisions or actions sought	The Board is asked to **discuss** the progress and the plans for Q2, as part of the overall approach to culture transformation. It is recommended that the Board continue to endorse the actions taken to date and individually and collectively own and support the programmes aimed at improving organisational culture, leadership practice and staff experience.

1. Introduction and Background

The diagnostic phase was completed in May, with discussion held at the Executive Management Board (EMB) throughout April and May. The diagnostic phase found several reviews had been held recently, coupled with feedback from surveys such as the Staff Survey and leadership visits, and it was clear that many issues had been identified.

The information from the previous reviews and surveys was themed and a series of actions recommended for Year 1, as part of the delivery plan for the People and Cultural (P&C) Strategy. In addition, a set of principles were agreed with EMB to guide changes to ways of working and to support the culture narrative.

Culture transformation occurs when all elements of organisation culture are consistent, and reinforce the behaviours, attitudes, beliefs and actions required. Previous interventions had focused mostly on the individual, with minimal change to the structures and supports.

We have agreed there must be consistency across all elements, to address both systems and structures, as well as the individuals' behaviours and actions. This will be led from the top of the organisation, and must engage our people in the co-design and collaboration to define the culture we want.

The culture change we are aiming for will not occur quickly, and it must be sustained. To succeed in shifting to an improved culture, where our people have more positive experiences in the workplace more often, feel proud, connect with SECAmb, and recommend us as a place to work, we must re-establish trust and psychological safety.

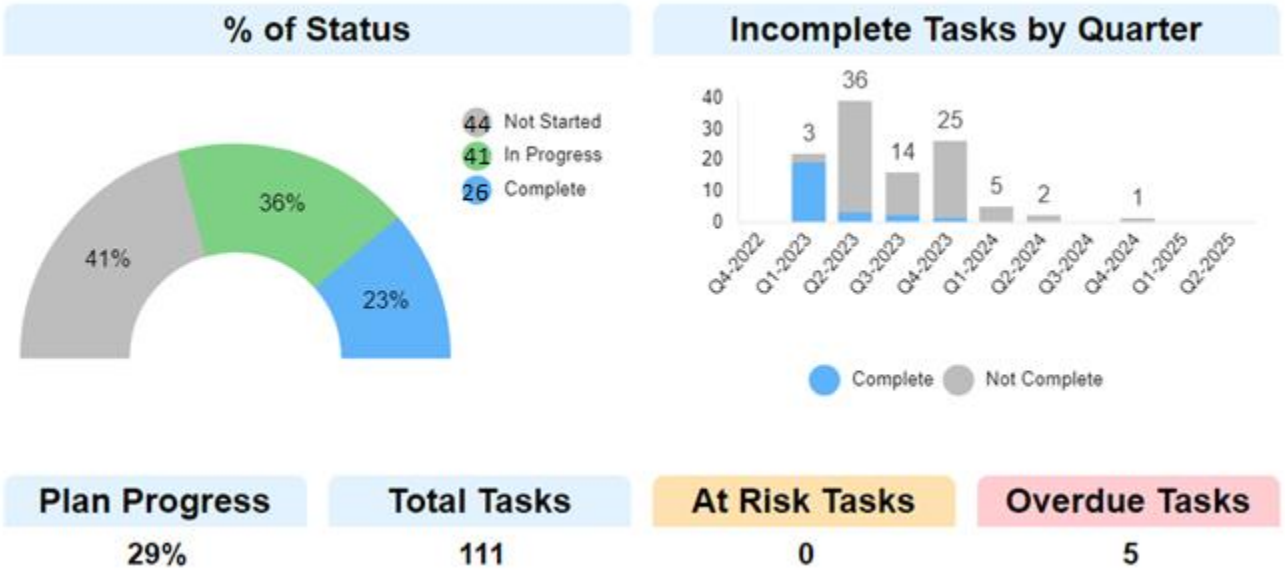
The first year will focus on rebuilding trust, re-engaging staff, addressing the issues raised in previous reviews and building the foundations to lead change.

2. Progress

Principles Agreed	•Top down approach •Distributive leadership •Use the Trust strategy as a lever for cultural change (engagement)
Strategies Approved	•People & Culture : Delivery plan progressing •Comms & Engagement •Quality Improvement (QI)
Manager Leadership development programmes	•Executive development programme design commenced •Senior Manager and Operational Manager programs to follow Exec development •Manager Essentials under development •Manager Fundamentals - initial rollout near completion
Delivery Plan	•Delivery plan approved and underway (see 2.1 Dashboard) •Culture Dashboard Design group established, first meeting held July •Culture Change Communications plan underway

2.1 People and Culture Delivery Plan Progress Dashboard (as at 20/07/2023):

(Full delivery plan is available on the Staff Zone)



	Action	Progress
1	All our corporate teams have scheduled time for every team member to participate in appraisal (2 hours per person)	The policy does not prescribe 2 hours, and this is being considered as part of the appraisal review group, given 2 hours is provided to all operational staff. The delay in closing this action is due to gaining assurance that the planning of corporate staff, trajectory of completion and tracking against trajectory is currently not reported or monitored within any group. It is held by local managers / directors. To be raised at Senior Management Group. Will be completed in Q2
2	Re-confirm through communication to our people, our commitment to training being held, list the programs that will	This action has been delayed in finding a relevant communication to place the message within. There have been reminders in senior meetings across the Trust, but not as a

	be ring-fenced, and ensure REAP and other policies reflect this	whole Trust comms. This will be added to the next REAP status update. Will be completed in Q2
3	In reference to the Senior Leadership visits, a communication package to be developed and published	The package is under-development, waiting final leadership visit dates for 2023 to be confirmed, before being uploaded to the Staff Zone. Will be completed in Q2
4	Update policy on the development of policies and procedures	Due to current mediation activities with Trade Unions (TU), ability to sign off this policy is impacted and the proposed finish date cannot be achieved. New proposed finish date is end of August as discussions with TUs continues. Will be completed in Q2
5	Audit to confirm all TRIM cases have been acknowledged and are being managed	A high-level review was completed and confirmed there were no known cases outstanding, however a more in-depth audit is yet to be completed. A lead is being confirmed for the TRiM actions. Recent discussions have identified some gaps in Trust oversight of TRiM, and this is being rectified. Lead to be confirmed by end of July and project due dates will be adjusted as a result.

3. Next Phase:

3.1 Q2 continues to address the housekeeping and People and Culture delivery plan actions, as the emphasis starts to shift to better equipping our leaders, increasing communication and creating space to talk. The key deliverables in Q2 are listed below.

3.2 <u>Delivery Plan Q2 Actions:</u>

3.2.1 Changed process for appraisal, introduction of process for 1:1s
3.2.2 Out of date policies reviewed and updated.
3.2.3 Design and development of modules to support policy rollout, and delivery of workshops to managers focusing on ‘softer skills’.
3.2.4 Middle Manager Development program designed and approved.
3.2.5 Relationship with Trade Unions remains a focus.
3.2.6 Review and evaluate effectiveness of Occupational Health processes, and Traumatic Risk Management (TRiM) process.
3.2.7 Review of Datix incidents and a focus on sharing learning
3.2.8 Reverse mentoring program to launch.
3.2.9 Evaluate Trust confidence in, and knowledge of, access points as mechanisms for speaking up
3.2.10 Awareness workshop for all our people to commence.
3.2.11 Improved process for uniform distribution, and engagement on our uniform

3.3 <u>Leadership development:</u>

3.3.1 Leadership development programs for Executive team, Senior Management Group and the Operational Managers to commence. It is necessary to prepare our managers for leading the change, ensuring all senior leadership have the knowledge and skills required, and can demonstrate the culture we seek to embed.
3.3.2 Coaching, connecting, developing and coordinating the leadership to role-model and champion the culture change, ensuring they have the capacity and capability to be change leaders.
3.3.3 A specific co-designed program for the Operation Unit Manager (OUM) / equivalent operation managers, to commence Q2, following the OUM/ Operation Managers participating at the Board development day. As part of their program, they will lead urgent intervention of ~4 key areas within the housekeeping, to be confirmed at the next Board Development Day.

3.4 Communications plan agreed and commenced:

3.4.1 A themed campaign, under one of the Trust Priority headings “Getting Things Right for our People” has been established, with a page created on the Staff Zone supported by tags and posts across Yammer.

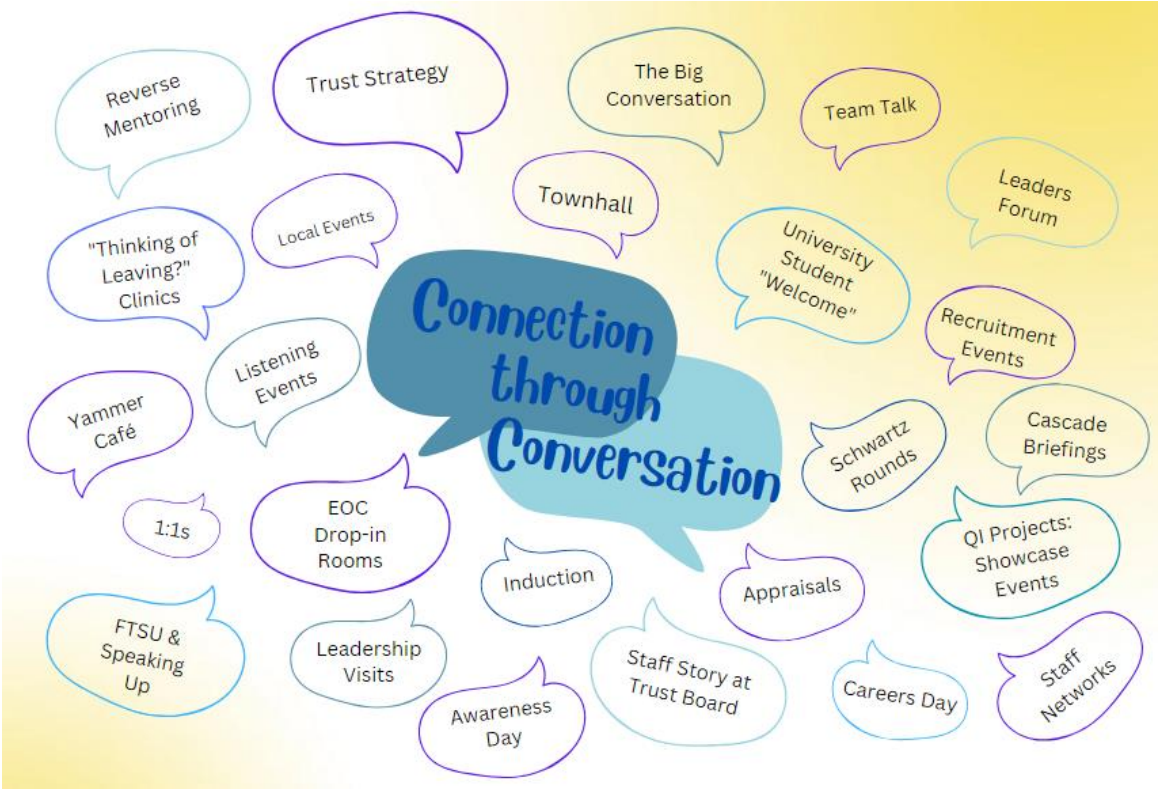
3.4.2 Confirming the narrative, broadcasting a positive vision and a path forward, and creating a personal responsibility to change

3.4.3 Multi-modal, regular messaging across out Trust, sharing the actions from the people and culture delivery plan (including the housekeeping), and reinforcing the change messages.

3.4.4 The plan sets out weekly, monthly and annual ‘campaigns’ and messages

3.4.5 We will increase the opportunities for our people to ‘talk’, beyond the ‘Speaking Up and Freedom to Speak UP (FTSU)’ frameworks. This will create greater connection to each other and the workplace. People that are connected are more likely to be happier at work, have higher productivity, less absenteeism and greater job satisfaction. Creating multiple avenues to talk will also support engagement, and reverse the sense that the only conversation needed is the one that raises issues and concerns. Picture 1 shows the variety of approaches planned.

3.4.6 Analytics gathered on a monthly basis to measure the ‘reach’ of communications



Picture 1: Modes of communication and Engagement with our People

3.5 EOC:

3.5.1 In April 2023 Moorhouse Consultancy presented a final roadmap and plan for the EOC Cultural approach, completing their work with SECAmb. The plan detailed a number of quick wins that were completed / near completion, as well as medium and longer term interventions for cultural change. The plan was to transition to the local management for continued momentum, with oversight in the EOC Senior Leadership Team (SLT) meetings. It is fair to say this oversight has been lacking, and progress has stalled.

3.5.2 In discussions with the Director of Operations, there will be direct intensive support provided to the EOC management team by the Programme Director – Cultural Change, to continue to implement the actions identified. An action group has been established, initially chaired by the Programme Director, scheduled fortnightly from August 2023. The focus will be to progress the work at pace, while supporting and enabling the local management to take ownership within 3 months.

4. Measures

4.1.1 A Dashboard working group has been established to consider which metrics should be included, and the expected changes to the current results through each of the interventions.

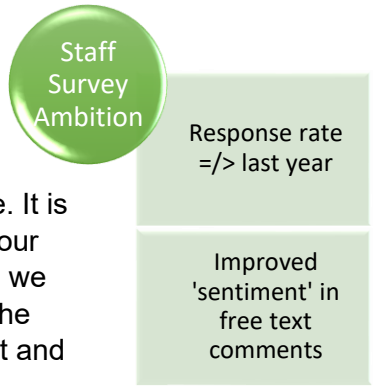
4.1.2 Many metrics already exist in the Trust, such as the results of the Staff Surveys and the data in the IQR. To measure culture, the focus will be on creating 'groups' of measures that reflect on overall metric, for example the strategy outcome "We will recognise good work and celebrate achievements and excellent practice", can be an overall score from a series of measures such as: how often our rewards and recognition program is used, the staff survey scores for question "The people I work with show appreciation to one another"; "How satisfied are you with the extent to which your organisation values your work?"; "My immediate manager values my work", and the National Staff Survey 'We are recognised and rewarded' theme score. A collection of relevant metrics is being created for each of the 16 strategy outcomes.

4.1.3 Approximately 50 metrics have been identified for discussion, the majority already reported within SECAmb or as part of the Staff Survey. The Business Intelligence team will support development of the dashboard. It is expected the first draft will be available by September.

4.1.4 The group have also explored how to create intelligence metrics, from the free text within the Pulse and Staff Surveys, to measure 'sentiment' and thematic changes.

4.1.5 There will also be consideration given to how we utilise the Awareness Day to have ongoing data capture with 'real-time' information via an attendee survey.

4.1.6 We recognise the Staff Survey is a pivotal data point for measuring culture change. Q3 is an important time as we move into winter pressures and we want the organisation to feel different for our people. It is also when the next staff survey will be live. Although it is unlikely that our staff survey results will shift significantly and show the cultural change we aim for, it would be a positive result if at least as many responses as the previous survey are received, and if there is a change in the sentiment and themes within the free text.



5. Risks / Issues:

Risk:	There is a risk that the actions planned for Q2/3 will not be delivered due to competing priorities across the Trust, taking leads away from the planned work.
Impact:	Failure to complete the planned actions will delay delivery of the P&C strategy, and may erode the trust and engagement being developed with our people.
Mitigation:	Fortnightly meetings between Programme Director and actions leads, with established escalation route to SMG / EMB Trust priorities confirmed to support focus on delivering the P&C strategy.

Risk:	There is a risk that the requested funding will not be approved, leaving several actions without adequate resources to deliver.
Impact:	If funding is not provided from NHSE, the Trust may be required to fund, leading to a cost-pressure, or the section of work will need to be reviewed resulting in either delayed delivery, or abandonment.
Mitigation:	Alternative sources of funding to be considered Progressing with planned expenditure, at risk, which will impact cost savings

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	

Name of meeting	Trust Board
Date	
Name of paper	Update on delivery of Communications & Engagement Strategy

This report provides an update at the end of Quarter 1 on the delivery of the Communications & Engagement Strategy following its approval by the Trust Board in April 2023.

1.Introduction

1.1 In April 2023, the Board approved a new Communications & Engagement Strategy for the Trust.

1.2 This was developed following an external review by a specialist communications agency (Hood & Woolf), which provided a number of recommendations for incorporation into the new Strategy covering areas in which we could improve our communications approach.

1.3 A Plan to support the delivery of the Strategy was developed during April 2023, and was shared with EMB. This Plan needs to remain flexible to take account of changing Trust priorities during the year.

2. Key deliverables in Q1

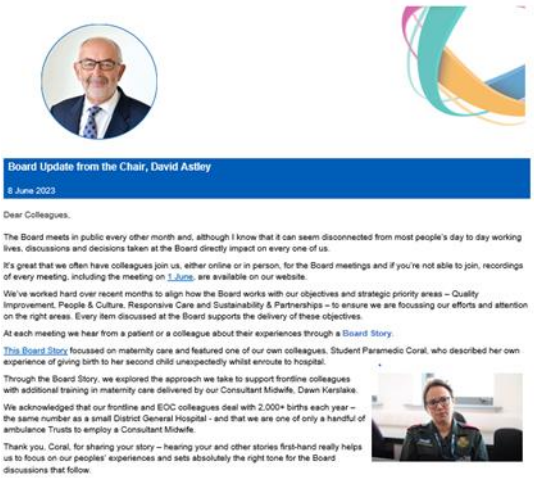
2.1 The following additional activities have been undertaken during Quarter 1, in line with the Delivery Plan, in addition to the 'business as usual' approach to supporting day-to-day internal and external communications:

- Development of Comms Plan and brand to support delivery of the People & Culture Strategy/Culture Programme

- Development, agreement and sharing of core narrative & brand to support our strategic priorities for 2023/24

- Refresh of Leadership Visits approach and programme

- Continuing development and improvement of comms mechanisms including the introduction of ‘Big Conversation’ sessions, phase one of a cascade briefing system and the Chair’s post-Board updates for colleagues



Board Update from the Chair, David Astley

8 June 2023

Dear Colleagues,

The Board meets in public every other month and, although I know that it can seem disconnected from most people’s day to day working lives, discussions and decisions taken at the Board directly impact on every one of us.

It’s great that we often have colleagues join us, either online or in person, for the Board meetings and if you’re not able to join, recordings of every meeting, including the meeting on 1 June, are available on our website.

We’ve worked hard over recent months to align how the Board works with our objectives and strategic priority areas – Quality Improvement, People & Culture, Responsive Care and Sustainability & Partnerships – to ensure we are focussing our efforts and attention on the right areas. Every item discussed at the Board supports the delivery of these objectives.

At each meeting we hear from a patient or a colleague about their experiences through a Board Story.

This Board Story focussed on maternity care and featured one of our own colleagues, Student Paramedic Coral, who described her own experience of giving birth to her second child unexpectedly whilst enroute to hospital.

Through the Board Story, we explored the approach we take to support frontline colleagues with additional training in maternity care delivered by our Consultant Midwife, Dawn Kerslake.

We acknowledged that our frontline and EOC colleagues deal with 2,000+ births each year – the same number as a small District General Hospital - and that we are one of only a handful of ambulance Trusts to employ a Consultant Midwife.

Thank you, Coral, for sharing your story – hearing your and other stories first-hand really helps us to focus on our peoples’ experiences and sets absolutely the right tone for the Board discussions that follow.

2.2 It has also been great to see positive regional and national coverage both internally and externally during the quarter around a number of important developments/stories including:

- NHS 75
- International Paramedics Day
- The first teams to move into the new site at Medway
- First SECAmb staff to graduate from new Paramedic Apprentice Programme
- Expansion of body-worn cameras

2.3 We recognise that there is more to be done and, during Q1 have developed and agreed an Improvement Case for re-structure/expansion of Communications Team. Once implemented, this will increase capacity and capability within the team and support the delivery of improved local communication the implementation of the new team structure (as referenced at 4.1 below).

3.Impact of changes made to date:

3.1 It is difficult to robustly measure the impact of the changes made to date. We are currently awaiting the results of the most recent Pulse Survey (July 2023), as well as looking ahead to the next national NHS Staff Survey later this year – both of which should provide some evidence of impact.

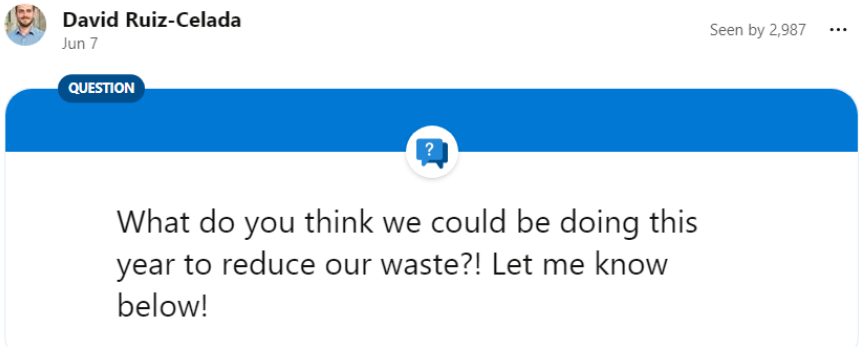
3.2 We routinely measure the analytics associated with our online communication mechanisms, including the number of 'views' of video resources, online posts and Yammer updates. This helps us to continually make changes as needed as we can see what appeals more to colleagues.

3.3 Analysis of the data has helped us to identify the need for a refresh and relaunch of the use of the Yammer social media platform in order to gain maximum benefit, our analysis shows that whilst many posts are gaining good visibility amongst colleagues, we are not yet seeing the consistent interaction with content that would indicate more effective use of the platform. This is incorporated into the Culture Programme Communications Plan.

3.4 There are also a number of 'softer' quantitative measures however which provide some evidence to support the changes made so far and are indicators of the levels of engagement:

- Pulse Survey return rate – looks likely to exceed our previous highest response rate and places us well above the national average for other Trusts
- Response to request for ideas from colleagues on the Efficiencies Programme – following an 'ask' via our internal communications mechanisms, we received almost 200 suggestions of potential efficiency savings from colleagues

- Feedback from Leadership Visits, from both managers and team members - provides a barometer of the issues being raised; 'poor communication' being raised less as an issue plus improved awareness of key programmes
- Participants/level of engagement in Big Conversation sessions – at each of the two sessions held to date, we have seen c.250 staff attending, with lively participation and dozens of questions/suggestions submitted
- A strong response from colleagues to the launch and development of our Green Plan, including active discussion and debate on online platforms



4. Future areas of focus

4.1 As we move forwards, the following will be key areas of focus during Quarters 2 and 3:

- Implementation of the expanded team structure which will support enhancement of our internal communication channels, especially through working with local managers
- Approval of Improvement Case for an introduction of a new online Reward & Recognition platform, as part of an integrated Recognition Framework
- Significant opportunities for engagement during development of Trust Strategy
- Regularly share analytics to demonstrate 'reach' of online communications to help to drive further improvements

5. Conclusion

5.1 The Board are asked to note the contents of the Report.

Janine Compton, Head of Communications

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	38-23

Name of meeting	Trust Board
Date	3 August 2023
Name of paper	People Committee Escalation Report – July 2023
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 20.07.2023 and confirms whether any matters require specific intervention by the Trust Board.

Item	**Purpose**	**Link to BAF**
Before the main agenda began an update was provided related to the so-called 'housekeeping', which is the response to the main recurring themes from the staff survey. This is one of the priorities within the People and Culture Strategy. The committee acknowledged the planning needed to address some of these issues, resulting in much of the delivery/impact falling in Q4, but challenged the executive to increase the pace so that progress is made more quickly. This will be a standing item for the coming year.		
Staff Retention	To seek assurance that the actions to improve retention are being implemented effectively.	P&C Objectives 1-12
There is significant focus in the new long-term workforce plan on retention and so the committee challenged the executive to go much further in ensuring SECAmb is an attractive place to work. The current retention plan has a number of initiatives but has had little impact on improving retention – we are at about 18% against a target of 10%. Progress is therefore disappointing and the committee is not assured. The executive accept that a different approach is needed, with clearer analysis of why staff are leaving so we can better target our interventions. For example, from the data that is available work life balance is a key reason for staff leaving and so we need to become a more flexible employer. This will be critical to the development of the Trust strategy.		
Leadership Visits	To seek assurance that the leadership visits are planned in advance, that they are being undertaken (at least within the agreed 90% tolerance), and that they are having a positive impact.	P&C Objective 2: *Implement new leadership visit process consistent with comms and engagement Strategy.*

The committee supported the refreshed approach introduced in June, to make these visits more structured, which ensure better follow up. The feedback is being collated to inform a report providing thematic analysis. The next update will therefore include the themes and the action being taken.		
Recruitment: On-Boarding	To seek assurance that the project is clear in how it will deliver the stated impact and that it is on track to do so	P&C Objective 3 – Rapid On-boarding QI project.
There is a very clear plan in place aimed at achieving the process improvements needed to reduce time to hire. The final control aspect due to conclude in Nov/Dec 2023 and the committee will review the impact then.		
HR Review	To seek assurance that the recommendations have been addressed and that they have had the impact expected. And that there is a plan to address any identified gaps, within a reasonable timeframe.	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 received a paper setting out progress against each of the recommendations from this HR review (reported to the Board in December 22). Whilst progress has been made with some recommendations the impact of which can be seen in the IQR, a number of changes are still at an early stage. The Committee challenged the progress on policy updates and the timing of updates to the grievance and disciplinary policies. External assurance is being sought from the ICB Chief People Officer and the outcome of this will be reported to the committee.		
Violence & Aggression	To seek assurance that the strategy and policy is robust in the effective management of violence and aggression, and that we are on track to comply with the national standards.	
There is significantly greater assurance with the Trust now 76% compliant with national standards, which demonstrates great progress and on track to deliver by December 2023. There is a clear plan for each area aimed at ensuring staff are kept safe from incidents of violence and aggression.		
Health and Safety	To seek assurance that the H&S controls are well designed and working effectively and that there is clarity on RIDDOR incidents.	
A good paper was received setting out the outcomes from the Health & Safety audits which reviews the overall effectiveness of Health & Safety management controls at a local level. Overall, the controls being applied at site level provide reasonable assurance.		

The report also provided analysis of the RIDDOR data, which was an area the Board enquired about in February, in the context of the IQR (see action log). During the last financial year, the Trust reported 131 RIDDOR incidents to the Health and Safety Executive, (151 the year before), which although puts us in the upper quartile is not inconsistent with other ambulance services. The H&S Manager reported that the number of incidents is in line with what we would expect for our employee headcount, and we seem to have an effective reporting culture across the Trust.

The committee will review H&S more regularly going forward to seek further assurance on how we are ensuring learning and triangulating data, for example the impact of health and safety incidents on sickness.

Workforce Plan	To provide an update on the delivery of the workforce plan and how any issues / risks are being managed.	S&P Objective 5 – Joint Workforce Plan BAF Risk 255 – Workforce Planning

We are slightly above plan for road staff but under for EMAs. The committee challenged the reliance on overtime and acknowledged that with the ambitious workforce plan and introduction of new rotas overtime is being more targeted. It was set at 2% initially so much lower than compared with recent years but in reality, it will be closer to 4%.

The committee explored the impact of the workforce plan on patients and noted that in relation to the Category 2 mean we are providing a better service than predicted. We are in the top 3 compared nationally and much of this is a consequence of an improved job cycle time.

Overall there is reasonable confidence in the delivery of our workforce plan and other actions in place to ensure delivery of safe services.

Specific Escalation(s) for Board Action	There are no specific escalations for the Board's intervention. .

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	The COB has been revised and will highlight any omissions.

omissions are recorded and carried forward	
To ensure the minutes are a factual, concise summary of the discussion	Ongoing
All authors to consider the assurance required and to fully address the requirements of the front sheet and the chair/secretary to have the authority to reject inadequate submissions	As above
The committee to consider how the dashboard can be maximised to provide assurance on the BAU oversight and also on the items on the agenda.	This action has bene superseded as there is currently no dashboard. The COB sets out areas of focus, and the committee is also directed by the Board as it identified gaps in assurance, including from the metrics in the IQR.
the chair to consider what assurance is required from subject matter leads in advance of documentation being supplied	Complete – as above.
The Chair and Trust Chair to consider if quarterly meetings offer the necessary assurance for the Board..	The meetings are now bi-monthly, consistent with the other board committees.
The Chair to consider if the Director of Quality & Nursing needs to be a core member of the committee. If not, then consideration needs to be given as to how Health & Safety connects with the committee.	They attend as needed, and always when H&S is being reviewed.
The Chair to consider how the committee can champion the corporate values (an opportunity to lead the way)	Ongoing
To ensure papers are assurance driven.	Linked to the items above re clarity on the assurance needed by the committee, as reflected in the report to the Board.
The Board development programme to include the culture of challenge within its development plan	Complete – see the Board Development Plan.
Consider how the committee connects up and down to the Trust Board.	The committee is directed by the Board and after each meeting provides escalation reports to the Board.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	39-23

Name of meeting	Board
Date	03 August 2023
Name of paper	Keeping Patients Safe Executive Summary
Strategic Theme	**Quality Improvement**
Author / Lead Director	Margaret Dalziel, Executive Director of Quality & Nursing (interim) Rachel Oaten, Chief Medical Officer

Executive Summary

This paper builds on previous Board papers outlining the progress made against Trust priorities cross-referencing them to relevant BAF Risks, RSP criteria and to the 'Must Do's' to address and improve areas identified through the IQR, CQC, Staff surveys, Audit reports, internal and external reviews and through our own quality assurance processes.

The BAF report reflects the expected progress made across all three Goals, with movement of QI Goal 2 from amber to green since the last Board update, as PSIRF has progressed at pace under dedicated leadership, and in conjunction with key stakeholders across the Directorates and in external provider and commissioning bodies. Identified within this paper are two emerging project risks to achieving the goals, firstly the attainment of funding for the training of core investigators for PSIRF as per the national standards (QI 3), and finally the capacity and responsiveness of Clinical Systems to enact the changes required for the QI Programme 'Keeping Patients Safe in the stack' (QI 1). These project risks are being managed with close collaboration across other directorates and groups, aiming for full mitigation.

The IQR reflects the continuous improvement and sustainability of these across all the patient safety areas, most notably status of Datix, the timeliness of complaints responses, and rates of Duty of Candour. Note is made of the IPC handwashing audits rates, that remain within expected limits but are indicating a gradual reduction in compliance over the past three months. Remedial actions are being planned and put in place to regain compliance but in a meaningful way as outlined on the IQR narrative.

All clinical elements within the MDs and SDs are also progressing at pace now with clear ownership and actions being enacted.

Finally, the Patient Engagement Community Forums have commenced, an evaluation of the first one held found on page 3 of this paper.

Recommendations, decisions or actions sought	The Board is asked to test whether there is sufficient progress with the corporate objectives, and the controls and mitigating actions against the relevant risks, as set out in the Board Assurance Framework and Integrated Quality Report. Where the Board identifies gaps in assurance, agree what corrective action needs to be taken by the Executive.

Update for Trust Board

Quality Priorities

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

Trust priority QI Project – 'Keeping Patients Safe in the Stack'.
Continues to progress well and to plan. Improvement Cases are now being completed following the Define, Measure & Analyse phase of the project for approval to implement improvements as set out in BAF paper. These will reduce non-value adding activity, reduce cognitive burden and allowing clinicians time to identify and support those patients most at harm of risk. There is a critical interface with Clinical Systems to progress these changes which is a **potential risk** to success of this project**.**

QI Management System
Progress is being made in developing and implementing a QI management system approach throughout the organisation (BAF Risk 14). The implementation of training as per the agreed development plan, and commencement of QI projects across the organisation is enabling the embedding of the recognition of a comprehensive QMS narrative, this being Quality Planning, Quality Improvement and Quality Control.

All members of the QI team have now commenced, and so progress continues at pace with not only the 2 Trust Priority QI programmes, but also 7 other projects owned by the relevant Directorate teams but now formally being supported by a QI facilitator to align to QMS. These are:

- Reducing the time to review and approve DPIAs.
- Hear & Treat
- Medicines Prompt card
- Tiresias version 2 implementation
- Local ePCR auditing by Paramedic Practitioners
- Datix process
- Blue Light Triage

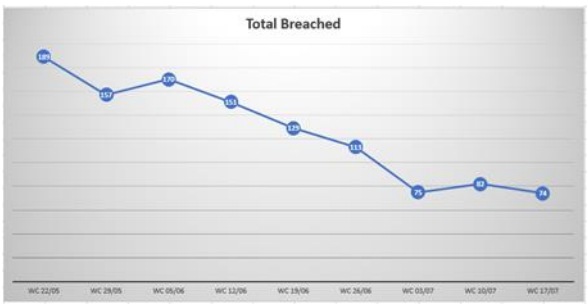
Achieving attendance of a minimum of 10% of staff to training this year is critical and is being well-supported, specifically by the Operations directorates in which many staff reside. This target number will be higher for 24/25 in order to get to tipping point and is being presented to ETDG.

A QI strategy outlining our ambition and delivery plan for the next two years is being presented to Board for agreement this month, having undergone full internal and external consultation.

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

Incident Management Process
The IQR reflects that improvements achieved from this past year have been maintained as currently there are only 3 breached SI reports (breached late June), with 11 active cases in total being investigated, all of which have trajectories for completion within the due date. The same improvement has been maintained with SI actions.

The number of overall Datix incidents that have overrun the 45-day cycle has now reduced well below the tolerance level to 8.5%, this rate having now been maintained below the target of 10% for the past three weeks as depicted below:

As of 20/07/23 		
New incidents awaiting allocation	90	10%
Being investigated	663	76%
Awaiting closure	114	13%
Total	**867**	

Complaints

Following further interventions, the complaints process has now returned to meeting the 95% target, with Compliance currently sits at 96%, expected to be maintained or exceeded as a refined model of support for Units that struggle with turnaround times.

Patient Safety Incident Response Framework (PSIRF)

The PSIRF programme is on track with all current milestones set within the programme plan and the PSIR Plan being well developed. This is planned to come to the October Board for agreement in line with national expectations and prior to ICS sign-off. The launch of PSIRF will take place in November 2023 a timeline set by changes that need to occur in concurrence within the design and full implementation of the incident module on Datix Cloud.

Training for a core team to meet the minimum national standards has now been designed, to be presented to the ETDG in August for support in funding. Timeliness in the delivery of this training may be a potential challenge to clear implementation of this initiative.

Patient Engagement

The Patient Experience and Engagement delivery plan is being implemented successfully with the first of four patient engagement events planned for this year across our regions having taken

place in July 2023.

This group discussed ways of better communicating with our patients in periods of service pressure to support the work around Keeping Patients Safe in the Stack (KPSitS). The evaluation of this was that the group felt the public require more information around our service pressures to make an informed decision on whether to call or use an alternative service. The KPSitS group will use the findings from this session to implement the necessary service improvements using the patient voice.

3 - Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk (RSP-L3, RSP-Q2, MD 6, MD 7, MD 14)

Risk management process

A paper was presented to Audit Committee on 20th July 2023 outlining progress against that five management actions set out following an internal audit undertaken in May 2023. These actions fully aligned to gaps in assurance as already identified by the Risk Assurance Group and presented to the Audit committee in April 2023, and relate to raising awareness of risk across the organisation, implementing, and embedding the risk management process as detailed in the updated Risk Management Policy.

To summarise progress made on enacting the plan against each action;

- The first version of the revised BAF was received by the Board in June.
- Compliance of risk registers continues to improve each month for all three metrics - for the 179 risks in the register the review rate has increased to 66.5% (target is 80%) following targeted interventions into each Directorate. The % of these risks with no controls in place is 16.2% (well within target of 20%), and % with no assurance in place is 39.11% (target is 20%).
- Performance review meetings have commenced with all Directorates clearly defining roles, responsibilities of risk owners and risk leads.
- 100% of risk owners and risk leads have passed their training in risk management.
- To raise awareness across all staff groups training is being designed in collaboration with the Communications team, Clinical Education, and the QI teams. A structured plan is in place to increase this campaign through the organisation by end of Q4. In addition, a Risk Awareness Showcase has been created providing updates on BAF, Extreme, Corporate and Directorate Risks shared monthly with all staff.

There are 11 risks that are rated extreme risks (scored 15+) on the corporate risk register and referenced in Section 3 of BAF report.

Activity within the corporate risk register over this period co-ordinated through RAG;

- 4 Risks closed (Risk ID 74, 148, 253 & 341)
- 6 new risks added to the register (Risk ID 391, 398, 405, 410, 411 & 415)
- 6 risks reduced in score (Risk ID 57, 86, 256, 273, 357 & 364)
- 2 risks increase in score (Risk ID 27 & 360)

Quality Assurance & Engagement Visits

Four successful two-day site visits have been undertaken with a paper being collated for EMB drawing out areas of assurance and areas of concern. There have been no areas of concern requiring immediate remedial action identified on any of the site visits.

The only delay to plan in this area (due to the change in leadership inevitably reducing pace) is the formation of a systematic model for feedback into corporate areas from these visits, though an ad-hoc approach has been taken thus far to progress changes for the Units to enable them to

succeed in service delivery and staff support. This model will be complete and implemented by 24 August 2023.

Improvement Journey

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

A forum for senior leaders in the Operations directorate is to be held over two sessions in September co-designed and co-led by the Exec Director of Q&N, Exec Director of Operations and the FTSU guardians. This will be focused on 'Speaking Up' and will aim to address reservations, increase understanding, and establish expectations around a Speak up culture, taking an appreciative enquiry approach.

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

The current work ongoing focuses on the following 3 areas, with headline progress:

- **Dashboard.** Now live and undergoing further testing to ensure accuracy and information governance compliance.
- **e-PCR & coding development**. Review of Ambulance Data Set (ADS) and SnoMed coding to support greater granularity of crew coding in ePCR to better inform the dashboard data.
- **Sustainable collaboration and discussion.** Network engagement and collaboration ongoing. Examples included P/EOLC clinical networking and working with Police partners to resolve management of incidents involving expected and unexpected deaths.

Future work planned will focus on:

- 111 & 999 data accuracy
- Verification of death broken down by place of care
- Inequalities data
- Skill mix / resource utilisation

MD 11 - The trust must ensure that staff administering medicines under a patient group directive have the required training and competency. (Regulation 12, (1) (2) (a) (g)).

- A PGD compliance report is now up and running and reported in the IQR. Data has been cleansed in the last couple months and will continue to be until we are more assured of the data. The data is pulled across manually from ESR which is a significant time burden. Work is progressing with adding locations to all staff on JRCALC, this will make it easier for reporting as the data can then be manipulated. There has been a decrease in compliance seen for this IQR but that is due to a Diazepam solution PGD release and staff needing to sign up to it (this will be closely monitored in next data pull)

- Risk ID 122 which links to PGDs is proposed for closure at the September 2023 Medicines Governance Group. A MoU has been developed and shared with the SECAmb PAP team to share externally. The MoU provides clear guidance on the responsibilities for both SECAmb and the Private Ambulance Provider, this ensures that everyone is clear what they need to do around the law and PGDs so that we are compliant (it is noted that regulators are taking interest in this in all ambulance services)

- PGDs are also featured in the current key skills being delivered to staff.

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QUALITY IMPROVEMENT

Our QI Strategy 2023-2025

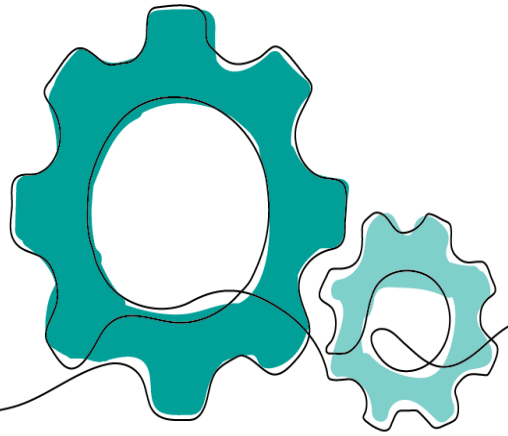
This document outlines our ambitions for QI and how and when we will enable delivery of this at SECAmb. This strategy is a working document and will be aligned with the revised Trust strategy when published in December 2023.

Introduction

The strategic vision at SECAmb depicts the importance of delivering high-quality care that is safe, appropriate for patients, financially sustainable, and integrated into the wider operational system.

To achieve our strategic goals, we are adopting a Quality Improvement (QI) approach. QI is a systematic and continuous process that aims to solve problems, enhance service delivery, and produce better outcomes for both patients and staff. We will embed and deliver this by following the guiding set of principles below.

1. Fostering a culture of continuous improvement and empowerment of colleagues at the interface of what we do and service users
2. Working collaboratively with system partners and cross directorates
3. Using digital tools & data to drive improvement
4. Iterative process of testing change ideas
5. Scale up and spread of improvement across the organisation.



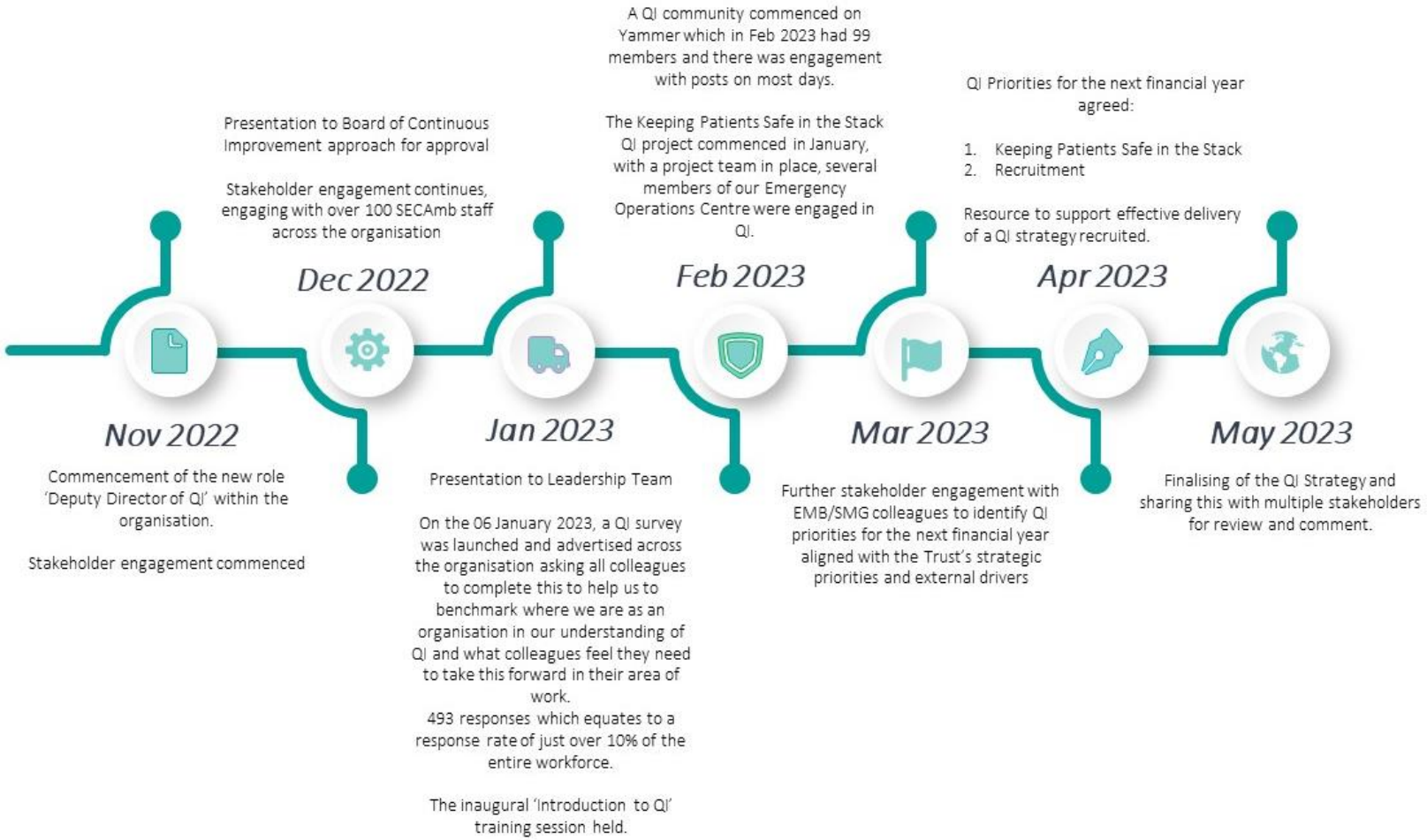
Why QI?

Research has shown that low-quality or substandard care can have a significant financial and human impact on the healthcare system. By incorporating QI, we aim to adopt a more proactive approach that focuses on preventing problems and issues rather than reacting to them. A QI approach provides a systematic and evidenced based framework that seeks to understand root causes. Achieving this requires an emphasis on cooperation and collaboration with engaged individuals who understand the context and can provide valuable insights to support problem resolution.

Developing our QI Strategy

The development of this strategy has been led by the Quality Improvement team and co-designed through engagement and listening to a breadth of staff from all levels across the organisation.

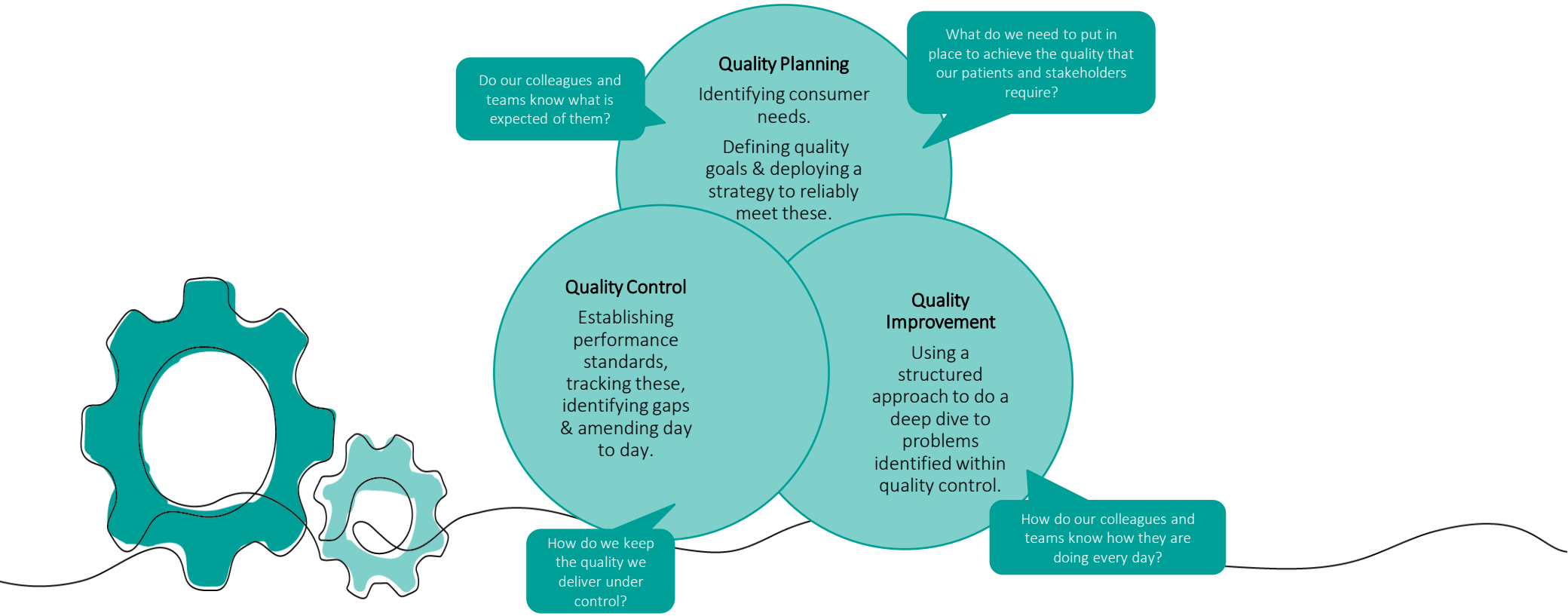
This has been a journey since the inception of a QI approach at SECAmb in November 2022.



Our Ambition

Our ambition is to develop and embed a QI approach across the Trust that aims to solve problems, improve service provision, and provide better outcomes for patients and our staff.

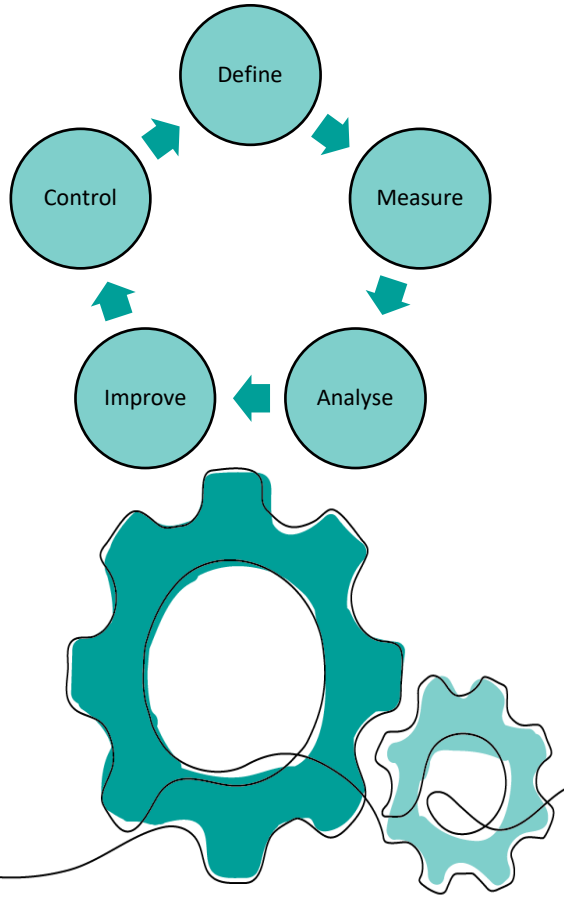
This involves a structured approach discussed on the next page to undertake a deep dive into problems or issues that are identified as part of a wider quality management system (QMS). A QMS is a whole organisation pursuit of quality that facilitates knowledge exchange and leadership principles to foster a culture of learning. It integrates a trilogy of quality activities; Quality Planning, Quality Control and Quality Improvement. The aspiration is to practice the principles of QI every day and at every level of the organisation utilising tools to support and enable this. We will be learning to think differently and approach challenges in a new way. QI will become second nature to all our teams and the way we do things.



Our QI Framework

Our QI approach will be underpinned by a robust and evidence-based framework; DMAIC. DMAIC is an acronym for Define, Measure, Analyse, Improve and Control and comes from Six Sigma methodology.

The DMAIC framework provides a structure for approaching and managing improvement to ensure all steps are taken and to maximise opportunity for success. Following the approach ensures that effective measurement is utilised, the root cause of problems is effectively addressed, and solutions are tested and embedded.



Define	We will describe the problem we are trying to solve and the value to the service/organisation if we do.
Measure	We will understand the process which we are trying to measure and use data to understand how big or small the problem is. We will determine baseline data and set SMART (specific, measurable, achievable, realistic and time orientated) goals.
Analyse	We will think and analyse root causes and which contributary factors have most significance on our improvement.
Improve	We will test the best solutions to resolve the root cause of the problems identified and confirm through small scale testing/pilots that these solutions will meet the objectives/goals.
Control	We will fully implement solutions and establishing ongoing mechanisms to embed improvements and share our learning. We will consider human and system factors to ensure both positive and sustained improvements.

What will this mean for our patients, people and system partners?

By adopting a structured QI approach across the organisation, we aim to realise the following benefits for our patients, staff, and system partners.

Our Patients will

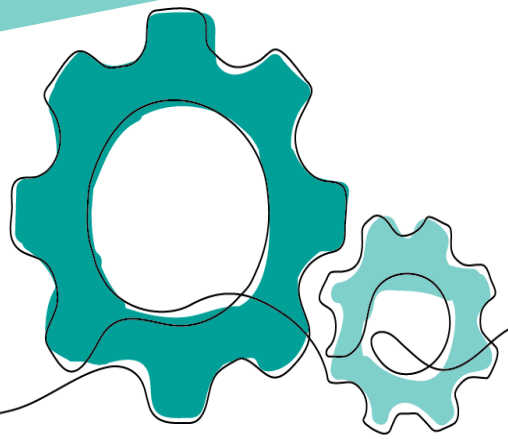
- Have improved outcomes
- Will know that we will identify problems earlier and that any changes to care are more likely to be positive and sustained
- Will be able to work in partnership with us to deliver the improvements that matter to them.

Our People will

- Will be aware of and engaged in the systematic process we have for approaching complex problems
- Will feel enabled to actively engage in quality improvement within their roles
- Will have the required skills and competence to lead improvement in practice.

System Partners

- Will see tangible improvements across care delivery ensuring that the organisation is as efficient and effective as it can be
- Will see SECAmb actively engaging in effective improvement led delivery of system priorities.



Where are we now?

Assessing contextual readiness is fundamental in preparing for transformation (Manley, 2019). Simply because we know an approach is well evidenced and the right thing to do, does not automatically translate into transformation in practice. Successful implementation is a careful synthesis of the nature of the evidence, the context in which the proposed transformation is taking place and how that transformation is facilitated (Kitson, 1998).

We know, because our people have told us, that our processes and ways of working can be inefficient, and this can have an impact on their ability to do their jobs well. As demonstrated below, our Board, senior leaders and managers across the organisation welcome a structured approach to improvement.

Evidence

- There is significant evidence to suggest that adopting a QI approach and culture is required to implement meaningful change.
- A QI survey was launched to benchmark where we are as an organisation in our understanding of QI
- 10% of the workforce responded (493 people)
- Key issues identified stopping staff making improvements were:
    - Lack of organisational support
    - Workload
    - Organisational culture
    - Time.
- Key improvements identified to enable staff to utilise a QI approach to their work were:
    - Training and development
    - Support from a central team
    - Access to tools and templates.

Context

- With the inception of a Quality Improvement team, we have an opportunity to understand and implement the skill set and required leadership to drive effective change.
- We have engaged 100 individuals, observed in EOC, undertaken an observer road shift.
- Our senior leaders and managers across the organisation are ready for change and welcome a structured approach to improvement.
- Some colleagues have already identified with improving as part of their role already (early adopters) and some need support.

Facilitation

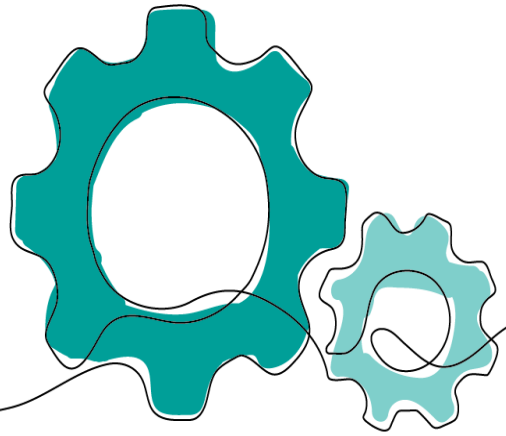
- QI is not something that just happens. It requires active participation, interdisciplinary collaboration, and a skilled workforce (Gustavo, 2017).
- We need to apply methods where colleagues feel they can make significant contribution to the culture and processes at SECAmb.
- Colleagues need to be enabled to undertake improvement (capacity) and have the confidence, knowledge, and skills to lead improvement (capability).
- Alongside the foundation of QI capacity and capability there is a strong reliance on data.
- Without data, we are unable to understand variation, make decisions about whether situations are improving or deteriorating or understand how capable current processes are in delivering their aims and objectives.

QI within Ambulance Trusts

Ambulance Trusts, as a sector, have not engaged with QI as successfully as other NHS Trusts. SECAmb has attempted implementation of a QI approach previously and been unsuccessful in embedding this.

The process of embedding QI in an organisation is a social one. In support of this, in 2018, NHS England and Improvement and the Ambulance Improvement Programme (AIP) supported the development of the 'Culture and Leadership Network for Ambulance Services' (CALNAS) which is overseen by the Association of Ambulance Chief Executive (AACE). The areas of focus for CALNAS are a culture that promotes learning, a focus on QI, and leadership which is inclusive, compassionate, empowering, engaging and collaborative. This aligns with our Trust values at SECAmb and our recently published People and Culture Strategy.

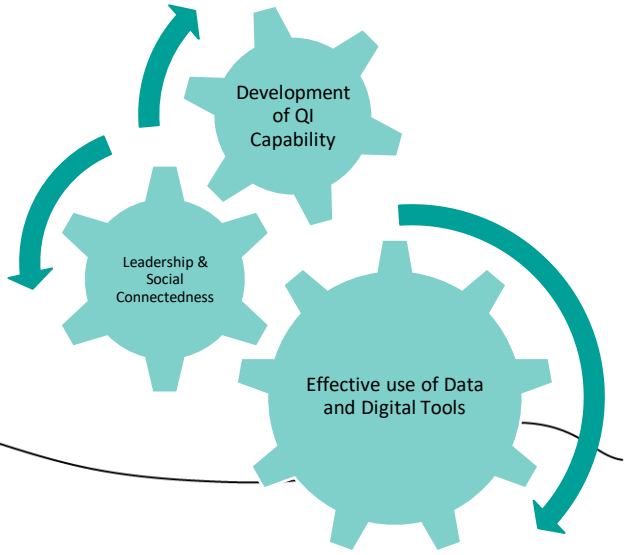
The structure provided through formal and informal professional relationships within ambulance services has historically adopted a military style hierarchy and delivery model designed to meet service demands (Pollock, 2013; Clompus & Albarran, 2016). This means that to enable success in QI we need to think about how to create a psychologically safe culture that supports our people to have a sense of control and influence over the improvements that they can deliver and how we support and trust them to do this.



We will achieve this through delivery of 3 key enablers:

- Development of QI Capability
- Leadership & Social Connectedness
- Effective use of Data and Digital Tool

The delivery plan as to how this will be achieved is detailed on the next pages.



Our delivery plan

Enabler 1: Development of QI Capability

How we will do it	2023-24	2024-25	How we will know we've been successful
• Embed and deliver DMAIC (Our Framework for QI, See Appendix 1) as the Trust's approach to complex problems across the organisation • Develop and deliver a QI training and development plan • Offer coaching and facilitation to local QI projects to maximise opportunity for success	• Train 10% of all staff (approx. 500) in Introduction to QI • Develop and implement a QI induction programme for all new starters to the organisation • Lead and facilitate two Trust wide QI projects on Keeping Patients Safe in the Stack and Recruitment • Provide QI team support, coaching and facilitation to at least 5 local QI projects	• Continue to train staff in Introduction to QI with a view to achieving 20% of all staff as a critical mass • For 95% of all new starters to be completing QI induction • Develop and implement QI practitioner & other levels of QI training • To support coaching and facilitation of at least 10 new local QI projects	• The concept of quality and quality improvement will be clearly articulated and understood across the Trust • Teams will be skilled and competent in utilising QI, enabling a bottom-up approach • We will see tangible improvements across care delivery and our processes will be as efficient and effective as they can be.

Our delivery plan

Enabler 2: Leadership & Social Connectedness

How we will do it	2023-24	2024-25	How we will know we've been successful
• Support all leaders to champion improvement principles & QI approach • Work with leaders to embed QI into management processes & practices • Creation of a community of improvement to increase spread and adoption of improvement practices and principles	• 25% of all Band 8s and above across the organisation to have received some form of QI training • A commitment to QI to be included in 95% of all new Job Descriptions across the Trust • To increase the QI community on SECAmb social media to 200 members • To increase the engagement with the QI page on the intranet by 30%.	• 50% of all Band 8s and above across the organisation to have received some form of QI training • QI objective to be identified in 50% of all Appraisals of staff across the organisation • Identify and train 'Qualitea time' leads within each OU/Contact Centre and deliver at least 10 'Qualitea time' sessions across the Trust.	• All leaders will be engaged in the systematic QI process we have for approaching complex problems • All leaders will have the opportunity and support to develop the required skills and competence to lead improvement in practice and coach others to do so.

Our delivery plan

Enabler 3: Effective use of Data and Digital Tools

How we will do it	2023-24	2024-25	How we will know we've been successful
• To work with the BI team to embed measurement for improvement and making data count at all levels of the organisation • Support identification of digital innovation opportunities and deliver technology enabled improvement.	• Ensure all QI projects utilise SPC charts, as appropriate, to demonstrate improvement and determine how in control our processes are • In collaboration with the BI Team and Strategy and Transformation team, develop a 3-year roadmap and pipeline for innovation • Develop and start to deliver 'Data Masterclass' training for individuals and teams in collaboration with the BI team.	• Delivery of 3-year roadmap and pipeline for innovation.	• We will understand current practice, processes and tools through measurement (including user experience), supporting us to direct our improvement efforts efficiently and effectively • We will see development of data skills, implementation of digital tools, methods & approaches across the organisation • We will make use of digital tools that enable teams to approach challenges from different perspectives and produce their own creative solutions.

How we will monitor and govern

The governance framework below details how assurance for the delivery of this strategy will be overseen. Quarterly reports on progress will be provided including details on the impact this strategy is having on our patients, staff and system partners.

SECAmb Trust Board

Quality & Patient Safety Committee (QPSC)

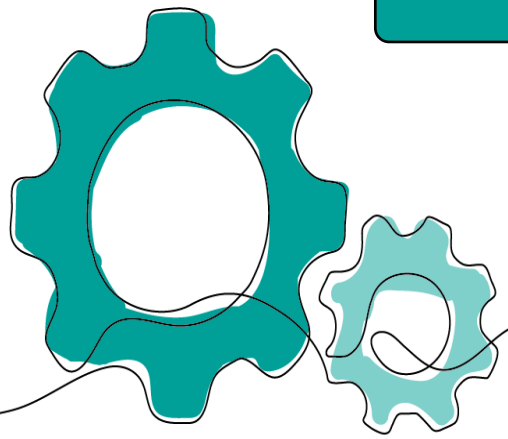
Quality Governance Group (QGG)

QI Team

Executive Management Board (EMB)

Board Assurance Framework (BAF)

Communication and sharing with all colleagues across the Trust



We would like to thank everyone who has contributed to the development of this strategy.

For more information, please contact the Quality Improvement Team at quality.improvement@secamb.nhs.uk

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	39-23

Name of meeting	Trust Board
Date	03.08.2023
Name of paper	Quality & Patient Safety Committee Escalation Report – June 2023
Author	Tom Quinn, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 29.06.2023 and confirms whether any matters require specific intervention by the Trust Board.

Executive Escalation: There is a national shortage of Ketamine, the QPSC was updated that mitigations are in place to safeguard the current stock until new stock arrives. After a robust governance process an interim process for the dilution of high strength Ketamine has been approved. New stock of the normal dose is expected to be in place by the end of July.

Item	Purpose	Link to BAF
Electronic Prescribing System (EPS) & Non Medical prescribing	This was a management response in relation to around the progress of Non-Medical Prescribing and the potential risks the delays are having on the 111 service.	Extreme Risk 28 – Drug Seeking Behaviour via 111 EPS

A summit meeting was held to discuss the ongoing concerns around the safety of the current EPS, the group supported that whilst the current mitigations are in place the system is safe to use. The mitigations in place take up multiple days per week, changing the system was an option that at this moment in time has been discounted as the contract with our current provider has a further two years to go.

The Committee have agreed that until the new Clinical Safety Officer has reviewed the system, they could not be assured that the EPS is safe.

Limited assurance was provided on the oversight of prescribing activity, however on the risks, the committee were assured that the risks were being mitigated.

The second part of this section was on non medical prescribers, the committee were assured that the minimum level of governance was in place.

At this time the Trust is only recruiting qualified and experienced prescribers due to the supervision burden. We are recruiting enough to meet our contract requirements and working with our partners IC24 we are able to meet the current demand.

The committee was not assured that a way forward to resolve the gaps identified in the need for NMPs, this is driven from the current financial position of the Trust and has asked that this be looked at again in the future.

Public Access Defibs	This was a management response from the April meeting, to confirm the rescue readiness of the 900 Public Access Defibs (PADs) since	QI Objective 5 – Improvements in out of hospital cardiac arrest survival rates.

	the implementation of The British Heart Foundations Circuit and to update the Committee on the plans to support communities improve survival from cardiac arrest.	

The committee was informed that there is a significant gap in the total number of PAD sites known to us due to the number of orphaned PAD sites. For the Trust to take on the orphaned sites would require significant investment.

There is a willingness to work more closely with our volunteers and communities and the committee were informed that a strategy is in development so a pragmatic approach is required at this time.

Although no preferred recommendation was presented, the Executive Director of Operations has a preference that would allow the Trust to fully quantify the gap.

The Committee were informed that the current BHF The Circuit has a limited life span of 18 months and the plans nationally after that are unclear.

The committee discussed the national drive to include "bleed kits" in PAD sites, at this time NHS Pathways does not support this, the Trust has agreed that this will remain the case for the time being.

The national groups that are aware of the Trust position and it was felt that this should be addressed at a system level going forwards.

Falls programme	This was a management response from the April meeting. To provide a further update to the committee on the implementation of the programme	N/A

The falls programme was a CQUIN in 2022/23 and was now being evaluated to review the impact of the Falls programme.

The Cat 3/4 Validation programme is impacting Falls calls, this is preventing CFRs being dispatched at present. The validation programme is causing a delay in the response to fallers. This programme is now being included in the 'Keeping Patients Safe in the Stack' QI project.

All new CFRs now receive the falls training as part of their initial training, support for CFR teams is provided by the Practice Development Leads and local PP teams where teams with an active Falls team can attend to take part in case reviews and adverse events.

The Quality and Nursing team will undertake a review to assess the impact of the falls team. This will look at the impact on patients, CFRs and staff.

A further summary of the plan to address the concerns raised has been asked for to come to a future meeting.

Integrated Patient Safety Report	To provide information and analysis of themes, trends and learning from incidents, learning from death, patient experience, and legal.	

The number of breached Datix is now 12% this is the lowest it has been. The persistent issue and highest report is external pharmacy issues, this is being picked up with our Commissioners.
There are 12 live SI cases.
Complaints have remained steady with staff attitude being the main cause.
We receive four times as many compliments as complaints.

Areas of concern are the lack of structured learning framework; this is being addressed now as the team have some capacity. The team are working closely with the PSIRF Implementation lead so that work is not duplicated.
The Committee was updated that learning from incidents is now on The Zone and ParaPass and the teams are able to see how many times the learning materials have been accessed. The committee were not yet able to be assured on this as there is a gap in demonstrating the learning from incidents.
The team were commended by the committee members on the hard work in reducing the backlog of SIs and asked whether a similar process could be used for complaints, this was confirmed that this would be the case.
The innovation of this paper was praised by the committee members.

Operation Carp – Action plan update	To provide an update on the action plan.	

All actions are progressing.
The Committee were informed that OTLs were now being allocated two hours training on Medicines during their monthly Teams C meetings, this training looks at reconciliation and the new electronic CD Register MEDX that is due to be introduced this year and next year.
On a recent QAV to Thanet OU, the teams there fed back that they felt they had been morally injured by this incident, this was due to the Key Skills training incorporating some of the lessons learnt from this incident, this is being reviewed by the Clinical Directors to see what information can be shared to assure the Operational teams.
A further update was requested in six months on the progress.

A QI Strategy to take the organisation forward and empower those closest to patients to lead improvement	To provide the draft strategy for review ahead of the Board on 3 August 2023.	Quality Improvement – Objective 2

The committee praised the team on the level of staff engagement that this strategy had achieved (100 leaders + 493 staff). The committee were assured that staff had been engaged and that the target of 10% of staff trained in QI methodology was achievable in this financial year.
The strategy is on target for being approved at trust Board in August.
This is also linking in with the Trust Strategy development and the recently approved People & Culture Strategy.

Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF.	To confirm progress with achievement of this objective.	Quality Improvement – Objective 4

A new group has been set up Patient Safety Oversight Group (PSOG) and will meet in July for the first time. The group includes both internal and external partners.
The Committee were assured that we are on track to deliver this on time.
The Committee were informed that one size does not fit all and that local adaptations would need to be made to ensure that PSIRF is successful.
A Board development session was requested to help the Board better understand the new system.

A Quality and Performance Management Framework that runs from our Patients to the Board	To set out the approach, aims and plan for the implementation of the Framework	Quality Improvement – Objective 7

This is in its infancy, June saw the first month of the framework in action with four dispatch desks taking part. The OU leadership teams were supportive of the metrics being used and felt that the link to people was a good move forward.
EOC dashboards are in development.
The Committee were informed how this framework links to the regional teams across the system, and how the quality aspects will sit in the system meetings as well as the Trust ones.
Assurance was given that all four pillars are incorporated into the framework.

Call Answer Mean Time of 10 seconds.	To set out the corrective action being taken in response to the IQR suggesting that unless there is a process change this objective / target will not be achieved.	Responsive Care – Objective 2

The Committee were informed that the Medway move was proving problematic at this due to it being difficult to recruit in the area at this time.
A QI project is in its infancy looking at the recruitment process, the plan is to bring new joiners in within 60 days.

The committee asked for assurance that we can monitor the impact on patient safety, this was given as we are capturing Datix, Serious Incidents and duplicate calls.
It was acknowledged that 111 has been able to move to an agile workforce, this has not been possible for the 999 service, however this is being reviewed nationally.
The committee noted that the 999 move to Medway was currently five months behind schedule and that Trustwide there are issues with recruitment and retention.
The Committee were informed that turnover in contact centres (including other emergency services and corporate centres) is approx. 20%, therefore does not expect our turnover to ever drop below 10%.

H&T Improvement Minimum 14%	To set out the corrective action being taken in response to the IQR suggesting that unless there is a process change this objective / target will not be achieved	Responsive Care – Objective 4

This area also is a challenge due to recruitment to vacancies, there has been a slight improvement due to the ability to undertake shifts at local OUs.
C2 segmentation is till being developed but it is expected that when introduced this will have a positive impact on H&T.
The Committee sought assurance on the safety of achieving 14% H&T, this was given by the ability to track the patient journey through the IT systems and to monitor both good and bad patient outcomes. It was further stressed that this will be directing patients to the right place for their treatment.

Specific Escalation(s) for Board Action	Concerns about recruitment & retention, low numbers are predicted to start on the next EMA course, the pipeline is slow.

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	The Committee have asked that all papers are to be shared 10 days before the meeting, with an option to send any questions via the BSM two days prior to the meeting, this is to allow for better preparation and to improve the discussions
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 – training / coaching is being provided.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	40-23

Name of meeting	Trust Board
Date	03 Aug 2023
Name of paper	Operational Performance & Efficiency
Strategic Theme	**Responsive Care**
Author / Lead Director	Emma Williams, Executive Director of Operations

Executive Summary

Goal 1: Deliver safe, effective, and timely response times for our patients.

There are three key metrics/areas of work in this goal, however the one of most significant challenge is 999 call handling. As can be seen in the IQR, whilst call answer time is demonstrating positive special cause variation, it remains above the target required. The graphic below is adapted from the Executive Weekly Digest on Performance and demonstrates three of the key drivers impacting this performance, recognising that whilst EMA hours have improved in Q1, these are unstable and fluctuate widely and with a greater proportion of newer staff, call handling time in longer as they build confidence and competence.

Goal 2: Implement smarter and safer approaches to how we respond to patients.

This target measures in this goal relate to 'Hear & Treat' (H&T) and the improved use of all resources.
Regarding H&T this continues to be at risk, as the key drivers for delivery are two-fold:

- Meeting the demand for additional clinical resources is be addressed through several routes, with a strong focus on rapid expansion of band 6 Paramedics working from local hubs across every dispatch desk.
- Implement several technical updates to support changes with the CAD system particularly

relating to the C2 segmentation programme which as a national ambulance service improvement will enable additional processes to be able to better assess C2 calls – building on the learnings and impacts of the C3/C4 revalidation programme. The update for C2 segmentation is planned for early August.

Goal 3: Provide exceptional support for our people delivering patient care.

The move to Medway for 111 at the end of June went very well with staff reporting high levels of satisfaction in working in a new purpose-built location. The move for EOC is still on track for mid-September.

Recommendations decisions, or actions sought.	The Board is asked to test whether there is sufficient progress with the corporate objectives, and the controls and mitigating actions against the relevant risks, as set out in the Board Assurance Framework and Integrated Quality Report. Where the Board identifies gaps in assurance, agree what corrective action needs to be taken by the Executive.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	41-23

Name of meeting	Board
Date	03.08.2023
Name of paper	Achieving Sustainability & Working with Partners
Strategic Theme	**Sustainability & Partnerships**
Author / Lead Director	Saba Sadiq, CFO David Ruiz-Celada, Executive Director for Strategic Planning and Transformation

Executive Summary

Partnerships Working (SP3, SP4)

As part of our annual plans, there are key system partnership enablers that will allow us to perform better and improve patient care:

- UEC Recovery Plan focussing on increasing our capacity and reduction in handovers
- Urgent Community Response improving appropriate pathways for patients into non-ED
- Regional Mental Health response plans

This work compliments our internal targets of improved Hear and Treat to 14% and are key to meeting Category 2 Mean of 30 minutes under Responsive Care annual objectives and it's a collaborative work between Quality, Partnerships, Data, and Clinical EOC colleagues, providing support to Operations.

Our ICB colleagues have now published the 5 year JFPs. As part of the development of the strategy over the next 6/7 months we will be engaging heavily with partners to map how our vision may support and align with the system.

The governance alignment to Kent, Surrey and Sussex has also now gone live as part of the alignment with the quality governance groups. This has been approved at EMB, and System levels

Strategy Development (SP1 and SP2)

Following extensive engagement and a competitive tender process, we have indicated a preferred bidder to support us delivering the Strategy over the coming 6/7 months.

We have established a Steering Committee for the Board to have monthly oversight of the evolution of the programme, and there is a weekly executive programme board that will oversee and coordinate the programme ensuring an inclusive and engagement process.

The programme will be delivered to define a new vision for the organisation and a 5 year strategic delivery plan. This will be done following the principles agreed with the Board and with our stakeholders:

- **Clinically Led**: an evidence-based strategy for our future clinical operating model. They will be working closely with our existing clinical leaders, operational managers and the CAG, to co-design the clinical delivery models of the future.

- **Our People**: within the core scope we expect to be able to publish our long term workforce plan, supporting the long term vision for SECAmb, and providing us with a response to the NHS long-term workforce plan which was recently published.

- **Inclusive Engagement**: In partnership with IPSOS, a wide-ranging engagement programme will be launched, encompassing online discussions, interviews, workshops, and seeking out to difficult-to-reach groups.

- **Innovation**: We heard a clear ambition to be bold in our approach to technological innovation. Our partner bring in a wealth of experience in this space and we will setup a dedicated tech group supporting the delivery of our clinical model.

- **Financial Sustainability**: Our partner will assist us in creating realistic financial projections considering the strained NHS finances. This will help make the strategy real and deliverable.

- **Partnership**: Our ICBs have been involved in the process, and we'll concentrate on a shared vision for the Ambulance Service's role within the UEC pathway.

- **Execution**: The Strategy's core deliverables will include a detailed delivery plan for the Board to drive transformation activities, however we will be focusing on shifting to a model of empowerment where the change can be delivered by those closest to patients.

This work will also define our operating model, and will define the mitigating actions for BAF Risk 14 (operating model) and 255 (workforce), by providing us with long-term answers to these strategic risks.

<u>Green Plan (SP8)</u>

The Green Plan has been completed and presented at FIC in July 23. Key interventions for de-carbonisation this year are included in the plan and in Q2 we will be establishing the internal governance oversight required to ensure we deliver the plans in line with approved plan. There remain significant risk due to the un-funded nature of the plan, and we will be incorporating the expenditure and investment required to support our de-carbonisation targets as part of the 5-year financial modelling associated with the strategy

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

Recommendations, decisions or actions sought	The Board is asked to test whether there is sufficient progress with the corporate objectives, and the controls and mitigating actions against the relevant risks, as set out in the Board Assurance Framework and Integrated Quality Report. Where the Board identifies gaps in assurance, agree what corrective action needs to be taken by the Executive.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	41/23

Name of meeting	Trust Board
Date	03rd August 2023
Name of paper	M3 Financial Performance Report
Executive sponsor	Saba Sadiq - Chief Finance Officer
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Kevin Steer (Head of Financial Accounting & Compliance), Rachel Murphy (Financial Manager - Projects, Business, and Investments)
Synopsis	This report provides an update on the Trust's Financial Position for month 3 year-to-date (YTD). In summary the Trust is reporting the planned, year-to-date £0.2m surplus for M3 YTD. Efficiencies of £0.4m were delivered against a plan at M3 of £0.8m (adverse variance of £0.4m). There are emerging financial risks that may impact upon delivery of the financial plan. These financial risks are overspends in our Operations directorate (e.g., £1.9m YTD on 999 and 111 predominantly in pay) and under delivery of the efficiency programme. Mitigations are being developed to address these emerging financial risks. Consequently, the Trust is forecasting achieving financial breakeven at year-end. The M3 cash position was £45.5m (an improvement of 19.7% compared to last month), and 12.6% against plan due to timing on settling the tax liabilities of the pay awards. We are forecasting a cash position at the end of March 2024 of £48.4m, which is £2.0m below. Financial risks outlined above would result in an adverse impact on the cash position and under delivery against the target.
Recommendations, decisions, or actions sought	The Trust Board are asked to note the a) The M3 financial performance b) The challenges facing the Trust in delivering its efficiency programme; and c) Mitigations are in development to address overspends and under-delivery of the efficiency programme through budget holders for the former and the Senior Management Group for the latter.

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

2023/24
Financial Performance Report
Month 3 Year-to-date

Contents

Executive Summary

The Trust reported a M3 year-to-date (YTD) financial performance of £0.2m surplus (plan was also £0.2m).

	Year to June 2023				Forecast to March 2024			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
Income	£79.4m	£79.9m	£0.4m	✓	£318.3m	£318.7m	£0.4m	✓
Expenditure	(£79.3m)	(£79.7m)	(£0.4m)	✗	(£318.3m)	(£318.7m)	(£0.4m)	✗
Trust Surplus / (Deficit)	£0.2m	£0.2m	£0.0m	✓	(£0.0m)	(£0.0m)	£0.0m	✓
System 'Control' Adjustments	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Reported Surplus / (Deficit)	**£0.2m**	**£0.2m**	**£0.0m**	✓	**£0.0m**	**£0.0m**	**£0.0m**	✓
Efficiency Programme	£0.9m	£0.4m	(£0.4m)	✗	£9.0m	£9.0m	£0.0m	✓
Cash	£40.4m	£45.5m	£5.1m	✓	£50.4m	£48.4m	(£2.0m)	✗
Capital Expenditure	£3.7m	£5.6m	(£1.9m)	✗	£25.9m	£25.9m	£0.0m	✓

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

Year to Date (YTD)

- To deliver this financial performance there were upsides and downsides. Upsides included £0.5m of interest received, £0.3m of vehicle disposals and £0.5m vacancies across the Trust. Downsides included £0.4m overspend in the Operations directorate. These our outlined more in detail later in this report.

- Delivery of £0.4m efficiencies for the year to date is £0.4m adverse to plan. Forty schemes at a value of £7.3m have been identified against the target of £9.0m. 52.5 percent of these schemes valuing £5.1m have been moved to the delivery phase. Once these are risk adjusted, the efficiency savings forecast reduces to £4.2m. This means the Trust has to find further schemes of £4.8m to bridge the gap in the efficiency programme. Mitigations in place include the contribution expected from the fourteen scoped schemes totalling £1.9m subject to Executive Director and Chief Finance Officer sign off and QIA approval prior to realisation. The urgent development of the further seventeen schemes recognised on the pipeline tracker and review of ideas identified from the communication and our people engagement to reduce the gap.

- The cash position increased by £7.5m this month to £45.5m. This is £5.1m above plan due to the timing between the receipt of the pay award funding and the additional payroll taxes being paid in July.

- Capital expenditure of £5.6m is £1.2m above plan due to timing of asset purchases, mainly in IT. The Trust is confident that it will deliver its capital departmental expenditure limit (CDEL).

Forecast Outturn

- The forecast is that the Trust will achieve breakeven at year-end. Mitigations are in development to support both reducing overspends to bring them in line with budgets and a concerted focus on delivering the efficiency programme.

- As required by the ICB, the Trust has reported an overall forecast breakeven as planned.

- The Directorate financial position check and Executive challenge process will continue focusing on ensuring all directorates deliver their allocated plan, including identifying further savings required to meet the breakeven forecast position.

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

1. Income

	Year to June 2023				Forecast to March 2024			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
999 Income	£71.3m	£71.3m	£0.0m	✓	£286.0m	£286.0m	£0.0m	✓
111 Income	£6.7m	£6.7m	£0.0m	✓	£26.9m	£26.9m	£0.0m	✓
HEE Income	£0.6m	£0.7m	£0.1m	✓	£2.2m	£2.3m	£0.1m	✓
Other Income	£0.8m	£1.1m	£0.3m	✓	£3.2m	£3.5m	£0.3m	✓
Total Income	**£79.4m**	**£79.9m**	**£0.4m**	✓	**£318.3m**	**£318.7m**	**£0.4m**	✓

- 999 income is as planned. The plan is based on the latest financial envelope and includes the additional £8.9m from NHS England to support ambulance capacity to achieve the C2 mean of 30 minutes.
  - The additional £8.9m national funding has been allocated to the Surrey Heartlands ICB and a catchup payment has been made in June 2023.

- 111 income is as planned, based on the expected contract value.

- HEE income is 0.1m greater than planned. This is to offset the additional costs associated with delivering university course to develop paramedic practitioners. The Trust has now received the funding schedules for 2023/24. Health Education England has merged with NHS England.

- Other income is £0.3m above plan and is linked to additional costs associated with international paramedic recruitment under HR and recovery support funding as part of the improvement journey.

2. Expenditure

By Directorate	Year to June 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Chief Executive Office	(£1.1m)	(£0.9m)	£0.2m	✓	(£4.2m)	(£4.1m)	£0.1m	✓
Finance	(£5.7m)	(£5.5m)	£0.1m	✓	(£23.1m)	(£23.0m)	£0.1m	✓
Quality and Safety	(£0.9m)	(£0.8m)	£0.1m	✓	(£3.6m)	(£3.6m)	£0.0m	✓
Medical	(£3.2m)	(£2.8m)	£0.4m	✓	(£12.8m)	(£12.7m)	£0.2m	✓
Operations	(£45.9m)	(£47.0m)	(£1.1m)	✗	(£188.9m)	(£190.4m)	(£1.5m)	✗
Operations - 111	(£6.7m)	(£7.5m)	(£0.8m)	✗	(£26.8m)	(£27.1m)	(£0.3m)	✗
Strategic Planning & Transformatio	(£6.9m)	(£6.7m)	£0.2m	✓	(£27.8m)	(£28.0m)	(£0.3m)	✗
Human Resources	(£1.3m)	(£1.7m)	(£0.4m)	✗	(£5.1m)	(£5.5m)	(£0.4m)	✗
Total Directorate Expenditure	**(£71.6m)**	**(£72.9m)**	**(£1.3m)**	✗	**(£292.2m)**	**(£294.4m)**	**(£2.2m)**	✗
Depreciation^	(£4.3m)	(£4.2m)	£0.1m	✓	(£19.1m)	(£19.1m)	£0.0m	✓
Financing Costs	(£0.6m)	£0.2m	£0.8m	✓	(£2.3m)	(£1.6m)	£0.8m	✓
Corporate Expenditure	(£3.4m)	(£2.8m)	£0.6m	✓	(£9.2m)	(£8.7m)	£0.5m	✓
Total Underlying Expenditure	**(£79.9m)**	**(£79.7m)**	**£0.2m**	✓	**(£322.8m)**	**(£323.7m)**	**(£0.9m)**	✗
Non-Recurrent Adjustments	£0.6m	£0.0m	(£0.6m)	✗	£4.5m	£5.0m	£0.5m	✓
Total Expenditure	**(£79.3m)**	**(£79.7m)**	**(£0.4m)**	✗	**(£318.3m)**	**(£318.7m)**	**(£0.4m)**	✗

^Depreciation now includes Rights of Use Asset depreciation, previously shown as part of directorate values (e.g. ambulance leases)

YTD performance against plan

- Total expenditure for the year to June was £79.7m, £0.4m higher than plan.

- The net adverse variance is driven by £1.1m higher than planned spend in the Operations service area and £0.8m in NHS 111. These are partly offset by underspends of £1.5m in other areas.

- The main driver for the Operations overspends is that the productive hourly rate (based on hours 'on the road') of £39.9 was 13.0% higher compared to the plan of £35.35. The main factors the following:

    - Although both recruitment plus attrition is in line with plan, and abstraction level of 30.4% is below plan of 31.9%, the YTD provision of substantive staff hours remain below plan by 9.5 percent because there are significant number of new recruits currently undergoing their training and not yet operational.
    - This means the utilisation of overtime, including late sign off increased to 7.5% of the total hours compared to planned hours of 2.6 to compensate for the shortfall in hours at an additional cost of £0.4m, leading to an overall under provision of hours of 5.5%.
    - The five bank holidays in April and May generated higher than planned enhanced Time of in lieu (TOIL) and impact of the annual average Unsocial Hours rate payments of £0.6m.
    - The extended recruitment led to circa 50 further new recruits at the start of the financial year at a value of £0.3m.

- Higher than planned spend of £0.8m in NHS 111 is largely because of the reliance on agency clinicians, GPs, and overtime at higher premium rates to facilitate a safe service delivery whilst sickness abstraction continues to track over 12 percent (target: 7%) and recruitment remains challenging. This is partly due to the enhanced bank holidays payments and the move to Medway. The latter happened in June and some stability is expected going forward.

- Partly mitigating these, are vacancies in support and back-office functions due to timing of recruitment of £0.5m, whilst restructures are in progress; £0.5m higher interest received in line with the high interest rate and profit on vehicle disposal of £0.3m. Further underspends

of £0.2m relate to the reduction in fuel (8.8 percent lower rate and litres respectively) and training of £0.2m.

- Depreciation and Rights of Use are slightly below plan by £0.1m due to timing.

- The quarter 1 forecast has addressed the issues established in the deep dive analysis into the adverse variances in operations. A progress update has been presented to Executive Management Board (EMB) and the communicated to the key stakeholders.

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

NHSE Categories	Year to June 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Pay/Staff Costs	(£56.4m)	(£57.2m)	(£0.8m)	✗	(£229.4m)	(£228.8m)	£0.6m	✓
Depreciation (including Rights of Use Assets)	(£4.3m)	(£4.2m)	£0.1m	✓	(£19.1m)	(£19.0m)	£0.1m	✓
Premises Costs	(£0.3m)	(£0.3m)	£0.0m	✓	(£1.7m)	(£1.7m)	£0.0m	✓
Transport Costs	(£4.5m)	(£4.1m)	£0.4m	✓	(£17.9m)	(£17.9m)	£0.0m	✓
Purchase of Healthcare (PAPs;IC24;HEMS)	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Supplies and Services	(£2.3m)	(£2.4m)	(£0.1m)	✗	(£9.5m)	(£9.4m)	£0.1m	✓
Establishment	(£1.3m)	(£1.2m)	£0.1m	✓	(£5.0m)	(£5.0m)	£0.0m	✓
Education Costs	(£0.6m)	(£0.3m)	£0.3m	✓	(£2.6m)	(£2.6m)	£0.0m	✓
Operating Lease Expenditure	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Finance Costs	(£0.4m)	£0.1m	£0.5m	✓	(£2.0m)	(£1.5m)	£0.5m	✓
Clinical Negligence (CNST)	(£0.5m)	(£0.5m)	£0.0m	✓	(£1.9m)	(£1.9m)	£0.0m	✓
Gains / Losses on Asset Disposal	£0.0m	£0.3m	£0.3m	✓	£0.0m	£0.3m	£0.3m	✓
Other	(£9.3m)	(£9.9m)	(£0.6m)	✗	(£33.7m)	(£36.3m)	(£2.5m)	✗
Total Underlying Expenditure	**(£79.9m)**	**(£79.7m)**	**£0.2m**	✓	**(£322.8m)**	**(£323.7m)**	**(£0.9m)**	✗
Non-Recurrent Adjustments	£0.6m	£0.0m	(£0.6m)	✗	£4.5m	£5.0m	£0.5m	✓
Total Expenditure	**(£79.3m)**	**(£79.7m)**	**(£0.4m)**	✗	**(£318.3m)**	**(£318.7m)**	**(£0.4m)**	✗

Full year performance against plan

- Despite some overspends for the year, mainly in pay, the Trust is planning to achieve financial breakeven, subject to mitigating actions put in place to reduce and eliminate risk associate with under delivery against efficiency programme and budgetary overspends.

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.

Trust Surplus / (Deficit)	£0.2m
System 'Control' Adjustments:	
Remove impact of Donated Assets	£0.0m
Remove impact of Impairments	£0.0m
Reported Surplus / (Deficit)	**£0.2m**

4. Efficiency Programme

Proposed schemes

Scheme Category	Fully Validated	Validated	Scoped	Total Schemes	Proposed	Total
	£000	£000	£000	£000	£000	£000
Discretionary Non Pay	-	-	84	84	-	84
Efficiency target	441	268	14	724	588	1,312
Estates and Facilities optimalisation	323	-	-	323	-	323
External consultancy & contractors	12	-	-	12	17	29
Fleet -Other Efficiencies	191	-	40	231	-	231
IT Productivity and Phones	-	-	271	271	-	271
Make Ready Process	-	-	250	250	-	250
Operations Efficiencies	2,189	7	1,124	3,319	-	3,319
Optimisation in Training	26	-	-	26	-	26
Policy & service reviews	1,480	-	129	1,609	-	1,609
Procurement contracts review	380	-	-	380	-	380
Taxi & Other Vehicle Hire	-	-	9	9	-	9
Travel and subsistence	12	-	-	12	38	49
Unidentified	-			-	1,118	1,118
Grand Total	**5,053**	**275**	**1,921**	**7,250**	**1,761**	**9,011**

Efficiency Delivery YTD June and Forecast Outturn by Directorate

Directorate	2023/24 M03 YTD Plan £000	2023/24 M03 YTD Actual £000	2023/24 M03 YTD Variance £000		2023/24 Full Year Plan £000	2023/24 FOT - risk adjusted schemes £000	2023/24 Full Year Variance FOT vs. Plan £000	
Chief Executive Office	9	0	(9)	✗	37	0	(37)	✗
Finance & Corporate Services	152	0	(152)	✗	632	562	(70)	✗
HR	38	0	(38)	✗	154	0	(154)	✗
Medical	125	0	(125)	✗	499	283	(216)	✗
Operations	326	0	(326)	✗	4,771	1,065	(3,706)	✗
Quality & Nursing	0	0	0	N/A	0	0	0	N/A
Strategic Planning & Transformation	199	303	104	✓	1,084	840	(244)	✗
Trust wide	0	138	138	✓	1,834	1,451	(383)	✗
Total	**850**	**441**	**(409)**	✗	**9,011**	**4,200**	**(4,810)**	✗

- The Trust's efficiency target for the financial year of £9.0m, represents 3% of operating expenditure.

- The tables above show the progress on developing the plans. We currently have 40 schemes identified on the Pipeline Tracker at a value of £7.3m. Out of these, 21 schemes totalling £5.1m have been moved to the delivery phase. 5 validated (£0.3m) and 14 scoped (£1.9m) schemes are currently awaiting CFO/ Director sign off and or QIA review. 91.4 percent of the £7.3m schemes are expected to be realised on a recurrent basis.

- We have delivered £0.4m savings YTD June 2023, which is £0.4m adverse to plan.

- The emerging risk impacting delivery reduces the £5.1m fully validated schemes transferred to delivery to £4.2m. This is a £4.8m shortfall compared to the £9.0m efficiency target for the year.

- More work and traction are required to develop mitigations to recover the shortfall. This will require progressing the approval of the 14 scoped schemes and to develop the17 additional schemes in the pipeline phase together with the further 'bottom up' ideas identified by our people through the recent communication and staff engagement programme.

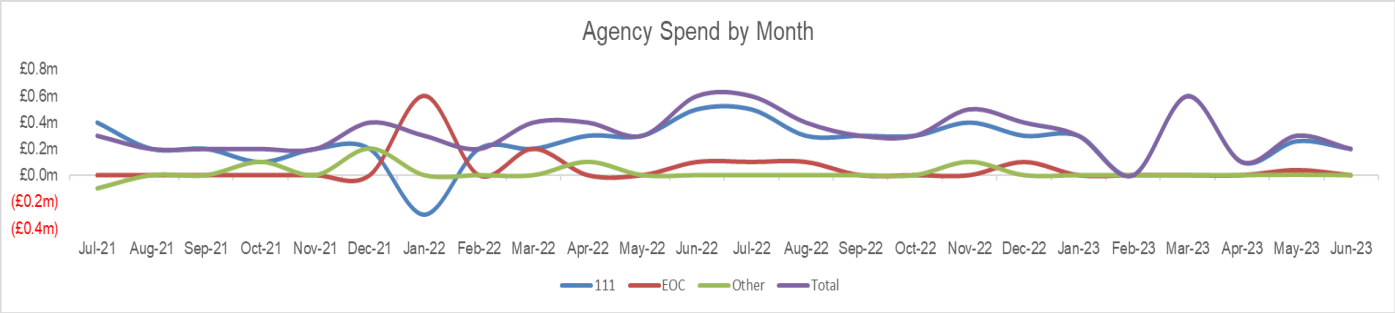
- The overall efficiency delivery risk is currently red. Therefore, focus on developing 53.3 percent of schemes is required to facilitate the delivery of the £9.0m target in the financial year 2023/24 and to build a pipeline of sustainable schemes beyond.

- Regular updates will be provided to the Joint Leadership Team meetings and Finance and Investment Committee.

5. Agency

	Year to June 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Agency Expenditure	**(£0.5m)**	**(£0.7m)**	**(£0.2m)**		**(£1.8m)**	**(£1.8m)**	**£0.0m**	

- Overall spend with agencies over plan by £0.2m. Majority of the agency spend was in NHS 111. 111 have put plans in place to reduce the number of agency clinicians used.



6. Cash and Statement of Financial Position

	£000 Previous Month	£000 Change	£000 Current Month	£000 31 March 2024
NON-CURRENT ASSETS				
Property, Plant and Equipment	117,059	535	117,594	123,875
Intangible Assets	2,234	(117)	2,117	2,118
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**119,293**	**418**	**119,711**	**125,993**
CURRENT ASSETS				
Inventories	2,614	(104)	2,510	2,430
Trade and Other Receivables	24,293	(12,237)	12,056	17,035
Asset Held for Sale	657	0	657	657
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	37,979	7,524	45,503	42,953
Total Current Assets	**65,543**	**(4,817)**	**60,726**	**63,075**
CURRENT LIABILITIES				
Trade and Other Payables	(57,889)	6,513	(51,376)	(55,484)
Provisions for Liabilities and Charges	(10,376)	0	(10,376)	(10,376)
Borrowings	(4,820)	(2,151)	(6,971)	(7,543)
Total Current Liabilities	**(73,085)**	**4,362**	**(68,723)**	**(73,403)**
Total Assets Less Current Liabilities	**111,751**	**(37)**	**111,714**	**115,665**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(9,528)	0	(9,528)	(9,528)
Borrowings	(23,983)	483	(23,500)	(27,626)
Total Non-Current Liabilities	**(33,511)**	**483**	**(33,028)**	**(37,154)**
TOTAL ASSETS EMPLOYED	**78,240**	**446**	**78,686**	**78,511**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,204	0	109,204	109,204
Revaluation reserve	6,871	0	6,871	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(37,562)	0	(37,562)	(37,562)
Income and expenditure reserve - current year	(273)	446	173	(2)
TOTAL TAX PAYERS' EQUITY	**78,240**	**446**	**78,686**	**78,511**

- Non-Current Assets are up by £0.4m in the month represented by new assets under construction of £0.2m, plus new Right of Use assets of £1.6m net of monthly depreciation of £1.4m.

- Trade and other receivables are up by £12.2m. The major movement is a £11.7m decrease of accrued income with the receipt of the pay award income and other block income. Also trade receivables invoiced is down £0.7m after a receipt from NHSE, Kent and Medway ICB and KSAAT in the month. The balance of £0.2m is the movement in prepayments and other debtors.

- Cash was up £7.5m after the receipt of the pay award income of £9m plus other block income. There is timing of around £5m increase of payroll taxes and pension where these are paid a month in arrears. Combined with the timing on some large payments to IC24 the increase will reverse next month.

- Trade and other creditors were down by £6.5m which was primarily a reduction in accruals of £10.4m made up of the pay award now transacted through payroll partially offset by an increase of £5.0m on payroll taxes and pension payable. The balance is made up of £0.9m decrease in trade payable.

- The provision balances are unchanged from year end.

- Borrowings increased by £1.7m primarily as a result of a new lease liabilities including one for 34 Skoda Kodiaq SRVs of £1.2m.

- The movement on the I&E reserve represents the Trust's reported deficit for the month and year to date.

7. Cash Flow Position

Cash Flow	Year to June 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
EBITDA	£3.3m	£4.2m	£0.8m	✓	£21.4m	£20.6m	(£0.8m)	✗
Working Capital / IFRS 16	£0.8m	£4.6m	£3.7m	✓	£13.8m	£11.4m	(£2.4m)	✗
Capital Payments	(£6.5m)	(£6.4m)	£0.1m	✓	(£18.4m)	(£19.3m)	(£0.9m)	✗
Proceeds from disposal of assets	£0.0m	£0.3m	£0.3m	✓	£0.0m	£0.3m	£0.3m	✓
IFRS 16 Lease Payments	(£1.0m)	(£1.6m)	(£0.7m)	✗	(£8.4m)	(£7.7m)	£0.7m	✓
Net PDC and interest	(£0.1m)	£0.4m	£0.4m	✓	(£2.2m)	(£1.1m)	£1.0m	✓
Cash Movement	(£3.4m)	£1.4m	£4.8m	✓	£6.3m	£4.2m	(£2.0m)	✗
Opening Cash Position	£44.1m	£44.1m			£44.1m	£44.1m		
Closing Cash Position	£40.7m	£45.5m	£4.8m	✓	£50.4m	£48.4m	(£2.0m)	✗

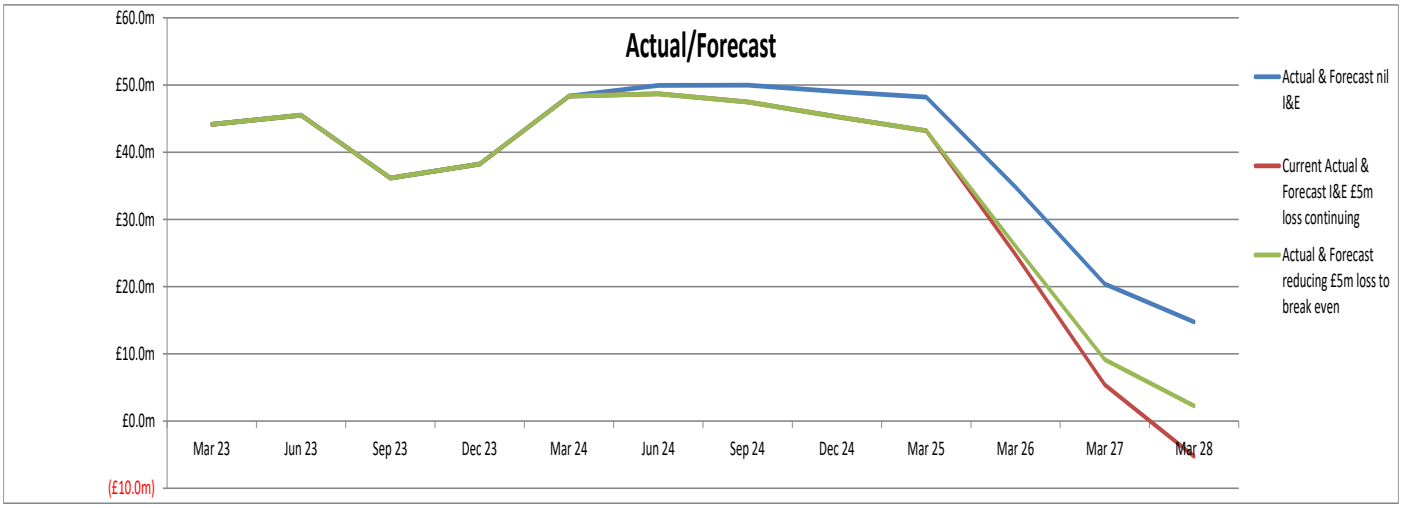
- The Trust's cash balance at June 2023 was £45.5m. The receipts for the year-to-date were £92.4m including proceeds from sale of Trust assets of £0.3m.

- Capital cash payments were £6.4m for the year to date along with other expenditure of £84.6m meaning the net increase of £1.4m for the year in the table above.

- The actual cash balance was £4.8m higher than plan primarily due to the pay award where the increased related payroll taxes and pension will be paid in July where the income from NHS England of £9m was received in month.

- This is then increased by the surplus on the I&E position of £0.8m. The remaining £0.3m represents is the net of other items.

8. Cash Forecast



- Forecast cash for the remainder of 2023/24 and then forecast or future years 2024/25 through to 2027/28 based upon the total capital expenditure plans, expected disposals and the Income & Expenditure (I&E) cash requirement for the Trust to operate from day to day following the 2023/24 plan submission.

- The upside case is indicated by the top blue line above, where a break-even I&E position has been assumed for all future years. This means our cash position will be around £15.0m due to significant planned capital investment in 2025/26 and 2026/27.

- The middle green line predicts the eroding cash position if the Trust reports a £5.0m deficit in 2023/24 and reduces the losses to zero over the forecast years whilst the red line shows the trend when the forecast losses for next year continues.

- Overall, though the block income arrangement has been assumed to continue in the new financial year, our cash position will continue to decline if the Trust persist to make deficits and will eventually run out within the next two years.

9. Working Capital Ratios

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	14	
Debtors % > 90 Days	5.0%	47.4%	
Trade Creditor Days	30	54	
BPPC - Value of inv's pd within target (ytd)	95.0%	89.6%	
Cash (£m)	40.7	45.5	

- Receivable days at month end are 16 days ahead of target after the clearance of the pay award accrued income plus the settlement of debt from various customers including KSAAT.

- Receivables % over 90 days are above target due to historic overdue invoices of £104k from NHS Horsham and Mid Sussex CCG for divert charges and £64k from NHS Lewes High Weald Havens CCG for disputed A&E charges. Both CCGs are no longer operating, and both have been absorbed into the new NHS Sussex ICB.

- Payables days are off target by 54 days for the month. The level of payables remains high with £2.7m of IC24 invoices for 111 having been cleared for payment but were not paid until July. Also £0.8m of Gresham Office Furniture invoices continue to await approval for payment which would reduce the level of creditors.

- The BPPC for value of invoices paid has declined in the month to reduce the YTD 89.6% short of the target of 95%. The shortfall in the month was because of late payments for Boost Pro System £0.4m, Laser Energy £0.2m and Churchill £0.1m where delays in processing the invoices against the purchase orders led to failing terms. This is especially true of Laser who are on 7 days terms which is a continual pressure on meeting the target.

- Cash is above plan at month end after the receipt of the pay award income and the catch-up of other block income. However, this increase represents timing as the increased income tax, national insurance and pension contributions related to the backpay will not be paid until July. This amount to £4-5m increase on the payable from last month combined with the payment of IC24 in July will inevitably reduce the balance in July.

10. Capital

	Year to June 2023				Forecast to March 2024			
	Plan	**Actual**	**Variance**		**Plan**	**Forecast**	**Variance**	
Estates	£0.0m	£0.1m	(£0.1m)	✗	£0.6m	£0.6m	£0.0m	✓
Strategic Estates	£1.5m	£0.7m	£0.8m	✓	£2.0m	£2.4m	(£0.4m)	✗
IT	£0.7m	£2.2m	(£1.5m)	✗	£5.1m	£4.7m	£0.4m	✓
Fleet	£0.5m	£0.2m	£0.3m	✓	£4.2m	£4.1m	£0.0m	✓
Clinical Operations	£0.0m	£0.1m	(£0.1m)	✗	£0.4m	£0.5m	£0.0m	✓
Total 'System' ICB Capital	**£2.7m**	**£3.2m**	**(£0.6m)**	✗	**£12.3m**	**£12.3m**	**£0.0m**	✓
PDC Funding	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Right of use assets (Leases)	£1.0m	£2.4m	(£1.4m)	✗	£13.5m	£13.5m	£0.0m	✓
Total Capital Plan	**£3.7m**	**£5.6m**	**(£1.9m)**	✗	**£25.9m**	**£25.9m**	**£0.0m**	✓

- The capital spend is £5.6m compared to the plan of £3.7m. This overspend is due to timing differences with spend at the end of 2022/23 and the lease for the 34 SRVs has gone live earlier than planned.

- The Trust anticipates meeting its capital departmental expenditure limit by year end. There are a couple of possible variations to the forecast plan that have not yet been incorporated. The Trust will receive a CDEL increase for the net book value of any sales made in the year, this could be up to £3.4m. There is expected to be an overspend against the plan for the MDC refit of circa £0.5m and potential spend on Crawley HQ of circa £1.2m. These projects are still in the early stages of progress and costs and timings are not yet known. However, the Trust has sufficient cash to be able to fund these projects should the CDEL increase be allocated by NHS England.

11. 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
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	Unlikely >20% <=50%	8
Forecast reflects the expected costs; This risk reflects any further deterioration to the forecast for any unforeseen and unexpected costs.	>£0.5m <=£1.0m	Possible 50/50	6
The impact of the funding received for the NHS pay award and the 'budgeted' increase in pay costs requires further mitigations; avenues being explored include further conversations with Commissioners.	>£0.5m <=£1.0m	Unlikely >20% <=50%	4

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

Opportunities	Impact	Likelihood
Additional sales 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
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	Unlikely >20% <=50%

- The table above shows potential opportunities for the Trust to be able to mitigate the risks and achieve this year's financial target.

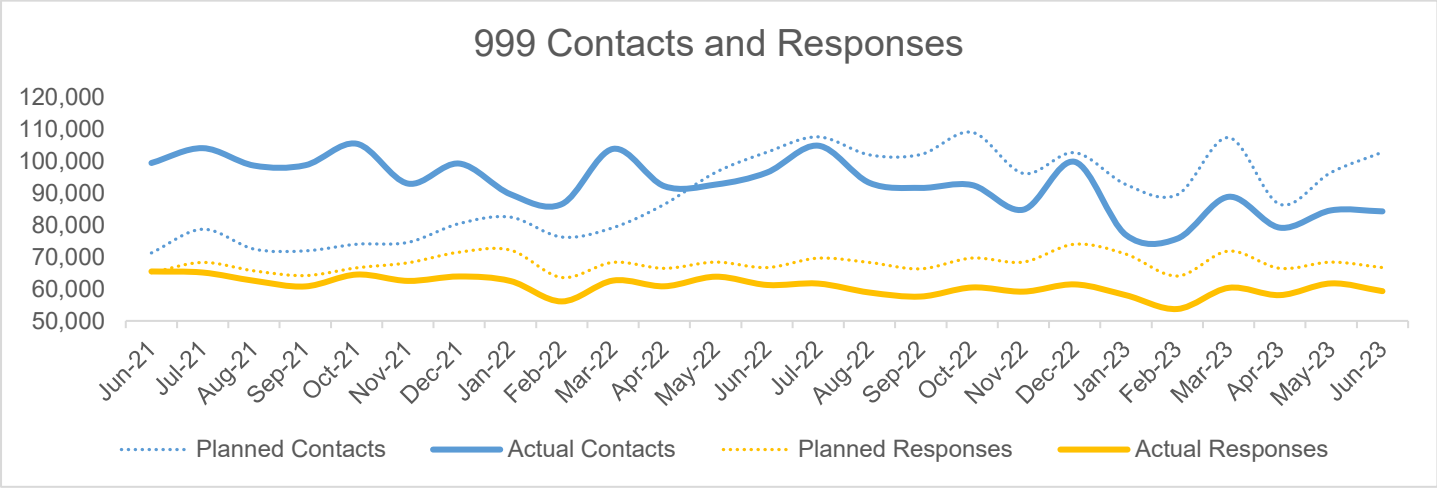
Appendices

A. Finance Pack

SECAmb_Finance_Pack_M03.pdf

B. Activity

999 Activity:



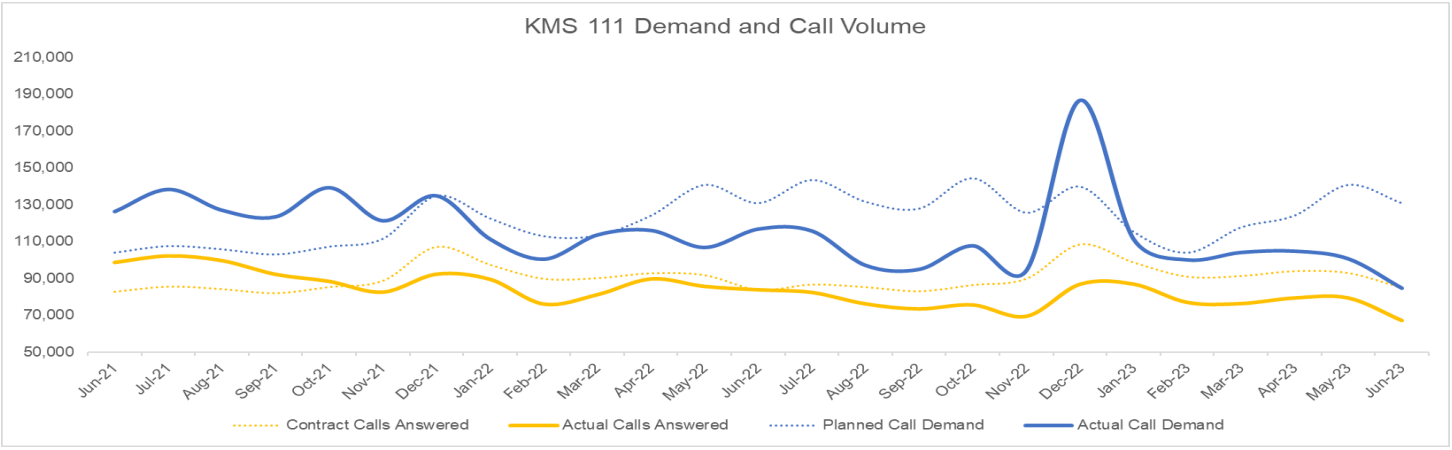
999 contacts (demand) is 11.8%t down against the last year, with response activity 3.3% lower.

This reduction in demand and activity has contributed to an improvement in Category 2 mean response times versus last year, with the C2 mean improving to 26.9 minutes year to date compared to 32.4 minutes last year to May, 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, 6,916 hours less were lost in the year to June 2023 compared to last year, this would be the equivalent of almost 7 extra ambulance shifts per day, helping to improve performance times.

C2 Mean currently stands at 26.9 minutes year to date against a plan of 30.7 minutes.

111 Activity:



June 2023 saw demand (calls offered) decrease by 15.8% than May 2023, partly due to the reduced number of days and no bank holidays.

Both demand and activity are down versus the same period last year with demand 14.5% lower and activity 12.8 percent down. This trend would indicate the Trust requires less staff to meet future demand.

Calls answered in 60 seconds performance slipped slightly to 45.0 percent for June against 45.2% in May 2023. National KPIs have changed for the 111 service, with proportion of calls abandoned and average speed to answer being the main KPIs being monitored going forward. SECAmb currently sits at 12.7% (10.3%) and 235 (179) seconds for these metrics (national). Standard target is 3.0% and 20 seconds.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

	Agenda No	41-23
Name of meeting	Trust Board	
Date	3 August 2023	
Name of paper	Finance and Investment Committee Escalation Report – 15 June & 27 July 2023	
Author	Howard Goodbourn, Independent Non-Executive Director – Committee Chair	

This report provides an overview of issues covered at the meetings on 15 June & 27 July 2023

Item	**Purpose**	**Link to BAF**
Financial Performance	To provide information on the Trust's financial performance, including issues and risks to delivery and to seek assurance that there is robust budget management to ensure we meet our financial plan.	SP Objective 6 – Meeting our financial BAF Risk 16 – Financial Sustainability

At month 3 we are on plan, but this was in the context of underlying operational overspends covered by underspends elsewhere. The committee explored the detail behind this and highlighted some concerns related to the planning and enhancements for Bank Holidays and a workforce gap in the budget setting process. The executive acknowledged these issues and are taking corrective action.

The committee reviewed the impact of the financial plan on workforce, performance and quality, noting that despite the overspends we aren't achieving the workforce hours that are needed. However, operational performance and in particular C2 mean is being achieved.

The committee also explored the seasonality of the finance plan and how we ensure we have the resources needed through the winter period to ensure we maintain quality. The executive expressed confidence that the budget has been appropriately stress-tested and will provide further assurance at the next meeting, including how we mitigate any adverse impact on staff, e.g. through over-reliance on overtime. The committee noted that the new quality assurance visits review these types of issues to triangulate performance, quality, finance and workforce so that issues are identified early.

One other issue of note related to delays in some invoices being processed. Further assurance on this will be received at the next meeting.

Efficiency Programme	To set out the efficiency schemes and seek assurance that they are robust and being tracked to ensure effective delivery.	SP Objective 7 – Cost efficiency improvements to ensure resources are focussed on delivering patient care.

		Risk 16 – Financial Sustainability
An update was received on the progress of the proposed £9.0m efficiency programme for 2023/24, which is a significant ask in the context of the Trust not having a good record of recurrent delivery. At Q1 the plan was £850k, and we achieved £441k. The schemes have recently been risk adjusted which has resulted in a decrease from £5.1m (schemes in the delivery phase) to £4.2m; a gap in our efficiency programme of £4.8m. The executive set out the steps being taken to close this gap and are confident in the process for identifying efficiencies. There have been really good ideas coming from staff across the organisation and this is culturally positive. The committee acknowledged the risks the executive is highlighting with delivery of the plan but is assured with the actions being taken. This will remain a standing item throughout the year.		
Fleet	To provide an update on Fleet activity / replacement plan.	SP Objective 9 – A new ambulance design and fleet strategy that meets the needs for the future.
A new risk was highlighted related to the recruitment of fleet maintenance staff. There is currently a national shortage of qualified vehicle technicians, and we are seeing very little responses from the job adverts when they go out. In response, the executive is reviewing the workforce model and our approaches to identify areas of improved efficiency to help manage the activity. This recruitment challenge highlighted that the Board has potentially focussed too narrowly on the operational workforce plan. It suggests the People Committee considers how it seeks assurance on the workforce plan for support services. Confirmation was received recently that the national fleet procurement will allow us to choose different vehicles, which will inform a review of our fleet strategy / replacement plan. The other issue to note related to the recent establishment of a Fleet Desk and the committee will in November as part of the review of the lease car policy, seek assurance that our use of hire vehicles represents good value for money.		
Information Technology	To seek assurance that IT activities are aligned to the current strategy and security/cyber controls are robust	RC Objective 8 – Integration of EOC 111 and MRC operations at Medway
A helpful paper was considered, setting out the recent IT activities, including the mobilisation of Medway. The committee still needs greater assurance related to IT resilience and notes the external review about to start. This will help to inform the development of a new digital strategy which will align with the overarching clinically led trust strategy.		
Commissioned Contracts	To provide an overview of all commissioned contracts and how they are being managed.	N/A
An update was provided on the Trust's NHS-commissioned contracts and services and issues to note include:		

KMSS - we are meeting regularly with KMSS and ensuring quality assurance with commissioners given this pass-through contract. Once a quarter the KMSS team will report performance to commissioners as part of the assurance cycle.

111/CAS - the contract expires in March 2025 and commissioners are required to give 12 months' notice to extend (for a further 2 years). The contract is co-terminus with the IC24 sub-contract.

999 – the executive continues to engage with commissioners on the delivery of its core services, and the review of the service specifications for both 999 and 111 is required to ensure delivery is consistent with changes in the UEC environment. The national service specification was last updated in 2018 and this is being reviewed nationally with AACE.

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

The committee reviewed the list of properties identified on approved business bases for disposal; the plan achieves circa £4.5m this year. It is satisfied with the governance process where properties for disposal are all part of approved business cases and at sale requires sign off by two directors. In terms of best value, we follow the NHS estates code of practice, which requires as a minimum two independent valuations and includes terms such as overage clauses.

Green Plan	To seek assurance on the progress with the development of the Green Plan.	SP Objective 8 – Delivery of our de-carbonisation commitments as set out by the Green Plan

This aspirational plan sets a trajectory on what we need to do. It will enable discussions with commissioners to help determine priorities and what can be afforded. It will feed into the overarching trust strategy. The committee noted that the plan will at least initially provide more of a refined problem statement than solutions. The four key areas of focus to reduce our carbon footprint include:

1. Fleet Transition – EV vehicles
2. Estates & Facilities – use of energy
3. Medicines - reduce Medicines and Consumables emissions by 80% by 2032.
4. People & Partners – to ensure we get engagement and buy in.

The committee explored if we have not just the money but the capacity to deliver on some of the aspirations. The executive agree we are not yet set up to deliver as it requires much change in our infrastructure. This reinforces the point that this is not yet a plan but the answers to the problem statements.

The committee reinforced that this needs to focus on things we can deliver, while not losing the overall aspiration that will be for the future. The complexity will therefore need careful communication. In the meantime, the Green staff network is up and running and some initiatives are being taken forward. The comms plan is due to be launched in August starting with simple message about the need to become sustainable and reduce our carbon footprint in specific ways.

A session is scheduled for the Board on 3 August to confirm the Board's role.

Data Strategy	To provide update on progress around the Implementation of a Data Strategy and its link to the Digital Strategy	
FIC updated on the transition from a standalone data strategy to a broader digital strategy for the Trust. The digital strategy will align with the Trust's overall strategy, integrating IT, data, and clinical information to improve patient care, staff experience, and Trust efficiencies. The strategy will be co-developed alongside the Trust strategy, ensuring immediate implementation and alignment with the Trust's strategic objectives. So while the trust strategy is clinically led it will be digitally enabled.		
Operational Performance	To seek assurance that SECAmb is reaching the targets agreed, and mitigations are in place to address any gaps.	
The committee reviewed the current performance data and where we are seeing improvements, such as with job cycle time which is contributing to achieving the in-year C2 mean target (despite lower than plan hours). Some additional short-term funding has also been agreed to support C2 mean, H&T and call answer performance.		
Improvement Case Process	To seek assurance that the new approach will improve the process and includes clarity on how investments will be prioritised at the same time as maintaining financial control.	
The committee supported the new process, with the main change relating to the focus on benefits and challenged how the executive ensure cases are prioritised to mitigate 'first come first served'. It also reinforced the link to budget setting, to ensure funds are identified.		
Post Project Review – Performance Cell	To seek assurance that the benefits identified in the original Business Case have been delivered.	
The committee received a really helpful report setting out the benefits realised, those not realised and the key learnings. It believes that quality has been significantly improved by the work of the performance cell to help integrate our narrative and assisted the related improvement plans. For example the FTSU dashboard and the approach to PSIRF which has been helped by analysing data to determine our safety priorities, which will come to Board soon. Also, the development of our strategy will use big data on population health to drive decisions.		
Specific Escalation(s) for Board Action	There are no escalations requiring specific Board intervention, however the following is for awareness: 1. The risk to the delivery of the efficiency programme. The committee will continue to seek assurance and will escalate to the Board as required. 2. The recruitment difficulties in fleet and the suggestion that the People Committee takes a broader view on workforce planning, to cover support services.	

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 was reviewed and updated to align with the revised BAF and approved by the Board in June.
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 part of the BAF (objective / risk). The BAF along with the IQR is used to ensure the COB continues to ensure the right focus 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.	The quality and performance management framework aims to achieve this – it is one of the corporate objectives in the BAF.
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.

South East Coast Ambulance Service
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	Agenda No	41-23
Name of meeting	Trust Board	
Date	3 August 2023	
Name of paper	Strategy Steering Committee Escalation Report – 25 July 2023	
Author	Max Puller, Independent Non-Executive Director – Committee Chair	

This report provides an overview of issues covered at the meeting on 25 July 2023.

The committee convened for its inaugural meeting to set out the roadmap for our strategic development process. This follows a rigorous, inclusive procurement process, which is currently in a standstill period. We are currently in the pre-mobilisation phase, and stand ready to support our strategy development once procurement finalises.

Item	Purpose	Link to BAF
03/23	Approval of TOR	**

We scrutinised the Terms of Reference (ToR) and ultimately approved them, subject to several comments and builds from our members. Notably, we identified room for strengthening our emphasis on inclusivity. Additionally, we agreed to revisit the timelines for the circulation of papers, ensuring the programme maintains momentum while offering members sufficient time for in-depth review before meetings.

04/23	Provide the members with assurance around: · Programme phases and scope · Proposed governance arrangements · Engagement plan with our stakeholders	BAF Risk 255 (Operating Model) BAF Risk 267 (Workforce)

Our main agenda item walked through the Trust's plan for developing our strategy over the next six to seven months. By December, we will have a clear vision and direction of travel for our strategy, culminating in the creation of a detailed delivery plan during Q4. This will set us up for success, through clear action plans, to deliver on the strategy from 1 April of the subsequent financial year. Crucially, these deliverables also include a comprehensive workforce plan.

The committee meticulously evaluated the proposed engagement plans, querying whether the breadth of the stakeholders was sufficient. Reassurance was offered, and it was agreed that a more detailed stakeholder map and engagement plan would be provided for our August meeting.

We also noted that all groups initially involved in shaping the strategy development scope had recently been contacted with an update on the procurement process, closing the loop on their contributions to our strategic approach.

The high-level governance arrangements received approval from the committee. Starting in August, our focus will shift towards patient needs analysis, engagement, and co-design sessions of the integrated care delivery model. While further refinement of the detailed programme and engagement plans will be needed during initial mobilisation, particularly concerning hard-to-reach groups, the committee was assured of the programme's comprehensive scope, ensuring our strategy will be both innovative and sustainable, and inclusive in its development.

The need for a clear 'identity' for SECAmb to emerge from our strategy was also emphasised, acknowledging the importance of this element for our colleagues.

05/23	Cycle of Business	**

The committee noted the cycle of business, with more details to come in our August meeting, once the plan is in place. Moving forward, the committee will meet every month, 10 days before Board, for the duration of the programme. This will ensure ongoing scrutiny, assurance, progress tracking, and timely problem-solving for any issues that arise. Additional, ad hoc meetings of the SteerCo may also be called as needed.

Specific Escalation(s) for Board Action	None

Strategy Steering Committee

Terms of Reference

1. Introduction

The Trust is developing an ambitious long-term strategy aimed at sustainably delivering high-quality, equitable, and efficient care to our patients. Central to our strategic efforts is our steadfast commitment to our people. We seek to foster an inclusive, supportive culture that champions innovation, collaboration, and continuous learning while prioritising a work environment where colleagues feel valued, engaged, and empowered.

Our strategy, underpinned by principles and success factors such as strong programme management, stakeholder engagement, clinical leadership, and robust data and analytical capacity, highlights our dedication to our people and the communities we serve.

In support of this key initiative, the Board has established the Strategy Steering Committee. This Steering Committee will serve as a key link between the Programme Board and the Trust Board, providing strategic oversight, informed decision-making, constructive challenge, and essential governance to the Strategy Programme.

2. Purpose

The Steering Committee is established to provide strategic oversight, informed decision-making, challenge, and guidance for the Trust's Strategy Programme. It serves as an essential forum for strategic discussions, addressing key challenges, and ensuring alignment with broader organisational objectives. It bridges the communication gap between the Trust Board and the Programme Board, represents the interests of key stakeholders, and navigates the programme's high-level risks. The Steering Committee's purpose is to foster the successful execution of the Strategy Programme, promoting the continued growth and advancement of the Trust.

These terms of reference set out the membership, quorum, remit and responsibilities, accountability, and reporting arrangements of the Steering Committee.

3. Objectives

The primary objectives of the Steering Committee are centred around ensuring the successful delivery of the Strategy Programme and its alignment with the overarching goals of the Trust. They include:

i. Strategic Alignment – ensuring that the Strategy Programme aligns with and advances the Trust's strategic vision and programme aims, and those of its respective integrated care systems.

ii. Governance and Oversight – providing governance oversight, ensuring adherence to best practices, relevant regulations, and guidelines, and resolving issues escalated by the Programme Board.

iii. High-Level Risk Management – overseeing the strategic and high-impact risks of the programme, working closely with the Programme Board to manage more detailed risks.

iv. Stakeholder Representation – representing and addressing the interests and concerns of key stakeholders in the strategy programme, including the Trust Board and the Programme Board.

v. Decision-Making – making critical strategic decisions about the programme, including final approval for significant changes to the programme's scope, budget, or timeline.

vi. Strategic Communication – facilitating strategic discussions related to the programme and providing regular updates to the Trust Board.

Overall, the Steering Committee's aim is to guide the Strategy Programme effectively towards realising its objectives and delivering maximum value for the Trust.

4. Membership

The Steering Committee membership will comprise representatives from the Executive and Trust Board. The Committee may also invite internal and external subject matter experts or stakeholders as deemed necessary to provide additional insights and perspectives.

The Steering Committee members have decision-making authority on behalf of the Trust within the agreed scope as defined by the objectives and purpose of the Strategy Programme.

The Steering Committee shall consist of the following core members:

i. Chair: Max Puller, Non-Executive Director

ii. David Ruiz-Celada, Programme SRO (Strategy)

iii. Dr Rachel Oaten, Programme SRO (Clinical)

iv. Saba Sadiq, Chief Finance Officer (Finance/Digital)

v. Ali Mohammed, Executive Director of HR and OD (People)

vi. Prof Tom Quinn, Non-Executive Director (Clinical)

vii. Dr Subo Shanmuganathan, Non-Executive Director (People)

viii. Howard Goodbourn, Non-Executive Director (Finance)

ix. Paul Brocklehurst, Non-Executive Director (Digital)

For clarity, all Executive and Board members are designated as "members" within the context of the Steering Committee. Their input will be particularly valuable when pivotal decisions are needed, leveraging their unique insights and expertise to guide the strategic course of the programme.

In attendance:

i. Matt Webb, Programme Director (AD Strategy & Partnerships)

ii. Janine Compton, Head of Communications

iii. Claire Webster, Programme & Portfolio Manager

iv. External consultants supporting programme

Membership will be reviewed regularly to adjust for changes, as required by the purpose of the Steering Committee. Any recommended changes will be presented to the Trust Board.

Workstream leads/subject matter experts will be invited to join the part(s) of the meeting that relate to their workstream areas.

5. Governance and reporting

The **Programme Board**, chaired by either programme SRO (Strategy/Clinical), weekly, is responsible for driving the programme, making design/steering decisions within the pre-determined gateways, overseeing day-to-day running of the programme to time and budget, managing risks, issues, and communications requirements. Reporting to the Steering Committee*.

The **Steering Committee** [this group], chaired by the nominated Non-Executive Director, 10 working days before each formal Board, is responsible for undertaking final decisions at each gateway, setting direction for subsequent gateways, and overseeing communications and engagement effectiveness. The Steering Committee will share insights and lessons learned to foster an environment of continuous improvement, transparency, and shared accountability. Reporting to the Trust Board.

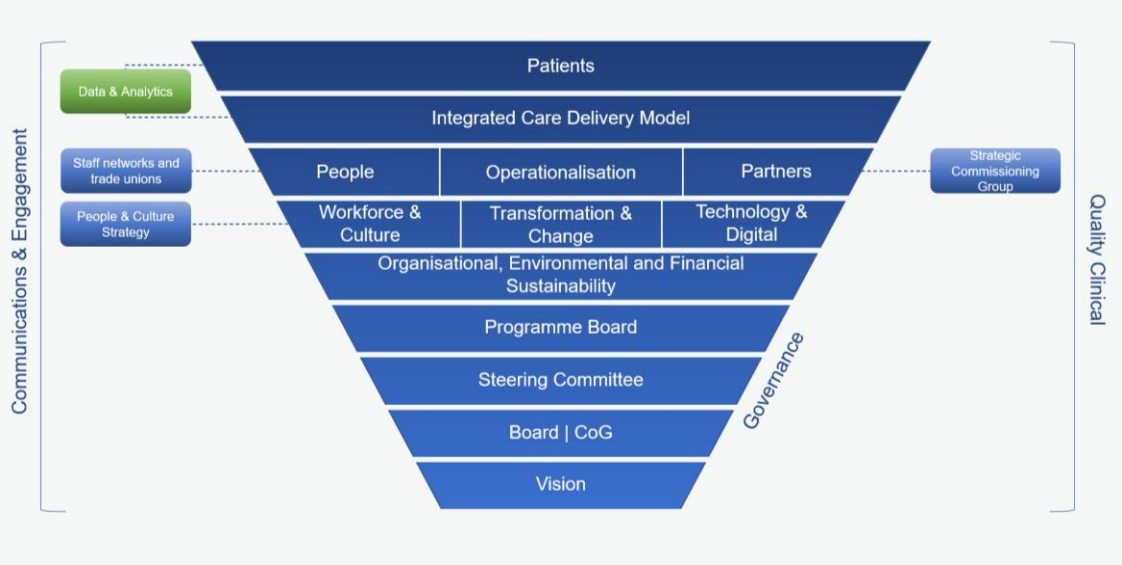
The **Trust Board** will make decisions requiring full formal Board approval, receive gateway approvals and updates from the Steering Committee, ratify recommended direction of travel and approve the final Strategy and associated documentation. The Trust Board is the ultimate point of escalation.

The Chair of the Steering Committee is responsible for keeping these terms of reference up-to-date and will escalate concerns to the Trust Chair as necessary.

Members of the Steering Committee will report to their respective teams and stakeholders following the agreed reporting arrangements.

Notification of attendance, especially by a nominated deputy, must be communicated to the Steering Committee Chair before the meeting.

The Programme SRO (Strategy) and Programme Director will also update the Strategic Commissioning Group bi-monthly, ensuring strategic alignment and collaboration with external partners.



6. Administration

The programme team, comprising the Programme Director and Programme & Portfolio Manager, will provide administrative support as necessary and ensure the most up-to-date information is shared through the agreed reporting process.

All papers relevant to the agenda should be submitted no later than five working days prior to the meeting to ensure their currency and allow adequate time for review. These documents should be pertinent to the agenda topics, thereby maintaining their relevancy and effectiveness in furthering the committee's objectives. Committee members wishing to add additional items to the agenda must do so at least four working days before the scheduled meeting to give all colleagues ample time to consider the proposed issues.

The meeting agenda and papers will be distributed by the programme team at least four working days prior to each meeting.

Action points from the previous meeting will be made available by the programme team ahead of the next meeting and will be formally ratified at the subsequent Steering Committee meeting. Steering Committee members are expected to provide updates on action points promptly before the next scheduled meeting.

7. Quorum

The Steering Committee will be considered quorate when the Chair, at least one Senior Responsible Owner (SRO), and at least one Non-Executive or Executive Director representing each of the following key areas – Clinical, People, Finance, and Strategy – are in attendance.

Should a standing member be unable to attend, they are expected to send a briefed deputy with appropriate delegated authority in their place.

8. Meeting frequency

The Steering Committee will convene monthly, scheduling meetings 8-10 days before each Trust Board meeting. This schedule maintains a regular cycle of communication, review, and decision-making essential for effective oversight.

In response to urgent matters or unforeseen challenges, the Steering Committee reserves the right to call additional meetings as necessary. This adaptable meeting schedule ensures the committee remains agile and proactive, maintaining the momentum of the Strategy Programme.

9. Risk management

The Steering Committee plays a key role in the oversight of risk management for the Strategy Programme. This includes reviewing and providing guidance on the strategic and high-impact risks escalated by the Programme Board.

The Programme & Portfolio Manager, in collaboration with the workstream leads, is responsible for maintaining a detailed risk register and for escalating significant risks to the Steering Committee via the SROs. The most recent risk register report should be included in the Steering Committee meeting papers, ensuring members are informed of current risks.

The Steering Committee, in turn, will consider these risks in their strategic decision-making process, ensuring that risk mitigation strategies are effectively implemented and align with the Trust's overall risk tolerance and strategic objectives.

10. Standing agenda items

The Strategy Programme will be executed according to the predefined roadmap, which outlines key milestones, decision gateways, and expected outputs at each stage. The Steering Committee plays a crucial role in this process, making informed decisions at each gateway point based on the programme's progress, risk status, and alignment with strategic objectives.

As such, the Chair will set the agenda for each meeting, ensuring that it includes, at a minimum:

Introduction and quoracy
Review and Approval of Previous Meeting Actions
Strategy Programme Progress Update
Risk Management
Strategic Decision-Making
Communications, Stakeholder Engagement, and Inclusion
Resource Allocation
Governance and Reporting - Including escalations to the Board
Next Steps and Action Items
Any Other Business

Review arrangements

The Terms of Reference for the Steering Committee will be reviewed annually, or as required, to ensure that the objectives and focus of the group remain relevant and in line with the strategic priorities of the programme.

Terms of Reference for
Strategy Steering Committee

Document Control

Audience	Strategy Steering Committee
Document Title	Terms of Reference
Document Status	Approved
Document Version	1.0
Issue Date	14/07/2023
Key contact	matthew.webb@secamb.nhs.uk

Version Control

Version	Date	Name	Comment
0.1	14/07/2023	Matt Webb	Document creation / Initial draft by Programme Director.
0.2	16/07/2023	Claire Webster	Document review and comments provided by Programme Manager.
0.3	18/07/2023	David Ruiz-Celada	Document review and comments provided by Programme SRO (Strategy).
0.4	20/07/2023	Max Puller	Document review and comments provided by nominated Non-Executive Director.
1.0	25/07/2023	Matt Webb	Approved by Steering Committee.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	41-23

Name of meeting	Trust Board
Date	03.08.2023
Name of paper	Partnerships update
Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning & Transformation
Author(s)	Matt Webb, Associate Director of Strategy & Partnerships Ray Savage, Interim Head of Strategic Partnerships

This paper provides a comprehensive overview of the Trust's key initiatives and strategic priorities with its partners. It covers the alignment of governance structures with the Trust's Integrated Care Systems (ICSs), updates on Integrated Care Boards' (ICBs) Joint Forward Plans (JFPs), the regional mental health response, the Regional Ageing Well Programme, and ongoing collaboration with St John Ambulance. Each initiative is focused on improving healthcare service delivery, patient outcomes, and collaboration across the Trust's four ICSs.

Governance and Reporting Alignment with ICS

The Trust is aligning its governance and reporting structures with multiple integrated care systems (ICSs) to coordinate resources effectively, with the first Strategic Commissioning Group meeting scheduled for August 2023.

UEC Recovery Plan Delivery and Improvement Support

NHS England's new UEC Recovery Plan delivery and improvement support aims to enhance patient care and improve response times, with the Trust coordinating tailored support across three system levels. This involves targeted initiatives, resources, and a 'Recovery Champions' programme running until March 2025.

ICB JFPs Update

Integrated Care Boards (ICBs) have finalised their Joint Forward Plans (JFPs), and the Trust is actively supporting these initiatives for improved whole-systems healthcare service delivery. These will be reviewed as part of the Trust's own Strategy development which will provide us with a 5-year roadmap which will align with the JFPs.

Regional Mental Health Response

The Trust is supporting a regional mental health response, including the development of the "Right Care Right Person" model and initiatives in line with the 2022 Mental Health Commissioning Guidance.

Regional Ageing Well Programme

The Trust's Regional Ageing Well Programme aims to enhance care for lower acuity patients with strategies optimising patient flow and data capture.

Collaboration with St John Ambulance

The Trust is collaborating with St John Ambulance for year-round surge capacity, ensuring patient safety and high-quality care delivery.

Recommendations, decisions or actions sought	The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in October (2023).

1. Introduction

This report updates the Board on the following key ongoing regional Urgent & Emergency Care (UEC) priority areas, as reported to the Executive Management Board throughout Q1 (2023/24).

1) Alignment of Trust and Integrated Care System (ICS) Governance and Reporting Structures
2) Launch of UEC Recovery Plan Delivery and Improvement Support
3) Integrated Care Board (ICB) Joint Forward Plans (JFPs)
4) Regional UEC Mental Health response
5) Regional Ageing Well (UCR) programme
6) Collaboration with St John Ambulance

2. Summary since the last report (June 2023)

2.1. Alignment of Trust and Integrated Care System (ICS) Governance and Reporting Structures

2.1.1. The 2022 statutory ICSs introduction has posed challenges for ambulance services that operate regionally, including SECAmb, as we must now navigate multiple ICS boundaries. To improve system efficiency and operational delivery, there has been a call for ambulance trusts to align their internal governance structures and reporting mechanisms with their respective systems. Consequently, there is a pressing business need to align Trust and ICS governance and reporting mechanisms for enhanced commissioning, performance management and quality oversight.

2.1.2. The Trust has worked with its lead and associate commissioners to undertake a re-evaluation of its regional commissioning and internal governance structures. The aim is to improve stakeholder engagement, strategic alignment, service integration, and patient safety and care. (A fuller update is provided within Appendix 2). Phased plan:

2.1.2.1. Phase one (Q2 2023/24): Implement a supra-ICS SECAmb commissioning governance structure which includes:

2.1.2.1.1. Joint ICB/SECAmb Chief Executives Meeting (in place)

2.1.2.1.2. Strategic Commissioning Group (start in August)

2.1.2.1.3. ICS Collaborative for Clinical Quality (in place)

2.1.2.1.4. 999 Contract Review Meeting (in place)

2.1.2.2. Phase two (Q3 2023/24): Implement system-focused clinical quality meetings aligned to each ICS's UEC Board.

2.1.2.3. Phase three (Q4 2023/24): Evaluate the need for additional (or changes to existing) roles to enhance the effectiveness of the transition.

2.1.3. This alignment will enhance the Trust's coordination and communication with provider partners and ICS stakeholders. Without this alignment, Trust leaders may face overload, which could compromise the ability to deliver on critical outcomes.

2.1.4. The proposal has been developed with the consideration of the Trust's Senior Leadership Team and has received full approval from the Trust's Executive Management Board and endorsement from the ICS Collaborative for Clinical Quality. A consultation with the Trust's lead commissioner and associate commissioning colleagues has

commenced to agree on an implementation plan; the inaugural Strategic Commissioning Group meeting is scheduled for August 2023

2.1.5. In summary, this alignment will enable the Trust to deliver consistent UEC services at scale while addressing the local requirements of each system. By adopting these recommendations, the Trust will demonstrate its commitment to improving system efficiency, patient outcomes, and overall healthcare delivery through aligned governance and reporting structures.

2.1.6. Section assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) Detailed evaluation conducted to address challenges in regional 999 commissioning and internal governance.	(-) Challenges in coordination, decision-making, and resource allocation across multiple ICS boundaries.	A1 - Support planned alignment of governance and reporting structures with ICSs. A2 - Seek assurance on each phase, provided through future Partnerships Board reports.

2.2. Launch of UEC Recovery Plan Delivery and Improvement Support

2.2.1. Under the National UEC improvement initiative, each system has been tiered into one of three UEC levels, confirmed to each ICB CEO in June 2023. The Trust is currently coordinating with its integrated care boards to tailor the partner provider support required according to these allocations.

2.2.2. On the 13th of July, NHS England launched its first NHS Improving Patient Care Together (NHS Impact) Programme related to the Urgent and Emergency Care (UEC) Recovery Plan, aimed at improving patient care using evidence-based quality improvement. This programme is available to all UEC tiers.

2.2.3. The plan's key objectives for 2023/24 are: 1) to increase the efficiency of patient care in emergency departments with the aim of admitting, transferring, or discharging 76% of patients within four hours by March 2024, and 2) to improve ambulance response times for Category 2 incidents to an average of 30 minutes.

2.2.4. NHSE has requested that each system selects four priority initiatives out of ten high impact initiatives proposed (see Appendix 1), where engagement will facilitate significant progress before winter. These must be confirmed by 28th July 2023.

2.2.5. The programme is positioned to provide tailored support to systems, enabling all involved to achieve their ambitions as outlined in the UEC Recovery Plan and will run until March 2025.

2.2.6. Section assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) The Trust is ready to support its respective systems, collaborating with ICBs to tailor support based on their unique challenges, tiering and resource needs.	(-) The specific challenges, support and resource requirements may vary across systems.	A3 - Monitor the progress of each system's improvement initiatives through the future Partnerships Board reports.

2.3. ICB Joint Forward Plans (JFPs)

2.3.1. JFP Finalisation and System Governance

2.3.1.1. Each ICB has successfully finalised its Joint Forward Plan (JFP) in consultation with its partner providers, meeting the NHSE deadline of the 30th of June 2023.

2.3.1.2. SECAmb provided feedback to all JFPs as indicated at the Board in June 2023.

2.3.2. NHS Kent & Medway

2.3.2.1. The NHS Kent & Medway Integrated Care System (ICS) has a JFP that aligns with its Integrated Care Strategy. Its main goal is to reduce health inequalities, enhance accessibility, and improve regional healthcare services. Current initiatives include reconfiguration of community services for the next financial year and developing efficient UEC pathways.

2.3.2.2. Measures are being proposed to streamline care pathways and reduce unnecessary ambulance deployments. NHS England is supporting the system with an 'Alternatives to ED' initiative through a 'Getting it Right First Time' review of East Kent UEC pathways. A similar initiative is being pursued in West Kent to provide the Trust with viable alternatives to ED conveyance during peak demand periods. The Trust is actively engaged with these two system reviews.

2.3.2.3. The JFP also emphasises mental health needs and crisis intervention, aiming for early and community-based access to services. Services like Safe Havens and Crisis Cafes are being reconfigured, and options for expanding professional support, such as that provided to the Police, are being explored for Trust clinicians.

2.3.3. NHS Sussex

2.3.3.1. The Shared Delivery Plan (SDP) [JFP] of NHS Sussex, reflecting the Sussex Integrated Health and Care Strategy, focuses on four main sectors to improve patient care and system efficiency. Eleven CEO-led workstreams, including the UEC Programme Delivery Board, have been established to ensure effective governance and oversight.

2.3.3.2. The UEC Programme Delivery Board is divided into five key domains: UEC Intelligence, Optimising Current Capacity, Admissions Avoidance, Reducing A&E Wait Times, and UEC Vision & Strategy. The Trust's priorities are integrated into the SDP's framework through these domains.

2.3.3.3. The Trust will be appropriately represented at each Board and sub-board/group, coordinated by the Strategic Partnerships team. The Trust plays an active role in these groups to align the SDP with its strategic priorities.

2.3.3.4. The NHS Sussex SDP seeks to improve emergency responses, and enrich patient experiences through various initiatives, including integrated teams, workforce development, digital technology, enhanced primary care, streamlined discharges, and reduced health inequalities. These initiatives directly impact the Trust by fostering improved collaboration, reducing response times, and providing appropriate care pathways for lower-acuity patients.

2.3.3.5. On the 11th of July, the Sussex Integrated Care System held its 'Strategy Delivery Workshop,' focusing on achieving system-wide change and improvement initiatives, which resonate with the Trust's commitment to community-based healthcare.

2.3.3.6. The workshop highlighted the importance of population-focused systems of care. The Trust recognises its crucial role in supporting the system with this priority and is committed to contributing to the development of core offers that guide supportive leadership and integrated community teams.

2.3.3.7. Despite limited progress due to system capacity constraints, the Trust remains dedicated to exploring and supporting opportunities for provider collaboratives.

2.3.3.8. Looking ahead, the Trust anticipates the next UEC Board meeting and subsequent workshops to contribute its expertise in shaping system, place and neighbourhood partnership focus areas.

2.3.4. NHS Surrey Heartlands

2.3.4.1. The NHS Surrey Heartlands JFP, emphasising the ICS strategy and the NHS Long Term Plan, was submitted to NHSE on the 30th of June 2023. The plan advocates a multi-sector collaboration to refresh service delivery for the Surrey Heartlands community.

2.3.4.2. NHS Surrey Heartlands is also progressing its One System One Plan, incorporating the Fuller Stocktake, focusing on five key areas. These serve as groundwork for interventions aiming to fulfil the ICS's main objectives, especially improving UEC services and patient outcomes.

2.3.4.3. The JFP's strategic goals align with the ICS's One System One Plan. The Prevention initiative aims to enhance community health, reducing non-emergency demand and improving response times, whilst 'Delivering Care Differently' focuses on optimising UEC pathways, positively impacting 999 service delivery.

2.3.4.4. The newly established Delivery Oversight Group (DOG) is vital in ensuring effective JFP and strategy delivery governance. Its focus on workforce development and care coordination is anticipated to benefit the Trust by improving UEC services. The DOG, which remains separate to the UEC Board, reports to the ICB and includes partner provider executives and place leaders.

2.3.4.5. The SECAmb Executive Management Board is currently considering executive representation across the Trust's four ICSs.

2.3.5. NHS Frimley

2.3.5.1. NHS Frimley's JFP, in alignment with the ICS strategy, underscores its contributions towards shared ICS goals. It identifies three overarching objectives: enhancing local community health and well-being, delivering high-quality patient care, and ensuring service sustainability.

2.3.5.2. The Partnership Assembly, originally scheduled for July 2023, where further discussions and enablement of the JFP were to take place, has been postponed to September 2023 due to ongoing frontline industrial action. This postponement was necessary to conserve resources to support the system response.

2.3.5.3. Currently, the strategic focus is on appraising options for the minor injuries and minor illness provision within the ICS. There was a necessity to augment service provision in the NHS Frimley (South) region due to a shortfall in assessment, resulting in continuous revisions. This critical evaluation will help facilitate the introduction of appropriate community pathways for UEC, either within acute settings or the community, thereby reducing the dependency on emergency services.

2.3.6. Section assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) Trust contribution and feedback to all four ICS JFPs, following EMB consideration.	(-) Further details awaited regarding conversion of each ICS's JFP into a detailed delivery plan, and alignment with the Trust's developing strategy.	A4 - Acknowledge the Trust's contribution to the final JFPs and monitor the progress of these through the future Partnerships Board reports.

2.4. Regional UEC Mental Health Response

2.4.1. The Trust is collaborating at ICS and regional levels with NHSE, mental health and UEC commissioners, and providers to establish a regional mental health response in line with the 2022 Mental Health Commissioning Guidance for Ambulance Services.

2.4.2. Following the Home Secretary's endorsement in February 2023, the College of Policing and the NHS are working on a “Right Care Right Person” framework to ensure appropriate responses to individuals in mental health crises.

2.4.3. This approved national model originates from a Humberside police pilot, aiming to redirect incidents that do not involve immediate risk to life and limb away from a police response and to the relevant healthcare providers. This shift is reported to have significantly reduced police deployments and saved considerable policing time.

2.4.4. A National Partnership Agreement incorporating these principles is currently in development. The anticipated toolkit, due by July 2023, will assist forces in adopting this model. Following the toolkit, guidance for ICBs and mental health trusts is expected.

2.4.5. Within the Trust's footprint, all three Home Office police forces have committed to working with partners to develop a suitable implementation plan, keeping in mind the forthcoming national toolkit, proposing an 18-month implementation phase.

2.4.6. In NHS Surrey Heartlands, Surrey Police support this initiative and are working with the National Police Chief's Council and other agencies for effective implementation. NHS Frimley (South) is served primarily by Surrey Police, however, Hampshire Police is also in the early stages of adoption. Kent Police, committed to collaboration, plans to gradually introduce a new operational model over the next 12 months and discussions in Sussex are focusing on funding and priorities, particularly the expansion of the current Blue Light Triage enhanced pathway.

2.4.7. In addition to the Right Care Right Person model, both the NHS Surrey Heartlands and NHS Kent & Medway ICSs are exploring the enhanced Blue Light Triage pathway. This pathway is currently in use in Northwest Sussex, where it has led to a reduction in ambulance conveyance and patients detained under Section 136 of the Mental Health Act.

2.4.8. Finally, the Trust continues to support discussions regarding Mental Health Response Vehicles, which will be hosted by the respective mental health trusts within the southeast. Bids for these vehicles have been finalised with the first delivery expected in Q4 and the rest throughout 2024-25. Further details on the deployment model for these vehicles is awaited from each ICS.

2.4.9. In conclusion, the Trust remains dedicated to enhancing mental health response services and working in partnership with relevant stakeholders to ensure a consistent, regional approach that improves patient outcomes and reduces health inequalities.

2.4.10. Section assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) All police forces within the Trust’s footprint intend to collaborate with provider partners on the new models.	(-) Implementation details and timelines are not yet specified within each ICS.	A5 - Monitor the progress of each system’s approach to the Right Care Right Person model through the future Partnerships Board reports.

2.5. Regional Ageing Well (UCR) Programme

2.5.1. The Trust's Patient Flow Programme continues to make significant strides towards enhancing the provision of care for lower acuity patients. This collaborative programme encompasses the Trust's clinical, Integrated Urgent Care (IUC), field operations, quality, and strategic partnerships functions in synergy with the Trust's ICSs. The primary objective is to augment the 'Hear and Treat' rate to 14% through optimising referrals to primary care, secondary care, and community health services, particularly to Urgent Community Response (UCR) services.

2.5.2. The Trust is working with commissioners and provider partners to successfully streamline the referral process for Trust clinicians with the implementation of ICS single point of access. This advancement is proving particularly advantageous for clinicians within field operations operating out of their primary areas.

2.5.3. The Trust's IUC team has also implemented daily touchpoint calls with UCR teams within each ICS as part of this programme. These touchpoints enable community teams to assess and manage C3 and C4 incidents that can be more appropriately addressed within the community, thereby reducing avoidable ambulance responses and conveyances. Following a 12-week review, and subject to an evaluation, providers will gain access to a portal that facilitates direct response to suitable calls. This approach aims to reduce the workload on Trust clinicians, freeing up capacity to respond to higher-acuity calls.

2.5.4. Recognising the need for accurate data capture, the Trust is working with commissioners to develop a regional dashboard led by the NHS Surrey Heartlands Business Intelligence team. This tool will allow providers and commissioners to review regional appropriate primary care, secondary care, and community pathway activity, understand capacity, map care pathways, and ensure compliance with national standards.

2.5.5. Additionally, the Trust is taking steps internally to improve data quality, including enhancement of the electronic Patient Clinical Record (ePCR) system for more comprehensive information capture when a referral is made and development of a Power BI report capturing daily referrals, both accepted and rejected, from the UCR touchpoints, enhancing transparency. This initiative aims to address the existing issue of under-reporting, as current data suggests only 15% of See & Treat responses result in a referral or onward action.

2.5.6. Internally the Trust is now capturing attempted and successful referrals into UCR services through the daily touchpoint calls. The table below details the volume of referrals made from the 8th of May to the 30th of June. It also demonstrates the challenge our staff are presently experiencing with only 22.9% of referrals being accepted by UCR services.

2.5.7. The Strategic Partnerships and Performance and Predictive Analytics teams are working with partners through the Regional Ageing Well programme to mitigate these constraints, through improving ease of access, greater referral consistency and enhanced data integration as outlined above.

2.5.8. NHS Surrey Heartlands and NHS Frimley will be included when their daily touchpoint calls begin on the 8th and 7th of August respectively.

UCR Referrals	Attempted Referrals	Accepted Referrals	Acceptance Rate
Kent and Medway ICB	42	11	26.2%
Sussex ICB	150	33	22.0%
Surrey Heartlands ICB	0	0	-
Frimley ICB	0	0	-
Total	**192**	**44**	**22.9%**

2.5.9. The Trust's commitment to improving appropriate referrals, refining data capture, and optimising patient flow remains steadfast. These initiatives are aimed at enhancing the Trust's preparedness for the winter of 2023/24.

2.5.10. Section assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) Progress in the Patient Flow Programme and successful development of ICS single points of contact. (+) Initiation of daily touchpoint calls with UCR teams. (+) Ongoing development of regional dashboard and efforts to enhance system data quality.	(-) Under-reporting of referral activity across all systems, including failed vs. successful referrals.	A6 - Monitor the progress of the Patient Flow Programme through the future Partnerships Board reports and integrate KPIs into the IQR for system-level metrics across Kent, Surrey, Sussex and Frimley (see Appendix)

2.6. Collaboration with St John Ambulance

2.6.1. In line with NHS England's August 2022 directive, the Trust has initiated a new collaboration with St John Ambulance (SJA) to enhance patient care during peak demand periods and alleviate potential stress on its services. This collaboration is part of a wider initiative to ensure 'year-round surge capacity' across the healthcare sector.

2.6.2. The Trust is pleased to announce that, after seeking further clarity and diligently addressing outstanding governance concerns, the collaboration with SJA has been re-established.

2.6.3. The Trust now expects to benefit from the added capacity that SJA can provide, estimated at 3-5 shifts per day. This increased support is anticipated to play a pivotal role in meeting the service's needs, especially during periods of high patient demand or reduced service capacity.

2.6.4. To maintain a strong and accountable service framework, the Trust's Clinical Education Team is collaborating closely with SJA. Their objective is to implement strict governance measures ensuring secure and equitable service provision.

2.6.5. Section assurance actions:

Positive assurance	Gaps	Recommended Board Actions
(+) The Trust has re-established collaboration SJA to ensure year-round surge capacity and	(-) Historical procedural discrepancies currently being	A7 - Monitor the impact of the collaboration and ensure rigorous governance measures

patient care during peak demand periods, addressing previous governance concerns.	mitigated by the Trust's Clinical Education Team.	are established to uphold safe and equitable service provision.

3. Conclusion

3.1.1. This update has outlined significant progress in key areas of the Trust's strategic priorities, including alignment of Trust and ICS governance and reporting structures, the Regional UEC Mental Health Response, the Regional Ageing Well (UCR) Programme, and the renewed collaboration with St John Ambulance. The Trust remains committed to continually enhancing patient care while navigating the unique challenges across its four ICSs.

3.1.2. The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in October (2023).

Annex 1 – 10 High Impact Interventions

1. **Same Day Emergency Care**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2. **Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay (acute)**: Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4. **Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
5. **Care Transfer Hubs**: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6. **Intermediate care demand and capacity**: Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7. **Virtual wards**: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.
8. **Urgent Community Response**: Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.
9. **Single point of access**: Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
10. **Acute Respiratory Infection Hubs**: Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Appendix 2 - Alignment of Trust and Integrated Care System (ICS) Governance and Reporting Structures

8 ICB SECAMB Governance Alignment.pdf