South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors
Meeting to be held in public.

14 September 2023

The Orchards, New Road, East Malling, Kent, ME19 6BJ
10.00-12.30

Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
031/23	10:00	Chair's Introduction	**-**	-	Chair
032/23	10:01	Apologies for Absence	**-**	-	Chair
033/23	10:01	Declarations of Interest	**-**	-	Chair
034/23	10:02	Minutes from the previous meeting, Action Log and Matters Arising	**Y**	-	Chair
Statutory duties: performance and holding to account					
035/23	10:05	Chief Executive's Report	**Y**	To receive an update from the CEO	Simon Weldon
036/23	10:25	Development of the new trust strategy – Clinical Case for Change	**To be tabled**	Information	David Ruiz-Celada
037/23	10:40	**Areas of assurance:** • People and Culture Strategy - delivery • IT resilience • Impact of additional funding on operational performance In order to drive the discussions above, included are the Board Committee Escalation Reports, the Integrated Quality Report and the Board Assurance Framework Report.	**Y**	Holding to account, assurance and discussion	All Non-Executive Directors present
11:45 - COMFORT BREAK					
Statutory duties: Member and public engagement					
-	-	-	**-**	-	-

Committees and reports					
038/23	12:00	Nomination Committee Report	**Y**	Information	MW
039/23	12:10	Governor Development Committee Report	**Y**	Information	Kirsty Booth
040/23	12:15	Governor Activities and Queries Report	**Y**	Information	Leigh Westwood
General					
041/23	12:20	Any Other Business (AOB)	**-**	-	Chair
042/23	12:22	Questions from the public	**-**	Accountability	Chair
043/23	12:23	Areas to highlight to Non-Executive Directors	-	Assurance	Chair
044/23	12:24	Review of meeting effectiveness	**-**	-	Chair
		Date of Next Meeting: 28 November 2023 – Banstead	**-**	-	Chair

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

PLEASE NOTE: This meeting of the Council is being held in person at **The Orchards, New Road, East Malling, Kent, ME19 6BJ,** in addition to using Microsoft Teams. The meeting will be video-recorded and made available for public viewing following the meeting. Anyone who asks a question gives consent to being recorded and the publication of their participation in the meeting.

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

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South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 22 June 2023

Present:

Michael Whitehouse	(MW)	NED and Chair of Audit Committee and Senior Independent Director (Chair)
Brian Chester	(BC)	Public Governor, Upper West
Leigh Westwood	(LW)	Public Governor, Lower East
Martin Brand	(MB)	Public Governor, Upper West
Linda Caine	(LC)	Public Governor, Upper East
Kirsty Booth	(KB)	Staff Governor (non-operational)
David Romaine	(DR)	Public Governor, Lower East
Ann Osler	(AO)	Appointed Governor – Upper West
Angela Glynn	(AG)	Appointed Governor – University of Brighton
Harvey Nash	(HN)	Public Governor
Peter Shore	(PS)	Public Governor
Andrew Latham	(AL)	Public Governor, Lower West
Nicholas Harrison	(NH)	Staff Governor (operational)

In attendance:

Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee, Chair of Operational Performance Committee
Tom Quinn	(TQ)	NED
Liz Sharp	(LS)	NED
Subo Shanmuganathan	(SS)	NED

Apologies:

David Astley	(DA)	Chair
Lisa Bell	(LB)	Appointed Governor – Sussex Police
Peter Lee	(PL)	Company Secretary
Mark Rist	(MR)	Appointed Governor – Fire Service
Sinead Mooney	(SM)	Appointed Governor – Local Authority
Barbara Wallis	(BW)	Public Governor
Colin Hall	(CH)	Public Governor, Upper East
Vanessa Wood	(VW)	Public Governor
Chris Gonde	(CG)	NED
Max Puller	(MP)	NED
Paul Brocklehurst	(PB)	NED

Minute taker: Julie Harris (JH) Assistant Company Secretary

Item No.	Introduction and matters arising
001/23	**Introduction** MW welcomed all, noting the initiative to go paperless. BC requested that papers be provided a week ahead. LC noted the issue with opening embedded documents.
002/23	**Apologies for Absence** As above
003/23	**Declarations of Interest** None
004/23	**Minutes from the previous meeting, action log and matters arising** The minutes were taken as an accurate record of the meeting. BC noted a matter arising surrounding the critical IT failure report. SW confirmed the current status of the issue, including resilience (external review), wider look at operating processes in the context of the outage, as well as the current resources within the IT function. Confirmed that the CAD is due for procurement in 2025. The action log was reviewed with no outstanding actions.
	Statutory duties: performance and holding to account

005/23	**Chief Executive's report**
	
	SW took the report as read highlighting:
	• the contribution of the role of SECAmb in national celebrations, such as the coronation parade
	• how to make SECAmb a great place to work
	  ○ quality of care is first rate
	  ○ making practical issues (circa 40) better
	  ○ SECAmb's future strategy
	  ○ Tell our story – attract and retain staff
	  ○ CEO priorities (to be provided at the August Board meeting)
	
	MW noted the boards support for the new CEO.
	
	DR noted his concerns regarding the current attrition rate. SW agreed that attrition is a risk and noted the importance of working with our partners, issues surrounding the current open market approach, acknowledged that there are occasions that SECAmb is not always the best place to work and provided assurance that we will do our part in a market where there are more jobs than people and solving some of those issues. TQ confirmed there is a board development next month on clinical leadership and what that means, including NED leadership as well as paramedic leadership. MB provided context surrounding the commercial market, financial issues, competitive wages and questioned what the principle drivers for attrition were. SW spoke to the staff autonomy, funding for commissioned/non-commissioned work, workforce challenges, publication of the workforce plan. SS confirmed that management training and accountability are at the forefront of the people committee.

006/23	**Strategy Development** DRC provided an overview on the organisational strategy development process, including: • the focus to engage with various groups within the organisation, good feedback • Tender pack has been published with expressions of interest due in July, • Putting together evaluation panel • Key outcomes so far • Open forum on 29 July 2023 • Stakeholder insights • Next steps, task and finish group, 4-6 week engagement plan MW questioned the timetable and whether they were in-line with NHS planning business cycles). DR questioned the plan surrounding resilience. DRC noted the number of scenarios in the tender pack. MB suggested limiting the timeline and not to make it too generic in nature and questioned what the 'initial question' to the stakeholders would be. MW provided context in terms of the political landscape, what is practicable and confirmed the timetable in terms of engagement process, synthesising results and determining the next stages. PS questioned the scale of the strategic engagement in terms of fiscal commitment. DRC provided an overview on the interest in the project, confirmed that the time commitment is until December 2023. AL commended the work done thus far and questioned what we think we would get from an external consultancy. DRC provided information surrounding expectations. SW added the importance of investing in strategy, capital investment will have significant impact long-term – good value for money – defining the future of the organisation. We owe it to our staff to contribute and to know what our strategy is. KB commended the level on involvement that has occurred thus far and noted the importance of all staff owning the strategy and having an opportunity to being involved. HN reiterated the importance that we need to know what we want to be, balance between intellectual capital and financial investment, vision of empowerment, long-term cultural change and questioned what we are going to use the consultant for and why are they not involved in the delivery. AL suggested that the consultant would help move the strategy forward. MW confirmed the board's commitment to this plan, and drop-dead date if December 2023.
Comfort Break	
007/23	**Board Assurance Committees' escalation reports to include the key achievements, risks and challenges:** **Areas of assurance (determined at the GDC meeting):**

	KB questioned the efficiency plans (are they achievable) and how that work is progressing. HG noted his encouragement that the efficiency planning is being done different and his reservation about achieving £9M but have specifics on more than £6M including hear and treat, sickness and overtime as a main focus for efficiencies – which is a really good result. SW added that we reached out to staff to gain insight on how to achieve efficiencies and was impressed with the feedback return, spoke to current fiscal environment and issues with NHS England. PS questioned the funding for the recent pay award. AM confirmed that the pay award from last year and this year will be fully funded barring a few points in the national agreement (career breaks/bank staff). AL noted the budget under threat and questioned the forecast failings (new recruitments). HG confirmed the adverse variance but does not cause great concern and in terms of the recruitment shortfall, there was a information disconnect in the process (position did not get fed into the budgeting process) – confirmed that this is a learning point. SW confirmed that this was taken to executive management board yesterday and will be coming to committee business in due course and spoke about the due diligence undertaken (updated forecast for the year). KB questioned the availability of training for budget holder. SW confirmed that the plan is to devolve more authority to staff, increased responsibility over budgets. HN questioned the future of 111CAS and assistance provided by Vocare. SW confirmed that the decision has not been made and forms part of the strategy planning programme. MB referred to the finance report and questioned the £40M to £50M reserve increase. HG spoke about depreciation, noting that £20M is being generated in the operating cash flow positive minus spending £12M. MB questioned the £8.9M budget input from NHS and the £17M that was expected... HG confirmed that we have received the first portion of that money and expect to receive the remainder throughout the fiscal year. HG further explained that the pro-rata share of the national funding was reduced due to our being a more effective organisation, thus awarding more money to less effective organisations. MB questioned the status of single virtual contact centres. HG confirmed that it was in abeyance. MB questioned the status of contracting and procurement and sought assurance that it is fit for purpose. MW provided historical context and assurance that there is an action plan in place and a follow-up report is expected in July/September. MB questioned the control environment and whether there is a systemic issue. MW explained the four levels of assurance and confirmed that the systemic issue stems from leadership and noted that there was nothing on fraud with external audit/internal audit, but there is something along culture and management grip that needs to be worked on reinforced with appropriate training. AL questioned the level of appraisals not meeting target. SS agreed that the level is not where we would like it to be, noting problems with the ESR system (obfuscating the real reason appraisals are not being done). Meaningful 1:1 and meaningful appraisals are a focus of the People Committee, noting more work needing to be done. Positive steps in reporting, quality data to allow us to get a better handle in granular detail to enable holding to account. AL reiterated the importance of engaging in meaningful appraisals. SW added the importance that this needs to be a meaningful experience for both the appraisee and appraiser.

	PS noted the danger in setting a target for appraisals and suggested caution which pay perpetuate the cynicism that we are experiencing today. HN suggested a 100% appraisal target. LC questioned the support to staff who are on long-sickness absence back to work. SS noted the focus of the People Committee on sickness and confirm that there is not enough data being provided at this time (which is revealing in itself), speaking to health and wellbeing support, work fitness, maternity returns – there is further work to be done and committed to reporting back to the Council. SW mentioned the work needed to be done surrounding the TRIM service, process of engaging with staff to ascertain what they need, what kind of organisation do we want to be, and what makes it great to be here in the future. MB questioned the 7 OUs targeted for sickness interventions, and the triangulation piece surrounding grievances, quality, and performance data. SS provided some context. SW confirmed investment in managing grievances and committed to working with staff side colleagues to bringing that number down and associated linkages. BC questioned the benchmarking on sickness. SW confirmed that sickness has varied significantly over the past three years, ambulance sector is particularly challenged (lower levels of staff satisfaction, national issue, culture, etc.). KB questioned the concerns surrounding the Medway move, redundancy, loss of high-level redundancy, and impact on patient safety. TQ confirmed that there is no assurance at this time due to lack of data surrounding redundancy – number are not bottomed out. SS confirmed that there is assurance surrounding the work being made to supporting the affected staff members. SW commended all the work surrounding Medway opening, confirming 111 opening next week, no reports of patient safety concerns (under continual review), staffing challenges and opportunities, that there is 100% learning needed to be done in terms of the handling of events surrounding Medway (including return on investment). KB questioned the status of the EOC culture review, action plans, Morehouse Review, staff survey vs. TED. SS confirmed that findings from such review and surveys are collected and actioned. NH questioned the progress on the backlog of grievances/disciplinary which is an inter-departmental issue (not only an HR issue). MW confirmed that there is more to be done on this. SW confirmed that this indeed is not only an HR issue, and are investing in people to address the backlog, noting the importance of de-escalating some that simply require an apology, authority and autonomy to management needs to be supported. MW noted his assurances that actions are being undertaken to address the issue.
Statutory duties: member and public engagement	
008/23	**Membership Development Committee Report** BC took the report as read, and provided an overview including increasing membership, lack of benefit for members, gazebo/supporting equipment/ambulance (to be reviewed). CoG approved the report.
Committees and reports	
009/23	**Nomination Committee Report**

	LW took the report as read. CoG approved the report.
010/23	**Governor Development Committee Report** LW took the report as read. CoG approved the report.
011/23	**Governor Activities and Queries Report** LW took the report as read. CoG approved the report.
General	
012/23	**Any other business** BC requested clarification surrounding the FIAT/Mercedes ambulances. SW confirmed there is a clear direction of travel to not purchase further FIAT ambulances, noting a national specification currently is being written, allowing for a more fulsome choice going forward. KB confirmed that the current FIAT configuration has been redesigned by our staff and the new design will be implemented with the last 57 to be delivered. MB questioned the scheduling of leadership visits. SW noted that staged managed visits are not welcomed by staff. As such, leaders are to attend various areas/ambulance informally and engage in discussion
013/23	**Questions from the public** None
014/23	**Areas to highlight to Non-Executive Directors** - Engagement and use of consultants surrounding the strategy framework and plan - Assurances surrounding Medway and continuity of knowledge and experience - Culture within the organisation (particularly around grievances, mitigate escalations by having conversations and engagement) - Financial management
015/23	**Review of meeting effectiveness** - Issues with technology - Timeliness of papers
	Date of next Formal Council of Governors Meeting: • **Annual Members Meeting – 14 September 2023**

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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:

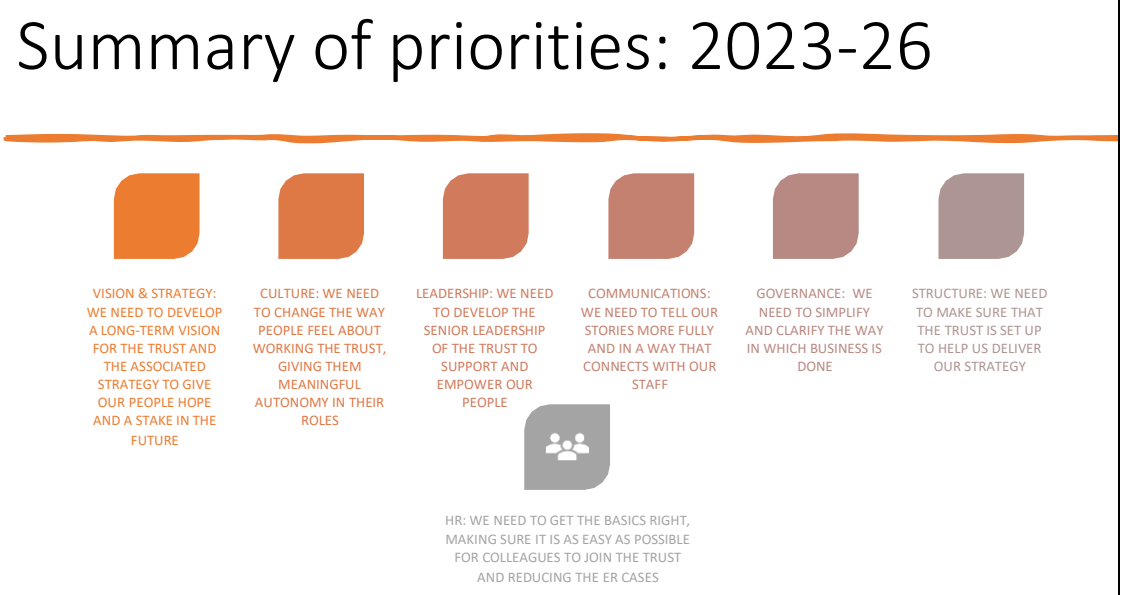
- Close monitoring of our financial plan for the year and the progress of our Efficiencies Programme
- Driving the process to develop a new Trust Strategy
- Scrutiny of our Culture Programme and the progress being made

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

9	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. 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.

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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.

Turn the page for the next Agenda Item

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.

Turn the page for the next Agenda Item

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	Responsive Care	People & Culture	Sustainability & Partnerships
We listen, we learn and improve	*Delivering moderns healthcare*	*Everyone is listened to, respected and well supported*	*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.
	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.

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.

***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.

South East Coast Ambulance Service
NHS Foundation Trust

Quality Improvement

QUALITY IMPROVEMENT

Summary

June 2023

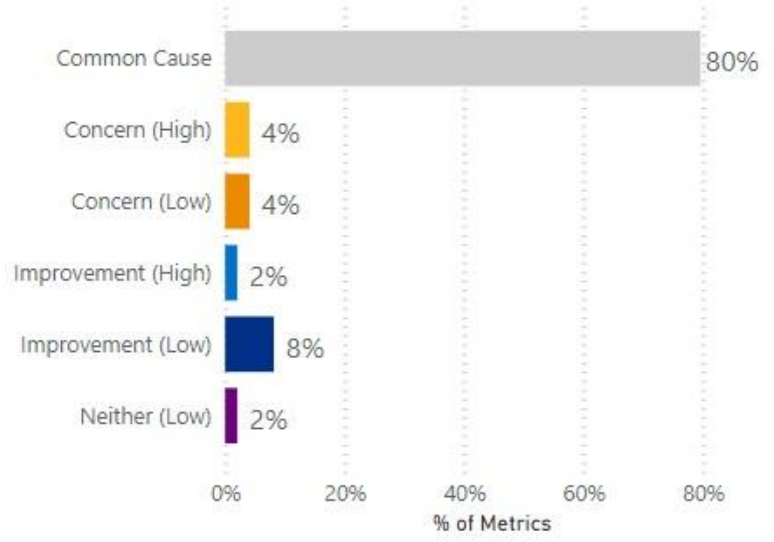
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Medicines Management % of Audits Completed		Count of Moderate Harm Incidents Complaints per 1000 999 Calls Answered Complaints relating to privacy and respect % Outstanding Actions Relating to SIs, Outside of Timescales
Common Cause		Acute ST-Elevation 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.

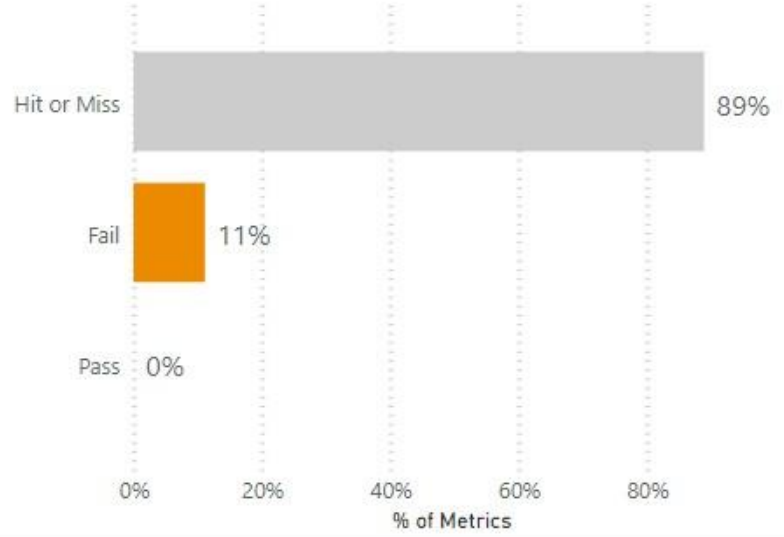
QUALITY IMPROVEMENT

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

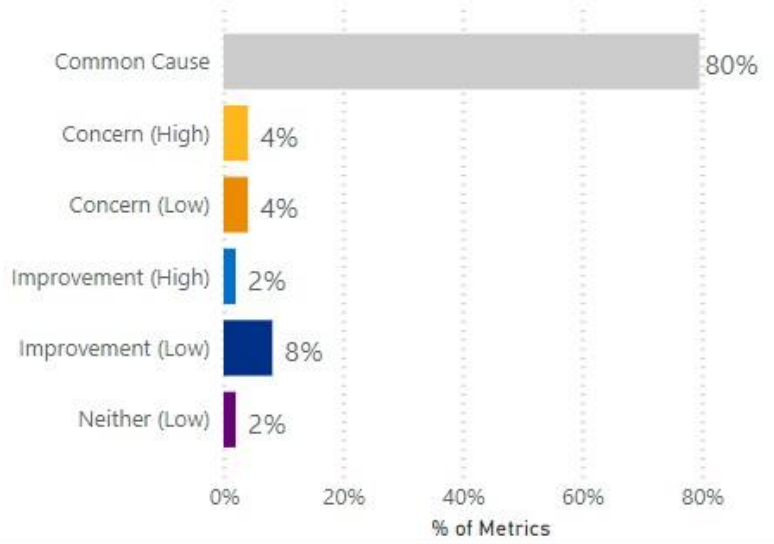
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Jun-2023	0%		-0.07%	0.02%	0.1%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Jun-2023	56%		44.1%	65.1%	86.1%		
Complaints 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		

Data checking

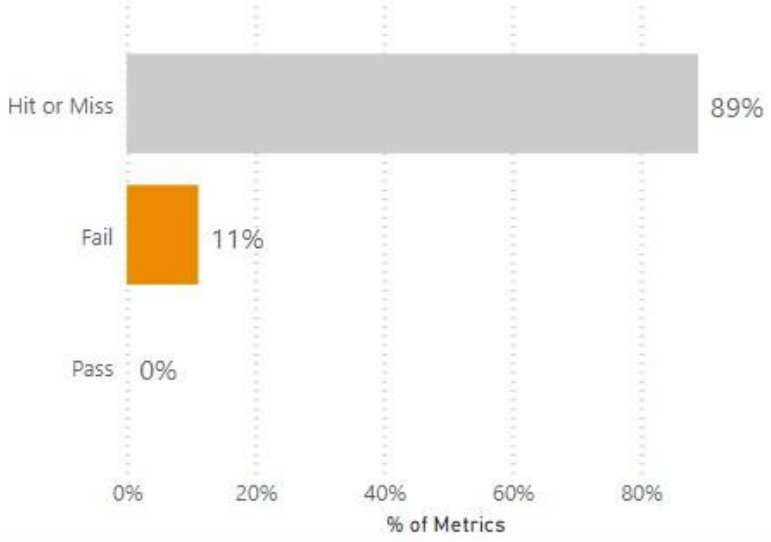
QUALITY IMPROVEMENT

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

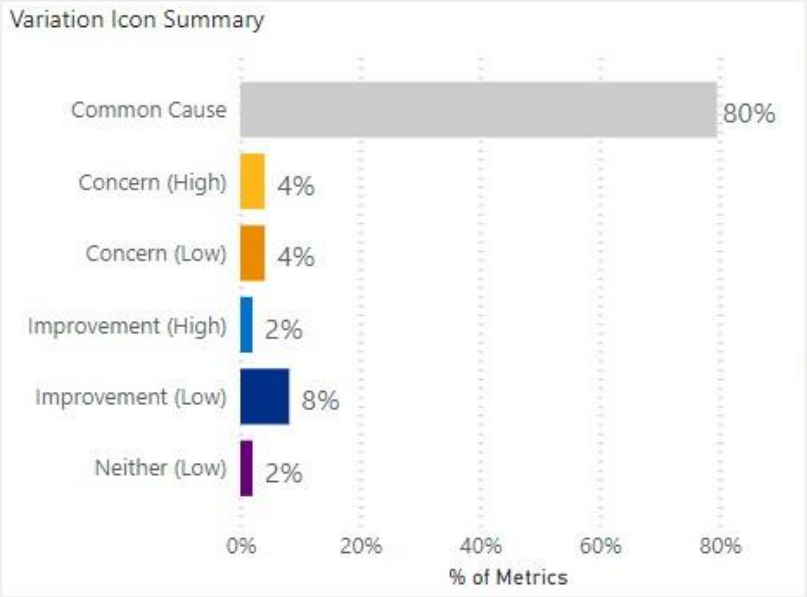
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	May-2023	50%	45.1%	28.03%	48.35%	68.67%		
**Cardiac ROSC ALL %	Quality Improvement	May-2023	28.2%	23.8%	18.14%	26.02%	33.89%		
**Sepsis Care Bundle %	Quality Improvement	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%		

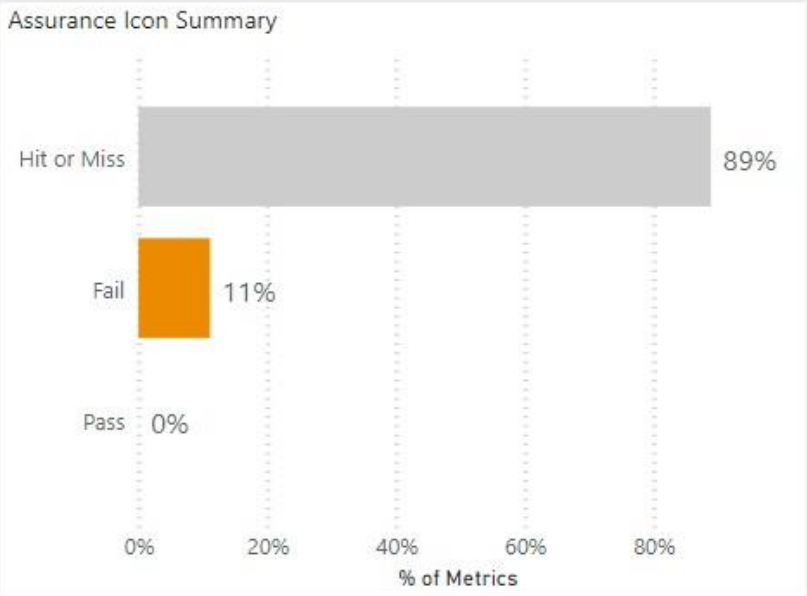
Infection Prevention Control

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)





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

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.

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

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)

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.

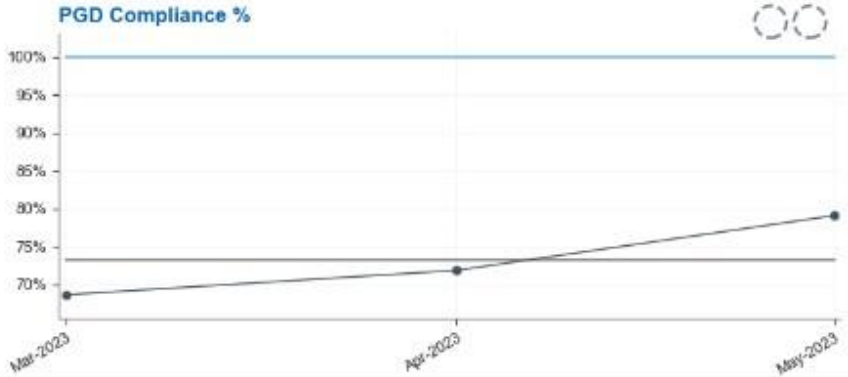
Non compliance to medicines audits is being picked up through Medicines Governance Group and Senior Operations representatives. These audits are also discussed in medicines lead subgroup. There is also work ongoing to change this over onto a new reporting platform. This is currently in test phase.

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?

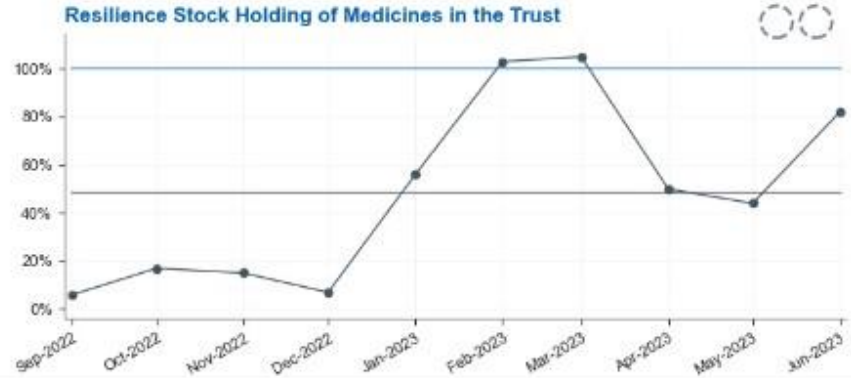
Medicines team have met with Power BI team and software developers to move forward with medicines data and presentation on central platforms. PGD workplan and CQC 'must dos' all progressing forward. OTL report moving onto central dashboard.

Medicines Safety Officer (MSO) role being advertised for medicines team. This post holder will focus on patient safety and medicines incidents and learning.



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

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?

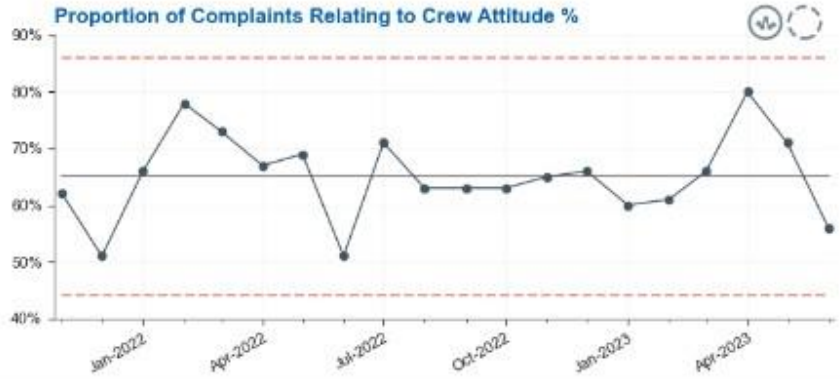
Stroke - ongoing two year UCL study of stroke telemedicine to evaluate if stroke telemedicine extends time on scene. Audit results indicates minimal extra time (about 3-5 minutes) for Kent telemedicine centres, with Frimley achieving the second best time on scene for all stroke units in SECAmb in spite 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.

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

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)

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

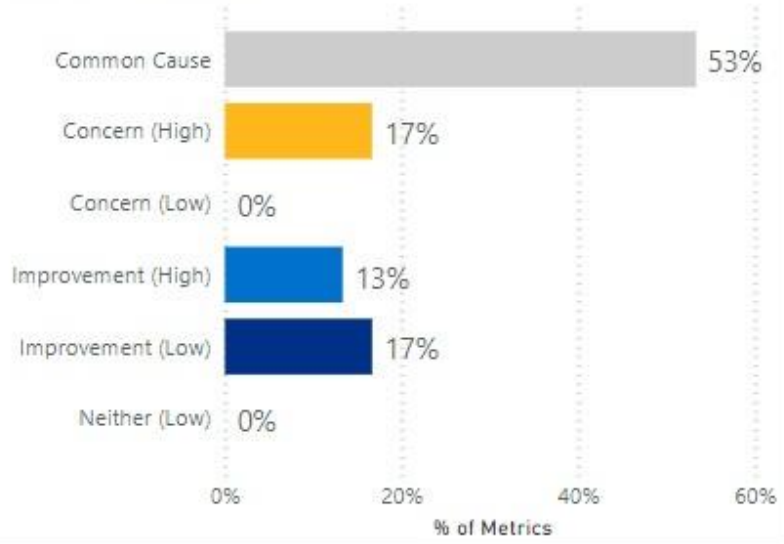
Summary

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	

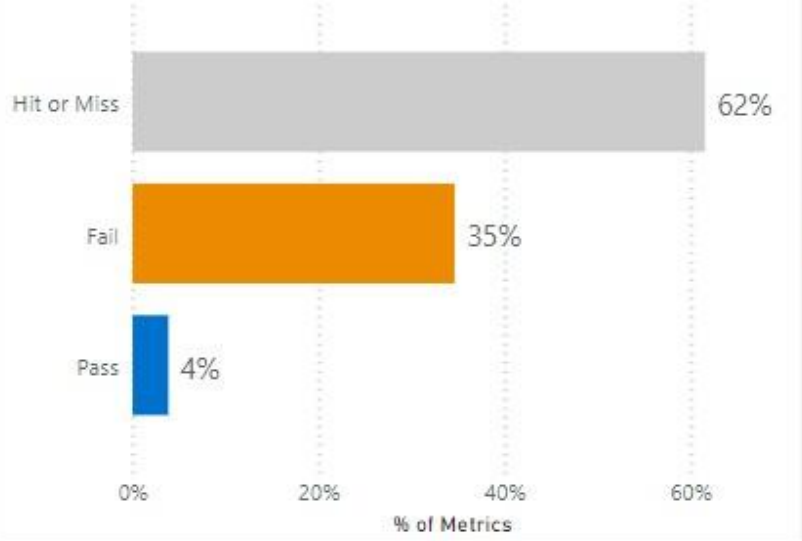
PEOPLE & CULTURE

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%		

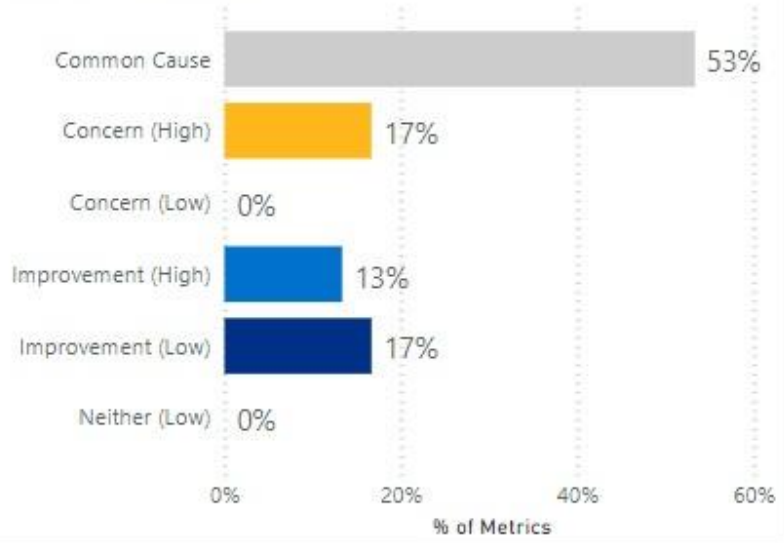
Employee Experience

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%		

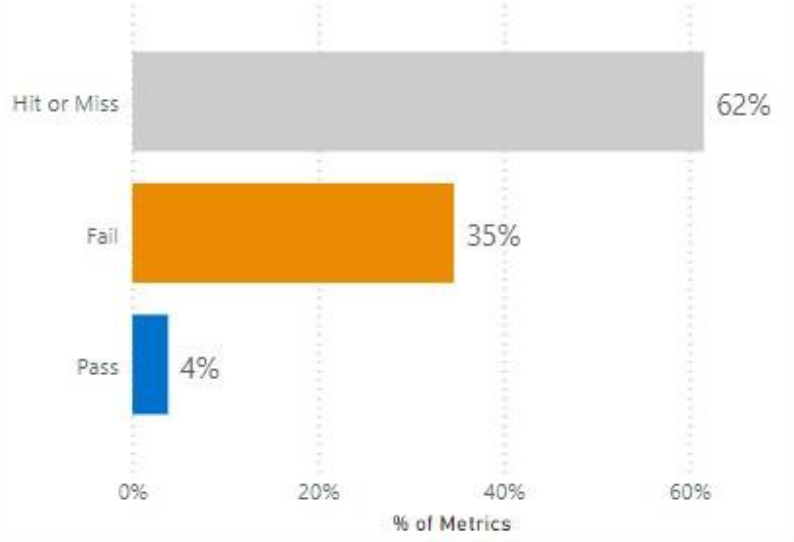
PEOPLE & CULTURE

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)

- 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.

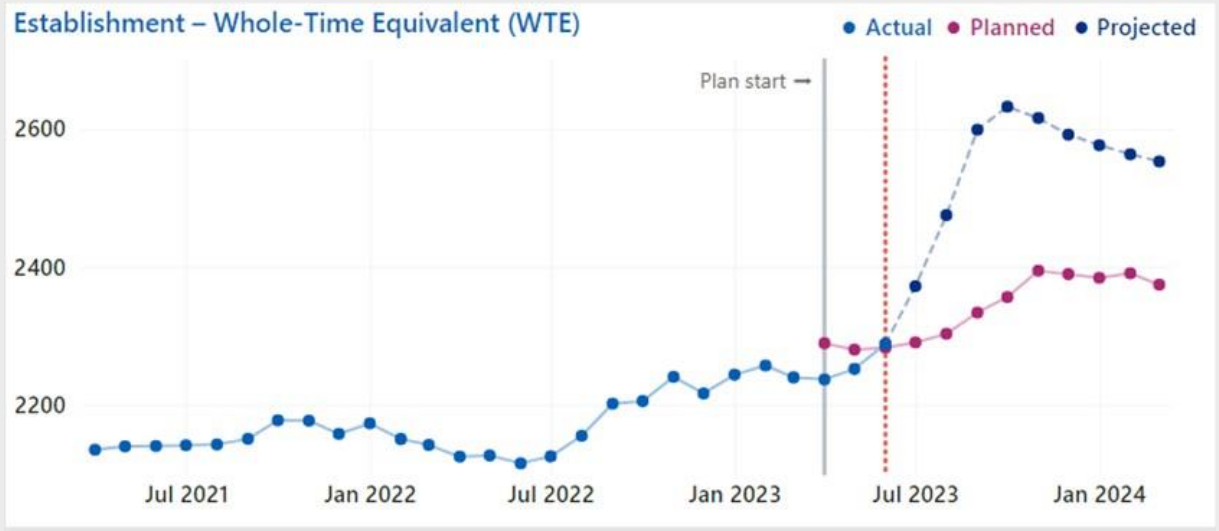
Complexity is added to the data for July and August with the recent Medway relocation (redundancies and leavers). This should stabilise by Nov/Dec one we know the outcomes of those on trial periods (as a result of accepting alternative roles to redundancy)

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.

(999 Frontline)

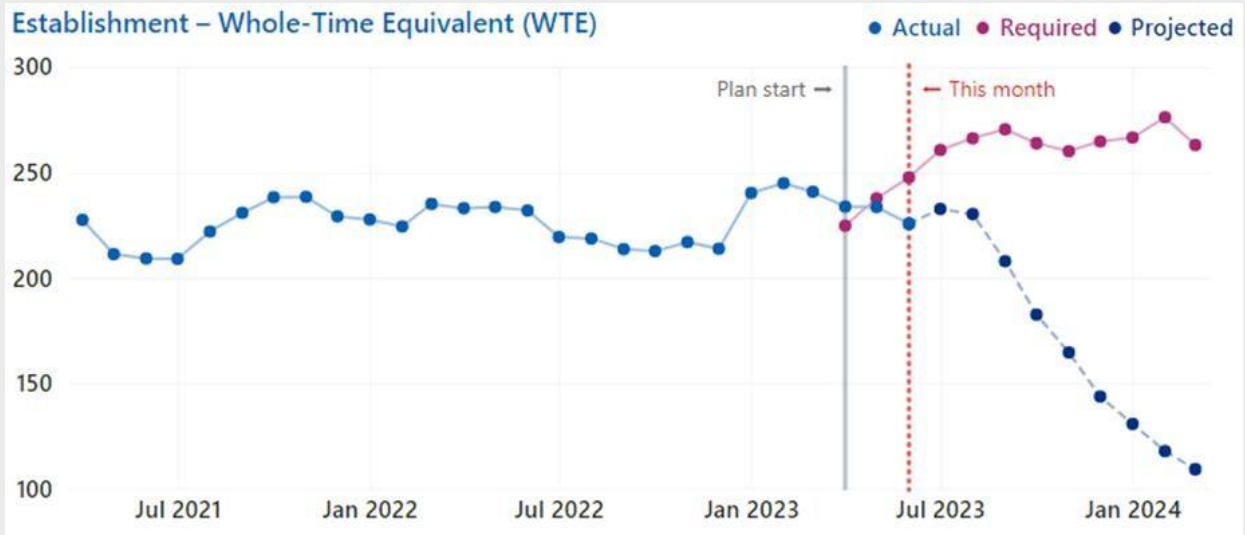


Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
June's data shows an increase in WTE slightly ahead of the workforce plan (5.6FTE) Attrition was lower than planned which has helped this number.
NQP recruitment continues with a strong position for 23/24 and more confirmed 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.

Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

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

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.

Employee Experience

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

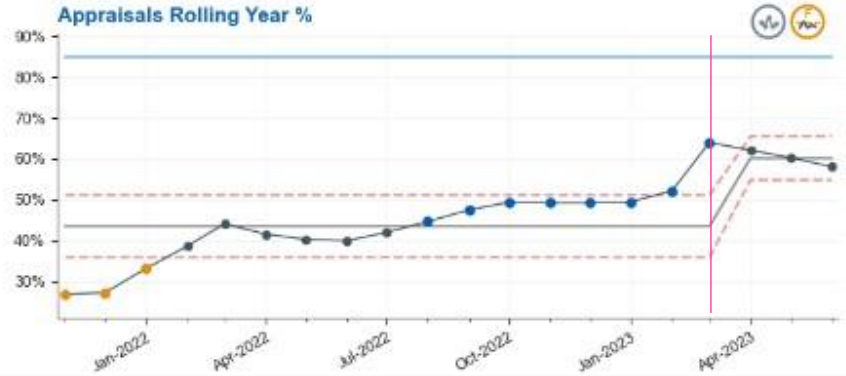
Employee Suspensions

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.

South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

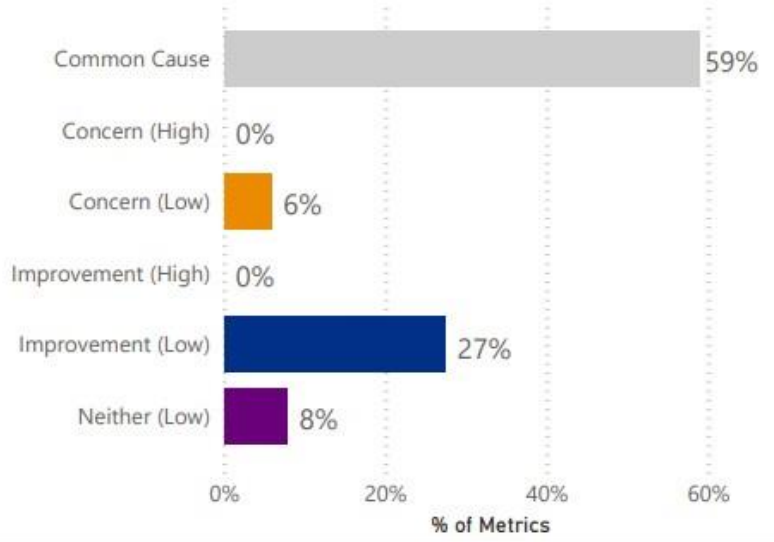
June 2023

	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

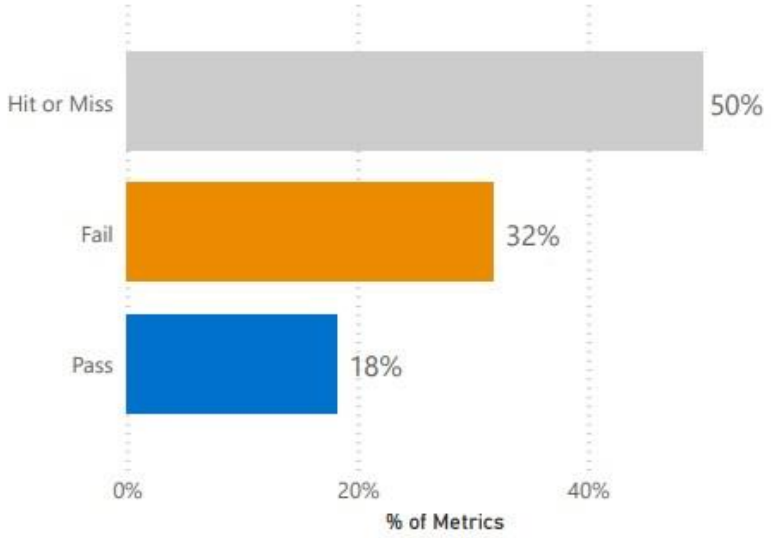
Not included: Metrics that are not on a story board, metrics with common cause variation with hit or miss assurance and metrics with common cause variation without a target.

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

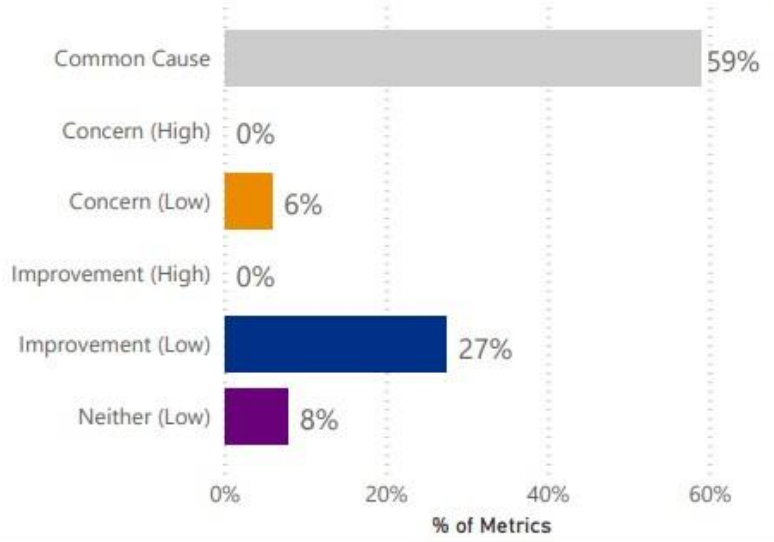
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Jun-2023							
Section 136 Mean Response Time	Responsive Care	Jun-2023	00:21:35		00:15:25	00:27:26	00:39:27		
Cat 1 Mean	Responsive Care	Jun-2023	00:09:18	00:07:00	00:07:30	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)

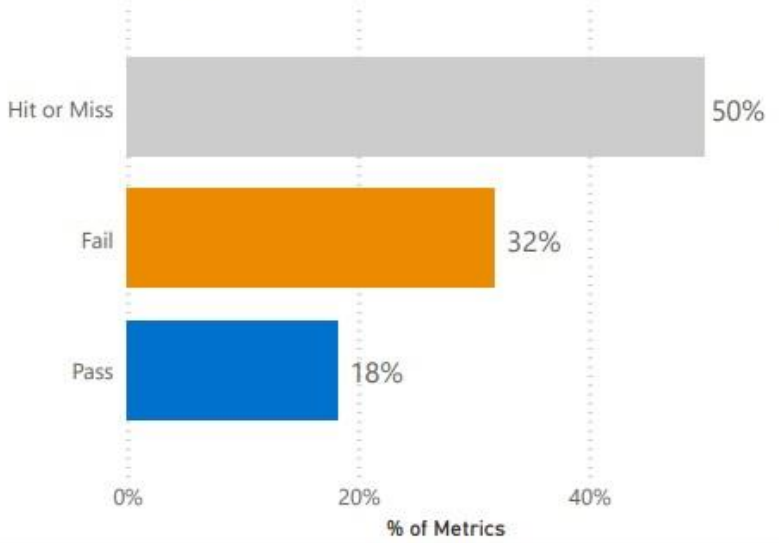
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Jun-2023	24.9%		19.41%	24.43%	29.44%		
999 Calls Answered	Responsive Care	Jun-2023	68260		49603.62	72887.3	96170.98		
999 Call Answer Mean	Responsive Care	Jun-2023	00:00:33	00:00:05	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		

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		

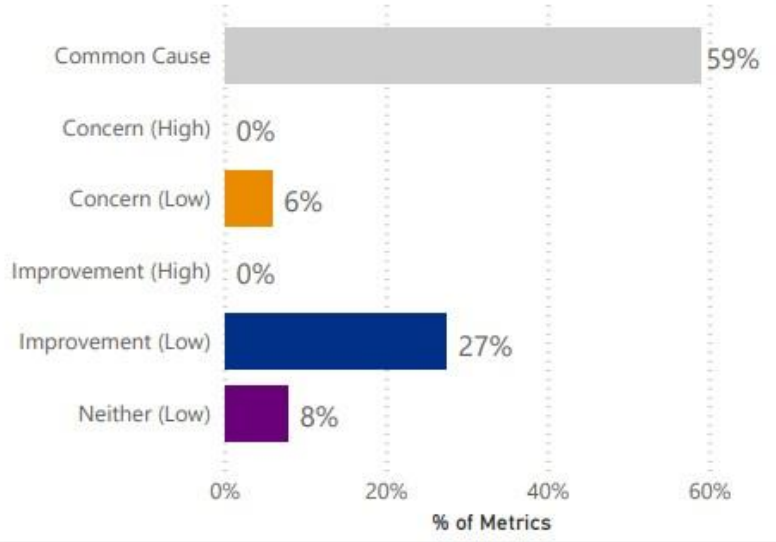
111

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		

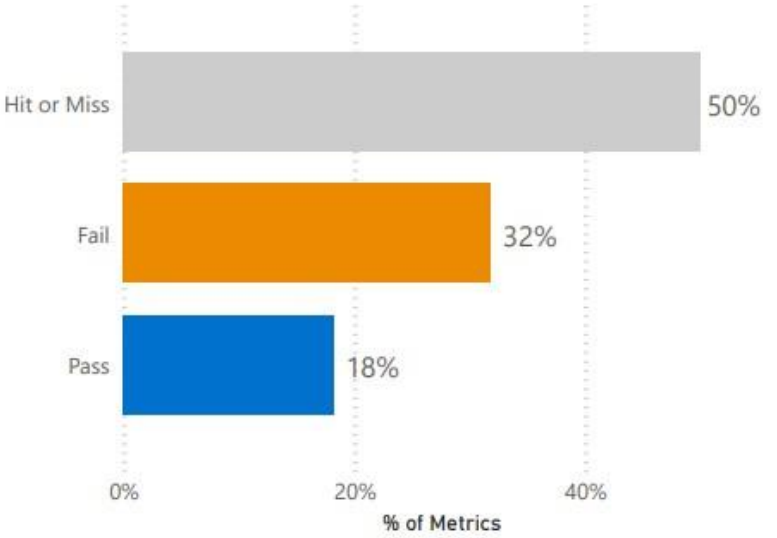
RESPONSIVE CARE

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%		

Response Times

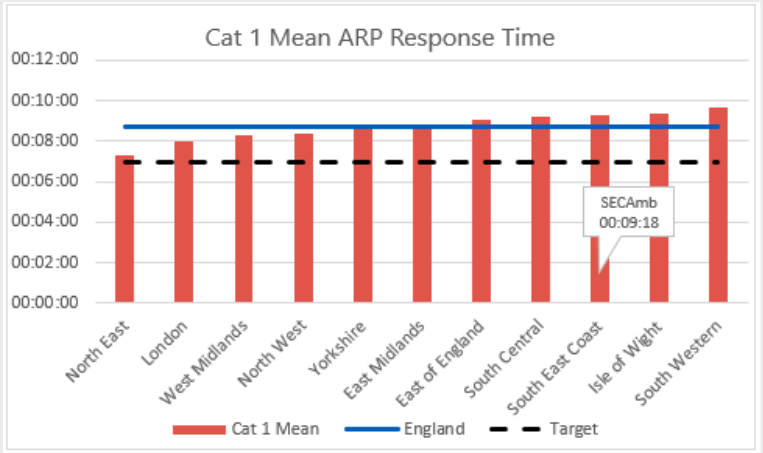
Summary

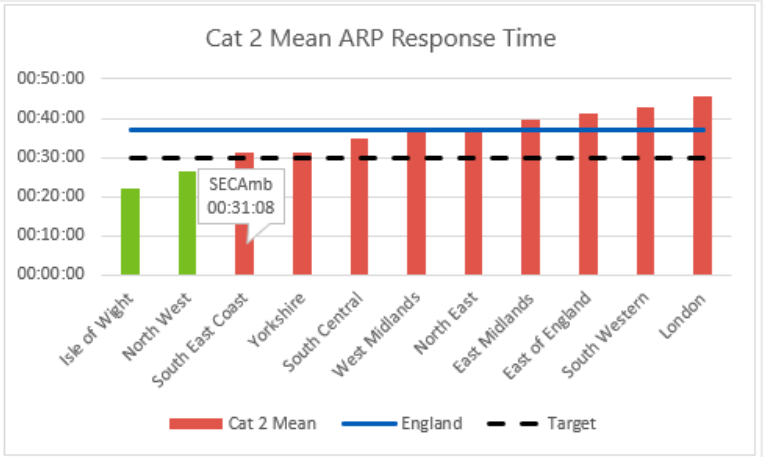
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against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

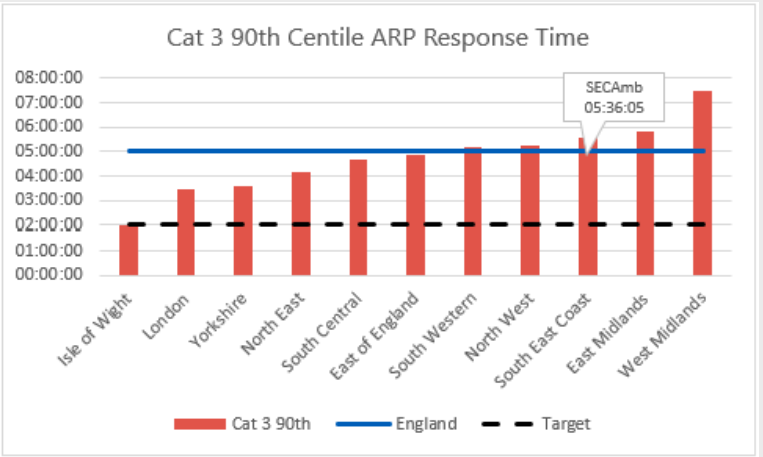
What actions are we taking?

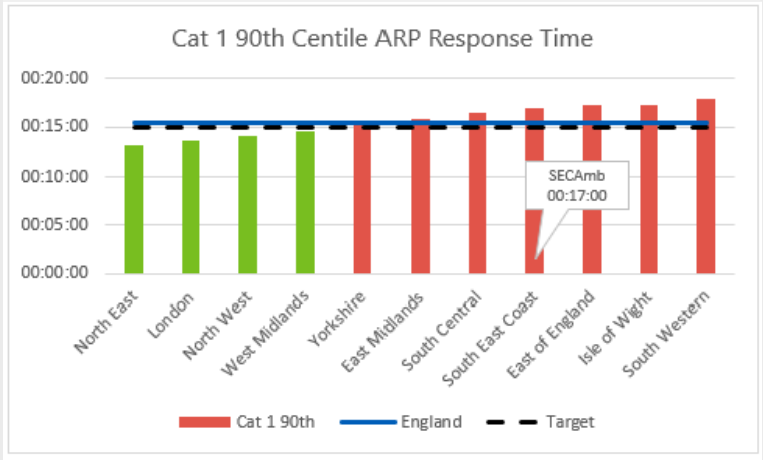
- Maintenance of high proportion of clinical validation of C3 & C4 calls from the Trust's 111 service (KMS 111) and to ensure that all calls requiring attendance have been appropriately assessed (92.1% for June - consistent with the previous 3 months).
- C3 & C4 Clinical Validation continues, with focused 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.

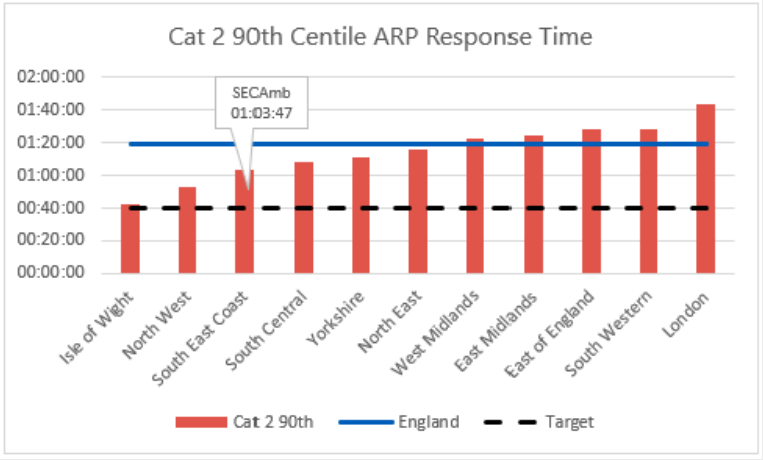
ARP Response Time Benchmarking (June 2023)

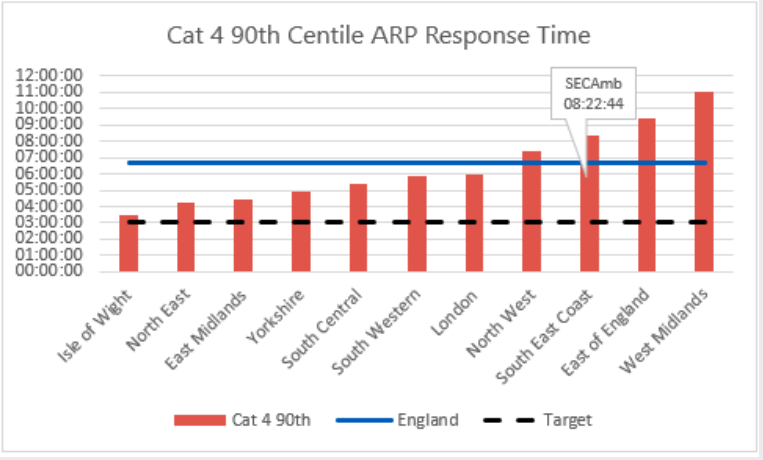












Summary

- 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

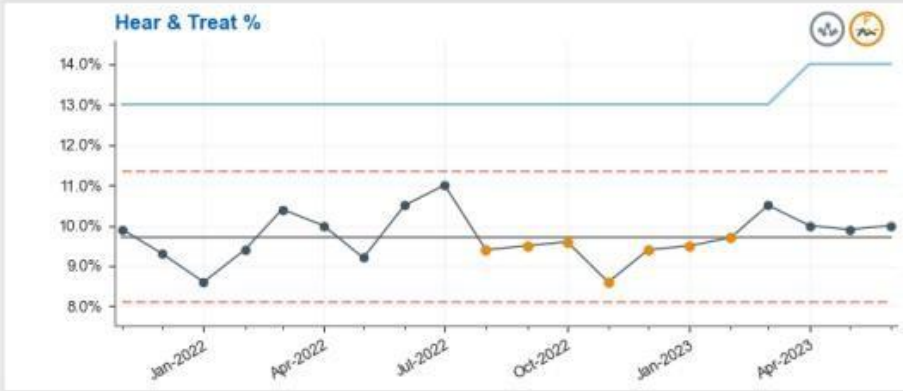
Dept: Operations 999
IP: Responsive Care
Latest: 68260

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.

Utilisation

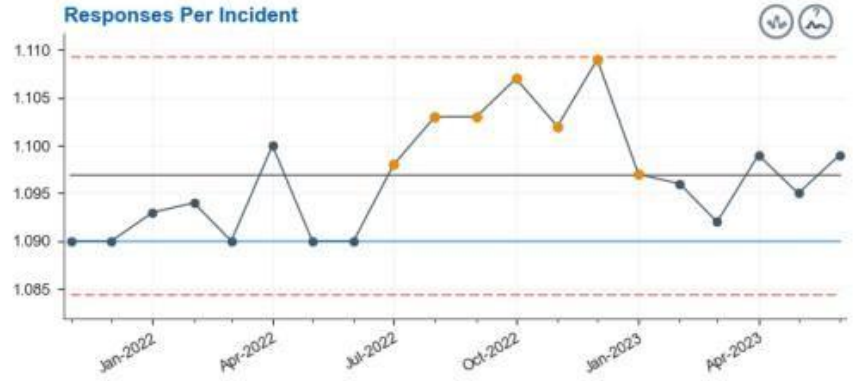
Summary

- 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.

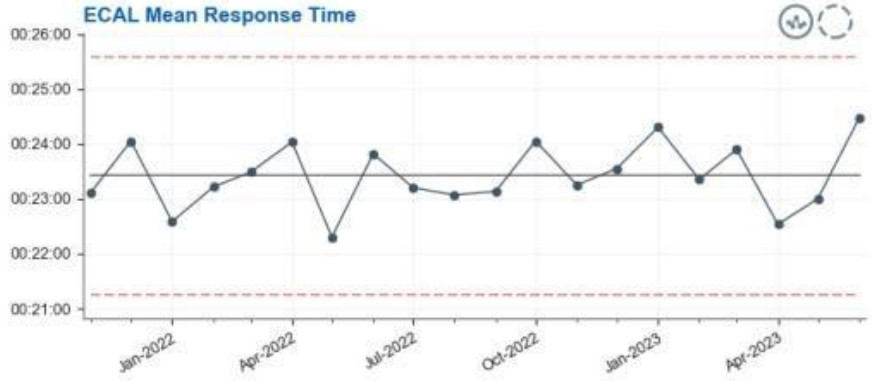
What actions are we taking?

- 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.

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 recommendationsare 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 fromcrew 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

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.

111-3

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.

111-2

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.

111-4

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?

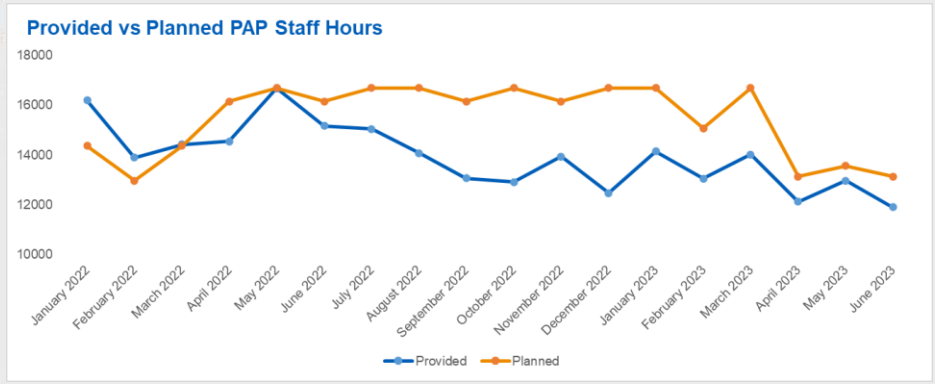
- The Trust is ***realigning the service model*** to the budget settlement with the Kent & Sussex commissioners which is a significant reduction on the 2022-23 settlement.
- The service continues to protect the wider healthcare economy by being a benchmark nationally for 999 and ED validation, in addition 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.

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

Delivered Against Plan

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).

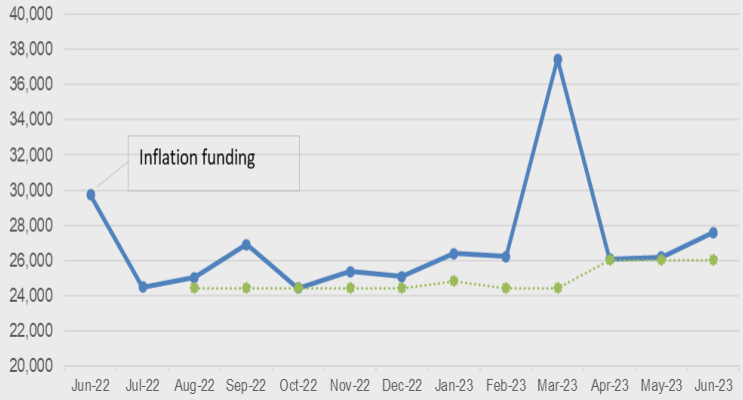
What actions are we taking?

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.

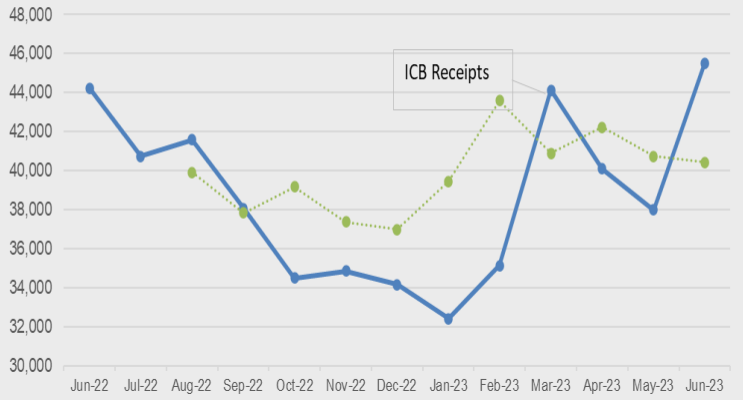
Delivered Against Plan

Actual Plan

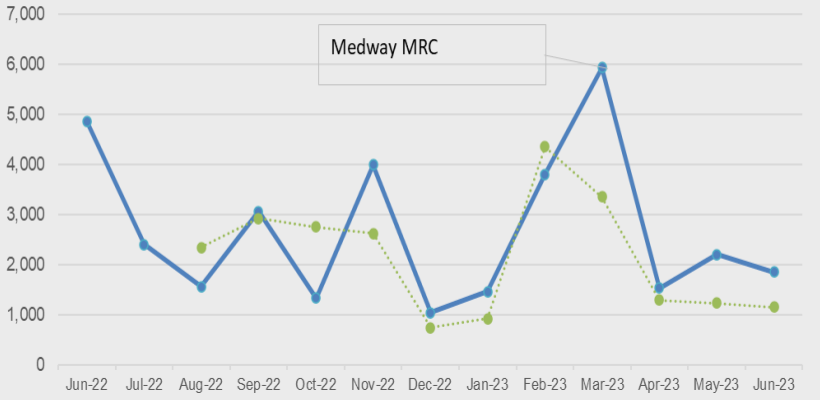
Income £000s



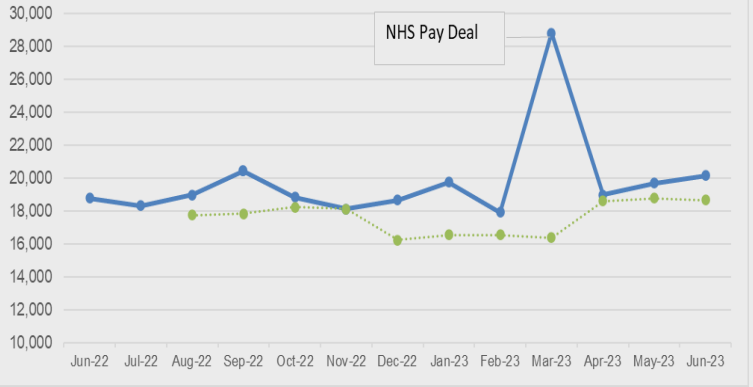
Cash £000s



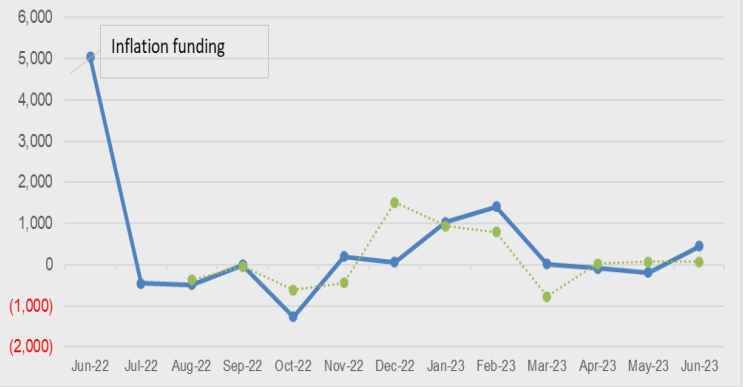
Capital Expenditure £000s



Pay £000s



Reported Surplus / (Deficit) £000s



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

Turn the page for the next Agenda Item

	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.

Turn the page for the next Agenda Item

NHS
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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
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.				

In Year Risks to achieving the objectives

Goal 2	Making internal processes effective	
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 Objectives

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
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				

In Year Risks to achieving the objectives

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.

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

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

Progress to date:

- RC7:
  - ODOOS performance QTD is 4.3% 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:

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

SP5:

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

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

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

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

Integrated Quality Report Metrics for Assurance	**Variation**	**Assurance**
WF-1 "Number of Staff WTE"		
WF-3 "Time to hire"		
999-12 "999 Frontline Hours Provided %"		

Gaps in Control

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. **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-L7	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.			↓
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)

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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.

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SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST

Council of Governors

Nominations Committee Report

22 August 2023

1. Introduction

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

1.2. This report provides an overview of the most recent meeting on 22 August 2023.

2. Chair recruitment

2.1. David Astley's final term comes to an end next year with a plan to step down in May 2024.

2.2. The meeting on 22 August 2023 was to help select a partner to support the search of a new Chair. The committee met with three different recruitment agencies.

2.3. The committee has appointed Gatenbysanderson.

3. Next Steps

3.1. In the coming days the timetable for the search and selection process will be confirmed.

3.2. This will ensure engagement of all key stakeholders.

3.3. The aim is for interviews to be conducted in December 2023 / January 2024.

4. Recommendation

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

Michael Whitehouse

Chair (on behalf of the Nominations Committee)

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SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor Development Committee

17 August 2023

1. Introduction

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

1.2. The duties of the GDC are to:

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

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

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

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

1.6. The minutes are attached as an appendice of the most recent GDC held on MS Teams 17 August 2023.

1.7. The GDC meeting in August covered: feedback from the previous CoG, agenda setting for the upcoming CoG, Governor training and development requirements.

2. Items of note

2.1. The full minutes have been circulated, and Governors are strongly encouraged to read them in full.

2.2. Plans were presented that are underway for Governors to attend Quality and Engagement Visits.

2.3. Governors were reminded of the opportunity to shadow ambulance shifts and listen in to calls for 999 / 111.

2.4. It was agreed only SECAmb e-mail addresses are to be used moving forward with.

2.5. It was agreed that NHS Futures would be used a document depository for all of our Governors.

2.6. Governors were reminded of the process for escalation and the correct route in which to escalate or advise of any issues to note

3. Recommendations:

3.1. The Council is asked to:

3.1.1. Note this report; and

3.1.2. Read the minutes provided.

3.2. All Governors are invited to join the next meeting of the GDC on 28 September 2023.

Richard Banks (On behalf of the GDC)
Assistant Company Secretary

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South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Governor Activities and Queries

September 2023

1. Governor activities

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

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

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

Date	Activity	Governor
1st April 2023	Godalming Festival	Ann Osler Martin Brand Sam Bowden
2nd April 2023	Brighton Marathon	David Romaine
13th April 2023	Quality and Patient Safety Committee	Andrew Latham Barbara Wallis Harvey Nash
15th April 2023	English Festival	Colin Hall Linda Caine
20th April 2023	Peoples Committee	Andrew Latham Barbara Wallis Harvey Nash
22nd April 2023	Spring Live!	David Romaine Harvey Nash Sam Bowden
18th May 2023	Governor Development and Membership Development Committee	Leigh Westwood Brian Chester David Romaine Andrew Latham Martin Brand Ann Osler Sam Bowden Harvey Nash Peter Shore Linda Caine Amanda Cool Nicholas Harrison

23rd May 2023	NHS Providers – Governor Focus Conference	Kirsty Booth Nicholas Harrison
25th May 2023	Audit Committee	Andrew Latham David Romaine
9-11 June 2023	South of England Show	Angela Glynn Brian Chester David Romaine Harvey Nash
15th June 2023	Finance & Investment Committee	Andrew Latham Martin Brand
22nd June 2023	Council of Governors	Andrew Latham Angela Glynn Ann Osler Brian Chester David Romaine Harvey Nash Kirsty Booth Leigh Westwood Martin Brand Nicholas Harrison Peter Shore
20th July 2023	Peoples Committee	Brian Chester Martin Brand Peter Shore
27th July 2023	Finance and Investment Committee	Harvey Nash Linda Caine
17th August 2023	Governor Development Committee	Andrew Latham Brian Chester Harvey Nash Kirsty Booth Linda Caine Mark Rist Peter Shore
22nd August 2023	Nominations Committee	Andrew Latham Angela Glynn Brian Chester
28th August 2023	Edenbridge & Oxted Show	Amanda Cool Ann Osler Martin Brand
3rd September 2023	Brighton Speed Trials	David Romaine
17th September 2023	Brooklands Emergency Services Show	Ann Osler Brian Chester Martin Brand Sam Bowden

2. Governor Enquiries and Information Requests

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

Date	Query	Response
August 2023	Query raised from Harvey Nash. Volunteers attend events at their own expense.	**Response from Dave Wells, Head of Community Resilience.** The purpose of the conference is to bring all our volunteers together to offer the opportunity to Celebrate, Network, and share information. We have several national speakers to enhance the day along with recent developments supporting our volunteers. The Trust has funded the venue, teas, coffees, and a hot lunch for all volunteer attendees. The event was hosted on a Saturday as it was for volunteers and most work Monday to Friday, so a weekend was deemed more appropriate as other Trusts do. All we ask is that the volunteer picks up the cost of mileage to the event location and home again. There is no obligation for volunteers to attend the day, especially if they feel aggrieved at this decision, however I have received no other concerns about this. In SECAmb we do value our volunteers and invest heavily to ensure they have the correct tools to carry out their role along with appropriate support. This event was to ensure our volunteers feel valued and appreciated and is a way of giving something back to you all.

July 2023	Query raised from Martin Brand relating to the entry license requirements for new – starters and the associated costs.	**Response received from HR.** All front-line staff are unable to start unless they hold a current C1 entitlement on their driving license. Should the candidate struggle to pay for a C1, we offer an interest-free loan of 18 months, see attached. The loan repayments will start 1 month after their start date and will automatically be deducted from their salary each month. They will be required to complete the loan agreement before we give details of which driving school they can use.

Recommendations

2.2. The Council is asked to note this report.

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

Jodie Simper
Corporate Governance Manager

Richard Banks
Assistant Company