South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

05 October 2023
10.00-13.00

Trust HQ
Nexus House, Crawley

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
44/23	10.00	Welcome and Apologies for absence		-	DA
45/23	10.01	Declarations of interest		To Note	DA
46/23	10.02	Minutes of the previous meeting: 03 August 2023		Decision	DA
47/23	10.03	Matters arising (Action log)		Decision	PL
48/23	10.05	Chair's Report		Information	DA
49/23	10.15	Audit & Risk Committee Report		Information	MW
50/23	10.25	Chief Executive's Report		Information	SW
Strategy					
51/23	Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report**		
Responsive Care – *Delivering modern healthcare for our patients*					
52/23	10.40	**Operational Performance & Efficiency**	Board Story		EW
			Winter Plan		EW
			Call Answer Performance		EW
Sustainability & Partnerships – *Developing partnerships to collectively design and develop innovative and sustainable models of care*					
53/23	11.15	**Achieving Sustainability / Working with Partners**	Strategy Development – Clinical Case for Change		DR
			Partnerships Report		DR
			Finance Report		SS
			FIC Report		HG
	11.40	**Break**			
People & Culture – *Everyone is listened to, respected and well supported*					
54/23	11.50	**Improving Culture**	NHS Long Term Workforce Plan – Our Response		AM
			People & Culture Strategy Delivery Plan		AM
			People Committee Report		SS
Quality Improvement – *We listen, we learn and improve*					
55/23	12.30	**Keeping patients safe**	PSIRF Plan		MD

			Quality & Patient Safety Committee Report	TQ
Board Effectiveness				
56/23	12.50	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
57/23	12.55	Any other business	Reinforced Autoclaved Aerated Concrete	SS
After the meeting is closed questions will be invited from members of the public				

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 03 August 2023

Trust HQ, Nexus House

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Simon Weldon	(SW)	Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
Saba Sadiq	(SS)	Chief Finance Officer
David Ruiz-Celada	(DR)	Executive Director of Strategic Planning & Transformation
*Emma Williams	(EW)	Executive Director of Operations
Howard Goodbourn	(HG)	Independent Non-Executive Director
Liz Sharp	(LS)	Independent Non-Executive Director
**Max Puller	(MP)	Independent Non-Executive Director
Margaret Dalziel	(MD)	Interim Executive Director of Quality & Nursing
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Rachel Oaten	(RO)	Chief Medical Officer
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

*Left the meeting at 12.17
**Joined at 12.17

In attendance:

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

Chairman's introductions

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

30/23 Apologies for absence

None

31/23 Declarations of conflicts of interest

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

32/23 Minutes of the meeting held in public 01.06.2023

The minutes were approved as a true and accurate record.

33/23 Action Log [10.03-10.09]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

SS asked that we capture on the log the issues discussed last time, related to having clarity on the trajectory for Hear and Treat. Agreed to add this to the log.

Action
H&T trajectory to be set out in the relevant paper in October.

34/23 Chair's Report [10.09–10.16]
DA used his report to set the context for the meeting reinforcing the revised approach to the BAF, and the actions taken in response to the board effectiveness review. A key focus today is People and Culture in the context of the NHS long term workforce plan.

DA then reflected positively on the recent Board development day, which involved some of our operational manager; this engagement is helping the connection of the Board. Before summarising the outputs of the last meeting of the Council of Governors and giving credit to all those involved in the development of the new Medway site.

DA asked PL to outline the approach to the development of the Board TOR. This was one of the recommendations from the Board Effectiveness Review. PL confirmed that this is consistent with the Constitution / Standing Orders, were reviewed by the Audit Committee and are recommended for the Board's approval.

Subject to a minor amendment to 6.3.6 (to state *health related research*) the TOR were agreed. They will be reviewed at least annually.

35/23 Audit & Risk Committee Report [10.16–10.24]
MW updated on the last meeting, highlighting three issues:

1. Internal Audit has helped to identify a potential concern related to financial control, and while the committee is confident this us being dealt with it has asked SS to report back in December, with additional assurance based on her review.
2. Assurance is needed in the ongoing resilience of IT/Digital given recent incidents and the external review underway. The committee is confident this is being addressed, but reinforced the need for resilience as we enter winter.
3. There is increasing assurance in the approach to risk management. The main ongoing issue relates to embedding, for example where a clinical risk arises we must ensure we learn and implement systemic change.

CG asked about the issue in the report about working while sick. MW confirmed the ongoing oversight of this at the committee and reinforced that despite the need for even tighter controls, when benchmarked against others we are not an outlier. Also, our reactive approach to handling incidents is robust.

36/23 Chief Executive's Report [10.24–10.53]
SW noted that this meeting falls on his 101st day in role. He has spent much of this time listening and talking to our people and partners. This has helped to distil his priorities, some of which relate to challenges previously identified. SW reinforced that these priorities are not things for the short term, but rather the next three years. He expects continued progress this year, but is clear that sustainable change will take time,

especially as there are some complex issues and debates to have. SW asked for the Board to support these priorities, which he has shared with internal and external stakeholders. The Board acknowledged its support.

SW then referred to the recently published NHS long term workforce plan, which he and the executive team welcome as it signals important change. The theme today is how we respond to these challenges and SW drew the Board's attention specifically to retention. There are three themes in the plan – recruitment; reform; retention. It is the latter that SW suggested we focus, to ensure this is a great place to work. In October, the aim is for the executive to set out its answer to the retention challenge. One aspect of this is the work we do on TRIM; Natalie joins today to describe the work she has done on this.

Having set out his longer-term priorities, SW asked the Board to note three issues that is being given his immediate attention:

- IT resilience – an external review has begun to help us confirm if we have the right infrastructure to support our strategy going forward. The output of this review will come to the Board in either October or December.
- Medicines Distribution Centre – the initial report was considered yesterday at EMB and this will inform the plan to address this longstanding issue.
- HART / SORT review – concerns were raised about our capability to respond to a major incident and in response we have commissioned an external review currently under way, to compare what is in place with national standards, leadership and culture. This report will also be shared with the Board in either October or December.

Lastly, SW updated on the progress with the ACAS mediation with our recognised unions. DA thanked SW for his update and on the mediation, thanked the executive and union colleagues on reaching a platform to move things forward. DA then opened for questions.

LS thanked SW for listening, especially on the issue with the MDC. SW updated that he has met the Chief Pharmacist and her challenges are the right ones and we need to respond to them. The longer-term solution will likely require a board level discussion as the options will have significant challenges. How we respond to these challenges is how the Board will be judged.

SS referred to the investment in TRIM, which is a real achievement especially in light of the number of wellbeing referrals confirmed in the IQR. She then asked about the additional £2.5m funding and how this will be used over the next 3 months to improve operational performance / patient care. Specifically, SS asked if this will be quantified to demonstrate improvement in call handling and H&T given the challenges here. SW confirmed that EW led this work to establish the bid with next to no notice. EW explained that the bid had to be specific to how we would spend the money and what it will deliver. It is a time limited (14 week) investment to help ambulance services get to a stronger position ahead of winter. It is specific about the hours and impact on H&T and call answer. SW added that one of things staff commented on was overtime availability had dropped and we know how some rely on this; this additional investment will support this.

DA reminded the Board that we said in the last trust strategy that we wanted to be a trusted partner and we have made some good progress e.g. handover delays are much better here than in other parts of the country. Winter planning meetings nationally are positive and clear direction is being provided. The Board noted the need to have a really robust plan in response, which the Board will review in October.

TQ welcome the opportunity for staff to obtain additional overtime but asked that we ensure we get the balance right to support staff welfare. SW invited Natalie to speak as a recently appointed OUM, and she explained the work we do to monitor closely each individual to ensure they aren't working too much. EW

added that we have been tactical about where the overtime is needed and equates to two additional shifts per dispatch desk per day.

HG congratulated the team for Medway. SW paid tribute to Eileen Sanderson and colleagues for their leadership in the project management.

37/23 Primary Board Papers

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

38/23 Improving Culture [10.53-12.48]

Board Story

Natalie Cole, joined to talk to the Board about her role in TRIM, to help frame the discussion on culture and improving staff experience. MD introduced Natalie, explaining that TRIM was one of the issues arising from staff feedback related to access and availability, as part of the P&C programme. Natalie then explained the background to trauma and, in context of SECAMB, the difficulty in picking up trauma experienced by our people. She then took the Board through some slides that we tabled. The service was rolled out in 2016 and some of the stats cited included 20 thousand days lost in 2019 due to mental health; over 1100 people have accessed TRIM, mostly from paramedics and EMAs; only 3% of these people required referral to other services. Natalie explained that there is still some stigma we are trying to breakdown, although staff can self-refer if they want to keep their identify confidential. She then provided some examples from staff on how this service has benefited them.

DA thanked Natalie for her presentation and opened to questions. There were some questions of clarity and one about the how we align with other interventions, such as MH first aid training, to which Natalie outlined how we teach TRIM across the trust and link in with the MH team and WB hub.

AM then summarised his cover paper, which drew out the issues from the BAF and IQR, related to People and Culture. He highlighted some specific areas such as the workforce plan which he confirmed was broadly on track, and the focus on retention, which he accepted is an area we haven't got right. AM also noted the new Intranet page setting out all the work we have done, linked to the strategy, to help ensure the right balance between celebrating successes and ensuring focus on the priorities for improvement. Lastly on the serious misconduct cases, the Board noted the significant decrease. AM confirmed that we cannot demonstrate cause and effect yet, but nonetheless this is a positive step.

HG referred to the data on suspensions and the language used that could imply we are reducing suspensions to meet a target. He asked for assurance that we are suspending staff when it this is needed / the right thing to do. AM responded that we aren't reducing inappropriately; we have clear criteria and will suspend when it is needed. He went on to confirm the main reason for the reduction is more timely resolution.

TQ referred to the section of the IQR confirming the annual rolling turnover rate and asked if we understand the hot spots. AM responded that we do have this data and can report accordingly.

SS referred to training and the data showing stat man and appraisals, and linked this to the BAF risk that describes staff doing training / CDP in their own time. She asked if we could include CPD in the days provided for training, e.g. key skills. AM responded that firstly, abstraction is a significant issue so when we set the annual training plan it is then hard to flex in-year. Secondly, AM confirmed that the ETD group is looking at this actively. EW added that this is a hot topic, and we need to acknowledge that each year there is a national directive on areas of training to include, in addition to what we pick up locally from our data and learning from incidents etc. The challenge therefore is fitting in what we are required to provide and what we identify locally, all within the commissioning envelope.

MW challenged this response, reflecting that it was too complex to what was a simple question. He suggested that if finding a way to provide time for CPD is an issue, as SS raised it then the response has been the same for the past few years, e.g. it's too difficult when what we need is to find a way through it. SW responded that this question is a challenge of our workforce plan and what our offering is going forward; this is the exciting part where the Board should focus, because part of the offer will need to be enabled by the system, linked to what we are funded for. But we need to name our offer linked to our new strategy and ask as a system whether we are up for it. This is the type of transparency we need. The Board agreed.

NHS Long Term Workforce Plan

AM referred the Plan, which is a long and detailed document, and relatively light on the ambulance service. He suggested therefore that in addition to responding to the core retention challenge we need to raise the awareness of the ambulance sector challenges, because we still do not feature despite the profile through COVID.

DA agreed that we need to be clear about our response to the plan which will need to track back to the new strategy.

SW reflected that some of this will come up later under the P&C delivery plan, but the initial debate is about what our offering should be to our people such that they want to stay here. This will then inform the plan we intend to bring back in October.

SS felt that staff want the right and safe culture so the elements that contribute to this are good management and leaders. SS added that the reason she asked about training earlier is because good CPD shows how we invest in the development of our people. This will help them then feel invested in the organisation.

RO described a need for us to be bold and radical. Every organisation will look at their education offering so we need to be ahead of the curve. We must eradicate staff doing training in their own time, so a review of the abstraction rate to allow meaningful and tailored training and appraisals is needed.

DR commented being struck by two things, firstly how we upskill our tech capability which will play into the role we might have in the future. And secondly, how we tackle inequities. The strategy needs to consider these things and feed into the difficult discussion on funding.

TQ reminded the Board that we are behind the curve on clinical supervision so need to challenge ourselves on our ambitions with this.

MW fed back the importance of focus, as we can't do everything. He outlined three issues he is concerned about. Frist, the work experience, which we need to make better. Second, the career structure, which needs more clearly defining. Third, risk appetite, and the need to acknowledge it is unacceptable if people leave the Trust due to having a poor experience that we can reasonably address, but on the other hand it is good if they move on through development to different roles / organisations.

HG suggested one opportunity might be to exchange people between providers in the system.

DA summarised that we can't be on our own with this, as it has to be integrated. SW agreed and thanked the Board for its feedback / suggestions, which will inform the development of some guiding principles e.g. career structure; system-based approach to careers; being clear in what is the core offer; high expectations on clinical supervision; recognising we have a multidisciplinary workforce with different interests.

The Board noted the engagement opportunities between now and the meeting in October, when the response to the Plan will be shared.

P&C Delivery Plan
Tina Ivanov, Culture Programme Director, joined for this item.

AM introduced the paper reflecting on the people we lost as part of the Medway move, which reinforces the need to be clear about why people are leaving us, to inform our offering discussed earlier. The paper reflects progress during the first quarter, linked to the P&C strategy. The majority of the actions are complete, and those overdue relate to actions needing time to embed; these will be delivered in Q2. One of those actions relates to TRIM, which is now progressed, as we heard earlier.

Tina added that the comms plan has been launched, including the dedicated pages on the Intranet. There has been positive feedback on this. Lastly, with regards measures and the ask for a culture dashboard (as reflected on the action log), Tina explained that we are trying to collate information already in the IQR. This will be developed during Q3.

CG did not think it is very clear from the report how we are integrating WRES data. TI responded that WRES DES feed in to how we understand outcomes as part of the work on the Dashboard. She acknowledged this is a status update paper and going forward the aim will be to clarify priorities and focus more on outcomes.

AM added on the six high impact changes, there is a national EDI plan published which will bring back to Board with our plan / response. A key part of this is for every board member to have an EDI objective, which is in place.

Action
The Board to consider the response to the National EDI Plan.

SS referred to the EOC section in the paper and a statement that says the oversight of leadership has been lacking; SS expressed concern about this asked what happens if we don't achieve the impact. Tina responded that the 3 months is what we are offering to managers for coaching. We have a new manager and lots of priorities within the EOC and so are pushing this to ensure culture is the number one priority. In addition, we will be providing intensive support to get managers where they need to be and escalate quickly if more support is needed. Therefore, this is about ensuring capability of managers and it will help change the focus on what we expect to see as outcomes / impacts, rather than what action needs to happen.

EW added that this is about supporting managers and we are doing the Fundamentals programme and work with the middle layer e.g. OUMs and EOC equivalents. We have had really robust discussions in recent weeks to ensure we address the issues sustainably.

SS came back on this, explaining that while she appreciates the effort, she remains concerned as this is the third review in EOC 111, and so we must now get it right. SS wants to get a sense from staff that things are changing.

DA summarised that the Board has heard the challenge, and the response from the executive about the difficult conversations and positive initiatives in place.

SW added that it is good to have a programme director leading this work, specifically. SW has challenged on the immediate priorities for the year ahead and the longer-term direction. We have heard from staff directly about things like flexible working and how we become a flexible employer. The other issue is how we treat

people who are pregnant and also feedback related to international paramedics. SW is therefore indicating that he is working with the executive team to extract some really key priorities and articulate the problem statement(s) more clearly. We will then bring these back into Board conversations. SW reflected that we might have too many priorities so will likely need to focus on fewer.

With regards the EOC, SW commented that EW has described the areas of action, and while further discussion is needed, he is working with EW to ensure the right support to the leadership team. In the meantime, EW is working with team leaders directly. SW felt that the previous reviews have probably been too reactive and short term. What we need is a longer-term view, which the actions described will aim to achieve.

[Break 12.17-12.30]

Comms and Engagement Plan

JC introduced the paper, providing a summary of what has been delivered since the strategy was agreed in April. A business case to expand the comms team was recently agreed and this will allow more geographically based support to our local teams.

PB asked how these changes have been received. JC responded that it is not an easy measure but we have some green shoots, e.g. pulse survey, big conversations, and the engagement resulting in ideas from the efficiency programme. JC felt that we are starting to realise the link between getting the story telling right and staff engagement.

SW felt that we need to get better at telling stories internally, which is one of the reasons for the additional investment in the comms team. SW has seen consistently good things happening, which we don't always make enough of. There are two specific targets, we will need to poll staff on how far the strategy conversation has reached, and as we make to make changes what evidence there is that it is being felt by staff.

SS asked about the approach to comms business partners. JC clarified that the investment was agreed in principle yesterday and it will be an evolution of the new roles to be recruited to. This acknowledges the responsibility of local managers for comms and engagement, but with support.

MP felt that stakeholder mapping is a key enabler of the work we need to do. JC responded that we had a session in June with an external company and used the outputs as part of the strategy development work. DA asked that we see the product as part of the next update to give assurance that we are reaching and engaging the right people, especially as we get in to the strategy development.

Action
The next comms and engagement plan update in December to include how we are mapping our key stakeholders, especially in the development of the new trust strategy.

People Committee Report

SS summarised her report noting the improvement in the quality of papers. The main concerns related to the retention plan and progress with the 'housekeeping' actions. The committee has asked for an evaluation of International Recruitment for its next meeting.

DA asked if we are getting to the root causes of RIDDOR. MD responded that overall themes relate to MSK injuries which is in line with the national picture. However, we are looking through QI at ensuring we are making analysis of the right data to inform the root causes; this is a work in progress.

39/23 Keeping Patients Safe [12.48-13.20]

MD summarised her report, confirming the improvements highlighted in the BAF and IQR. We are also making progress with PSIRF, and the Plan is due to come to Board in October. The Board noted the work to start the system level incident groups, which aim to ensure clarity on patient outcomes and health inequalities. MD explained that this is surfacing nuances in the reporting culture where there might be less direct patient safety incidents reported than we would like; we will benchmark this and establish if anything is being normalised.

The QI team is fully established and starting to make good progress. MD referenced the QI strategy which is for the Board's approval. The first patient community forum has been held and MD outlined the positive feedback from patients about how we provide them information to inform choice in their care.

SS asked about PSIRF if there is a need for QI and PSIRF training; if so, how confident can we be in delivering PSIRF given the challenges discussed earlier related to the call on training time. MD responded that this training is for a core few within the incident team, between 5 and 10 people.

HG referenced the IQR demonstrating positive metrics under quality. There are only three failures, but two are academic as we don't have targets. The third is compliance with NHS Pathways; the Board noted this was a gap in assurance identified previously as per action 10-23.

<u>QI Strategy</u>

Jo Turner attended to present this strategy. She described how it was developed in partnership with stakeholders and the ambition to embed a whole quality management system, with QI being one part. Jo added that the Board should be aware of the sector context and why QI hasn't always been successful in the ambulance sector, reinforcing that we must trust staff to deliver improvements within this framework. There are three enablers – QI training; leadership; and social connectiveness.

DR reflected that QI was brought to life where the logistic team went through the methodology to help provide five times more uniforms each week than previously, using the QI tools. The methodology is Six Sigma, which he supports.

MW asked how we will get independent assurance this is working and making a difference. Jo responded that we do have KPIs within the strategy linked to the enablers. However, QI is about cultural transformation and so we should in time also see benefits being reflected in what staff say in the staff survey (the question related to feeling able to make improvements in my area of work). Jo added that the proof then comes through the QI projects as each one has clear KPIs for impact.

DA commented that there is also a national push for QI and so we could invite the national lead to come down to provide feedback, for example.

SW reminded the Board that we will get independent evidence via the Well Led Review. He added that the most important thing we can do is continue to talk about it otherwise it won't permeate through the organisation. We are at the bottom of the curve and so need to relentlessly ensure we bring the strategy to life through actions of this Board.

The Board supported the strategy and acknowledged its tole in living and breathing QI to set the tone for a trust that is quality driven.

QPSC Report

TQ summarised the report and highlighted the specific escalation related to call answer and H&T, which led to a discussion about the key issues being allocation of resources, recruitment and sickness management. These are priority areas within the BAF and the Board will keep this under close scrutiny.

With regards to the gap in clinical safety officer (CSO), RO confirmed she is now the CSO at least for the time being and HAS coordinated group that have undergone CSO training. There are lots of issues to work through, including electronic prescribing.

40/23 Operational Performance & Efficiency [13.20-13.33]

In EW's absence, DR summarised the key aspects from the paper linking to the IQR and BAF risks. He highlighted that in Q1 the C2 mean has exceeded the 30 min target, and that there has been a significant reduction in job cycle time; this is a result of the work undertaken last year that is now starting to have an impact. DR added that culturally, this has happened organically and not through chasing people.

In terms of EOC, call handling and hear and treat is a concern. The C2 segmentation trial in August will help hear and treat and as discussed earlier we will bring back the trajectory to the next Board meeting.

HG referred to the benchmarking data and noted that we are doing well on C2, and while this has previously been understood to be to some extent at the expense of C3 and 4, the concern now is C1 performance is deteriorating (bottom quartile). He therefore asked if this is linked to the focus on C2. DR responded that C1 mean is a function of where the resources are and is also impacted by call answer time, which we know is poor.

DA suggested that we need to explain better some of the rural challenges with C1.

Following a question from TQ about the impact of expanding Band 6 paramedics into hubs locally and ensuring they are well-equipped, there was a discussion about the training and mentoring in place. The Board felt that further assurance that this is consistently applied.

Action
QPSC to seek assurance that appropriate training, mentoring and supervision is consistently in place for Band 6 paramedics who are being expanded in the local hubs, linked to EOC.

SW responded to the discussion which he feels links directly to the strategy question. While job cycle time (JCT) has seen sustained improvement, as we develop the new strategy we need to establish the drivers so we know how to maintain this, and from this analysis we need to derive our workforce model. So if JCT for example relies on PPs do we need more of them? The strategy will need to answer this and therefore we need to understand the caseload analysis and whether we have the right training and what group of people help optimise response times.

PB asked if we have forecasted ahead the resources needed in 111. SW responded that this is part of winter planning and also needs to align funding with expenditure. Another question that requires an honest debate as part of the new strategy is what it costs to provide 111 CAS.

41/23 Achieving Sustainability / Working with Partners [13.33-13.53]

Finance Report

SS confirmed that we are on plan at month 3, with a small surplus, but with some operational pressures. The efficiency programme is off plan and the risks are being worked through to strengthen the pipeline of schemes and as discussed earlier some good ideas are coming through. The Board noted that we are on track despite the issues and risks to deliver breakeven by year end.

SS asked why we are so far off the efficiency programme. SS outlined some of the reasons leading to delays in schemes being developed, with an undertone over optimism.

DA drew the link to QI and the need to not just save money, but ensure we are more efficient. He then summarised that the financial position is relatively stable, but we have challenges and need to open about this to ensure we remain in control.

MW reflected that while he agrees we are in control, it is a more challenging period than ever before and the efficiency programme has a high degree of uncertainty. The Board acknowledged this and the related risks.

FIC Report

HG summarised his report, reinforcing the risk to the efficiency programme, which he agreed was always ambitious. At the most recent meeting a new issue was highlighted related to recruitment of vehicle technicians, which the Board noted.

Action
Noting the People Committee has to-date focussed on the operational workforce plan, the Board asks that it considered the wider workforce plan to ensure clarity on support services and any related risks to operational or corporate delivery.

SW acknowledges this is a challenging position to deliver. He reassured the Board that he challenges the executive team to ensure the right balance between financial and quality / performance risks. The context is that the local system and across the Southeast there is a significant financial challenge so we need to do all we can to achieve breakeven.

Strategy Committee Report

The report noted; there were no questions.
The TOR were not approved; noting the work still to do.

Partnerships Report

DR highlighted three points:

1. The work across directorate to align governance to ICBs.
2. We have finalised the 5 year joint forward plans – the Board noted this and the input we have had.
3. St John Ambulance scheduled to help provide some capacity for winter

There were then some questions related to the acceptance rate for UCR referrals and the patient flow group that is established. Also about the ICB conversation being about place and localism but acknowledging the need for us to operate at scale with consistency. The Board reflected the link to landing our new strategy as in our clinical model we need to describe what we do at place and across region.

DA thanked DR for this report which helps set out the work ongoing with our system partners.

42/23 Review of Board Effectiveness [13.53-13.55]
TQ reflected that this was probably the best ever set of board papers.

Our Leadership Way:

- Compassion
  Asking Natalie if she is supported is a good example of compassion.
- Curiosity
  Plenty of questions around equalities and how different groups affected.
- Collaboration
  QI strategy a great example to support cultural improvement.

43/23 AOB
None

There being no further business, the Chair closed the meeting at 13.55.

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

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
15.12.2022	70 22c	As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.	DR	Q4 2023/24	Board	IP	July Update: While this was initially planned for Q1 it is suggested that we defer this until early next year, as a better time to do this will be once we have developed our clinically focused Trust strategy as this should revolve around patient outcomes. We will in any event need to refresh the IQR then so it will be sensible to do it all at once.
15.12.2022	70 22e	The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.	SW	Q4 2023/24	Board	IP	Added to the BD plan for 2023/24.
06.04.2023	10 23	The Board has noted the special cause variation in the IQR related to NHSP audits. It has asked QPSC to follow this up, to understand the reasons and what corrective action is necessary. There is also a cultural issue here related to the support we provide staff who are audited, e.g. ensuring it is a learning tool, not punitive.	EW	24.08.2023	QPSC	C	Considered by the committee in August - see report to Oct Board
06.04.2023	11 23a	AUC to explore the reasons why staff are perceiving detriment as a result of speaking up and seek assurance that the processes in place will mitigate this.	MD	21.09.2023	AUC	C	20.07.2023: A panel has been set up between FTSU, Director of Q&N, Deputy Director of Operations, Deputy Director of HR and Director of Strategic Planning to go through highlight of cases, captured on the FTSU dashboard, where detriment has been put forward by the person raising the concern. The aim is to explore the options then available to us to address this situation in a systematic way and we will report back on what that process will be. Until we explore this area in an experiential way, we will not be clear on the best way to address it. 05.10.2023: See AUC report to Board on the Agenda
06.04.2023	11 23b	As part of the development of the IQR, SPC charts don't work well for rolling targets and so need to present this data in a more helpful way for the Board. Stat Man Training and Appraisals, two examples identified by the Board in April.	DR	TBC	Board	C	03.08.2023: Stat & Mand - Will now be a line chart. It was agreed SPC wasn't appropriate for this one, as it would be unlikely to ever hit the target except in March due to the nature of the data. Appraisals - Because the process changed to appraisals now being done monthly based on start date, this is one that should be able to be shown Rolling and have meaning in the SPC format. See IQR August that explains this. At the meeting in October HG clarified that the issue was an analysis of activity by type which doesnt appear in the IQR. He feels it is fundemental to know how we are spending time by specific care pathways eg stroke / falls etc. and is a key inout to the strategy. The executive agreed and will comit to this as as part of stratregy work. Rolling annual turnover – most board reports have this so unlikely to change.
06.04.2023	11 23c	As part of the development of the People and Culture Delivery Plan, clear metrics / dashboard to be established that demonstrates impact on culture.	AM	03.08.2023	Board	C	03.08.2023: Picked up under the People & Culture item on the agenda (see minute)
03.08.2023	33 23	H&T trajectory to be set out in the relevant paper in October.	EW	05.10.2023	Board	IP	See RC agenda item
03.08.2023	38 23a	The Board to consider the response to the National EDI Plan.	AM	07.12.2023	Board	IP	
03.08.2023	38 23b	The next comms and engagement plan update in December to include how we are mapping our key stakeholders, especially in the development of the new trust strategy.	JC	07.12.2023	Board	IP	
03.08.2023	40 23	QPSC to seek assurance that appropriate training, mentoring and supervision is consistently in place for Band 6 paramedics who are being expanded in the local hubs, linked to EOC.	RO	Q4	QPSC	IP	
03.08.2023	41 23	Noting the People Committee has to-date focussed on the operational workforce plan, the Board asks that it considered the wider workforce plan to ensure clarity on support services and any related risks to operational or corporate delivery.	AM	Q4	People Committee	IP	

Key

- Not yet due
- Due
- Overdue
- Closed

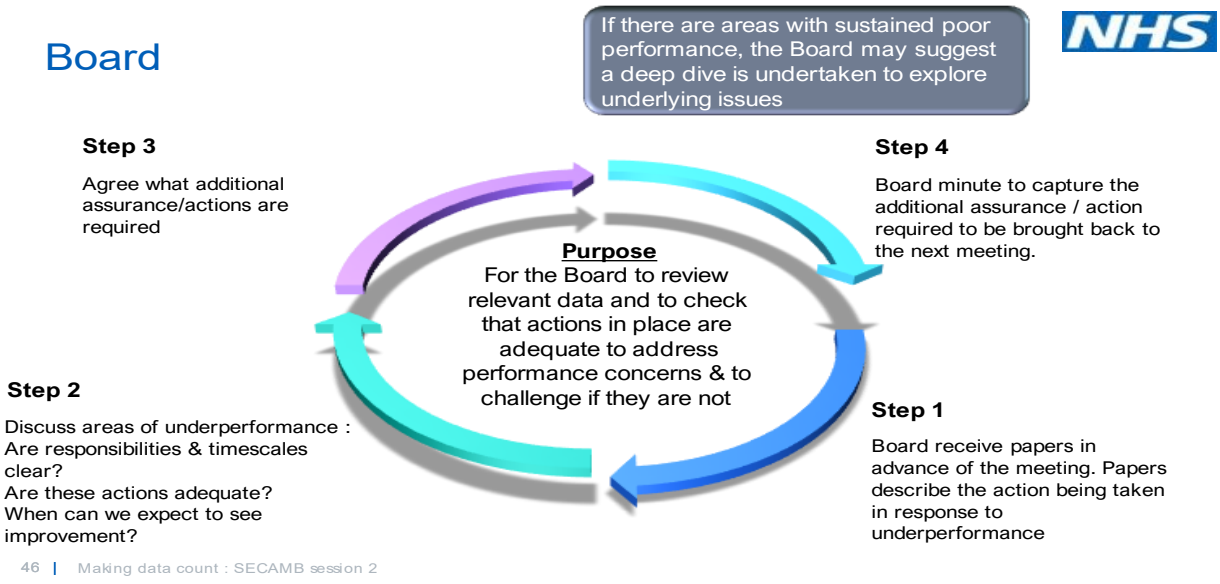
NHS
South East Coast Ambulance Service
NHS Foundation Trust

		Item No	48-23
Name of meeting	Trust Board		
Date	05.10.2023		
Name of paper	Chair Board Report		
Report Author	David Astley, Chairman		

Board Meeting Overview

I would like to start by confirming that my final term as Chair comes to and end next year and the Council of Governors has begun its search for my replacement. The plan is to handover by May 2024. I will have plenty of time to reflect on my time here and in the NHS, but between now and then my complete focus is on leading the Board to help the improvement journey we are on.

Meetings of the Board continue to be framed against the current strategic goals, as set out in the Board Assurance Framework (BAF). This helps provide the Board with greater clarity on progress against the organisational objectives and the main risks to their achievement. The BAF together with the Integrated Quality Report are the Board's primary documents used to inform the Assurance Cycle and where there are gaps in assurance.



The theme of this meeting is demand management and winter planning. The Board Story will help to set the context for this and, in addition to seeking assurance from the IQR and BAF, we will consider the Winter Plan to ensure we are best placed to meet the needs of our patients and ensure the welfare of our people.

The Board acknowledges that our operating model (one of the main strategic risks) will not enable us to meet the changing demands and patient need in the medium to longer term. This is

why one of our main priorities for the year is to develop in partnership with our key internal and external stakeholders a new clinically-led, patient focussed, trust strategy. On the agenda is an update on progress following the recent engagement sessions.

We will also consider the work undertaken since the last meeting in August, to develop our response to the NHS Long Term Workforce Plan. As we agreed last time, our main focus needs to be on retention; making SECAmb a great place to work.

Equally important is the new approach set out in the Patient Safety Incident Response Framework (PSIRF). We had a really thought-provoking development session on this in September and look forward to receiving the PSIRF Plan.

Board Development

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

1. Board Connectivity

Following on from the July session, circa 20 of our operational managers joined to help the Board explore its connectivity to the wider organisation. This interactive session considered what is means to have meaningful autonomy, which will be part of an ongoing conversation. We also explored how the Trust should respond to the priorities set out in the recently published Long Term Workforce Plan.

2. Strategy

This was very much a patient-centred session working through who are our patients are, why they need us, and how we should be responding. The outputs of this have helped provide greater clarity on the clinical case for change, which is on the agenda.

3. Patient Safety

The Board was privileged to hear a really moving story from a father whose experience of the SI framework was a catalyst for the move to the Patient Safety Incident Response Framework. The session that followed provided clarity for the Board on the difference between the SI Framework and PSIRF, ensuring a clear understanding of the Board's responsibilities and oversight and how this will influence the development of our new strategy.

Council of Governors / Annual Members Meeting

Our Governors have a key role in our governance structure, holding the Board to account for the performance of the Trust. They do so on behalf of the Trust's members, who include our staff and our public. The Council of Governors last met in September, the morning of the Annual Members Meeting. The key areas of concern / ongoing assurance included the following:

- It welcomed the work of the Board to ensure meaningful autonomy, in doing so shifting what seems to be a centralised culture in the ambulance sector. It reinforced the need to sustain this over the longer term.
- Acknowledging the positive work to open the new Medway centre, the COG urged the Board to ensure management uses this opportunity to address some of the culture issues.
- The need for the new retention plan to be really ambitious.

- The COG also reinforced its ongoing commitment to be engaged in the development of the new trust strategy.
- And explored the progress made in identifying the causes and therefore corrective action related to the issues connected to the medicines distribution centre and EPRR.

The AMM was a great success. It was well attended and there was a real sense of optimism, especially linked to the excitement of shaping a new future for SECAmb.

Upcoming Events

October is **Freedom to Speak Up** month. The importance of having a good speaking up culture continues to be reinforced. It is everyone's responsibility, and as a Board we have a particular duty to also listen and act.

At its most recent meeting, the Audit Committee explored the progress we are making to improve our FTSU culture (see separate report). The Board has been asked to make a personal FTSU pledge and as Chair, *I pledge that the Trust Board through its words and deeds will promote a culture in SECAMB that encourages speaking up. Our objective is to deliver safe and high-quality patient care. It is only possible if all colleagues feel they can speak up and raise concerns on matters of patient safety or staff welfare without detriment*.

It is also **Black History** month and I was pleased to see that we will be celebrating in different ways, including with an event being held at the Trust HQ, on 27 October between 11am and 1pm. I would encourage all Board members to attend if they can.

I would also like to mention and promote the Trust's **BME Leadership Development Programme**, which I learned about recently. Please see the flyer enclosed.

South East Coast Ambulance Service
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BME LEADERSHIP DEVELOPMENT PROGRAMME

The Black, Asian & Minority Ethnic Leadership programme is aimed at BME staff at Bands 5 & 6. This positive action initiative is to help the Trust achieve greater representation, equality and diversity at more senior levels. This is part of a range of initiatives to help make the organisation more inclusive and equitable organisation for all staff and patients.

It's time to thrive!

- Are you a Black, Asian or Minority ethnic colleague at bands 5 & 6?
- Are you keen to progress and be an inspiring, empowering leader?
- Keen to boost your career, confidence, direction, impact, influence?

This is an inspiring and empowering six-day programme run over three-four months to help you flourish in your life, career and leadership journey.

This programme delivered by a leading UK coach / facilitator will help you to:

- Become an inspiring, empowering, authentic and inclusive leader
- Boost your clarity, confidence, career direction and raise your visibility
- Be more strategic and impactful with seniors, peers and stakeholders
- Empower and develop your team and flourish in your career
- Gain coaching, developing, communication and mindset/ life-balance skills

Overview in brief

- Launch and Induction | **Mon 4th Dec**
- Day 1 | **Wed 13th Dec**: You, your brand and leadership essentials
- Day 2 | **Tues 16th Jan**: Career development, coaching skills, job application & interview skills
- Day 3 | **Tues 20th Feb**: Presentation, communications and influencing skills
- Day 4 | **Thurs 7th Mar**: Action learning / group coaching to help you reflect, grow and problem solve
- Day 5 | **20th, 21st & 22nd Mar**: Coaching: inspiring one-to-one coaching on your goals
- Day 6 | **Mon 29th Apr**: Team presentation and graduation

Benefits of attending / learning outcomes

You will leave this programme

- With clarity, direction, confidence, skill, resilience, and resourcefulness as a leader
- Able to develop, empower your team and influence and key stakeholders
- Able to present/ communicate effectively in meetings, interviews, talks and networking
- With greater strategic awareness, consciousness, compassion and life balance skills

RASHEED OGUNLARU

About the speaker / coach

Rasheed Ogunlaru is a leading life coach, speaker and leadership coach. He is author of Soul Trader – Putting the Heart into Your Business and The Gift of Inner Success. His clients include entrepreneurs, entertainers, leaders and organisations – including NHS Trusts and Leadership Academies. His work in the NHS has included two award winning career and leadership programmes. He often speaks in the media including appearances on ITN and BBC News. He is known for his unique 'become who you are' approach and helps people of all backgrounds find lasting fulfilment – from within.

He is the life and business coach partner to the British Library's Business and IP Centre. Rasheed is a trained trainer and qualified as a coach with distinction from The Coaching Academy in 2004. He has served as an associate coach with the academy for well over a decade. Prior to becoming a coach Rasheed's first career was in PR/ media – including as a press officer / media spokesman for Which? He is a former Co-Director of Samaritans (Central London Branch). Rasheed is also a singer songwriter.

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South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	49-23

Name of meeting	Trust Board
Date	5 October 2023
Name of paper	Audit & Risk Committee Escalation Report – 21 September 2023
Author	Michael Whitehouse, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 21.09.2023.

Internal Audit Progress Report

There were two final reports considered at this meeting - SI Management (Reasonable Assurance) and Medway MRC (Partial Assurance). The committee was pleased with the progress with SIs which puts us in a positive position to take forward the new Patient Safety Incident Framework. However, PSIRF will rely significantly on the learning framework which is in development, and the committee is still not fully assured that the learning from past significant incidents has been fully embedded. For example, the Thanet incident from 2022 which the committee will come back to at its next meeting in December.

There was also some focus at this meeting on areas where greater assurance is needed from previous reviews, such as stat man training, procurement, and contract management. These are all areas with executive focus and the committee will continue to seek assurance with the actions being taken.

Lastly, noting the ongoing review of the executive structure, the committee will test by the end of 2023-24 that there is no subsequent dilution of governance.

Counter Fraud

As reported last time, 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. A review is being undertaken by RSM that will report in December. In the meantime, the committee continues to encourage the executive to communicate as clearly as possible when sanctions are applied following incidents of fraud.

Risk Management

The committee continues to have increasing assurance with the progress for embedding our risk management processes. This is demonstrated by a high compliance with risk reviews (description of the controls and actions) where we are seeing >95% which compares to circa 60% in the Spring.

The executive is clear on the work still to do, and the coming weeks will see a focus on <Band 6 staff to improve their awareness and responsibilities with risk management. The Quality Assurance Visits are

helping to reinforce the progress still needed to ensure a better alignment on risk awareness between operational and corporate managers. The aim is to focus on this during Q3 and so will pause the work on risks appetite / tolerance, until Q4. The committee supports this prioritisation.

FTSU

The FTSU Guardian joined the meeting to provide her report on the work to improve our FTSU culture and, in particular, the gap in assurance the Board identified earlier in the year, related to incidents of detriment. The committee reinforced the need to ensure not one person who raises a concern will suffer detriment as a result. The FTSUG confirmed that there are signs of an improving culture in relation to the number of times people are speaking up, and set out the steps to ensure issues are dealt with effectively.

The committee will continue to receive regular reports to ensure progress is being made. In doing so it will ask the executive to be clearer on how it is assessing the impact of the culture programme and staff development, as currently it is difficult to assess and therefore seek assurance on the sustainability of any improvement.

Information Governance

The committee is assured by the controls in place to ensure effective information governance. There is good leadership and supportive training and awareness. The increasing complexity of IG was acknowledged and the committee reinforced the need to ensure the right balance between information sharing for the benefit of patients, with the duties under GDPR.

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.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	50-23

Name of meeting	Trust Board
Date	05.10.2023
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 August and September 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:

- Considerations of options to improve/replace the Medicines Distribution Centre
- Our response to the NHS Long Term Workforce Plan, with a particular focus on retention
- A new approach to Reward & Recognition
- Executive Team Development

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 **Engagement**
During August and September, I have continued to spend time with a number of our key regional and national system partners including regional and national ICS Chief Executives, NHS Providers, IC24 and St John Ambulance. These meetings have all provided good opportunities to discuss areas of joint working.

7	I have also spent time visiting both South Central and East of England Ambulance Services during recent weeks, including meeting their Chief Executives and touring some of their facilities. Both visits were incredibly useful in terms of sharing good practice, as well as discussing the challenges facing the sector.
8	On 13 September 2023, I attended a Winter Planning session, led by the Prime Minister at No 10 Downing Street, together with a number of my NHS Chief Executive colleagues from across the country.
9	It was a helpful opportunity to share our perspective on the very real challenges that this winter is likely to provide. I took the opportunity to highlight the need to continue to develop single points of access and clinician to clinician contacts to facilitate alternative care pathways. I also made the case for national recognition for the role call handlers play.
10	We will be discussing our winter plan at the Board. I am pleased to report the development of our partnership work with St John and the additional capacity that they can help provide during the winter period. I expect this capacity to come on stream during October and ramp up in the subsequent months.
11	I am also pleased to continue to host our series of 'Big Conversations' – monthly online sessions, to which all colleagues are invited, and which provide a good opportunity to discuss a particular key issue.
12	We have held four sessions so far, with topics covering our aspirations and hopes for the NHS in the future (as part of the NHS 75 events), the development of our Trust strategy, patient safety and leadership. All sessions have been well attended, with good contributions from a wide range of colleagues and lively discussions.
13	**Visit by Helen Whately MP** On 1 September 2023, Helen Whately, MP for Faversham and Mid Kent and Minister of State for Social Care, visited our new Medway Hub.
14	The Minister has Urgent and Emergency Care (UEC) as part of her portfolio and was interested to see NHS 111 in operation, understand more about the Make Ready system and meet some of the staff based there.
15	Although our East EOC colleagues had not yet moved to Medway, Ms Whately was able to see the Make Ready Centre and 111 service in operation and speak to some of the staff working there.
16	**Visit by Wes Streeting MP** On 22 September 2023, Wes Streeting, MP for Ilford North and Shadow Secretary of State for Health visited Hastings Make Ready Centre as part of a visit initiated by the GMB.
17	Mr Streeting was able to see the Make Ready Centre in operation, as well as spending time discussing the key issues affecting the ambulance sector with local GMB representatives and myself.

18	**Annual Members Meeting (AMM)** On 14 September 2023, we held our Annual Members Meeting (AMM) in West Malling, Kent.
19	As well as undertaking formal Trust business, including the signing off our Annual Accounts for 2022/23, it was a great opportunity to look back at our achievements and challenges during the year and to look forwards with the development of our new Trust Strategy.
20	I especially enjoyed looking at the various 'stalls' which showcased the work of different teams within the Trust. Thank you to everyone who took part.
21	**Development of our new Trust Strategy** During August and September, we have started the important work to develop a five-year strategy for SECAmb.
22	Our clinical teams have developed a clinical case for change using our patient data and we have planned engagement sessions with our ICB colleagues to take place in October 2023, where we will develop our initial diagnostics and overlay the system forward plans with the needs of our patients.
23	We have also now completed the procurement of a strategy partner, and with this additional support, we will be able to progress extensive engagement with our people, patients and partners, to ensure everybody has a chance to have their voice heard as we develop the strategy.
24	I would also like to thank all the members of the public, SECAmb colleagues and members who shared their views regarding the development of our new strategy at the Annual Members Meeting in September.
25	**Second series of '999: Emergency Call Out'** In late August 2023, we saw the launch on 5Star of the second series of '999: Emergency Call Out' which showcases the work of the Joint Response Unit (JRU) in Kent.
26	The JRU sees paramedics and police responding to emergencies together on a vehicle and being targeted towards particular incidents which are likely to benefit from the skills of both services.
27	Following the success of the first series, the second series will include 15 episodes and provides an excellent opportunity to focus on the specific work of the JRU, clearly demonstrating the skill, compassion and care undertaken by all colleagues every day as well as the strong working relationship between Kent Police and ambulance colleagues.
28	**Brighton Pride** It was great to see a fantastic turn-out, once again, in early August for Brighton Pride, with more than 100 SECAmb staff and volunteers and representatives from other national ambulance LGBT+ networks taking part in the parade.

29	The parade also saw the first appearance of our specially decorated 'Pride ambulance', made possible through the support of some of our suppliers and our GMB and Unison unions.
30	Well done to everyone involved – a great opportunity to celebrate diversity across our service with our local community.
	B. Regional Issues
31	**East EOC re-located to Medway** Earlier this month, we saw our new multi-purpose ambulance and contact centre in Gillingham become fully operational when our East Emergency Operations Centre (EOC) team moved in, joining their frontline road and NHS 111 colleagues.
32	The new centre provides us with much improved facilities for our control room staff and provides greater capacity, resilience and operational flexibility, as well as bring local recruitment opportunities across both 999 and 111 services.
33	The move marked the end of more than 36 years of 999 call taking and ambulance dispatch in Coxheath near Maidstone and, although I know the end of an era brings a touch of sadness for some, the new space and facilities available at Medway are long overdue.
34	I'm delighted we are at the point where all three aspects of the centre will be fully functioning under the one roof, and this marks the end of many years of planning and hard work. I would like to thank all those who have been involved in delivering such a major project. Our staff and, in turn, our patients, will benefit from the development and I wish my colleagues well in their new home.
35	**Clinical Co-ordination Hub trial** In early September 2023, we begun the trial of a new Hub, which brings together support from a number of NHS partners to provide additional support to our clinicians. In turn, this will help to ensure patients are receiving the most appropriate treatment and care for their needs and avoiding unnecessary transport to hospital.
36	The Hub, located at a Kent Community Health NHS Foundation Trust (KCHFT) site next to Maidstone Hospital, consists of SECAmb Paramedic Practitioners, (PPs), as well as clinicians from Maidstone and Tunbridge Wells NHS Trust (MTW) and urgent care teams, including the Home Treatment Service, at KCHFT.
37	The Hub will work with ambulance crews to decide whether a patient requires transport to the emergency departments at Maidstone or Tunbridge Wells Hospitals or could receive more appropriate treatment from an equivalent community service.
38	The aim is to ensure patients get the right care, in the right place, first time and I am very much looking forward to seeing the results of the trial and, if successful, understanding how we can apply this approach across other areas in our region.

39	**External review of HART/SORT/Resilience** We have now received the first draft of the external review into the Resilience and Specialist Operations department that I commissioned earlier this year, following a number of issues being raised.
40	Following finalisation of the report, I will work with the teams involved to ensure we are addressing the findings to ensure we have a sustainable and properly funded model moving forwards.
41	**External IT Review** An external IT review was commissioned in June 2023 to look at recent network outages and the resilience of our Computer Aided Despatch (CAD) system.
42	This review has been widened recently to also include governance, how the team works and human factors to make it a holistic review of IT within SECAmb. Saba Sadiq, our Chief Finance Officer is the Executive Lead for this work and will report back to the Board in due course.
43	**Medicines Distribution Centre** At our last meeting in August I updated the Board on the challenges faced by colleagues working out of the Medicines Distribution facility in Paddock Wood and that options were being considered on how to provide this service sustainably going forward. These options suggest that we will need to relocate the facility probably to a bespoke unit. In the meantime, work needs to be done in Paddock Wood to make the current facility workable. Immediate actions include the installation of a goods lift.
	C. National Issues
44	**Pulse Survey results published** In early August 2023, the results of the National Quarterly Pulse Survey (NQPS) for Quarter 2 (carried out in July 2023) were published.
45	We saw 902 colleagues complete the survey, giving a response rate of close to 20% - our highest response rate to date and one which well exceeds the national average for NHS Trusts.
46	We also saw some encouraging signs of improvement compared to previous SECAmb scores: • Our Employee Engagement score (calculated from advocacy, involvement and motivation questions) is the highest we have seen in any wave of the NQPS and exceeded the average for the ambulance sector for the first time • The number of colleagues feeling positive has outweighed the number feeling negative for the first time • Core metrics (team support, feeling informed, and proactive action on wellbeing) show significant improvement in each area

47	While we know we have a long way to go to make SECAmb the best place it can be for all of our people, the latest results do show improvement in all areas.
48	**Visit by Health & Safety Executive (HSE)** On 26 September 2023, the HSE visited SECAmb as part of their national programme of visits.
49	They had two particular areas of focus: • MSK (Musculoskeletal) issues experienced by staff • Violence and abuse of staff
50	We were asked to share information regarding the measures we have in place to address both of these areas and how we review and monitor the effectiveness of these measures.
51	As this visit is part of a wider national review, we expect to hear more about their findings and overarching themes in coming months.
52	**Freedom to Speak Up month** October is national Freedom to Speak Up (FTSU) month and as part of our work to raise the importance of this internally, our senior leaders are sharing their own 'pledges' on what they will do, personally, to support this important agenda.
53	I am very happy to share my own pledge here – "I pledge to do all that I can to make SECAMB a place where speaking up is welcomed and all our leaders think it is a core part of their roles both to speak up themselves and encourage their teams to do so."
54	Ensuring that all colleagues feel able to speak up and, importantly, that we will listen and take action where needed is a key part of our improvement journey and one I am committed to supporting whenever possible.
	D. Escalation to the Board
55	**Operational Performance** Ambulance services across the country continue to work hard to deliver responsive and good quality care to those we service. However the national position remains challenged in terms of meeting the required performance levels for call handling and response times.
56	Year to date, SECAMB continues to hit the C2 performance target. This is an excellent achievement given the national context. Further, our hospital handover times continue to be among the best in the country.
57	The position is more challenged when we consider call answering times. Key drivers of underperformance include the recruitment and retention of staff in the West. I have asked the Executive Team to review our options as this picture has become persistent.

58	The situation is similar for 111 providers who are experiencing high numbers of calls, resulting in inconsistent service levels, often impacted by local and national issues such as the recent industrial action.
59	The additional national funding secured is being used as planned with good progress, particularly relating to providing additional clinical support in EOC and in field operations. More information on this will be provided by colleagues as they present their reports.
60	We remain at REAP Level 3 but continue to keep this under close review.

South East Coast Ambulance Service NHS Foundation Trust

	Agenda No	51-23
Name of meeting	Trust Board	
Date	05.10.2023	
Name of paper	Board Assurance Framework (BAF) 2023 24	
Author	Peter Lee, Company Secretary	

The BAF 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.

An aggregated assessment against the Objectives within each Goals is RAG-rated, as illustrated below.

The Board is asked to specifically note the following:

1. The target for Responsive Care Objective 2 (call answer) was Q2. This objective has therefore not been achieved and the corrective action being taken is described in the separate paper provided.
2. Cyber Security has been escalated to the BAF – section 2 (strategic risks).
3. Amendments have been made to the RSP Exit Criteria since the last meeting in August. This followed a review between the Trust, the ICS and NHS England.

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

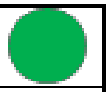
The focus of each Board committee is informed by this BAF to help oversee delivery and management of the key risks, as set out in each of the committee annual plans.

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:

QI 1:

The timescales for implementing the identified improvements for the Keeping Patients Safe in the Stack QI project have been revised, now applying two phases that allow for capacity within the operational and critical systems teams who have had to prioritise other projects including C2 segmentation and the move to Medway MRC. Phase 1 initial improvements will commence from 01 November 2023, and the more complex improvements are planned to go live in Q4 23/24.

QI 2:

The QI Strategy has been signed off by the Trust Board. The QI team have hosted one of three planned 30-minute virtual sessions to introduce the QI strategy across the organisation. Further planned engagement session are taking place over the next couple of months.

QI 3:

Year to Date, we have trained 147 (30%) colleagues in 'Introduction to QI'. Training evaluation suggests that this is significantly improving people's motivation, confidence, and competence in QI, evidenced in requests for the team to support over 7 local QI projects across the Trust. The QI team have commenced delivery of a QI induction session at the corporate induction for operational colleagues.

Goal 1		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	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 has identified high impact easy to implement initiatives to implement imminently. • People are given specific tasks to complete even if not attending project meetings. • Revised timescales for high impact hard to implement improvements to give critical systems time to complete other high priority initiatives.				
		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				
	• To date 54 colleagues across EOC, 111 and field Ops have attended the QI sessions with 373 still to be trained. • Discussions are being had with the SLT of the Operations directorate, with a plan to include QI training in key skills sessions for 111 & EOC colleagues. • Plans are in place for the QI team to attend several Team C meetings within this financial year to support training for operational leadership teams.				

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 approved by QGG.
- Trust patient safety priorities identified, and full plan will be presented to Board in Q3. Plan shared at Board development session, by way of introduction.
- National standards for training and competencies established and a paper has been presented to Education Training and Development Group. An external provider will be required at a cost to the Trust. Improvement case submitted to support funding for this.
- Trust wide communications and engagement plan being prepared for launch in September that include webinars, printed materials, and inclusion on the 'Big Conversation'.
- Continued BI support is being provided for the analysis and identification of learning themes.

- Membership and agenda for systems-based Incident review groups that replace centralised SIG have been developed as part of a wider multidisciplinary team and TOR are 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 1-1 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 and Clinical Leads identified and in place by end of Q3 Quality & Clinical Governance Group relaunched in assurance-focused format in October 2023, for formal evaluation in March 2024 All five elements in place, connected and functioning by end of Q4	Q4
	QI 8	**A Quality compliance and Engagement Framework through local visits, that helps us assure the improvement we are making (QA&E visits)**	
	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
- First iteration of the EOC quality report has been developed and made available to EOC teams - 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 being implemented for reformatting the Trust-wide Quality & Clinical Governance Group (QCGG) integrating Clinical, Operations and Quality in assurance across the KLOE
- Quality leads and Clinical leads established for the System Based Clinical and Quality Groups.
- Agenda and TOR completed for SCQGG, and initial meeting dates organised.
- 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:

- Five successful visits have now taken place since commencement in April, to Banstead, Chertsey, Thanet, Worthing, and Ashford with very positive evaluations from staff and visitors alike.
- Two-way feedback is provided within two weeks to OUs for further dissemination and setting of corrective actions. This information is then fed back into monthly Q&P reviews.
- Further iterative co-design changes have been made to the format of the QA&EV receiving evaluation from all staff and visitors.
- Full years programme plans are now with Directorates, commissioners, and Governors with very good engagement.
- Pre-visit briefings have been developed and implemented with wider teams to assess weightings in KLOE. This is an improving model as more data becomes available.
- We are involving wider group of staff in visits and capturing feedback from those in the Units as well as the visitors. ICB and external stakeholders are involved in the process and successful feedback has been obtained.
- Thematic Analysis completed on the first four visits undertaken to identify common themes, trends, and challenges at a systemic level.
- Paper presented at joint leadership forum on the above thematic analysis with recommendations shared.
- Update on process and outcomes of visits being presented at the next Surrey Heartlands contract review meeting and QPSC.
- The proposed model for feedback to corporate functions is under development and discussions are being held with HR directorate to ensure that work isn't duplicated with the leadership visits.

Goal 3	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	QI 7 Dashboard not developed by end of Q2 thereby stalling the commencement of integrated Performance & Quality Reviews.	[3X3+9]	3X2=6	3X1=3
	Mitigation			
	Close working with BI to obtain a minimum data set that enables the conversation to commence, while further metrics are collated. BI have dedicated 2 WTE of senior analyst resource solely to this work.			
	Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
	QI 8 Lack of engagement with staff who may regard this as a punitive exercise rather than an engagement and supportive tool	[4X3=12]	4X2=8	4X1=4
	Mitigation			
	• Continuous co-design with operations staff at all levels of the organisation • Set out comprehensive communication plan to keep high awareness, draw out learning and the 'so what' factor, and keep colleagues updated on progress. • Bespoke approaches to different stakeholders. • Follow-up of actions for wider Trust with regular feedback. • Work with Directorate BSM to identify a cohort of 6-7 visitors for each of the visit days in advance			

People & Culture

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

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

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

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

Communication package developed and new space created on Staff Zone.

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

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

Goal 2		Making internal processes effective	
In Year Objectives	**PC5**	**Supporting our leaders completing appraisals by actively removing blockers**	
	Measure	Appraisals > 85%	Q4
	PC6	**We will give our managers the time to prioritise 1:1s**	
	Measure	1:1s happening for all colleagues measured through Leadership/Quality Visits	Q1-4
	PC7	**Project to analyse and make changes to improve compliance against overruns**	
	Measure	Reduction in LSO% and Mean overrun time	Q2
	PC8	**Continue to deliver the fundamentals leadership training for first-line managers**	
	Measure	>95% completion of first line management fundamentals	Q4

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

Progress to-date:
Define "1:1" and communicate with our people - draft statement in discussion.

A Task & Finish group will be established to recommend how all our people will have access to at least 30 minutes of 1:1 time with their manager per month and explore options for recording and reporting the interactions. – to commence in Q2.

PC7: Late Sign-off and over-runs
Progress continues with additional paper presented to the People Committee demonstrating improvement in both duration and proportion of shifts registering an over-run. There is some correlation in the improvement since early July with the completion in the implementation of the new rotas in field operations.

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	Programme underway to understand the contributing factors, however the risk relates to being able to create localised targets and trajectories with associated delivery plans.	3x3=9	3x3=9	3x1=3
Mitigation				
	Risk Description	**Initial Score C + L**	**Current Score C + L**	**Target Score C + L**
PC8	Nil current risks identified, action on track			
Mitigation				

In Year Risks to achieving the objectives

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

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

Progress to-date
PC12 - First mediation meeting held in June.

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

Responsive Care

Goal 1		Deliver safe, effective, and timely response times for our patients	
In Year Objective	**RC 1**	**A Category 2 Mean response time that is improved and closer to National Standards**	
	Measure	Mean C2 response time of 30 minutes	Q1-4
	RC 2	**A Call Answer Mean time of 10 seconds**	
	Measure	Mean Call Answer time of 5 seconds	Q1
	RC 3	**Implementation of dispatch improvement actions to improve effectiveness of resource utilisation (RPI, cross-border working)**	
	Measure	Trust wide mean target of 84% activity completed by own desk resources, and with a reduction in variation to less than 20% between the max and min performance	Q3

Progress to-date:

- RC1: C2 mean of 26mins 43secs (August), noting YTD (to 27/09/23) C2 to of 28mins 12secs.
- RC2: Call answering mean 24secs (August).
- RC3: Mean activity on own dispatch desk 100.4%, with a maximum variation at 38.7% with a consistent pattern of those areas who both 'export' and 'import' resource.

Focus on improving performance through actions to optimise capacity:

1. General
    - Reduction in sickness – improvements particularly seen in Field Operations approx. 7% for Q1 to date, whilst EOC remains at approx. 10%
2. Emergency Operations Centre
    - Recruitment of EMA continues to be a challenge but there has been some initial tentative increases in potential candidates in the Medway/Gillingham area as a result of some very well publicised larger recruitment events.
    - A comprehensive action plan is in place to mitigate the risk relating to call answering because of the staffing challenge in EOC – this is covered in the additional presentation at Trust Board in October.
3. Field operations
    - The full suite of new rotas was implemented by the 10th July. The DCA compliance of provision against plan in August was over 90% - an improvement on previous months. A review of the impacts of the rota implementation is being scoped to be able to evidence the level of benefits realised.
    - As seen in the IQR, there is continued improvement in overall job cycle time both in terms of time on scene and wrap-up.
    - Continued collaborative working with Acute partners focusing on hospital handovers has seen an average daily handover in August of 17mins 13secs with 50.4% occurring within the optimal 15mins and 0.8% at over 60mins.
    - The additional short term additional finances have resulted in an approx. increase of 1000hrs per month for DCA cover at key times – this is against a target of 1600hrs per week.

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.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
	Mitigations				
	• Additional scrutiny through EMB relating specifically to the call answering risk. Monthly performance reporting to EMB will provide assurance on progress of actions and associated impacts. • 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 October 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 August was 12.1% in - this places SECAmb 4th out of the 11 English ambulance trusts, a significant improvement over previous months.
- 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.
- C2 segmentation commenced on 06/09/23 with initial positive results contributing to improvements in hear and treat levels.

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%. 92% of attendees report that they

have completed the day and now feel more confident about responding to major & complex incidents.
- 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.
    - Paramedic Practitioner cohort to complete additional training to utilise the PACCs system to provide support for clinical callbacks
    - 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

In addition:
- Continue to engage with national programmes as listed – senior leaders in all service lines are involved in ongoing developments.

In Year Risks to achieving the objectives	Goal 2	Risk Description	Initial Score	Current Score	Target Score
	RC4	Inability to create additional capacity to support the delivery of the increase in 'hear and treat' rate.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
	Mitigation				
	• Implementation of Operational Change Portfolio Group with all programmes moving to a more robust oversight and accountability approach – linked to the efficiencies programme. • Whilst improvements are being seen, the sustainability of this is dependent on longer term workforce plans.				
		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:
  - LSO performance and improvements presented in a paper to the People Committee in September demonstrating an improvement from the start of the year as well as since the implementation of the new field operations rotas in early July.
  - ODOOS is an area being considered as part of a wider workstream relating to tactical hub/management – further details to be provided at a later date.
- RC8: All services are now live at the Medway site – EOC moved in
- 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.
- 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	Capacity to progress this work with an evidence-based approach in an appropriate timescale.	3 x 4 = 12	3 x 4 = 12	3 x 2 = 6
	Mitigation				
		Risk Description	**Initial Score**	**Current Score**	**Target Score**
	RC8	None – fully complete			
	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				
	(Update April) 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. **(Update October)** – this risk is now considered retired as the procurement lots have been returned and we will have several options and builds to choose from as part of the updated national fleet specification that we have been involved in developing.			

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 **Amber** because we have been delayed in starting the programme due to delays associated to the procurement process and award. The delay is of 7 weeks, and we have progressed work internally without external support in the meantime to provide mitigation. This includes the development of a Clinical Case for Change through engagement and workshops between clinical and operational managers, and using detailed patient analysis we have developed from our own data.

We now have a partner on-board and at the time of writing (25/09), we are kicking off with them to map out the detailed programme.

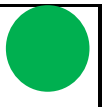
The programme has initially been revised at the advice of the core team and stakeholders involved, whilst we will still aim for draft options in December, the Board is likely to receive a developed option with high level delivery roadmap in February, with a full strategy ready for publication by the end of March 2024. (Previously we aimed to sign off a direction of travel in December, with a publishable Strategy in February). This programme with be reviewed, however the programme team have recommended adjusting the original milestones to ensure meaningful engagement can take place.

Progress to date:

- Extensive engagement has been completed with multiple key stakeholder groups. The procurement has now finalised and we have on-boarded a partner to help us deliver this work.
- 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)
- Development of a Clinical Case for Change following 4 workshops (1x with ICBs and 3x with our clinical and operational managers)

- Board Development session with clinical and operations managers in September to confirm and test the clinical case for change.
- Clinical case for change will be presented to commissioners in 3x individual ICB workshops in early October, including overlay with their individual Joint Forward Plans and Strategies, as part of the Diagnostic phase.

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. (retired risk)~~	~~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**
	SP1/SP2	Delays to the procurement process (c. 7 week) impacting our programme timeline and ability to meaningfully engage stakeholders as part of the development of the strategy	4x3=12	4x2= 8	3X2=6
	Mitigation				
	- We have started the work without external support by developing a strong evidence-based clinical case for change with our clinicians. - The programme is being re-viewed in light of the new start time. - The new key milestone dates are to have a draft direction of travel (end of stage 2) by December, however this may still require further work in the new calendar year and may not be ready by the public Board time in December. - It is still the plan that a Strategy will be published this FY with a 5-year delivery plan, including workforce and financial plans.			

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 Q4.

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.

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 C + L**	**Current Score C + L**	**Target Score C + L**
	SP5	See BAF Strategic Risk 255			
	Mitigation				

Goal 3		**Become a Sustainable Urgent and Emergency healthcare provider**	
In Year Objectives	**SP 6**	**Meet our financial plan 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:
At M5 (August) year-to-date the Trust's financial performance is in line with the financial plan with a surplus of £0.3m. The efficiency programme has delivered £1.6m of efficiencies which is £0.6m behind plan. There is a continued focus on ensuring that the Trust delivers its efficiency programme with a workshop to be held in October 2023 to support this as well as weekly check and challenge sessions.

The Trust is forecasting delivery of its 2023/24 financial plan.

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.

The following sustainability projects are currently underway as part of our Green Plan for this year:

- Electric SRV Trial as part of the national Zero Emissions EV Trial for Ambulances
- Removal of single-use cups from SECAmb stations
- Switch to purchase low/zero carbon electricity through our supplier

In addition, in Q1 the Green Staff Network has been established. The group is now meeting regularly with the support of a NED and an Executive sponsor from the Board.

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 that 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 has been developed with progress being made on mitigating the identified issues.				
	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				
There is a weekly check and challenge session taking place ensuring that there is continued focus on delivering efficiencies. In addition, a workshop will be held in October 2023 for the Joint Leadership Team where the focus will be on identifying further efficiencies as well as unlocking issues to be able to support delivery of those schemes already in the efficiency programme.				
	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 10 year 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			Aug 22	Sep 22	Dec 22	Feb 22	Apr 22	June 23	Aug 23	Oct 23			
14	*Operating Model*	QPSC	-	-	1-3	1-3		20	16	20	20	20	20	20	20	20	⇔	08	Mar 24
255	*Workforce Plan*	PC	-	-	1-3	1		20		16	16	16	16	16	16	16	⇔	08	April 24
348	*Culture & Leadership*	PC	-	1-3	-	-		16			16	16	16	16	16	16	⇔	08	Tbc
16	*Financial Sustainability*	FIC	-	-	-	3		16	12	16	16	16	12	12	12	12	⇔	08	April 24
	Cyber Security	FIC														20	NEW	08	Mar 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.

Link to Risk 13 – Workforce Retention.

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		
	Specific risks relating to EMA recruitment and retention are on the risk register and have been reviewed in light of the on-going staffing and performance challenges.		

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.

	BAF Risk ID Cyber Security	Target Date: 31st March 2024

Underlying Cause / Source of Risk:		
There is a risk of loss of data or system outage due to a cyber-attack resulting in significant service disruption and harm to patients. Links to risks ID 70 – Cyber Training. ID 398 – Cyber Incident Response Plan	**Accountable Director**	Chief Finance Officer
	Committee	Finance & Investment
	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
• Firewalls are in place to protect the Trust's network perimeter and control inbound / outbound traffic flow. • Permissions are based on least-privilege with staff only being given access to what they need as a minimum. Any request for increased permissions are logged and approved via Marval. • Anti-virus / anti-malware is installed on server and laptop / desktop hardware and regularly automatically updated. • Servers and laptops / desktops are patched regularly. • The Trust and its CAD vendor are alerted to specific risks by NHS Digital to enable us to take swift resolution in and out of hours. • The Trust is able to respond to cybersecurity alerts concerning specific devices and works to immediately disable impacted devices and accounts. • The Trust is using NHS Secure Boundary and Imperva to protect the Trust network perimeter and some external-facing services. • Yearly penetration tests are completed by a third party to identify vulnerabilities in the IT estate. • Social engineering tests are conducted yearly to test corporate users willingness to compromise their accounts, devices or physical security. • Periodic cyber-attack exercises carried out by NHS Digital and the Trust's EPRR lead. • Remote monitoring of endpoints by Sophos Managed Detection and Response service	N/A		

Gaps in Control

- The Trust is not fully compliant with the DPST.
- There is no business continuity plan for a cybersecurity attack.
- There is no programme of training or awareness aimed at users on cybersecurity.
- There is no identity verification for in-person or telephone users approaching IT for support.
- There is no security on-call team.
- A standardised action card does not exist to explain the initial handling of a Trust wide cybersecurity event.

- A standardised action card does not exist to explain how the initial response to a cybersecurity event involving a single user or device should be handled.
- The Trust is particularly vulnerable to social engineering attacks.

Sources of Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) The Trust is partially compliant with the DSPT. (-) As the Trust is not fully compliant with the DSPT there is more work that it will need to do to ensure compliance. (-) The external IT review identifies cyber security as a risk.	Cyber security team has not had access to the relevant training.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
An external IT review was commissioned. The report will be delivered by end of September and will include a finding on cyber security which will enable traction on this issue and that it is followed up and improvements made.	CFO	March 2024	Report yet to be delivered at the time of writing this.
A penetration testing report was commissioned. This report identified issues.	CFO	March 2024	Improvement plan in development

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
Summary of Controls: 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.* Link to Risk 82 – HART capacity	20	16	06	Head of EPRR
Summary of Controls: LRF plans are in place; Incident response plans are in place for major incidents & MTA incidents; Card and plans are in place for a list of specific sites; Exercises with partner agencies run on a local basis to test plans and build relationships. **Board Oversight**: Audit & Risk Committee – see Board Report in December with assurance obtained following the EPRR Core Standards rating of 'substantial compliance'. Following concerns raised mid-year and external review was undertaken and due to report to the Board in Q3.					
447	**999 Call Handling Delays** *The Ambulance Response Programme (ARP) targets for call answering are not being consistently achieved due to recruitment challenges, high staff turnover and low call*	16	16	04	AD of 111 / EOC

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
	performance. This results in risks to patient safety, clinical effectiveness, patient experience, colleague experience and Trust reputation.				
Summary of Controls: Recruitment support including additional paid advertising; re-design of advert and use of external agencies; staff support given to HR Recruitment; and redesigned interview templates to be more robust; Part-time and non-core rotas introduced to support demand and work/life balance. **Board Oversight**: Quality & Patient Safety Committee – see Escalation Report from the most recent meeting. 999 call answer is a specific Board agenda item.					
346	**999 Handover Delays** *There is a risk of delayed patient handovers as a result of acute Trusts having limited capacity to readily accept new patients from crews during periods of demand, which may lead to patient harm.*	16	16	08	Head of Strategic Partnerships
Summary of Controls: Maximising alternative pathways to reduce conveyance. Working with acute Trusts to define process. **Board Oversight**: FIC – reviews operational performance at each meeting. There is current good assurance that this risk is being managed effectively. The next review will establish if the risk score should be reduced.					
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
Summary of Controls: 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					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
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. Board Seminar held in August 2023.					
34	**Sustainability in the Medicines Governance Team** There is a risk that medicines orders will not be met at the medicines distribution centre (MDC) due to increasing demand placed on staff at the MDC and the lack of resilience stock which may lead to areas in the Trust not having adequate amount of medicines to stock vehicles and patients not receiving medication. There is also a risk that other medicines portfolio work (eg PGD reviews) will not take place as a result of ongoing vacancy in the clinical pharmacist post which may lead to poor medicines optimisation and progression of any service improvement work in medicines.	12	**16**	08	Chief Pharmacist
Summary of Controls: 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. All medicines risks reviewed in March 2023. Update on the MDC provided in August – see Board report				
27	**Clinical Risk at Medicines Distribution Centre due to Increasing Demand and Lack of Space in the Unit** *The medicines distribution unit (MDC) at Paddock Wood MRC is insufficient in size to support the volume of activity now being processed through the unit. There is insufficient space to allow at times of high demand segregation between receipt and dispatch areas and processes to maintain control inbound/outbound goods are unmanageable. There is a risk that due to this lack of space and segregation of processes at the MDC, out of date medicines can be sent back out to station sites which may lead to potential harm to our patients. This risk is also linked to Health and Safety risk ID 760..*	15	15	03	Chief Pharmacist
Summary of Controls: Acquired a room on the GF to try and address some of the capacity issues with space. Recruitment is underway for resources for medicines team which includes registered pharmacy technicians to support with mapping out limited space we have and are available at all times during opening hours for queries. Business case agreed to install a new lift and longer term a search is underway for new premises.					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
Board Oversight: Quality & Patient Safety Committee. All medicines risks reviewed in March 2023. Update on the MDC provided in August – see Board report.					
136	**Process of tagging medicines pouches is not working effectively** *There is a risk medicines will not be available for the patient if paramedics are incorrectly completing paperwork following their daily assurance checks. Incomplete or incorrect paperwork leads to pouch tagging errors and there is a risk that the medicine will not be in the right place at the right time for the next Paramedic and patient due to incorrect tagging.*	15	15	03	Chief Pharmacist
Summary of Controls: Monthly report on tagging errors are presented to MGG; Due to operational activity and skill mix there is usually more than one pouch available on scene thereby reducing the risk that medicines is not available for patients; Business case approved to resource a fixed term Pharmacist in medicines team to support with extensive pouch review;. Fixed term Pharmacist and medicines project manager now in place to perform medicines pouch review and implement new systems where required; Pouch review commenced. **Board Oversight**: Quality & Patient Safety Committee. All medicines risks reviewed in March 2023. Update on the MDC provided in August – see Board report.					
360	**Clinical Education Estate** *As a result of increasing demand for educational courses and likely reduction of size of existing Clinical Education facilities, there will be insufficient / inadequate facilities to deliver the Clinical Education Training plan, which would lead to a negative impact on Workforce numbers, reduction in colleague satisfaction, and an inability to meet contractual obligations for course delivery.*	12	15	04	Head of Clinical Education
Summary of Controls: The Current CEC generally provides sufficient space for educational activity as planned against last year's workforce plan, although does require some variation in delivery dates in order to minimise pressure points; Alternative locations for 'satellite' delivery sites are currently being explored to provide resilience; Increase available teaching space for this year's increased requirement; provide an alternative site in case the available space at Haywards Heath reduces and minimise the impact of travel on course candidates. **Board Oversight**:					

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 fulfilment. **Note – the RSP Exit criteria was reviewed by NHSE and the below reflect the updated criteria, meaning there's some areas that do not have a prior rating.**

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-S1	To have developed, through a rigorous system of engagement, a Board approved strategy that reaches beyond the next 5 years.	**Achieved:** Selected a partner to help deliver the plan for the strategy, developed strong case for change using patient data and engaging with operational and clinical managers. This case was presented at and approved by the Board. The Boards involvement incudes improving governance, aligning the strategy with Integrated Care Systems, conducting sessions with the Unions to address concerns, actively engaging with staff networks, and establishing a people engagement through Council of Governors Meeting to ensure effective communication, feedback and support for our workforce as we implement the strategy. **Plan to exit:** By Q4 we aim to develop a comprehensive strategy encompassing a 5-year delivery plan, workforce plan, target operations model and a sustainable financial plan	n/a	**New**
RSP-D1 (previously RSP-L1)	Interim CEO appointed and the Trust's Board-level leadership seen as stable by the Trust Chair, Surrey Heartlands ICB and NHS England.	**Achieved**: A substantive CEO is in place, and we acknowledge that it takes time to establish board cohesion. We are actively addressing these concerns, which are a natural part of the boards evolving dynamics. **Plan to exit**: The development of a Trust-wide strategy will establish a clear vision to enhance SECAmbs resilience in the face of changes at Board and Executive level. An Executive structure review is scheduled for Q3/4 to facilitate the Strategy's implementation.		↑

		There will be a declaration of a new chair post, chief medical post, and Non-Executive Director changes. The CEO will also conclude structural conversations to define responsibilities and Directorate objectives in alignment with the ongoing Strategy development		
RSP-D2 (previously RSP-L6)	External Well-Led review co-commissioned and all key recommendations acted on effectively.	**Achieved:** In Q4 22/23, a review of Board effectiveness and leadership was conducted by NHSE Improvement Director. All recommended actions have been adopted, are actively monitored by the relevant committees and the Board and have been integrated into the Board Development Plan for 23/24. The ToR for the Well-Led Review were approved by the Strategic Advisory Meeting (SAM) **Plan to exit:** Embedding of recommendations, sharing of the development plan with system partners for visibility and input, and finalising external WLR timeframes closer to the planned exit date of March 24. We will also conduct a review our progress, assess which recommendations were implemented, evaluate our overall progress, and ensure our preparedness for compliance. A quality compliance assessment will be completed to track our progress against the review and report on our readiness for Well-Led		=
RSP-D3 (New)	There is sustained improvements in executive cohesion and collaboration as measured through the well-led review.	**Achieved:** An Executive Development plan will be initiated at the end of September. Executive informal meetings have been taking place and encouraging proactive engagement without requiring CEO prompts. **Plan to exit:** At the exit date we will be half way through our 12-month Executive development plan, which will be evaluated during the Well-Led Review		**New**
RSP-C1 (previously RSP-L5)	To move towards a more open and transparent culture that values partnership and collaboration. Evidenced by improved transparency and timeliness of reporting and information sharing with ICB partners and with patients.	**Achieved:** Arrangements for evidence and data sharing in place since July 2022. Have agreed a new governance oversight model incorporating contract quality and strategic elements, however recognising further refinement is needed. This new model became operational in Sept/Oct 24. In our workforce plan discussions with ICBs, we actively engage with the Assurance Steering Group, featuring presentations from SMEs sharing both success and challenges. Furthermore, we have appointed Quality Leads, a System Lead and Clinical Leads for each system to better align with the ICB structure		=

		Plan to exit: We aim to enhance transparency with our system partners by aligning our key focus areas for the next 9 months through a joint forward plan. Additionally, we're inviting support from system SMEs to participate in our internal weekly steering group meetings. We have already embedded a strong governance framework, and our commitment to continuous improvement is reflected in our collaborative efforts in designing this approach, including engagement at the local level with CEOs and the Strategic Advisory Meeting (SAM).		
RSP-C2 (previously RSP-Q3)	To have started to see a transformation in the Speak-Up culture of the organisation. Evidenced by an appropriately resourced FTSU process that is valued by the organisation and where staff feel more able to speak-up than in 2021.	**Achieved:** We've made an investment in our Freedom to Speak Up (FTSU) team, acknowledging their capacity and training needs. This included extensive internal training, including for the Board, and the consultation stage of our Speak Up Policy, aligning it with National FTSU guidance. We've made significant improvements in data accessibility, enabling us to identify hotspot areas and take proactive measures. This data is sourced from staff surveys, evidencing our progress through improvements, and tracking via the FTSU dashboard. Ongoing discussions emphasise the importance of evidence of speaking up across various organisational levels. While we're witnessing a transformative shift in this narrative, there's still work to be done. **Plan to exit:** The impact of our actions has not yet been fully realised, with a key focus on fostering psychological safety for speaking up in our Culture Improvement plan and People Strategy. We have planned significant leadership development for first-line and middle management this year to empower our workforce to address concerns locally. We aim to reduce detriment and retaliation based on evidence and ongoing efforts. Plans are in progress to enhance FTSU governance and processes, which tie into our broader culture improvement initiatives. The aim is that staff would have the confidence to speak up without fear of detriment, receiving proportionate responses and closing cases and reducing detriment, with a significant portion of staff providing positive feedback		↑

RSP-C3 (previously RSP-P3)	The Trust has a vision for clinical leadership that is supported by a Board approved clinical education strategy.	**Achieved:** Since the agreement of BRAGG, we've received approval for Phase 1 of our Clinical Education investment program, which is currently underway. Phase 2 is also in progress. Additionally, we have invested in the Clinical Education Strategy. The Board held a development session to discuss the definition of Clinical Leadership and we will continue to review this as we establish the Clinical Education Strategy. Clinical Education Strategy has been presented and approved, providing the necessary support for the investment in the Clinical Education team. **Plan to exit:** Challenges in establishing clear career pathways stem from the absence of a workforce vision. Phase 2 of our investment is expected to align with the workforce plan, which will be developed by Q4 as part of the Trust-wide strategy. We are continuously mapping and reviewing Clinical Leadership development and its definition, incorporating a Career Ladder narrative. Structural and portfolio changes will drive this development. Defining our vision for Clinical Leadership remains a work in progress, necessitating further definition and supported actions. Engagement and evidence will be sourced from stakeholders		↑
RSP-St1 (Previously 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. Exited the WNs and MDs reviewing regularly, ICS & NHSE invited **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-G1 (previously RSP-L2)	Clear lines of responsibility and accountability for individual executives.	**Achieved**: Portfolios re-arranged in Q4 to support interim executive arrangements. Further review of exec portfolios due to commence in Sept 24.		=

		Plan to exit: The 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-G2 (previously 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:** Our annual plan and objectives feature clear SMART objectives and milestone deliverables, which are integrated into a new Business Assurance Framework (BAF) driving the Board's business cycle. While the BAF is fully relevant, we acknowledge there is ongoing work, but we have enhanced its structure through internal audits and have achieved our targets. Subcommittees are demonstrating improvements in discussions related to risk and assurance, with implementation showing positive progress. The Chairs of these subcommittees feel they have gained better insights. Notably, examples like IT and EPRR highlight areas of concern and the board oversight on risk which explains our continued “Red” status. **Plan to exit:** We need to do further work to fully embed strategic risks, which will emerge from the strategic planning process in Q3/4, and provide evidence that the Board is actively managing risks dynamically. To support this, the Board Development plan includes a facilitated session by NHS providers on July 6th, emphasising the culture of risk management and the triangulation of work. There is also a need for additional efforts in addressing known risks and their progression onto the Risk Register, as well as their effective management.		=
RSP-G3 (previously RSP-L7)	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	**Achieved:** In Q4 22/23, a review of Board effectiveness and Well-Led was conducted by an NHSE Improvement Director. All recommended actions have been adopted and are actively monitored by the relevant committees and the Board. These actions are now integral to the Board Development Plan for 23/24. We've also had valuable input from frontline colleagues and Operational Unit Managers (OUMs) sharing their experiences working for SECAmb. Our leadership development plan will support our Executives based on this feedback.		↓

		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-G4 (previously 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-G5 (previously RSP-Q2)	Improved Board oversight and clarity on safety and quality metrics, ensuring there is good triangulation between demand and capacity issues driving ARP challenges, and the impact on patients and staff.	**Achieved:** We have significantly improved internal reporting to the Board by revamping our integrated quality reporting, covering quality, people, performance, and finance. We've also developed place-level (service line) integrated quality reporting to align with the new Quality and Performance management framework and Quality Compliance visits. Additionally, we've created a transaction information schedule for meetings and enhanced our data suite. **Plan to exit:** Complete the full quality assurance cycle by Q3 and assess its effectiveness.		=
RSP-G6 (previously 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. Further knowledge established around the efficiency challenges and delivery of £9m target **Plan to exit:** To achieve efficiencies and improvements for the Cat 2 Performance gap and implement a £9m efficiency program to meet our plan. A reforecast review will provide clarity for the planning round.		=
RSP-G7 (previously RSP-F2)	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.	**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: To achieve efficiencies and improvements for the Cat 2 Performance gap and implement a £9m efficiency program to meet our plan, reaching trajectory by year-end using our reserves.		
RSP-G8 (previously RSP-F3)	Trust can evidence delivery of financial trajectories for at least two most recent quarters.	**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:** To achieve efficiencies and improvements for the Cat 2 Performance gap and implement a £9m efficiency program to meet our plan, reaching trajectory by year-end using our reserves.		=
RSP-HR1 (previously 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:** We have a well-understood workforce plan for core services, with a focus on skill mix, and it is incorporated into our 23/24 plan as part of the UEC Recovery program. Recruitment and training for field operations are on track, but there are ongoing risks in Call Centres related to a site move and retention challenges, which affect call handling times. Commissioning work is ongoing for the Workforce plan. **Plan to exit:** A system review of the workforce plan for 23/24 will shape the long-term workforce plan in alignment with the broader organisational strategy, thereby contributing to a system-wide workforce strategy consistent with the NHS workforce strategy		↑
RSP-HR2 (previously RSP-P4)	Trust consistently achieving the agreed improvement trajectory for staff retention and sickness absence.	**Achieved:** Sickness levels significantly decreased from 11% to 7% Y-o-Y. Delivering absence challenge with retention, delivering a SR plan to board **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-HR3 (previously RSP-P5)	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff	**Achieved:** HR reporting improved with clear understanding of ER caseload and challenges. Re-structure underway to create dedicated ER case management team.		=

	turnover and exit interviews: themes, trends and learning.	**Plan to exit:** Red rating remains as Trust has >111 open ER cases and will continue to do so until the trend is reverse. Improvement in board oversight with consistent reporting and engagement		
RSP-Co1 (previously RSP-L4)	Improved communication and engagement channels between the frontline and the Board, inclusive of routes of escalation for risks and concerns.	**Achieved: E**nhanced communication channels and accessibility for our workforce through the development of a Communications and Engagement Strategy with external support. Additionally, we've successfully implemented leadership visits, quality and performance management, and quality assurance visits. Investment in the Communications Team will help support the plan to exit **Plan to exit:** Embed improvements, allocate resources effectively to support frontline impact, and enhance the organisation's identity and brand as part of the strategy development process. The resourcing plan is scheduled for Q2, and we are actively implementing quality assurance frameworks.		=
RSP-Co2 (previously RSP-P1)	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	**Achieved:** Significant increase in leadership visibility and a rise in Pulse Survey responses which improved from 812 (Apr 23) to 901 (Jul 23). This positive change spans various areas including employee engagement, advocacy, involvement, motivation, colleague mood, supported by team, well informed about changes and proactive support in health and wellbeing. **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.		↑

Appendix 1 - Risk Scoring

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

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

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

	No or minimal impact of statutory guidance		Issue of statutory notice		Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non- critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim	Complaint possible Litigation unlikely Claim(s) <£10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100-£1m	High profile complaint(s) with national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of moral within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days' coverage e.g. front page, headline Regulator concern	National Media <3 days' coverage Regulator action	National media >3 days' coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

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

Appendix 2 - SPC Icon Description

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

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

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

BRAGG Rating definitions

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – October 2023

Reporting Period: July & August 2023

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

Contents

Improving Quality of Information to Board – October 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.
- 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.
- **No further changes have been included from the August 23 to October 23 period**

Alignment Framework

Trust Priorities for 23/24

Quality Improvement

We listen, we learn and improve

Responsive Care

Delivering moderns healthcare

People & Culture

Everyone is listened to, respected and well supported

Sustainability & Partnerships

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

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

Icon Descriptions

				
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
	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.
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				Special cause variation where **UP** is neither improvement nor concern.
				Special cause variation where **DOWN** is neither improvement nor concern.
				Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

Annual Plan

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

Quality Improvment

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
CFR Attendances	Aug-2023	1078		1264.8		
Harm Incidents per 1000 Incidents	Aug-2023	1.62		1.33		
Count of No Harm Incidents	Aug-2023	1251		1107.4		
Count of Low Harm Incidents	Aug-2023	163		167.55		
Count of Moderate Harm Incidents	Aug-2023	2		6.45		
Count of Severe & Death Harm Incidents	Aug-2023	3		1.8		

People & Culture

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Sickness Absence %	Aug-2023	6.8%	5%	8.82%		
Statutory & Mandatory Training Rolling Year %	Aug-2023	75.8%	85%	73.07%		
Appraisals Rolling Year %	Aug-2023	59.5%	85%	59.44%		
Freedom to Speak Up: Total Open Cases	Aug-2023	40		18.44		
Freedom to Speak up: Cases Opened in Month	Aug-2023	5	3	9.4		
Freedom to Speak up: Cases Closed in Month	Aug-2023	12		8.9		
Time to Hire - Volume (Days)	Aug-2023	200	60	122.42		
Time to Hire - Ad-Hoc (Days)	Aug-2023	90	60	72.3		

Responsive Care

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Hear & Treat %	Aug-2023	12.1%	14%	9.9%		
999 Frontline Late Finishes/Over-Runs %	Aug-2023	44.8%	45%	49.94%		
Average Late Finish/Over-Run Time	Aug-2023	00:36:00		00:39:48		
999 Call Answer Mean	Aug-2023	00:00:24	00:00:05	00:00:39		
Cat 2 Mean	Aug-2023	00:26:43	00:30:00	00:32:46		

Sustainability & Partnerships

Metric	Latest Date	Value	Target	Mean	Variation	Assurance

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

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

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Quality Improvement

QUALITY IMPROVEMENT

Summary

August 2023

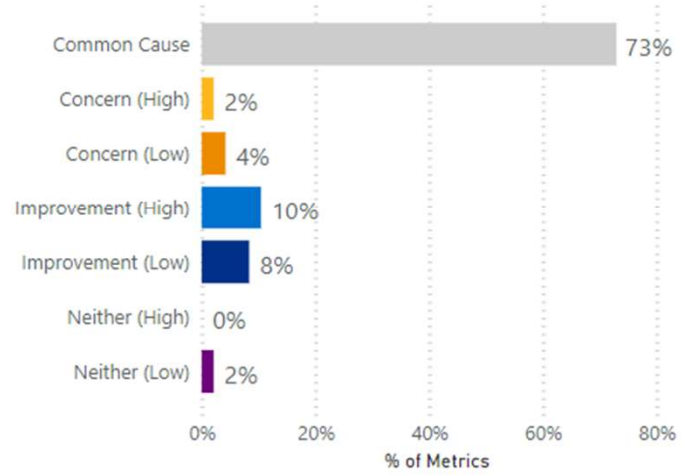
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Cardiac ROSC ALL % **Cardiac Survival ALL % Medicines Management % of Audits Completed Duty of Candour Compliance % Complaints Reporting Timeliness %	Single Witness Signature Use CDs Non-Omnicell	Complaints per 1000 999 Calls Answered Complaints 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 Hand Hygiene Compliance %	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 No Harm Incidents per 1000 Incidents Harm Incidents per 1000 Incidents Count of No Harm Incidents Count of Low Harm Incidents Count of Moderate Harm Incidents Count of Severe & Death Harm Incidents
Special Cause Concern		Safeguarding Training Completed (Children) Level 2 % **Cardiac Survival Utstein %		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.

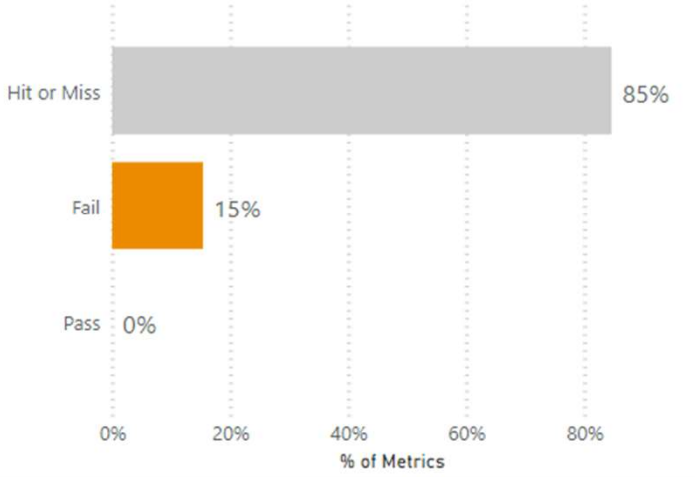
QUALITY IMPROVEMENT

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	Aug-2023	167		90.42	157.9	225.38		
Number of CD Breakages	Quality Improvement	Aug-2023	12	0	5.81	20.65	35.49		
Number of Datix Incidents	Quality Improvement	Aug-2023	1488		952.36	1411	1869.64		
Number of Incidents Reported as SIs	Quality Improvement	Aug-2023	4		-5.11	4.55	14.21		
Duty of Candour Compliance %	Quality Improvement	Aug-2023	100%	100%	66.15%	88.32%	110.48%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Aug-2023	137		61.4	109.7	158		
Number of RIDDOR Reports	Quality Improvement	Aug-2023	8		-0.82	10.8	22.42		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Aug-2023	3		11.13	40.25	69.37		
Health & Safety Incidents	Quality Improvement	Aug-2023	23		11.26	26.8	42.34		

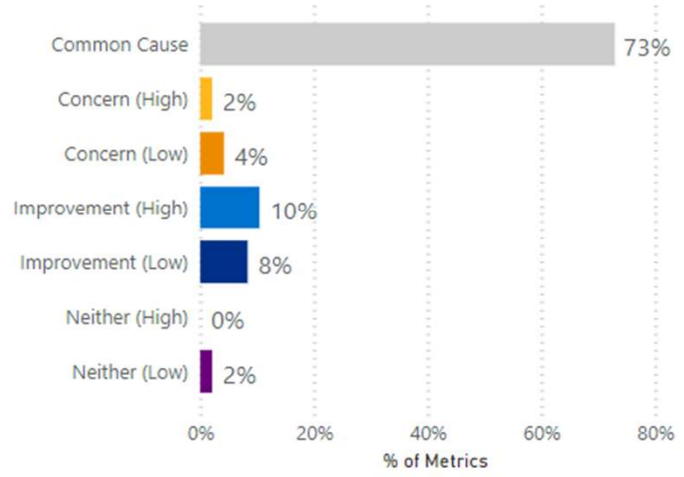
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Aug-2023	0%		-0.07%	0.02%	0.1%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Aug-2023	64%		47.12%	65.6%	84.08%		
Complaints Reporting Timeliness %	Quality Improvement	Aug-2023	100%	95%	31.29%	73.37%	115.45%		
Number of Complaints	Quality Improvement	Aug-2023	74		33.7	75	116.3		
Complaints per 1000 999 Calls Answered	Quality Improvement	Aug-2023	0.92		-189.24	104.33	397.9		
Number of Compliments	Quality Improvement	Aug-2023	200		60.61	164.67	268.72		

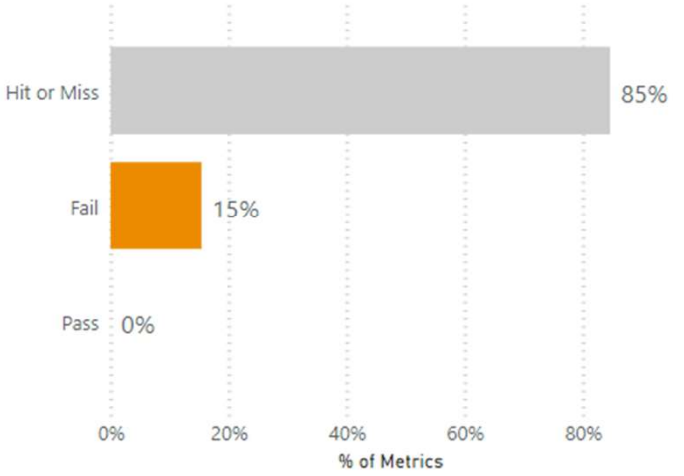
QUALITY IMPROVEMENT

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	Jul-2023	46.7%	45.1%	29.54%	48.87%	68.2%		
**Cardiac ROSC ALL %	Quality Improvement	Jul-2023	27.3%	23.8%	17.41%	26.72%	36.03%		
**Sepsis Care Bundle %	Quality Improvement	Jul-2023	88.1%	85%	82%	86.45%	90.9%		
**Cardiac Survival Utstein %	Quality Improvement	May-2023	10.6%	25.6%	6.18%	21.21%	36.24%		
**Cardiac Survival ALL %	Quality Improvement	May-2023	34.3%	9.6%	-0.24%	16.28%	32.81%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Jul-2023	65.7%	76.8%	60.27%	72.17%	84.06%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Jul-2023	74.1%	64.7%	62.49%	72.93%	83.36%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Mar-2023	02:29:00	02:22:00	02:12:48	02:34:28	02:56:08		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Mar-2023	03:28:00	03:14:00	02:51:19	03:40:32	04:29:45		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Mar-2023	01:38:00	01:29:00	01:22:17	01:40:20	01:58:23		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Mar-2023	02:35:00	02:20:00	01:46:24	02:36:56	03:27:28		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Jul-2023	98.2%	96.3%	95.53%	97.47%	99.4%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Jul-2023	92.1%	93.8%	85.7%	93.12%	100.53%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Jul-2023	80.1%	77.9%	68.11%	78.31%	88.5%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Aug-2023	105.1%		82.07%	103.59%	125.11%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Aug-2023	86.8%	100%	79%	85.33%	91.66%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Aug-2023	75.2%	100%	72.17%	89.81%	107.45%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Aug-2023	102.3%	100%	88.49%	99.18%	109.86%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Aug-2023	46.4%		12.31%	60.02%	107.73%		

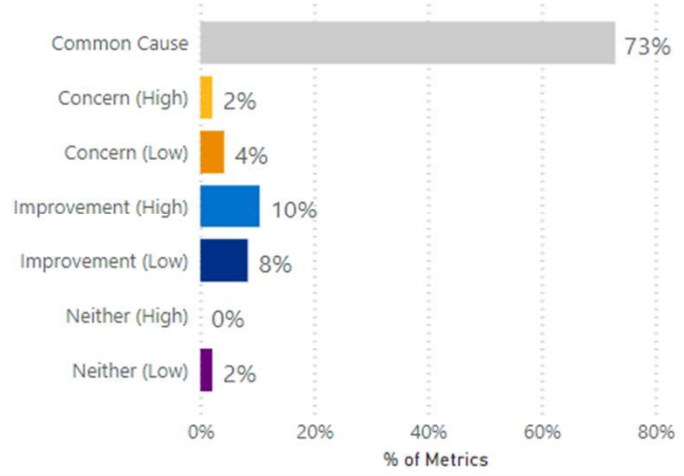
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Aug-2023	80.5%	90%	73.59%	87.27%	100.95%		
Deep Clean Compliance %	Quality Improvement	Apr-2023	91%	95%		87.44%			

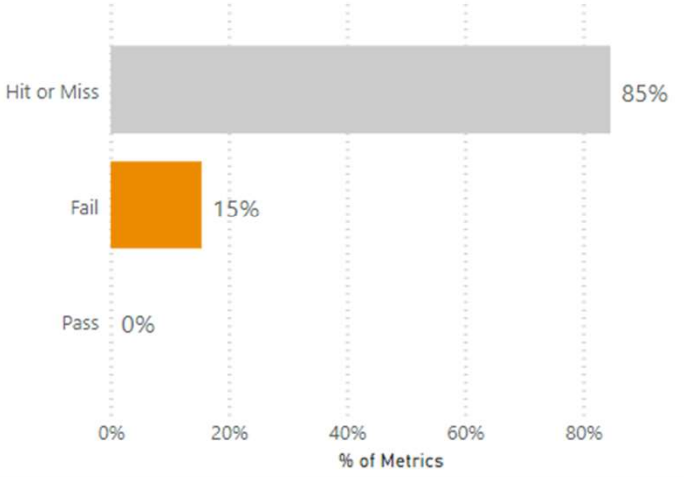
QUALITY IMPROVEMENT

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



Health & Safety

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Safeguarding Training Completed (Children) Level 2 %	Quality Improvement	Jun-2023	67.1%	85%	73.35%	79.56%	85.78%		
Safeguarding Training Completed Level 3 %	Quality Improvement	Jun-2023	44.2%	85%		59.26%			
Manual Handling Incidents	Quality Improvement	Aug-2023	26		9	27.2	45.4		
Organisational Risks Outstanding Review %	Quality Improvement	Aug-2023	4%	30%	-2.98%	39%	80.97%		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Jun-2023	44	0	17.32	42.5	67.68		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Jun-2023	26	0	8.95	75.63	142.3		
Medicines Management % of Audits Completed	Quality Improvement	Aug-2023	90.4%	100%	75.16%	88.31%	101.45%		
PGD Compliance %	Quality Improvement	Aug-2023	77.3%	100%		74.18%			
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Aug-2023	39%	100%		51.83%			

QUALITY IMPROVEMENT

SIs, Incidents, & Duty of Candour

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

Common cause variation, no significant change.

QS-1
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1488

Common cause variation, no significant change.

QS-17
Dept: Quality & Safety
IP: Quality Improvement
Latest: 3

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

QS-3
Dept: Quality & Safety
IP: Quality Improvement
Latest: 100%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

Summary

(QS-1) Non-SI incidents - The Trust continues to support an effective culture of incident reporting with a process that is in control.
(QS-17) SI actions – SI actions continue to be submitted to the directorates BSM's and action owners to ensure actions, as part of an improved process to ensure they are completed in a timely manner.
(QS-2) SI numbers – The number of incidents reported as SIs shows normal variation.
(QS-3) DoC – Due to an improved process, DoC has remained at 100% compliance for the past 6 months.

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 continues on the implementation of PSIRF which will go live in late Autumn.
- Work is ongoing on the development of the new incident module on DCIQ.

QUALITY IMPROVEMENT

Harm

QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 11.05

Common cause variation, no significant change.

QS-29
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1.62

Common cause variation, no significant change.

Summary

- An increase of No Harm per 1000 incidents reported has continued.
- The significant increase in the number of no harm incidents seen in March 2023 was due to a process change whereby NHS 111 incidents were included into the data having not been included previously. As such, this was not an improvement as potentially indicated. However, since May 2023, we have seen the number of no harm incidents continue to increase which is positive.
- In August 2023, the main theme/trend of incidents reporting No Harm was "Issues with Other Emergency/Health Services"
- There has been a slight increase in Harm per 1000 incident reported, however this figure is still inline previous months
- In August, the main theme/trend of incidents reporting Harm was "Manual Handling & Restraining Accidents"
- These figures show a continuation of the effective incident reporting culture the Trust aims to achieve.

What actions are we taking?

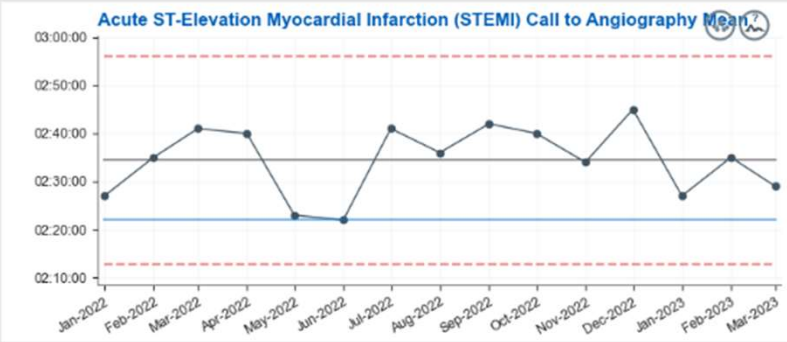
- Developing a robust mechanism of meaningful feedback to individuals / team and organisational wide learning.
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support continuous improvement.
- Continue to monitor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

QUALITY IMPROVEMENT

Impact on Patient Care - Cardiac

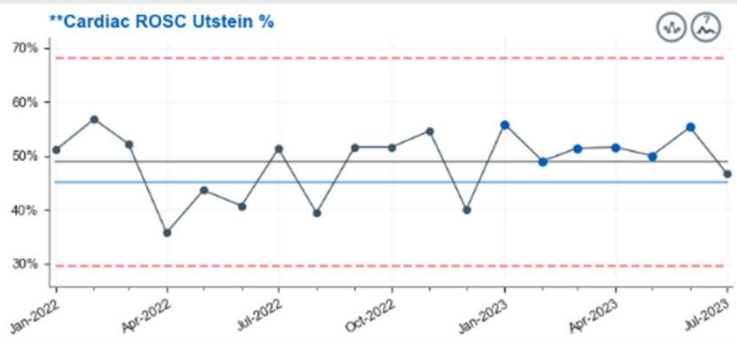
M-2

Dept: Medical
IP: Quality Improvement
Latest: 27.3%
Target: 23.8%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



M-6

Dept: Medical
IP: Quality Improvement
Latest: 02:29:00
Target: 02:22:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-1

Dept: Medical
IP: Quality Improvement
Latest: 46.7%
Target: 45.1%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

M-5

Dept: Medical
IP: Quality Improvement
Latest: 74.1%
Target: 64.7%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Cardiac Arrest Survival: – continues to demonstrate common cause variation, albeit with a mean to date above target. The annual Cardiac Arrest Report is published during Q4 reporting a validated retrospective one year sample, which provides greater accuracy. The report will provide the Board with greater insight of Trust performance, and benchmarking against other Ambulance Trusts.

STEMI Call to Angiography – continues to demonstrate common cause variation. Partly due to delays to arrival on scene and long journey times and partly due to crew behaviour on scene such as non-registrants waiting on scene for back-up, multiple attempts at ECG transmission or administration of the STEMI care bundle before leaving scene.

Acute STEMI Care Bundle Outcome: demonstrates common cause variation

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. There is a QI project underway regarding communication and time on scene for pPCI. 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

STEMI care bundle is currently being reviewed nationally and it is hoped that a bundle that has more evidence of patient benefit is forthcoming

QUALITY IMPROVEMENT

Medicines Management (1 of 2)

MM-1

Dept: Medicines Management
IP: Quality Improvement
Latest: 167

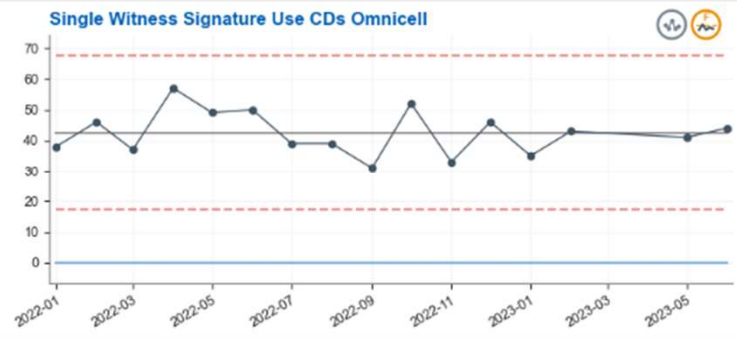
Special cause of a concerning nature where the measure is significantly HIGHER.

MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 90.4%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 12
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



MM-3

Dept: Medicines Management
IP: Quality Improvement
Latest: 44
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

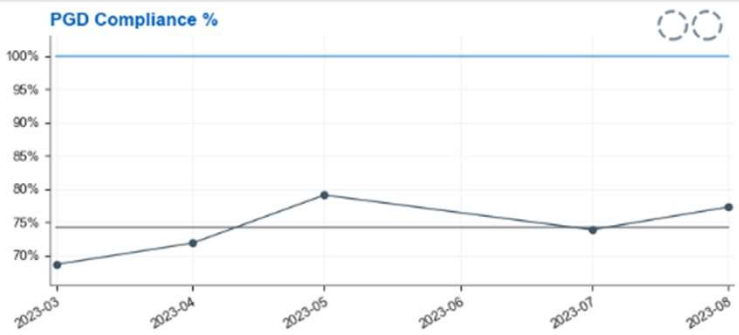
Summary

Note: Work is ongoing around reporting medicines incidents. Key skills 2023/24 has medicines in its lesson plan so this will be reported on going forward for assurance and oversight in the Trust.
Non compliance to medicines audits has improved over time. 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 awaiting Power BI to update.
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. MedX (new Omnicell technology) will be introduced into the Trust by December 2023, this will support single signature witness checks at Omnicell sites.

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. Medicines team awaiting on timeline for this change in reporting.
PGD workplan and CQC 'must dos' all progressing forward.
Medicines Safety Officer (MSO) role currently being advertised for medicines team. This post holder will focus on patient safety and medicines incidents and learning.
MedX training being conducting in each OU with OTLs. MedX rollout planned for December 2023 which will support all reporting around CD activity in the Trust.

QUALITY IMPROVEMENT Medicines Management (2 of 2)



MM-8
Dept: Medicines Management
IP: Quality Improvement
Latest: 77.3%
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: 39%
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 decline in medicines pouches available for medicines orders at the MDC . Resilience stock has decreased due to vacancies within the team and annual leave during the summer. 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. The MDC is not fit for purpose and there is not enough room in the unit to store the quantity of stock required to provide resilience across the Trust.

Patient Group Direction (PGD) Compliance in line with MD11 is continuously been monitored. The percentage compliance has dropped due to new PGDs going live and awaiting staff to sign up and receive authorisation.

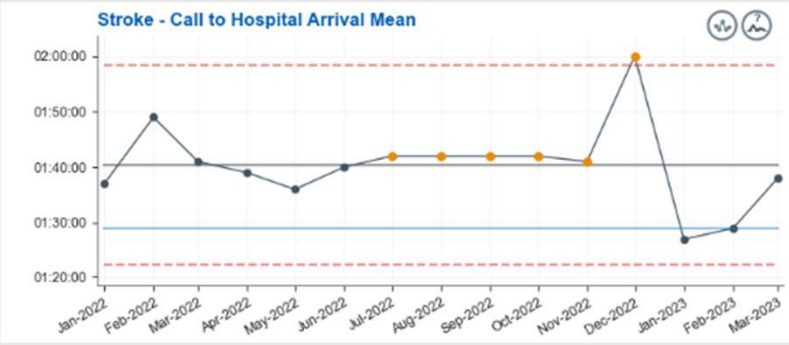
What actions are we taking?

Resilience stock recorded at MDC weekly. Alternative duty staff mobilised into support building this stock currently. However there is not enough space to house the staff required to meet the demand in this area of the business. Medicines team currently recruiting to vacancies to ensure sustainability in medicines pouch packing and resilience stock required. Three new starters join the team in September 2023 but there is physically nowhere to put the staff due to no desks/space available in the unit.

PGD report down to practitioner level being shared with OUMs monthly. Discussion around compliance is covered in the PGD working group. Work ongoing with Medicines System Lead and Power BI team to investigate if JRCALC data can be linked to ESR to support better reporting and cleansed data set. Currently resource intensive and a manual task. PGD case study on key skills lesson plan for discussion (directly linked to MD11 CQC must do)

QUALITY IMPROVEMENT

Impact on Patient Care – Stroke

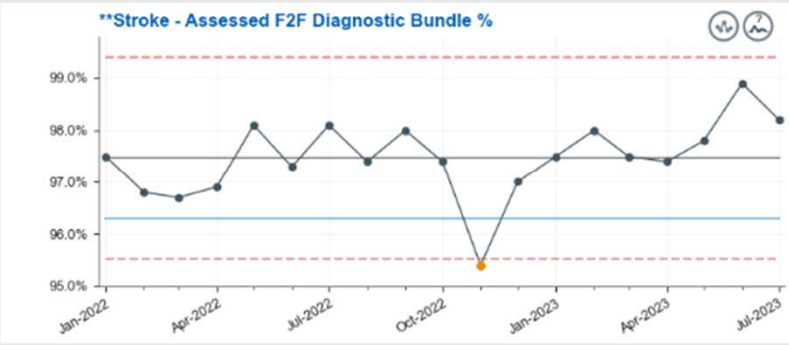


M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:38:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

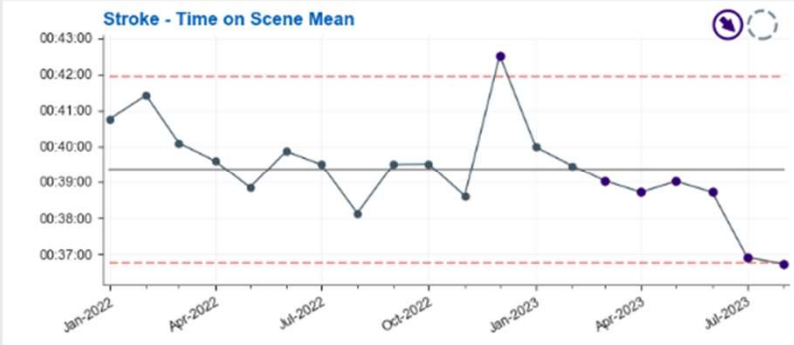
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:35:00
Target: 02:20:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-10

Dept: Medical
IP: Quality Improvement
Latest: 98.2%
Target: 96.3%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-28

Dept: Medical
IP: Quality Improvement
Latest: 00:36:44

Special cause variation where DOWN is neither improvement or concern

Summary

Stroke – Common cause variation continues. We are not meeting the national targets for Stroke patients due to overall delays in arrival at scene, however, once we arrive with the patient, compliance against the Diagnostic Bundle has largely been above target since August 2021. Whilst there's no special cause variation identified, it's recommended that limits will be re-calculated from August 2021, which is likely to indicate the target is being consistently met.

What actions are we taking?

Stroke - ongoing two year UCL study of stroke telemedicine to evaluate if stroke telemedicine extends time on scene. Audit results indicates minimal extra time (about 3-5 minutes) for Kent telemedicine centres, with Frimley achieving the second best time on scene for all stroke units in SECAmb in spite of using telemedicine. Inconsistency between pPCI metric (call to balloon) and stroke (call to door) has been raised at national level. Mean time on scene for stroke generally across SECAmb is within reasonable parameters (approximately 34. minutes). This is to be added to the IQR as it has been identified as a key indicator for quality of care in one of our clinical priority areas. It is not possible to make any more improvements without addressing the Trusts C2 performance, although a QI dashboard which allows individual feedback to staff regarding their time on scene further as has been demonstrated in the Guildford OU.

QUALITY IMPROVEMENT

Patient Experience

QS-5

Dept: Quality & Safety
IP: Quality Improvement
Latest: 74

Common cause variation, no significant change.

QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 100%
Target: 95%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

QS-10

Dept: Quality & Safety
IP: Quality Improvement
Latest: 64%

Common cause variation, no significant change.

Summary

- No significant variation in the number of complaints or in the proportion of complaints relating to crew attitude.
- The SPC chart for complaints reporting timeliness demonstrates improvement which has been achieved following implementation of a QI approach applied to this process.
- Timeliness continues to be above the 95% target with August being 100%.

What actions are we taking?

- The aim is to continue to respond to at least 95% of complaints within timescale going forward.
- The Complaints Manager is currently undertaking complaints training with all operating units at their Teams C meetings plus ad hoc for new OTLS. This supports effective working relationships and enables effective collaboration across directorate to improve the complaints process.

QUALITY IMPROVEMENT

Safety in the Workplace (1 of 3)

QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 23

Common cause variation, no significant change.

QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 26

Common cause variation, no significant change.

Health & Safety Incidents

No significant variation, with themes and trends remaining static.

- During July 2023, 28 Health and Safety incidents were reported.
- During August 2023 (23) Health and Safety incidents were reported.

What are we doing

The Local (held at system level) and Trust-wide Health & Safety groups will continue monitoring incident trends.

Manual Handling Incidents

No significant variation

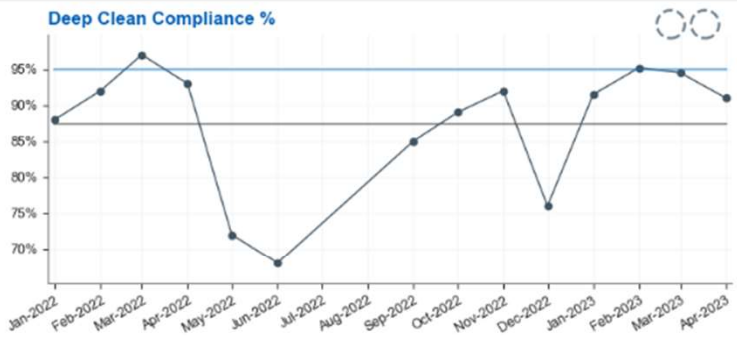
- Manual handling incidents reported in July 2023 were 16.
- Manual handling incidents reported in August 2023 were 26.

What are we doing

The Local (held at system level) and Trust-wide Health & Safety groups will continue monitoring incident trends. The H&S group is led by the Executive Director Q&N with the Head of Health, Safety & Security to ensure assurance is provided on all regulatory aspects and action plans agreed and acted on.

QUALITY IMPROVEMENT

Safety in the Workplace (2 of 3)



QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 91%
Target: 95%
Special cause or common cause cannot be given as there are an insufficient number of points.

QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 80.5%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Deep Clean Compliance %

Deep clean compliance data link is broken for the SPC chart. This will be addressed for the following reporting period.

Deep Clean Compliance:
July 2023 – 81.31% vs 95% target
August 2023 – 100% vs 95% target

Note – there is significant variation in compliance score depending on the site, so whilst the average is near or on target, there remain sites where delivering the deep cleans remains a challenge, for instance Guildford. This is driven by the infrastructure (need to move vehicles to delivery Make Ready), and workforce challenges, due to a 25% vacancy rate against Churchill establishment

What actions are we taking?

- Churchill wages were increased in April above the contract to meet NLW and increase competitiveness in the marked for Operatives. Despite this, the challenges persist.
- A harm review is being commissioned due to be completed in October, to identify the level or risk associate to variances and driven by vacancies.
- This will include a review of the auditing regime, as the KPIs show limited joint audits being undertaken and Churchill are reporting a 75% compliance of their internal audits.
- The RAG group will be independently reviewing the Churchill Capacity Risk – which is currently scored as an 8, however triangulation of the KPIs with the workload and the harm data will provide us with a better understanding of the risk and mitigations required.
- Harm data for August shows 3 low harm events, with 72 no-harm. In July this was 6 low harm with 1 moderate which is under review. The quality of the Datix reporting process will be part of the review in October.
- Churchill are reviewing their deployment model to provide us with a proposal to better match our needs with the limited capacity to better mitigate risk in geographies with of lower compliance in the meantime.

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 supporting the improvement of hand hygiene compliance across the Trust.

What actions are we taking?

- 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.
- Vacant IPC Practitioner role has been filled as a secondment focused on hand hygiene compliance over the next two months.
- IPC Lead will be reviewing the audit tool and specifically the questions asked to ensure effective understanding to enable reporting that is reflective of current practice.

QUALITY IMPROVEMENT

Safety in the Workplace (3 of 3)

Violence & Aggression

There is an upward trend apparent in this graph though not statistically significant at this point.
ASB is not significantly higher in August, it is lower in July with only 4 reports from call handlers as opposed to 14 in August.

Staff reported 115 violence and aggression related incidents in **July 2023.**
The sub-categories of these incidents are shown below:

- 43 verbal abuse
- 29 Anti-Social Behaviour
- 29 assaults

Staff reported 137 violence and aggression related incidents in **August 2023**.
The sub-categories of these incidents are shown below:

- 44 verbal abuse
- 42 Anti-Social Behaviour
- 24 assaults

What actions are we taking?

- Monthly monitoring at the Violence Reduction working group and Health & Safety group.
- We continue to triage all incidents and provide contact and support to staff if appropriate in reporting to police for investigation.
- Monthly partnership meetings are held with police to provide updates on cases involving our staff.
- BWC licences approved by the Trust for 2 further years. Expansion complete to 23 reporting sites with over 300 cameras available to staff. Usage continues to increase by staff.
- Partnership working internally with frequent caller teams and history marker group to improve sanctions and processes.
- 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.
- Review of Conflict Resolution Training complete with proposals submitted.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

August 2023

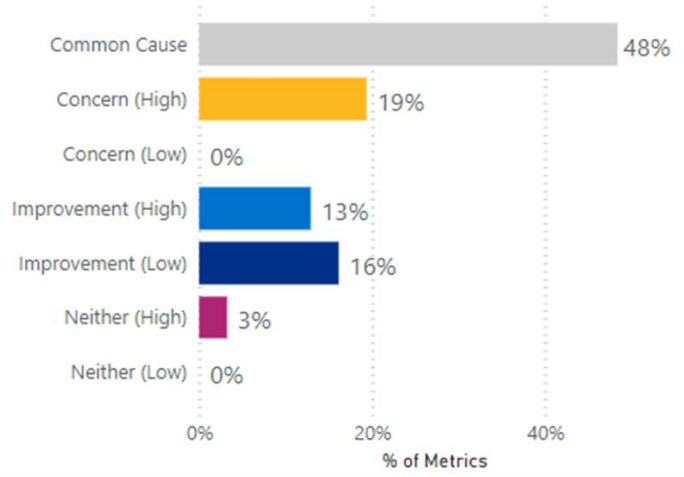
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		999 Frontline Late Finishes/Over-Runs % Current licence details held for Operational Staff % Freedom to Speak up: Cases Opened in Month Count of Until it Stops Cases	Number of Staff WTE (Excl bank and agency) Sickness Absence % Statutory & Mandatory Training Rolling Year %	Average Late Finish/Over-Run Time Sexual Safety Workshop Completion %
Common Cause	DBS Compliance %	Vacancy Rate % Turnover Rate % Individual Grievances Open Count of Grievances Closed % of Meal Breaks Taken Suspension Closures	Appraisals Rolling Year %	
Special Cause Concern		Number of Wellbeing Hub Referrals Time to Hire - Ad-Hoc (Days) Grievances Mean Case Length (Days)	Time to Hire - Volume (Days) Until it Stops Average Case Length Annual Rolling Turnover Rate	

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

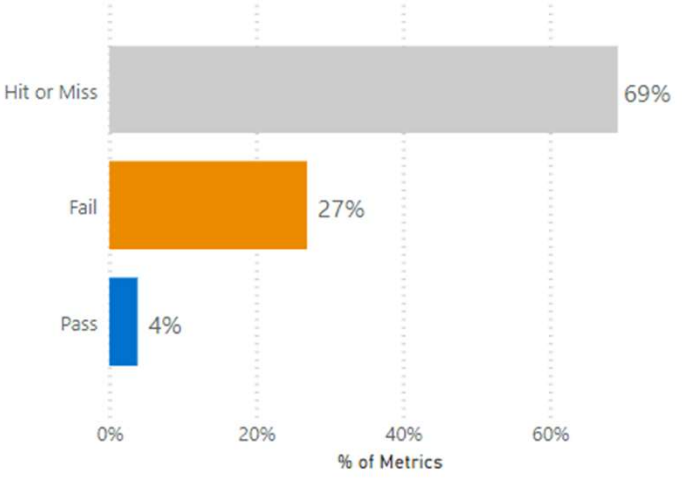
PEOPLE & CULTURE

Overview (1 of 2)

Variation Icon Summary



Assurance Icon Summary



Workforce

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Aug-2023	4176.89	4495.67	3925.31	4007.25	4089.19		
Vacancy Rate %	People & Culture	Aug-2023	7%	5%	0.14%	5.58%	11.01%		
Turnover Rate %	People & Culture	Aug-2023	1.3%	0.8%	0.59%	1.48%	2.36%		
Annual Rolling Turnover Rate	People & Culture	Aug-2023	18.9%	10%	16.9%	17.87%	18.83%		
Sickness Absence %	People & Culture	Aug-2023	6.8%	5%	6.83%	8.82%	10.8%		
DBS Compliance %	People & Culture	Aug-2023	100%	90%	100%	100%	100%		
Current licence details held for Operational Staff %	People & Culture	Aug-2023	98.2%	100%	90.54%	95.42%	100.29%		
Time to Hire - Volume (Days)	People & Culture	Aug-2023	200	60	68.43	122.42	176.4		
Time to Hire - Ad-Hoc (Days)	People & Culture	Aug-2023	90	60	47.65	72.3	96.95		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Aug-2023	75.8%	85%	63.38%	73.07%	82.75%		
Appraisals Rolling Year %	People & Culture	Aug-2023	59.5%	85%	54.65%	59.44%	64.23%		

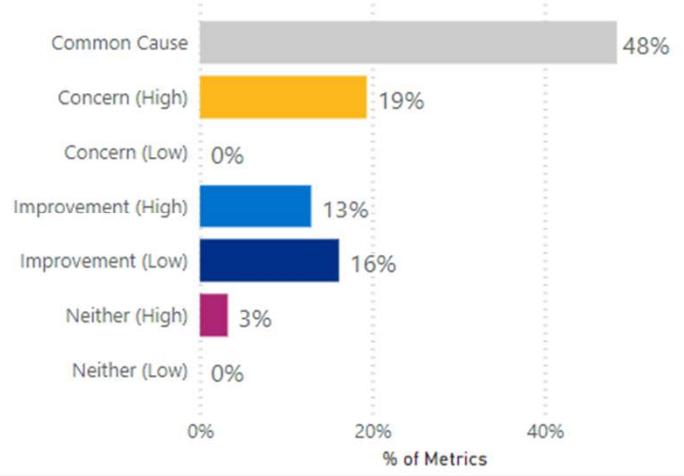
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Aug-2023	44.8%	45%	44.91%	49.94%	54.97%		
Average Late Finish/Over-Run Time	People & Culture	Aug-2023	00:36:00		00:36:01	00:39:48	00:43:35		
% of Meal Breaks Taken	People & Culture	Aug-2023	98.1%	98%	96.68%	98.11%	99.54%		
% of Meal Breaks Outside of Window	People & Culture	Aug-2023	52.1%		28.04%	55.05%	82.05%		

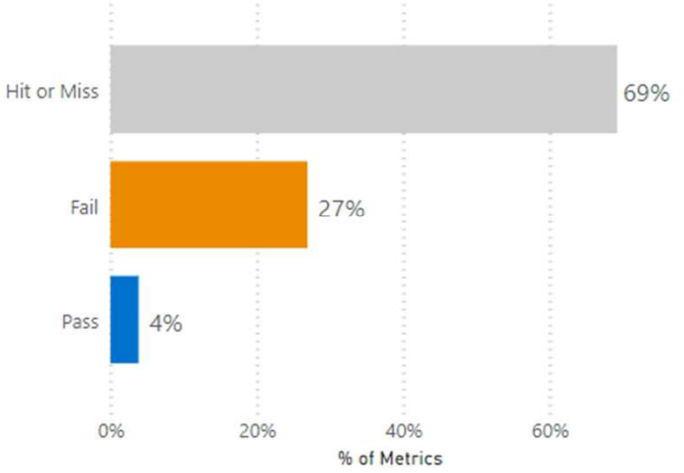
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

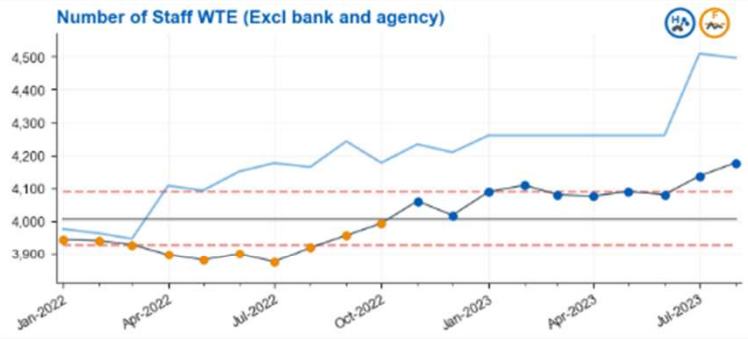
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Aug-2023	16	5	0.71	12.75	24.79		
Collective Grievances Open	People & Culture	Aug-2023	1	1	-1.62	1.6	4.82		
Count of Grievances Closed	People & Culture	Aug-2023	11	3	-1.38	11.5	24.38		
Grievances Mean Case Length (Days)	People & Culture	Aug-2023	152.88	93	52.81	103.53	154.25		
Bullying & Harrassment Internal	People & Culture	Aug-2023	0	2	-4.1	2.2	8.5		
Disciplinary Cases	People & Culture	Aug-2023	6	3	-1.82	4.2	10.22		
Freedom to Speak Up: Total Open Cases	People & Culture	Aug-2023	40		6.4	18.44	30.49		
Freedom to Speak up: Cases Opened in Month	People & Culture	Aug-2023	5	3	-0.82	9.4	19.62		
Freedom to Speak up: Cases Closed in Month	People & Culture	Aug-2023	12		-4.12	8.9	21.92		
Policies & Procedures Outstanding Review %	People & Culture	Aug-2023	66%	0%		55.21%			
Count of Until it Stops Cases	People & Culture	Aug-2023	0	3	-4.36	3.2	10.76		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Aug-2023	116	86	51.41	100.39	149.36		

PEOPLE & CULTURE

Workforce (1 of 3)

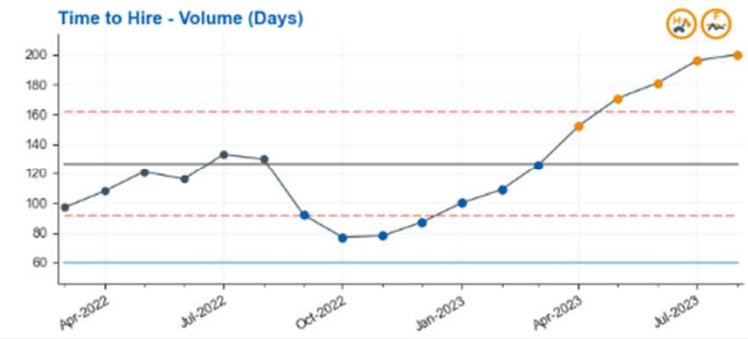


WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 4176.89
Target: 4495.67
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

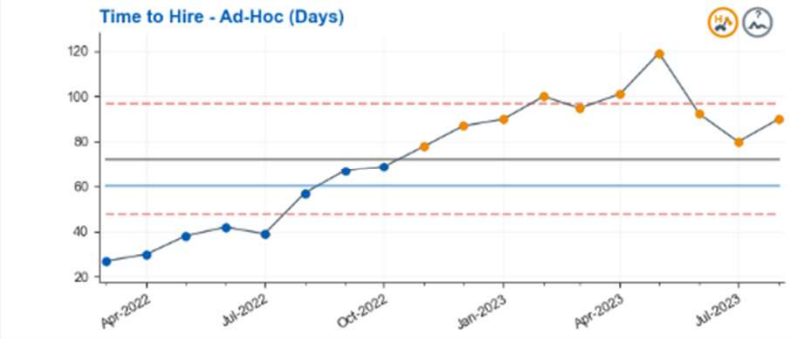
WF-4

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



WF-43

Dept: Workforce HR
IP: People & Culture
Latest: 200
Target: 60
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.



WF-51

Dept: Workforce HR
IP: People & Culture
Latest: 90
Target: 60
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

Summary

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. The current TTH target is 60 days – this figure is being reviewed as part of the Recruitment and Onboarding QI project.

The new budget for 23/24 was received at the start of August and applied to this month's report. This has shown, as expected, a rise in the vacancy rate for July and August as the correct increased establishment figures are calculating the vacancy rate.

What actions are we taking?

The Quality Improvement team have broken down the process into key phases and have identified where potential improvements are required. Metrics are being identified that will enable them to monitor progress with the plan to build a dashboard as part of the control phase. This will include TTH.

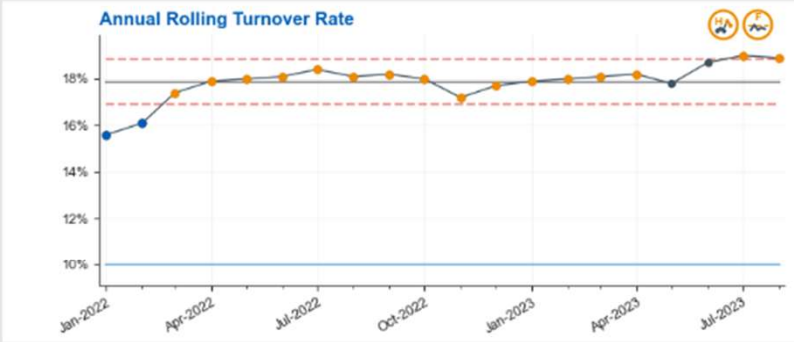
With an initial project focus on contact centre recruitment changes have started to help improve not only the candidate experience (streamlined application) but to also inform realistically of the roles that are being advertised (amendment to advert wording) This will continue through the process with next stage looking at the interview process and what improvements can be applied.

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: 1.3%
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: 18.9%
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, and where we are seeing improvement.

Staff retention remains a high concern. There are two risk register entries, Risk 84 (Medway) current grading 12, and Risk 365 (Trust wide) current grading 16.

Despite 58 colleagues leaving 111 in July, due to the Medway move, we still show a decline in turnover of 0.3% percentage points in month. NB: Medway will continue to add complexity to the data through Sept-Dec 23 as the EOC redundancies come into effect, and the relocation trial periods come to an end.

On a positive we are seeing declines in turnover. Most notable is Guildford OU (13.29% in April to 8.45% in August) Brighton OU (9.71% in July and 9.01% in August), Medway OU 12.1% in July and 9.95% in August). All three OU's have seen a higher-than-average number of new starters and are close to full establishment.
Corporately HR&OD have improved from 16.03% in July to 14.77% in August, Strategy & Planning 10.04% in July to 9.34% in August, and Medical 12.50% in July to 11.14% in August.

What actions are we taking?

Work has begun on the development of a new Trust Retention Plan. Through engagement with the Board and the Senior Leadership Team we have developed some initial ideas aimed at addressing the key reasons for leaving:

- Hours of Work - work intensity, working smarter not harder
- Patterns of Work
- Career Development
- Health and Wellbeing
- Pay, Terms and Conditions

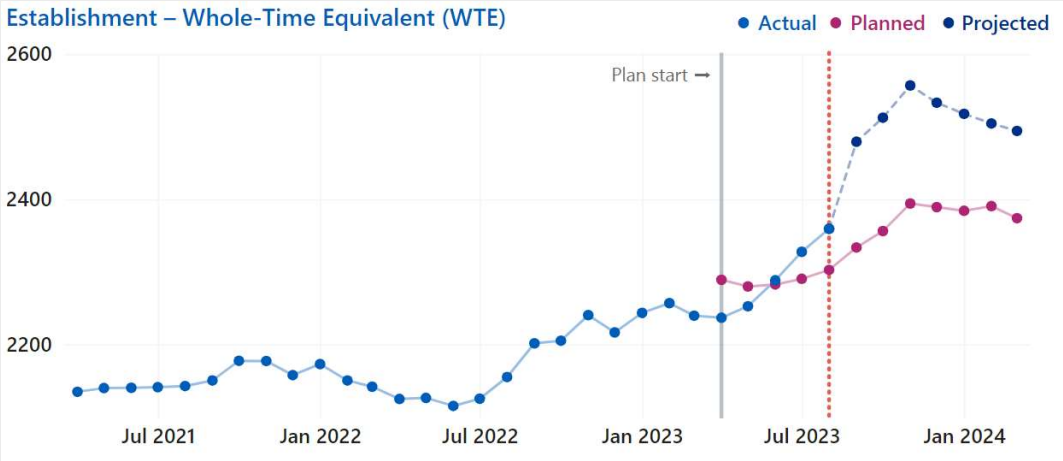
Tasked with being bold, creative, and ambitious, we have some good first ideas to evolve.
Engagement is key, and we have started with engaging the wider HR and OD teams, Unions, Networks, EOC/111, and New Starters.

We expect to present a draft plan in early October 23, and a matured plan for early November 23.

PEOPLE & CULTURE

Workforce (3 of 3)

(999 Frontline)



Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
August's data shows an increase in WTE ahead of the workforce plan (56.6FTE) 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. August showed a small gap between actual and planned for ECSW with a difference of 4.66WTE, however attrition has been lower than planned and will help the overall projected figures.

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.

(EOC EMA)

Summary – EOC EMA
EMA establishment for August showed a reduction of WTEs with a difference of -18.1% to plan. New starters were lower than planned with a difference of 5.0 WTE 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. An open day was hosted at the new Medway site at the beginning of the month (September), this attracted 75 people to attend on the day resulting in 27 applications for roles across the Trust. An open day is currently in planning stages for Crawley in October.

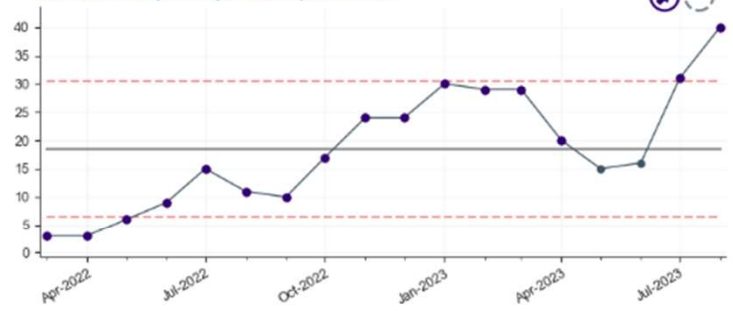
Additional Information
The workforce projection is currently based on confirmed recruits who currently have an offer of employment. As EMA recruitment typically only has a lead time of 2 months, no additional recruitment is factored into the projection beyond this point, which results in the chart only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

PEOPLE & CULTURE

Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

Freedom to Speak Up: Total Open Cases



QS-27

Dept: Quality & Safety
IP: People & Culture
Latest: 40

Special cause variation where UP is neither improvement or concern

Individual Grievances Open

WF-10

Dept: Workforce HR
IP: People & Culture
Latest: 16
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Count of Until it Stops Cases

WF-41

Dept: Workforce HR
IP: People & Culture
Latest: 0
Target: 3
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Count of Grievances Closed

WF-42

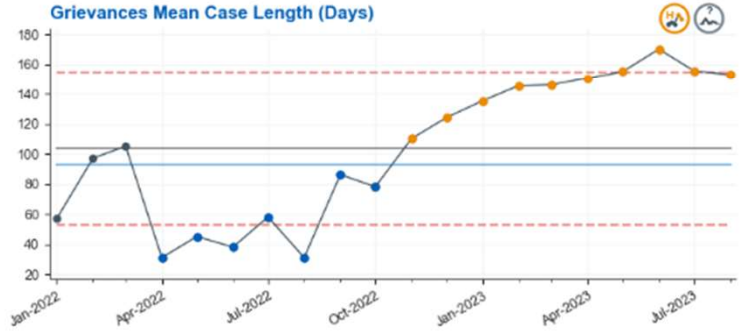
Dept: Workforce HR
IP: People & Culture
Latest: 11
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Until it Stops Average Case Length

WF-50

Dept: Workforce HR
IP: People & Culture
Latest: 219.67
Target: 93
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

Grievances Mean Case Length (Days)



WF-44

Dept: Workforce HR
IP: People & Culture
Latest: 152.88
Target: 93
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

PEOPLE & CULTURE

Culture (2 of 2)

Summary

Grievances
For the first time in several months there has been a slight fall in grievances due to collaborative working with TU colleagues to deal with issues and concerns informally.

There has been a significant focus on managing grievances as they arise seeking 'round the table' discussions with colleagues and TU representatives. This is supporting a downward trend in the length of time to close a grievance.

Until it Stops
To date a total of 574 Managers have attended a Sexual Safety Workshop for Managers. Currently, there are no recorded sexual harassment ER cases which may in part be due to improved awareness due to the Sexual Safety Workshops for Managers and the ongoing focus on eliminating sexual harassment through the wider Until it Stops campaign. The 2023 NHS National Staff Survey for the first time includes a question on unwanted sexual behaviour in the workplace.

FTSU
Overall number of concerns being raised remans within normal variation.
There is an expected variability across the year, but the significant ongoing rise in cases remaining open and are breaching the 93-day timeframe for closure from local teams, indicates the complexity of some cases, the approach being taken by some local managers and their understanding/awareness/motivation to find resolution or learning within a timely way.

What actions are we taking?

The Trust grievance policy (resolution policy) is out for consultation following work with key stakeholders including TU colleagues.

The Head of Employee Relations starts with the Trust in October. One of the ER Managers has been appointed and is expected to start in December. The ER Manager role is being readvertised to recruit to a further post.

Training for managers that chair panels has been commissioned to ensure they are able to make rigorous, robust, fair and thorough decisions in line with Trust policies and to deliver consistent standards. The aim is for the training to be delivered in November following the appointment of the Head of Employee Relations.

The NHS recently introduced the sexual safety charter. NHS organisations are asked to commit to work towards ensuring that the Charter is in place by July 2024. A full evaluation of the impact of the Until it Stops Campaign will be undertaken to benchmark our current position against the Charter and to identify any actions that need to be taken to fully meet the Charter.

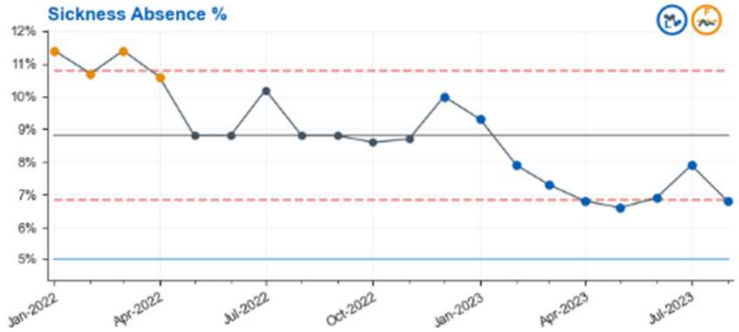
The People & Culture Strategy webinar on 9 October will focus on reflecting on the Until it Stops campaign so far and the next phase of the Campaign.

FTSU team have strong plans underway with Director of Ops and Director of Q&N, for an Ops-focused SLT Speaking Up workshops to be undertaken in the new year. This will explore the principles behind Speaking Up, the role and process of FTSU and why it is nationally structured as it is, and the barriers to seeking learning and simply being curious and compassionate.
In addition, November will see reinforcement of the messages about 'being curious' through Board Development Day with OUM Leads in attendance,

October is Speaking Up month so there is a whole programme of events organised by the FTSU team involving all staff networks, that will promote SU, FTSU and importance of learning, as well as explore what barriers may be in play to block this approach.

PEOPLE & CULTURE

Employee Sickness



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

WF-25
Dept: Workforce Wellbeing
IP: People & Culture
Latest: 116
Target: 86
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

Summary

We have seen a positive improving trend in sickness absence since the beginning of the calendar year. We continue the downward trend to 6.8% due to the continuing focus on absence management. We are however not an outlier when compared to other ambulance Trusts.

The most notable changes are with short term intermittent absence, driven through the Operations Directorate management, with HR support, which has seen a 1.3 percentage point improvement overall since January 2023

Mental health continues to be a challenge and the wellbeing hub are seeing an increase in the number of referrals and requests for support with mental health related matters. Despite this, we have seen in small decline in referrals to the hub overall.

What actions are we taking?

Health and wellbeing features prominently in the development of the new retention plan. Supporting and developing our managers with effective wellbeing conversations, interventions and a safe working environments are just some of the themes in the early draft of the plan.

We are reviewing the wellness plan to ensure that it remains effective, and we will adjust it as appropriate. We have a business case in progress to bolster mental health resilience within the hub so that we can better support our colleagues.

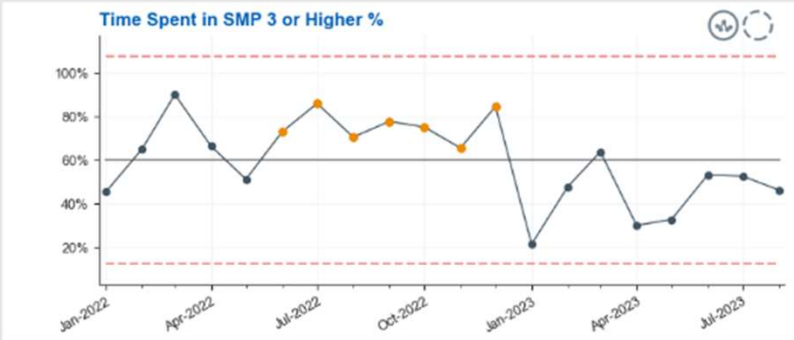
As well as the management focus on sickness absence, monthly scrutiny of action plans at Operations Senior Leadership meetings continue, with support from HR Advisors.

PEOPLE & CULTURE

Employee Experience

999-15

Dept: Operations 999
IP: People & Culture
Latest: 44.8%
Target: 45%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-14

Dept: Operations 999
IP: Quality Improvement
Latest: 46.4%

Common cause variation, no significant change.

999-27

Dept: Operations 999
IP: People & Culture
Latest: 98.1%
Target: 98%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- Whilst the late finishes and meal break metrics related directly to field operations, the impact of time spent at higher levels of SMP has a real impact on EOC staff, particularly those trying to manage response and flow (dispatchers and clinicians).

New targets set

- Paper presented to the Performance Committee demonstrating that as of mid-Sept, following the implementation of the new rotas, the LSO has reduced to the target level in terms of % of crews impacted, and in addition, the duration of the LSO has reduced to 35.5mins from approx. 40mins in Jan.
- % meal breaks taken to be sustained at 98% of all crews on shift per day across the FY

What actions are we taking?

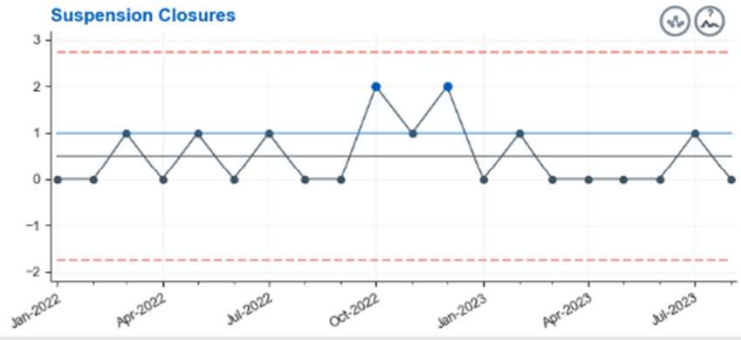
- A specific programme of work is ongoing within Ops focusing on LSO and reviewing contributory factors to identify those against with actions can be taken. To date 2 papers have been presented to the Performance Committee looking at the correlation/causation of 5 factors with LSO:
    1. Distance to nearest ED
    2. Proportion of incidents on each dispatch desk responded to by own resources
    3. Hand over time at local ED
    4. Conveyance rate
    5. Impact of implementation of new rotas

PEOPLE & CULTURE

Employee Suspensions

WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 4
Target: 10
Common cause variation, no significant change. This process will not consistently hit or miss the target.

WF-47
Dept: Workforce HR
IP: People & Culture
Latest: 57.14
Target: 70
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-45
Dept: Workforce HR
IP: People & Culture
Latest: 0
Target: 1
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

The number of suspension cases continues to decrease showing progress both in process terms but also in terms of considering alternatives to suspensions and removing suspensions as soon as practically possible. As a result, we have moved from c.20 suspensions at the beginning of 2022 to four open cases with an average length of suspension also decreasing substantially to an average of 72 days, well below the previous average of over 100 days in 2022.

Importantly, the continuation of the focus on sexual misconduct means that we currently do not have any sexual harassment cases within the four suspensions.

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.

The stakeholder group met to discuss the Disciplinary Policy which is being revised to reflect the Trust's approach to encouraging learning rather than retribution.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 75.8%
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: 59.5%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Appraisal update papers were presented to SMG and the Education, Training and Development Group in September with recommendations to support improving appraisal completion. Appraisers must schedule appraisal meetings and ensure appraisals are correctly recorded. The Operations directorate has allocated 2 hours per person for appraisals. Appraisals are mandatory for all employees, there is no equivalent mandated allocation of time for appraisals in corporate directorates.

What actions are we taking?

Several actions recommended by the Appraisal Working Group are being implemented by the Learning and Development Team to support the improving appraisal compliance, including:

- A MS Word version of the appraisal form
- Improved Trust communications to promote the Appraisal Hub and eLearning
- Introduction of proxy access to allow delegation of administrative tasks

SMG to continue reviewing progress and taking appropriate action to address under performance of appraisal and statutory and mandatory training compliance

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

August 2023

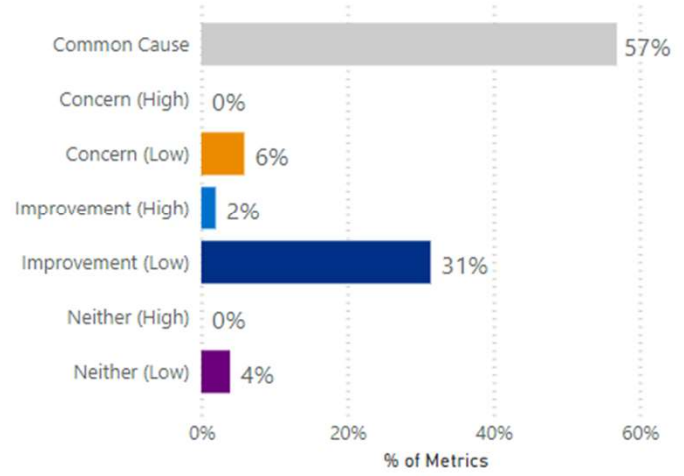
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %	111 Calls Abandoned - (Offered) % Cat 2 Mean Cat 2 90th Centile Cat 3 90th Centile	Hear & Treat %	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as a Proportion of Provided Hours... Number of Hours Lost at Hospital Handover Critical Vehicle Failure Rate (CVFR) 999 Referrals A&E Dispositions 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 % See & Convey % Average Wrap Up Time 111 Calls Answered in 60 Seconds % Cat 1 Mean	ECAL Mean Response Time % of planned vehicle services completed Incidents Cat 2 Proportion (Cat 1-4) Duplicate Calls % 999 Calls Answered Incidents
Special Cause Concern	Ambulance Validation %		See & Treat %	FFR Attendances

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

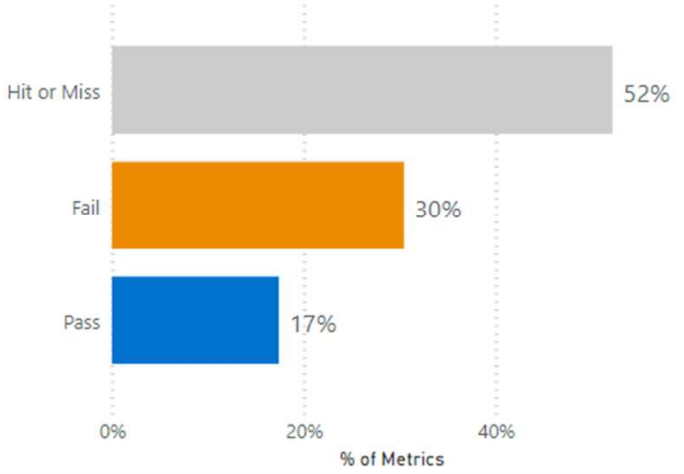
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Aug-2023							
Section 136 Mean Response Time	Responsive Care	Aug-2023	00:19:11		00:14:28	00:26:29	00:38:30		
Cat 1 Mean	Responsive Care	Aug-2023	00:08:34	00:07:00	00:07:27	00:09:05	00:10:42		
Cat 1 90th Centile	Responsive Care	Aug-2023	00:15:44	00:15:00	00:14:05	00:16:28	00:18:51		
Cat 1T Mean	Responsive Care	Aug-2023	00:10:02	00:19:00	00:08:57	00:10:50	00:12:43		
Cat 1T 90th Centile	Responsive Care	Aug-2023	00:18:24	00:30:00	00:16:36	00:19:55	00:23:13		
Cat 2 Mean	Responsive Care	Aug-2023	00:26:43	00:30:00	00:17:04	00:32:46	00:48:28		
Cat 2 90th Centile	Responsive Care	Aug-2023	00:54:13	00:40:00	00:32:45	01:07:14	01:41:44		
Cat 3 90th Centile	Responsive Care	Aug-2023	04:47:36	02:00:00	01:18:23	05:54:39	10:30:54		
Cat 4 90th Centile	Responsive Care	Aug-2023	06:49:35	03:00:00	02:14:03	07:52:52	13:31:40		
HCP 3 Mean	Responsive Care	Aug-2023	02:20:22		00:56:16	02:43:30	04:30:44		
HCP 3 90th Centile	Responsive Care	Aug-2023	04:59:50		00:48:11	06:19:19	11:50:28		
HCP 4 Mean	Responsive Care	Aug-2023	02:56:39		01:17:50	03:27:55	05:38:00		
HCP 4 90th Centile	Responsive Care	Aug-2023	06:29:38		02:18:12	08:11:02	14:03:53		

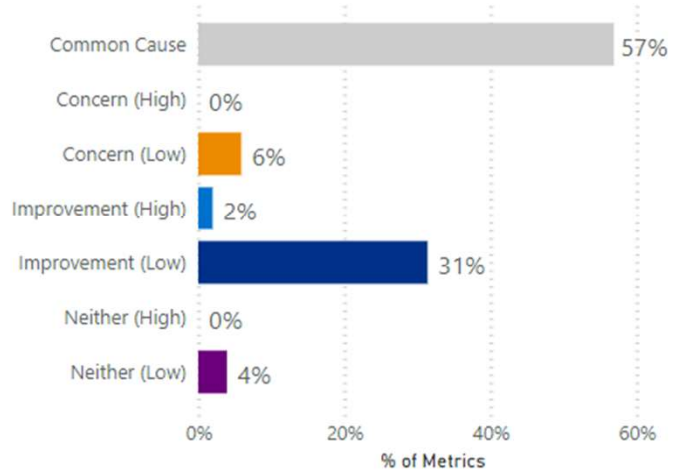
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Aug-2023	24.4%		19.51%	24.37%	29.22%		
999 Calls Answered	Responsive Care	Aug-2023	70105		49374.71	72302.65	95230.59		
999 Call Answer Mean	Responsive Care	Aug-2023	00:00:24	00:00:05	00:00:28	00:00:39	00:01:46		
999 Call Answer 90th Centile	Responsive Care	Aug-2023	00:01:33	00:00:10	00:00:55	00:02:05	00:05:06		

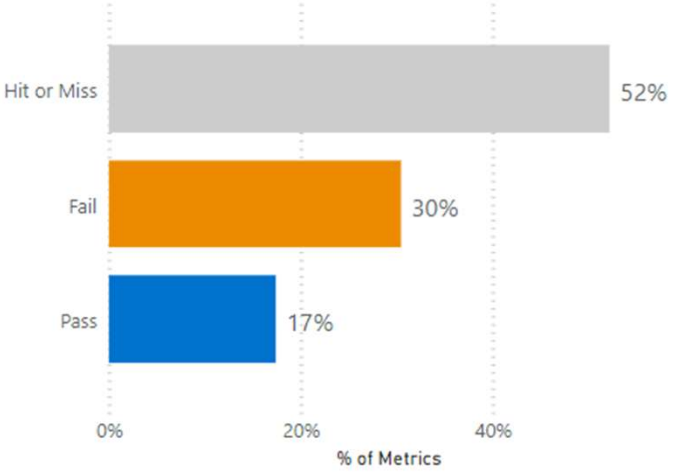
RESPONSIVE CARE

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Utilisation

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Aug-2023	90.7%	100%	82.61%	90.23%	97.84%		
Provided Bank Hours %	Responsive Care	Aug-2023	0.8%		0.55%	0.73%	0.91%		
Provided Overtime Hours %	Responsive Care	Aug-2023	7.1%		6.93%	9.66%	12.39%		
Provided PAP Hours %	Responsive Care	Aug-2023	5%		4.7%	5.51%	6.33%		
999 Operational Abstraction Rate %	Responsive Care	Aug-2023	35.1%	28%		35.76%			
999 Remaining Annual Leave FY	Responsive Care	Aug-2023	33.5%			31.1%			
Vehicles Off Road (VOR) %	Responsive Care	Aug-2023	13.3%	10%	9.01%	12.36%	15.72%		
% of DCA vehicles off road (VOR)	Responsive Care	Aug-2023	14.8%		11.08%	13.32%	15.56%		
% of SRV vehicles off road (VOR)	Responsive Care	Aug-2023	1.9%		-7.02%	7.41%	21.84%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Aug-2023	89		76.5	159.1	241.7		
Number of RTCs per 10k miles travelled	Responsive Care	Aug-2023	0.57		0.23	0.67	1.11		
% of planned vehicle services completed	Responsive Care	Aug-2023	62%		53.41%	72.5%	91.59%		
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	Aug-2023	82.8%	95%		92.97%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Aug-2023	63.3%		58.26%	62.74%	67.22%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Aug-2023	6.6%	13%	5.72%	7%	8.27%		
Incidents	Responsive Care	Aug-2023	61863		51807.58	59872	67936.42		

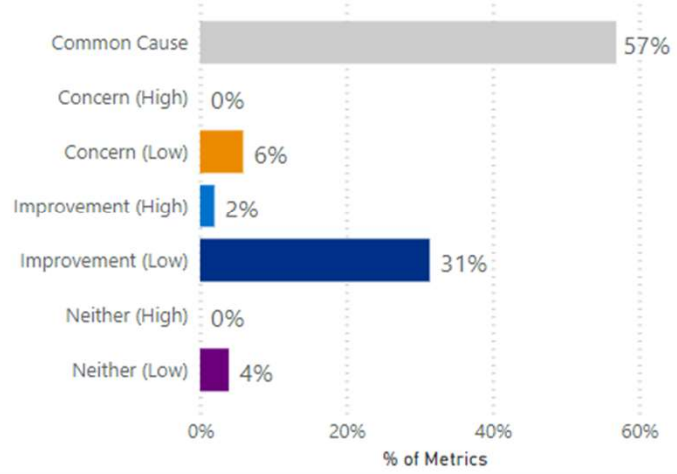
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Aug-2023	89543		69685.29	106522.65	143360.01		
111 Calls Answered in 60 Seconds %	Responsive Care	Aug-2023	40.1%	95%	3.96%	34.26%	64.56%		
111 Calls Abandoned - (Offered) %	Responsive Care	Aug-2023	16.1%	5%	1.82%	18.47%	35.12%		
999 Referrals	Responsive Care	Aug-2023	4521		4040.44	5472.5	6904.56		

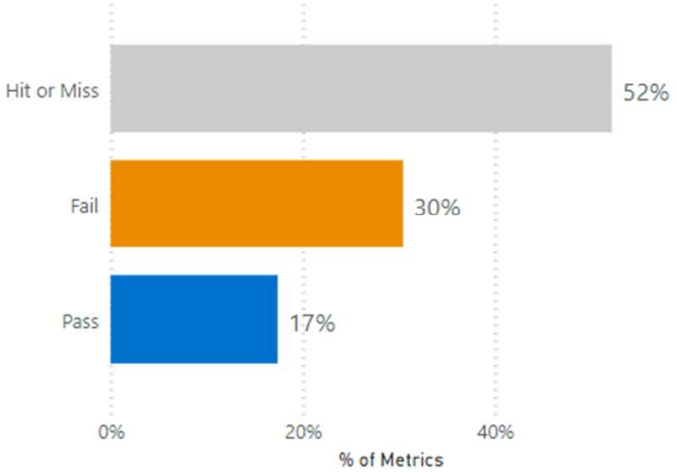
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

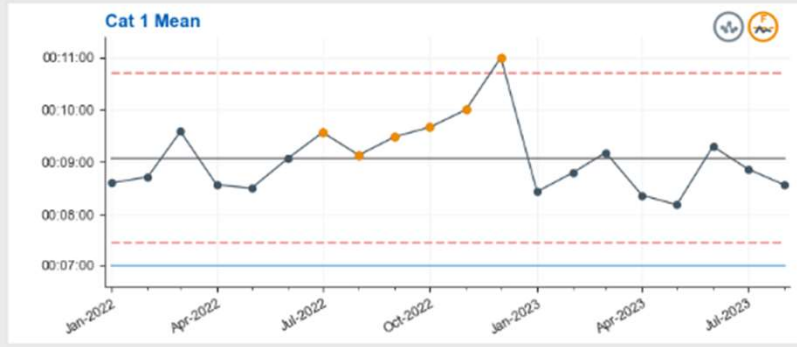
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Aug-2023	01:15:17		01:16:01	01:17:45	01:19:29		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Aug-2023	01:50:14		01:50:30	01:54:56	01:59:21		
Responses Per Incident	Responsive Care	Aug-2023	1.09	1.09	1.08	1.1	1.11		
CFR Attendances	Responsive Care	Aug-2023	1078		802.38	1264.8	1727.22		
FFR Attendances	Responsive Care	Aug-2023	146		98.48	210.9	323.32		
ECAL Mean Response Time	Responsive Care	Aug-2023	00:23:48		00:21:18	00:23:25	00:25:31		

111/999 System Impacts

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Aug-2023	12.1%	14%	8.17%	9.9%	11.62%		
See & Treat %	Responsive Care	Aug-2023	30.5%	35%	30.06%	31.65%	33.23%		
See & Convey %	Responsive Care	Aug-2023	57.3%	55%	55.93%	58.34%	60.74%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Aug-2023	0.9%		0.69%	1.39%	2.09%		
Number of Hours Lost at Hospital Handover	Responsive Care	Aug-2023	2453.24		1885.44	3828	5770.56		
Average Wrap Up Time	Responsive Care	Aug-2023	00:17:08	00:15:00	00:16:41	00:17:21	00:18:02		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Aug-2023	46.7%		44.48%	47.37%	50.25%		
A&E Dispositions %	Responsive Care	Aug-2023	7.1%	9%	6.82%	8.58%	10.34%		
A&E Dispositions	Responsive Care	Aug-2023	4866		5169.75	6700.65	8231.55		
Clinical Contact %	Responsive Care	Aug-2023	47.5%	50%	46.7%	50.64%	54.57%		
Ambulance Validation %	Responsive Care	Aug-2023	53.1%	85%	85.73%	93.14%	100.54%		

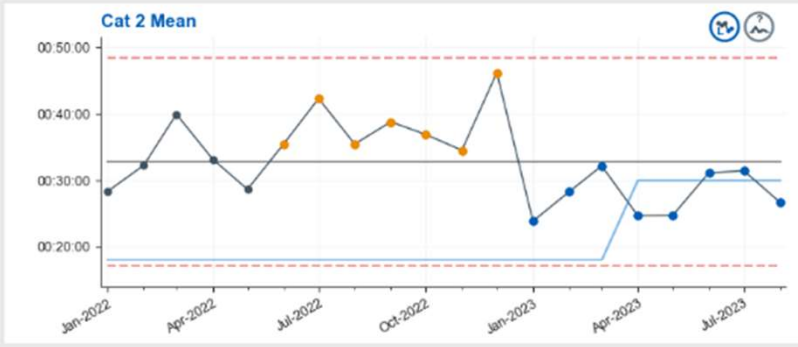
RESPONSIVE CARE

Response Times



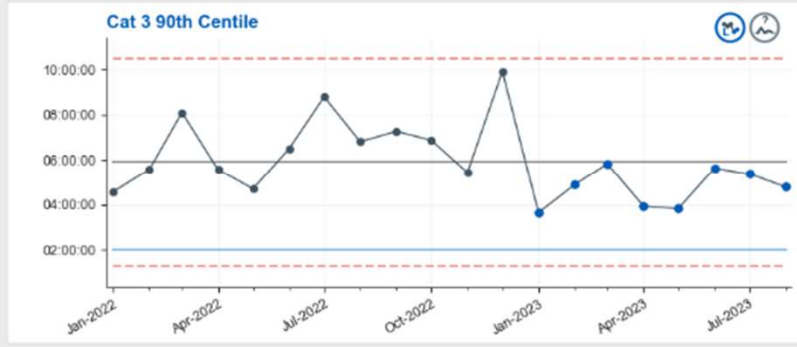
999-2

Dept: Operations 999
IP: Responsive Care
Latest: 00:08:34
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



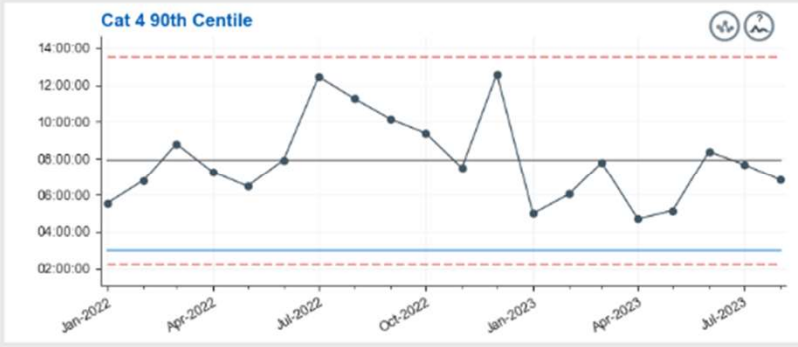
999-4

Dept: Operations 999
IP: Responsive Care
Latest: 00:26:43
Target: 00:30:00
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-5

Dept: Operations 999
IP: Responsive Care
Latest: 04:47:36
Target: 02:00:00
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-6

Dept: Operations 999
IP: Responsive Care
Latest: 06:49:35
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

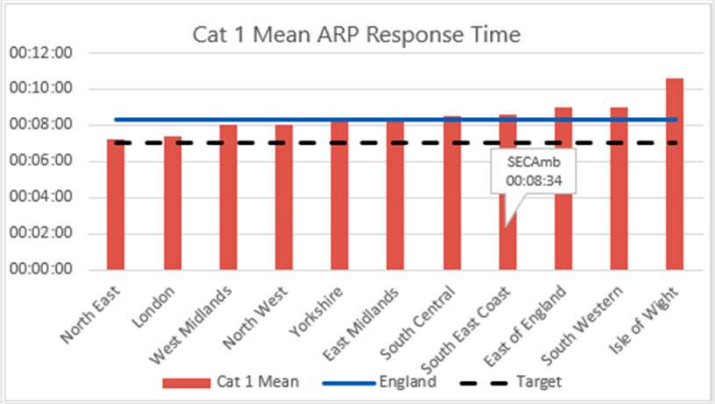
Summary

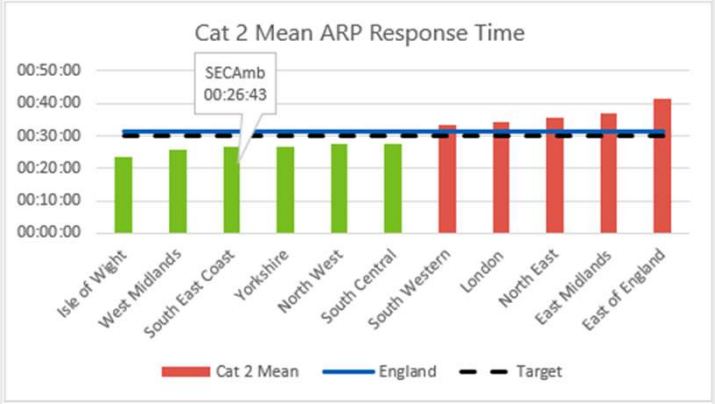
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against the delivery plan – in August 2023, performance was 26mins 43sec, against a national average of 31min 30sec.

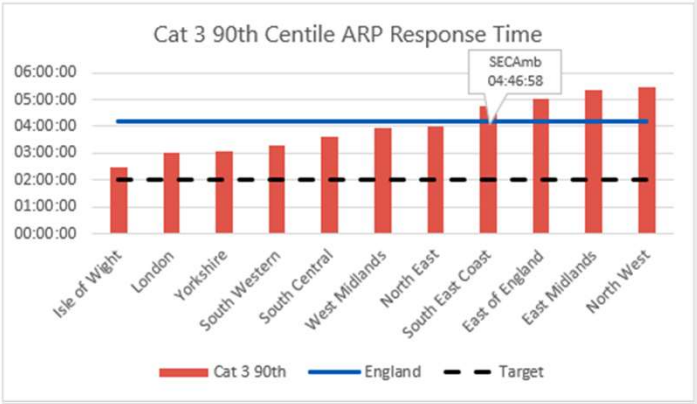
What actions are we taking?

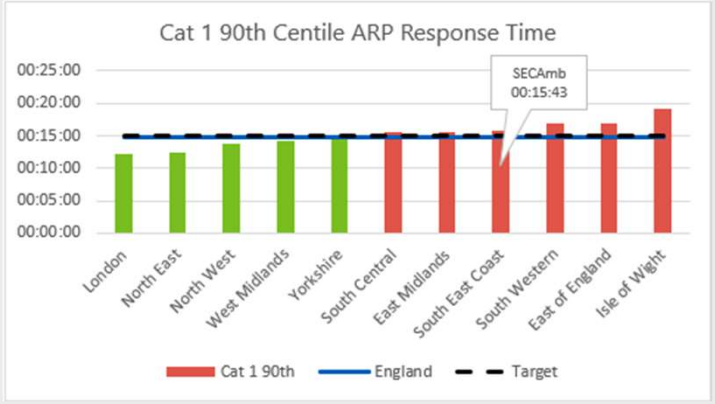
- Continuation of C3 & C4 validation, with a high proportion being validated in either the Trust's 111 (KMS 111) or 999 services. The aim remains to clinically assess every C3 or C4 call prior to ambulance dispatch.
- Continued focus on clinical staffing in EOC to maintain patient safety and support apposite ambulance dispatch, with significant investment in additional capacity via agency clinicians.
- Focused attention on abstraction management, particularly on sickness management and training planning.
- Ongoing focus on Urgent Community Response (UCR), with SECAmb working with downstream providers on daily calls to optimise system capacity.
- 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.

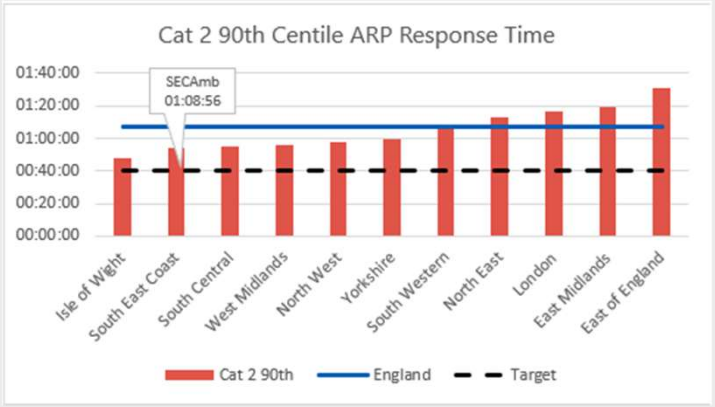
ARP Response Time Benchmarking (August 2023)

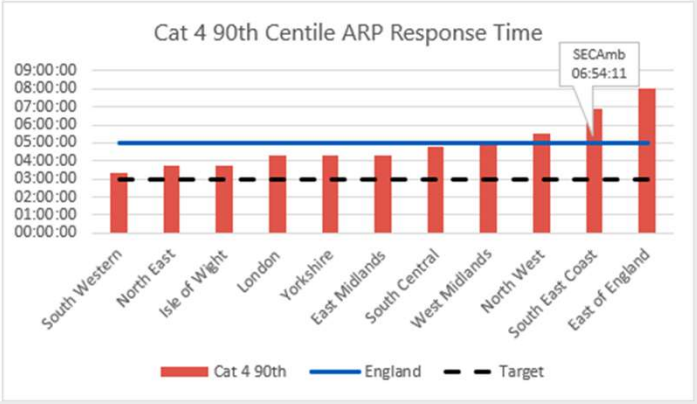












Summary

- C2 mean (a focus for the UEC recovery plan) is on track against the plan for 2023-24.
- Other ARP metrics continued to be notably under-performing against both target metrics and the English Average position.

RESPONSIVE CARE

EOC Emergency Medical Advisors

999-10

Dept: Operations 999
IP: Responsive Care
Latest: 70105

Common cause variation, no significant change.

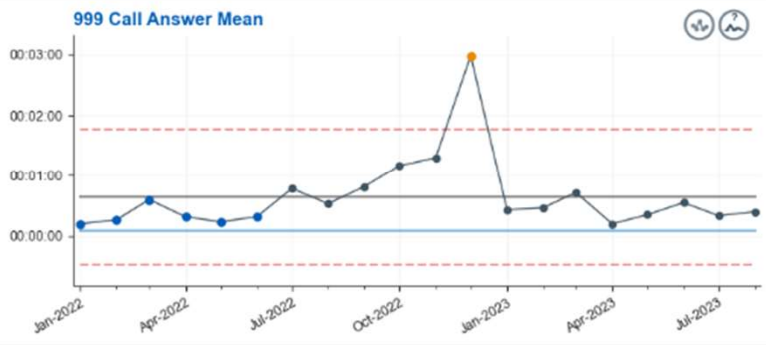
999-33

Dept: Operations 999
IP: Responsive Care
Latest: 24.4%

Common cause variation, no significant change.

999-9

Dept: Operations 999
IP: Responsive Care
Latest: 12.1%
Target: 14%
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.



999-1

Dept: Operations 999
IP: Responsive Care
Latest: 00:00:24
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 continues to fluctuate, underpinned by ongoing staffing challenges and rota inequalities, with 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.
- EMA recruitment and the resultant shortfall in EMAs remain the service's key area of focus, to improve performance and create 999 call handling resilience.
- ***Hear and Treat*** performance is on an improving trajectory, with August reflecting the service's best monthly performance for Hear & Treat (top half of national English ambulance league table).
- The service is on track with the planned trajectory for this financial year, with C2 Segmentation ready to go-live in September 2023 as per NHSE's timetable.
- Recruitment of Paramedics, especially via overseas continues and the Trust is utilising additional NHS E funding to source agency clinicians to support clinical assessment.

What actions are we taking?

- EMA establishment is currently at 18.1 WTEs below the planned levels for August. This gap is attributable to attrition being higher than planned this year, and an inability to recruit EMAs at the planned numbers, exacerbated by the imminent move to Medway. 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, although the recruitment and retention plans, supported by the HR Recruitment team's collaboration with the service's leadership team, should now realise better results because of the imminent move to Medway.
- ***C3 & C4 clinical validation model continues*** and ***C2 segmentation*** **i**s due in September, this has been accelerated with additional monies from NHS E during Aug-Oct.
- The ***Hear and Treat*** trajectory is for 12% by end of Q3 and 14% end of Q4 and the service is on track with these milestones. Additional support through the specialist Paramedics and B6 Paramedics working in local hubs continues to grow.
- The change to the EOC operating model and actions to improve H&T, and the EMA recruitment drive and associated operational efficiencies are reviewed through a formalised governance structure, overseen monthly by the Executive Director of Operations with the senior service leads, using key metrics and highlight reports.

RESPONSIVE CARE

Utilisation

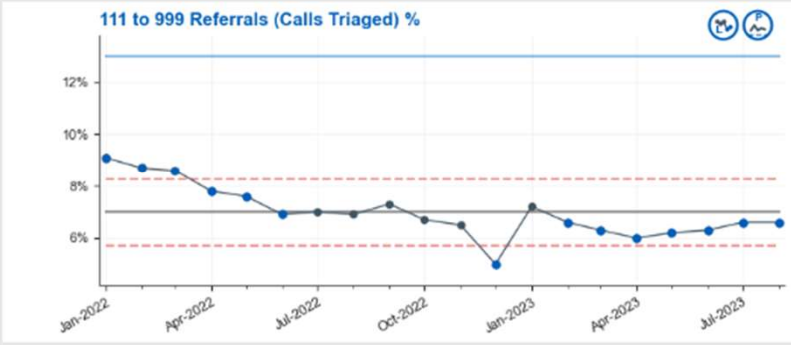
999-10
Dept: Operations 999
IP: Responsive Care
Latest: 61863

Common cause variation, no significant change.

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 90.7%
Target: 100%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

999-32
Dept: Operations 999
IP: Responsive Care
Latest: 63.3%

Common cause variation, no significant change.



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.6%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Summary

- From the Trust's 111 service, there is a high ***validation rate*** for all calls being proposed to be passed to 999 (contractual requirement of 50%) which contributes to an extremely low ambulance referral rate from 111 to 999 in Kent and Sussex.
- There have been fluctuations in ***frontline hours*** provided on a monthly basis this financial year and this has directly impacted on the Trust's ability to respond physically to incidents – However, 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.
- The additional funding from NHS E (July-Oct) has helped the service offer more overtime, and this has helped improve front line hours provided.

What actions are we taking?

- The 999 referral rate from the Trust's 111 service remains amongst the best nationally, this is protecting the 999 service.
- Greater flexibility between the Trust's 111 and 999 services to flex clinicians to maintain C3/C4 validation at a high level, prior to ambulance dispatch.
- 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.
- OMC led daily Urgent Community Response (UCR) calls, to facilitate appropriate referrals to other services and reduce pressure on frontline operations.

RESPONSIVE CARE

999 Frontline

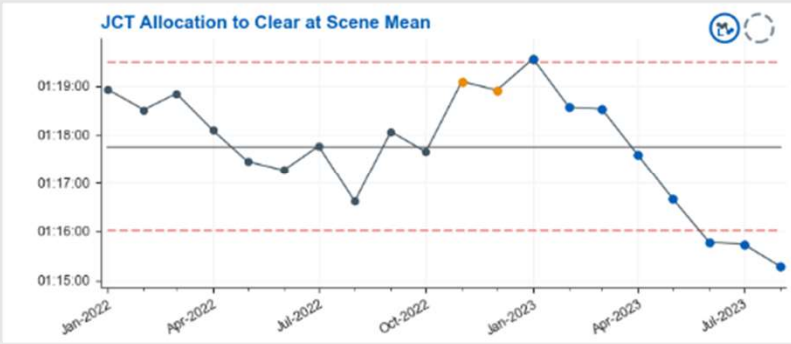
999-17

Dept: Operations 999
IP: Responsive Care
Latest: 1.09
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: 00:23:48

Common cause variation, no significant change.



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:15:17

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

999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:50:14

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

Summary

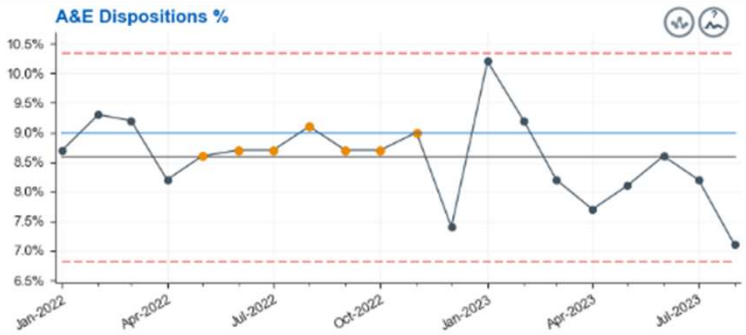
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with a deterioration in April however, August experienced a significant improvement.
- ***Job cycle time*** (JCT) provides a single metric between two points in the incident journey and is directly impacted by several 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 require longer to make referrals for ongoing care within the community. JCT has been on a improving trajectory this calendar year.

What actions are we taking?

- The Trust commissioned an external ***AACE review of the Dispatch function***, and the recommendations are currently being addressed 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 monthly. Phase 1 of this plan is due to be completed in September 2023.
- Continued focus on delivery of ***Paramedic Practitioner hubs*** to ensure optimal response to ECALs from crew staff to assist with on-scene decision making and signposting to clinical pathways; also support to work with OOH GP/primary care call-backs.
- Specific work has been undertaken in local dispatch desk areas focusing on hospital handover and on-scene times, which has resulted in the noted improvement in ***job cycle time*** since early 2023.

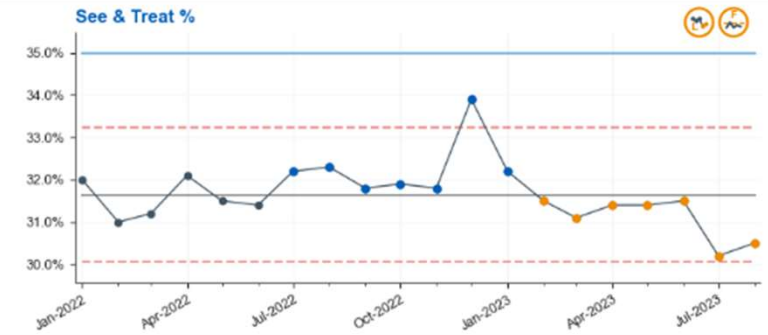
RESPONSIVE CARE

111/999 System Impacts



111-5

Dept: Operations 111
IP: Responsive Care
Latest: 7.1%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



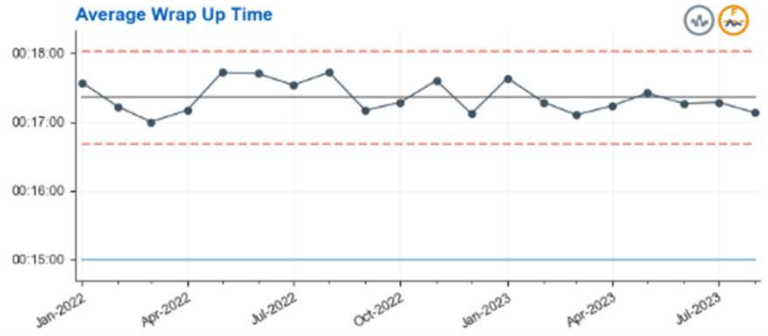
999-9

Dept: Operations 999
IP: Responsive Care
Latest: 30.5%
Target: 35%
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.

999-24

Dept: Operations 999
IP: Responsive Care
Latest: 2453.24

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



999-31

Dept: Operations 999
IP: Responsive Care
Latest: 00:17:08
Target: 00:15:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

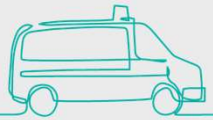
- The ***111 to ED disposition rate*** has been maintained at a very low level since the introduction of "111 First", Direct Access Booking (DAB) and ED validation. The Trust's 111 service has excelled at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111 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.
- 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, and this has been sustained in recent months, resulting in a performance that is currently on track.

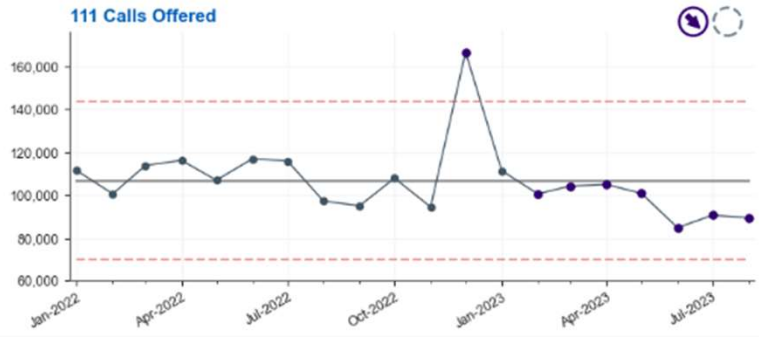
What actions are we taking?

- 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.
- Daily calls, held by Operations Managers Clinical (OMC) are held across Surrey, Kent and Sussex ICBs, with downstream providers to optimise system capacity.
- 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 because of this collaborative work.

RESPONSIVE CARE

111





111-1

Dept: Operations 111
IP: Responsive Care
Latest: 89543

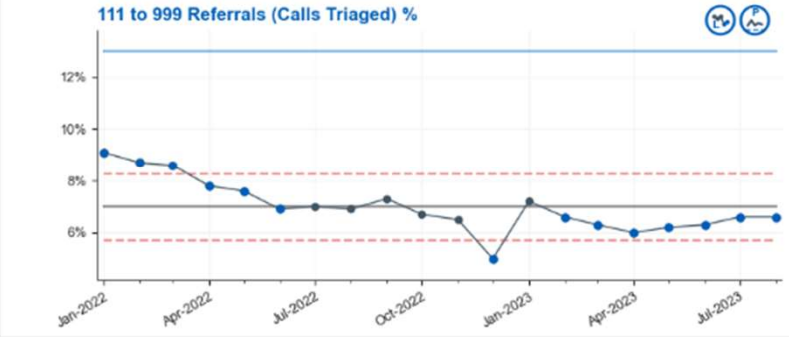
Special cause variation where DOWN is neither improvement or concern

111-3

Dept: Operations 111
IP: Responsive Care
Latest: 16.1%
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: 40.1%
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: 6.6%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Summary

- The service's ***operational responsiveness*** remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned calls.
- 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*** remain strong, and the service 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 (DAB)***, both of which exceed the NHS E national average.

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 - it is important to note that the Trust does not have enough funding in 2023/24 to meet the contractual operations metrics.
- 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 has ***secured additional support*** from an established 3rd party 111 provider, to support operational performance delivery across the first 5 months of 2023/24 on a 24/7 basis.
- The service is rapidly bridging its Health Advisor shortfall, because of the move to Medway in July, with almost 40 new Health Advisors passing NHS Pathways training and going live on the phones over the past two months.

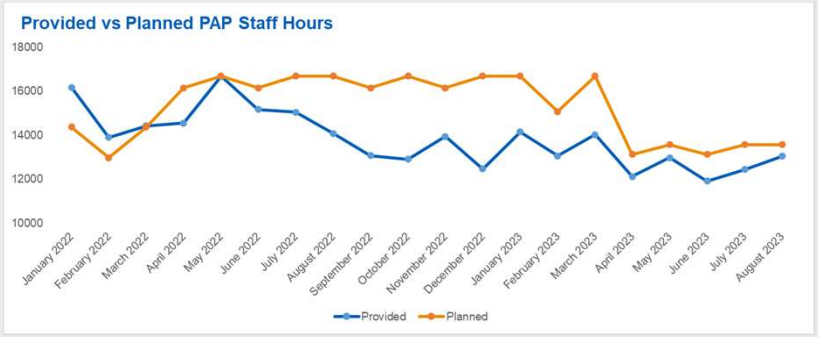
RESPONSIVE CARE

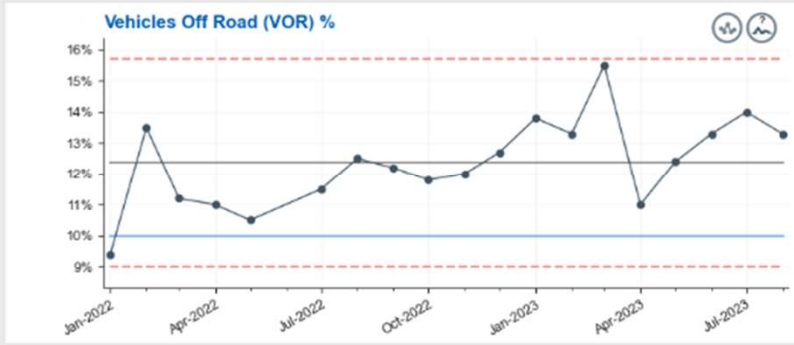
Support Services
Fleet and Private Ambulance Providers

FL-12

Dept: Fleet
IP: Responsive Care
Latest: 89

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





FL-13

Dept: Fleet
IP: Responsive Care
Latest: 13.3%
Target: 10%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

FL-3

Dept: Fleet
IP: Responsive Care
Latest: 62%

Common cause variation, no significant change.

Summary and Action Plans

Critical Vehicle Failure Rate and VOR Currently 25% of our operational DCA 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 known 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 managers group and escalated to Stellantis. 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.

The planned vehicle services lower compliance is driven by the vacancies – however we have an overly onerous regime of checks, and this is being reviewed as part of the efficiencies programme 23/24. This will be done in a way that we still remain in manufacturer guidance and ensuring vehicle safety is not compromised.

What actions are we taking?

Current concerns around parts supply have been raised nationally by Fleet Managers with an escalation meeting with Stellantis happening at the start of October.
Work is still ongoing nationally with DCA national specification refresh, Now the specification has been signed off all 3 DCA lots have gone out for tender by manufacturers. Those lots are for Lot 1: DCA Van conversion, Lot 2: Box Conversion and LOT 3: EV DCA Conversion.
Minor adjustments have been made to planned servicing schedules (mainly for non-operational vehicles) in collaboration with maintenance staff to reduce frequency and improve efficiencies in other areas.

Our **PAP** hour provision is now in-line with the 120 WTE capacity contracted for 23/24 and on-track to deliver a 5% financial saving as part of the wider efficiencies program. In addition, the roll-out of iPads to PAPs commenced in August and will be completed in Q3. We are also working with St John Ambulance to provide additional DCA capacity (c- 5/6 shifts a day at nil cost to SECAmb) from September, under the NHSE/I national surge support initiative, to strengthen our partnerships in preparation for the winter.

NHS
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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

£000s	August 2023				Year to August 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance		Plan	Actual	Variance	
Income	26,617	27,074	457	✓	132,790	133,820	1,030	✓	318,980	321,996	3,016	✓
Operating Expenditure	(26,522)	(26,974)	(452)	✗	(132,460)	(133,475)	(1,015)	✗	(318,982)	(321,998)	(3,016)	✗
Trust Suplus/(Deficit)	***95***	***101***	***6***	✓	***330***	***345***	***15***	✓	***(2)***	***(2)***	***0***	✓
System 'Control' Adjustments	*0*	*0*	*0*	✓	*1*	*1*	*0*	✓	*2*	*2*	*0*	✓
Reported Suplus/(Deficit)	**95**	**101**	**5**	✓	**331**	**346**	**15**	✓	**0**	**0**	**0**	✓
Cash	40,985	41,224	239	✓	40,985	41,224	239	✓	50,400	47,506	(2,894)	✗
Capital Expenditure	1,222	1,087	135	✓	5,858	8,229	(2,371)	✗	25,867	26,792	(925)	✗
Efficiency Target	700	965	265	✓	2,150	1,584	(566)	✗	8,988	8,988	0	✓

Summary

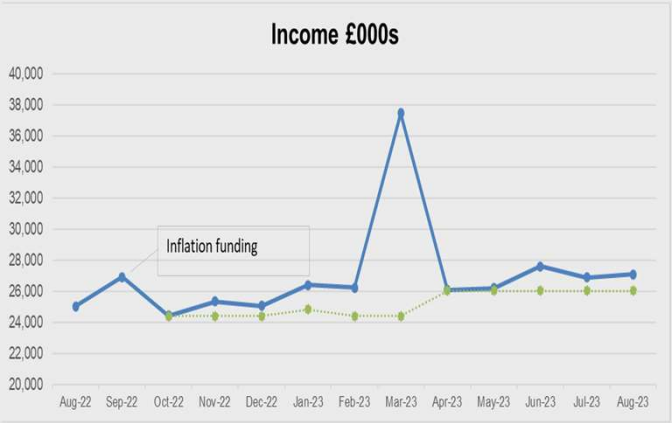
1. The Trust's financial performance is in line with plan with a surplus of £0.3m being reported YTD M5 (August). Financial pressures of £1.0m in operations were partly mitigated by vacancies across the Trust, profit on vehicle disposal and higher than planned interests received on cash in bank.
2. The efficiency programme has delivered £1.6m worth of savings at M5 YTD, which is a shortfall of £0.6m. 77% of the schemes have been generated recurrently. There is a concerted effort being made by SMG to identify efficiencies.
3. Cash position was £41.2m (£0.2m above plan) due to the timing of settling supplier invoices. The Trust is forecasting a cash position at the end of March 2024 of £47.5m, which is 5.7% below plan. This is driven by anticipated pressures in operations.
4. Capital expenditure of £8.2m is 40.5% above plan mainly due to the acceleration of spend to strengthen resilience of IT infrastructure. The Trust is confident that it will deliver its capital departmental expenditure limit (CDEL).
5. The Trust is forecasting to achieve the breakeven year end plan including delivery of the £9.0m underlying efficiencies.

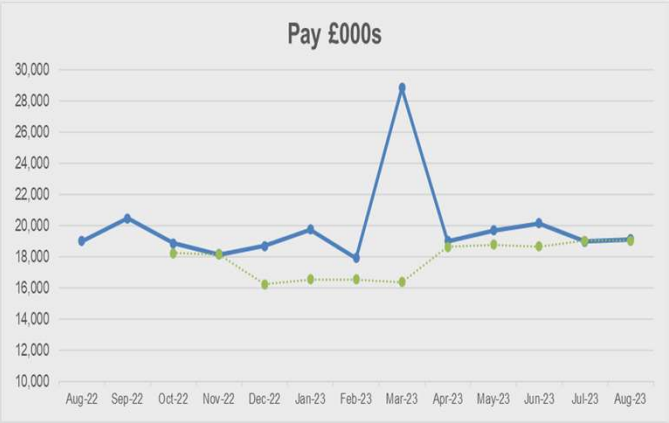
What actions are we taking?

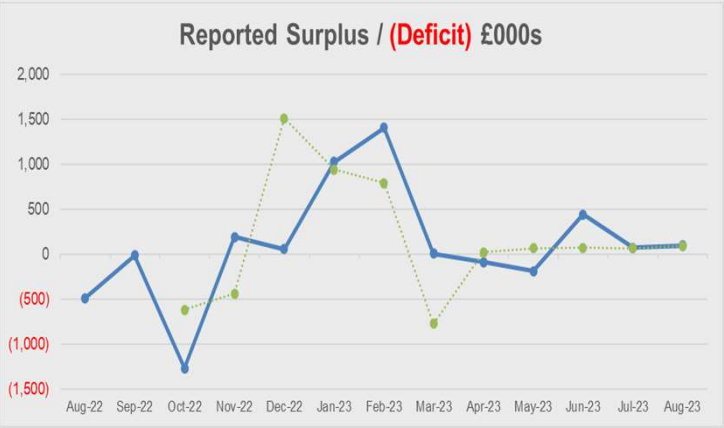
1. The Trust is working with budget holders to ensure that any overspends are brought back into line with the allocated budget allocation.
2. The Senior Management Group is focusing on identifying further efficiencies to support the delivery of the target of £9.0m. Weekly Check and Challenge reviews are in place to drive progress and the development of new schemes. This includes identification of opportunities and recognition of non-recurrent underspends to support the Trust achieving its efficiency target. Five new schemes were identified from our people's ideas which have been added to the pipeline tracker in M5. The pipeline and delivery trackers capture progress of the schemes identified, milestones and quantification of the financial opportunity of each scheme. Regular updates are being provided to the Joint Leadership Team meetings and Finance and Investment Committee.
3. Monthly Executive led directorate meetings are continuing to take place to nsure that each directorate delivers their element of the financial plan e.g., budget and efficiency target.
4. The deep dive carried out on the overspend in operations and the remedial actions identified to mitigate financial risk and to support the delivery of the Trust's financial breakeven plan at year end is tracking as expected.

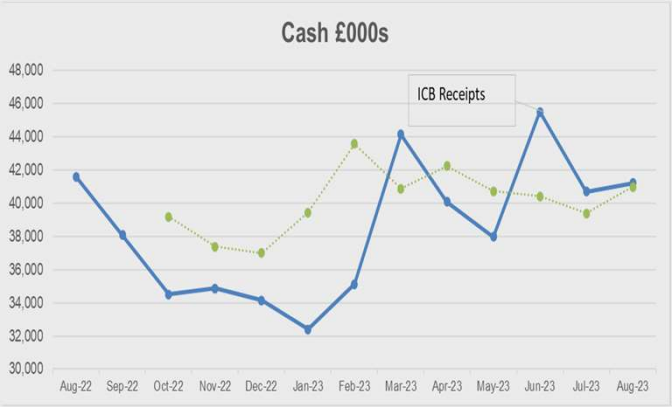
SUSTAINABILITY & PARTNERSHIPS

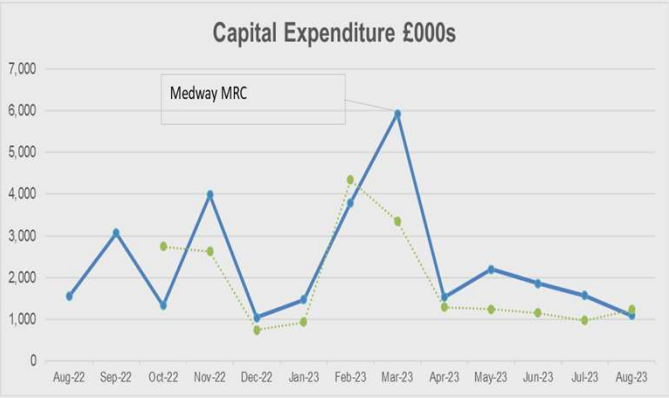
Delivered Against Plan











Summary

- The Trust's YTD M5 financial performance of £0.3m surplus is on plan.
- Financial pressures, notably in operations were partly mitigated by non-recurrent measures, including 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 surge in month 3 (June 2023) relating to the additional cost and income due to the NHS pay deal and the corresponding ICB cash receipts. Further capital expenditure is mainly 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

Agenda No	52-23

Name of meeting	Trust Board
Date	05 Oct 2023
Name of paper	Operational Performance & Efficiency
Strategic Theme	**Responsive Care**
Author / Lead Director	Emma Williams, Executive Director of Operations

Executive Summary

Overview

This paper provides an overview of the operational delivery functions of the Trust, particularly those linked to the goals within the Responsive Care strategic priority and is aligned to the risks identified in the Board Assurance Framework.

In summary, the Trust continues to focus on meeting the presented demand in a way that ensures delivery of a safe and responsive service, recognising the significant challenges that are experienced in doing so. Whilst progress against the C2 mean performance requirement is strong, call answering delivery continues to be poor despite concerted efforts to improve workforce recruitment and retention. The support of patients/callers via a 'hear and treat' approach is gaining strength resulting in additional resources being available for physical response as required. Progress against other aspects of the 999 and 111 services is included elsewhere in the paper with narrative against each of the goals.

Finally, it was with great excitement that the EOC team that had been based at Coxheath finally moved to the new hub site in Medway, joining the MRC and 111 service already located there.

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

RC1: A category 2 mean response time that is improved and closer to national standards.

- **RC1: C2 mean of 26mins 43secs (August), noting YTD (to 27/09/23) C2 to of 28mins 12secs.**
- Key messages:
  - This positioned SECAmb favourably against other ambulance services – 3rd out of 11 English ambulance services. The Trust remains in the bottom third for C1, C3 & C4 metrics.
  - Higher staff hour provision together with lower call volumes have led to an improvement in C2 mean. Both sickness and annual leave are showing an improved picture from last year.
  - Improvements in mean job cycle time have slowed, but the improvements appear to be embedded resulting in tangible, quantifiable efficiency improvements.

- Handover times are well in control and showing a significant and sustained improvement over last year's performance.
- At present approx. 1000 additional hours are being provided through the additional shifts because of the £2.5m extra funding to the end of October. This is not the fully allowance, however it is expected that this will pick up further in September following the end of the summer holidays.
- An initial review of the resource impact of the new rotas shows that both hourly compliance and late sign-off have moved in a positive direction for both metrics – as compared with June 2023, hourly compliance across the trust has increased on average from 88.14% to 90.19% and LSO has reduced from 48.6% to 45.5% with a mean duration decreasing from 36.9mins to 35.5mins.
- There is continued focus in all areas to reduce the impact on emergency departments, with encouragement for staff to refer patients to alternative pathways as appropriate. This has received additional focus in the Maidstone area where a short (4 week) trial has commenced – a doctor-led multi-disciplinary team has been set up (the West Kent Clinical Hub Pilot) whose intention is to support clinical decision making of ambulance and community clinicians with the intention to ensure appropriate onward referral/treatment of patients with applicable presentations. Early feedback is very positive.
- The junior doctor strikes continued in August and whilst there was a significant impact on the Acute Trusts, overall, very little impact was seen for SECAmb patients and crews thanks to planning and local collaborative working across all teams.

RC2: A call answer mean of in line with ARP performance standards (5sec).

- **RC2: Call answering mean 24secs (August).**
- Key messages:
  - 999 calls offered remains consistent and within expected ranges for this time of year.
  - Call answer time is more than four times the national target – National performance tables for August showed SECAmb in 11th place (out of 11) with no improvement on July's performance.
  - Experienced staff are key to greater efficiency in call answer performance per resource hour provided. This can only be achieved with improvements being made in the quality & quantity of staff recruited, and in staff retention.
  - The poor call handling performance is being seen despite additional overtime being made available as part of the £2.5m additional national funding.
  - The BAF performance risk is under review with additional narrative and content relating to a specific call handling risk.
  - A comprehensive paper was presented to QPSC in August considering contributory factors and implications for patients, staff, and the Trust. A further review and discussion was held at EMB on 27/09 to agree priority and additional actions.
  - Next steps: 1) Buy additional volume of another ambulance service; 2) Incentivising key shifts; 3) Dual-skill training for cohorts of 111 Health Advisors; 4) additional 11 HA courses converted to EMA training courses. Further information is provided in the additional presentation on call handling within this month's Trust Board pack.

RC3: Implementation of dispatch improvement functions to improve effectiveness of resource utilisation.

- **RC3: Mean activity on own dispatch desk 100.4%, with a maximum variation at 38.7% with a consistent pattern of those areas who both 'export' and 'import' resource**
    - Progress against the recommendations/actions within the review continues, with phase one focusing on improving processes and efficiencies within the team.

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

RC4: Improvements in our 'Hear and Treat' rate to a minimum of 14%.

- **RC4: 'Hear & Treat' for August was 12.1%.**
- Key messages:
    - Hear & Treat is showing ten weeks of sustained improvement and is now at the highest level seen since comparable records began (July 2017) and is in line with the Trust trajectory for this metric across the financial year.
    - H&T for August was at 12.1% - this places SECAmb 4th out of the 11 English ambulance trusts, a significant improvement over previous months, and on track against the agreed trajectory.
    - Through an increase in hear and treat, more patients are being assist virtually, therefore resulting in a slightly lower proportion of calls requiring an on-scene attendance, positively impacting resource availability.
    - C2 segmentation commenced 06/09/23. It is live daily between 12:00-22:00 with 2 dedicated clinicians, commencing with daily briefing for those undertaking the role that shift. Weekly key metric data is submitted to NHSE. Within the first week 32.2% of C2 activity met the criteria to be suitable for C2 seg. As a principle of the C2 seg. process is to ensure there is no delay to the patient through clinical review and contact, many C2 incidents that could be validated are dispatched upon and so miss the opportunity of the initial review to determine if they could receive a clinical assessment. Upon review, 8.99% of those calls clinically assessed via C2 seg. resulted in a downgrade to a H&T disposition, with 23.64% being diverted away from an ED, and 19.54% resulting in a downgraded ambulance response.
    - Progress against spending the additional money allocated for clinicians out of the £2.5m progresses well resulting in additional clinical capacity for H&T and C2 seg.

RC5: Continued working on key/national programmes – 999 IRP, & response to Manchester Arena Inquiry recommendations.

- **RC5: This is on track with the requirements within this programme of work,**
- Key messages:
    - 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%. 92% of attendees report that they have completed the day and now feel more confident about responding to major & complex incidents.

- Continued working with partner emergency services in the South East region and with national ambulance programme on the suite of recommendations from the Inquiry. The Trust is also preparing additional details relating to potential additional costs to meet the inquiry recommendations, in-line with other ambulance services.

RC6: Improved utilisation of all clinical resources from volunteers to specialist practitioners to achieve improved performance.

- **RC6: Focus on Specialist Paramedics (CCPs & PPs) and the Community First Responder (CFR) teams.**
- Key messages:
  - CCPs to support management of the number and duration of resources on scene through review and callback of appropriate calls.
  - PPs to complete additional training to utilise the PACCs system to provide MRC-based support for clinical callbacks.
  - Continued implementation of the falls training of CFRs, with additional focus on increasing utilisation.
  - The Emergency Responder pilot is coming to the end of its first year and working with colleagues from the Medical Directorate, clinical oversight and review continues to support the end-point evaluation next year.

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

RC7: An improvement in on-day out of service, late shift over-runs both a % of shifts and mean over-run time

- **RC7:** Current focus on Late Sign-Off (LSO) with improvements in % of shifts and duration of over-run since the start of the financial year and since full rota implementation in July.
- Key messages:
  - A comprehensive paper on LSO was presented to the People Committee in July building on the findings in the initial paper earlier this year and identifying the improvements in metrics seen more recently.
  - The programme of work related to on day out-of-service has been wrapped into a review of the functions of dispatch and the 24/7 tactical hubs.

RC8: Integration of EOC, 111 and MRC operations in one site at Medway.

- **RC8: Full delivery of all services on site at Medway is complete.**
- Key messages:
  - EOC East finally moved from Coxheath to Medway with the first shift commencing at 06:00 on Thurs 14th Sept. Initial feedback from staff has been positive in terms of both the new facilities and the co-location with the other services (MRC and 111).

Resilience & Specialist Operations

Hazardous Area Response Team (HART).

- Function: To provide the response arm for Specialist Operations, ensuring that care is available for patients in hazardous and challenging environments, as well as providing support to the wider SECAmb operations on more complex incidents.

- The KPI for HART is to ensure that there are 2 teams of 6 operatives on duty 24/7 – this is a significant challenge in the current environment due to funding issues and high sickness/absence levels within the team, partially linked to the introduction of the new physical competency assessment. August data shows this requirement was met 43.5% of the time, with 68% of the time there being a minimum of 10 operatives on duty, i.e. the Trust can provide 2 live teams.
- Staffing numbers are shared with the Strategic Commander daily on the 08:15 call. Any staffing shortfalls are addressed through normal mitigations up to and including the HART degradation plan (where total numbers of staff are 6 or less across each/both teams).
- The NARU Interoperability Report was published and its recommendations reviewed – an update on this will be presented to the Trust Board in December.

Specialist Operations Response Team (SORT).

- Function: The SORT manager and training team in Resilience are responsible for providing oversight and training for those wider trust operational staff who have volunteered to take on extra skills for MTA and CBRN incidents. (Required 290 Volunteers).
- The KPI for SORT is to have 35 trained staff on duty between 06:00 and 02:00 – in August the compliance against this metric was at 91.9% (100.0% during day shifts and 83.9% during the late/night shifts).
- 232 SORT staff are live currently, with targets have been set for each dispatch desk, and all SORT manager and training roles have been recruited to.

111

- Performance remains below target for call answering at 40.1% with an associated abandonment rate of 16.1%.
- Health Advisor (HA) vacancies remain at approx. 18% of the required levels, although initial results of the enhanced recruitment at the new Medway site are looking positive. Clinical staffing levels are on track with the target level delivering the multi-disciplinary workforce including paediatric, dental, and mental health nurses, pharmacists and GPs.
- Outcomes remain strong with the Kent, Medway and Sussex service being best in class for both ambulance disposition and direct booking into EDs.
- The 111 contract is required to undertake patient surveys and for July 6,000 were sent, 540 received (9.0%). The results showed 52% Very good experience & 14% good which is consistent with previous months, very poor is 15%.

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

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	52-23

Name of meeting	Trust Board
Date	05.10.2023
Name of paper	Patient story
Trust Priority Area	Delivering Modern Healthcare / Operational Performance
Author / Lead Director	Emma Williams, Executive Director of Operations

Sean Edward, Practice Development Lead, will be joining the Board meeting to outline one of the projects in place to help manage demand. Further details of this can be found here: Clinical Coordination Hub

This will help to frame the Board's consideration of the Winter Plan which sets out our approach to demand management over the coming months. One of the main aims will be to sustain the response times in C2 and take steps to improve our call answer performance, which impacts more directly our ability to respond in a timely way to patients requiring a C1 response. There is a separate paper describing the corrective actions we are taking in response to the 999 call handling challenges.

Recommendations, decisions or actions sought	The Board is asked to consider this Board Story as context for its consideration of the plan in place to meet the demands over the coming winters months.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	52-23

Name of meeting	Trust Board
Date	05 October 2023
Name of paper	Winter Plan 2023-24
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Emma Williams, Executive Director of Operations Dave Williams, Head of Resilience & Specialist Operations
Update summary	• As part of the annual cycle of business SECAmb is required to draft a plan for responding to the additional pressures and issues expected over the winter period. Some of these may directly affect the Trust, its patients and staff, others may have an indirect impact, such as those affecting patient flow across the wider system, which in turn results in an increase in hospital handover time. • This 2023-24 winter plan is a live document of which this is the first iteration. As with all plans, there is an understanding that as we progress into and through the winter period, the plan and associated actions will need to flex dynamically according to need. • The plan contains an overview of the current context in with SECAmb operates, some lessons identified from the 2022-23 financial year, and predictions on demand, resourcing, performance, and other challenges/issues expected. • At this time this paper contains the overarching, strategic content, with appendices currently being collated so each team/department is able to contribute their particularly aspects/contributions to maintaining service delivery over the months ahead.
Recommendations, decisions, or actions sought	• Trust Board to note the strategic content of the winter plan, to gain assurance on the planning that continues to go into each iteration, and the predictions of impact and challenges relating to service delivery over this period. • Following review at the Trust Board, further enhancements will be included and then the plan will be shared with all key local and regional stakeholders.

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

SECAmb Winter Plan 2023-24

V0.2

Please Note that this is a working document and will be updated as new information is obtained or the situation changes.

Contents

1. Context: Regional

- The NHS continues to experience significant levels of demand. The ongoing impact of Industrial Action and health inequalities has caused extended waiting lists, poor health outcomes and increasing co-morbidities.
- The NHS continues to experience significant levels of Urgent and Emergency Care demand. Moving towards the winter period, this is expected to increase, at a time when the financial situation of ICBs has translated into operational challenges for providers.
- SECAmb has experienced a particularly challenging year, with operations being faced with several significant problems including heatwaves, drought and extended periods of Industrial Action.
- This year's winter plan has been structured to include additional considerations such as:
  - Recognition that the NHS is undergoing extended periods of Industrial Action.
  - Continuing significant patient flow issues across the south-east region challenge partner providers in terms of their resilience and ability to respond to dynamic surges which in turn could impact interactions such as handover capacity/times.

1. Context: Trust

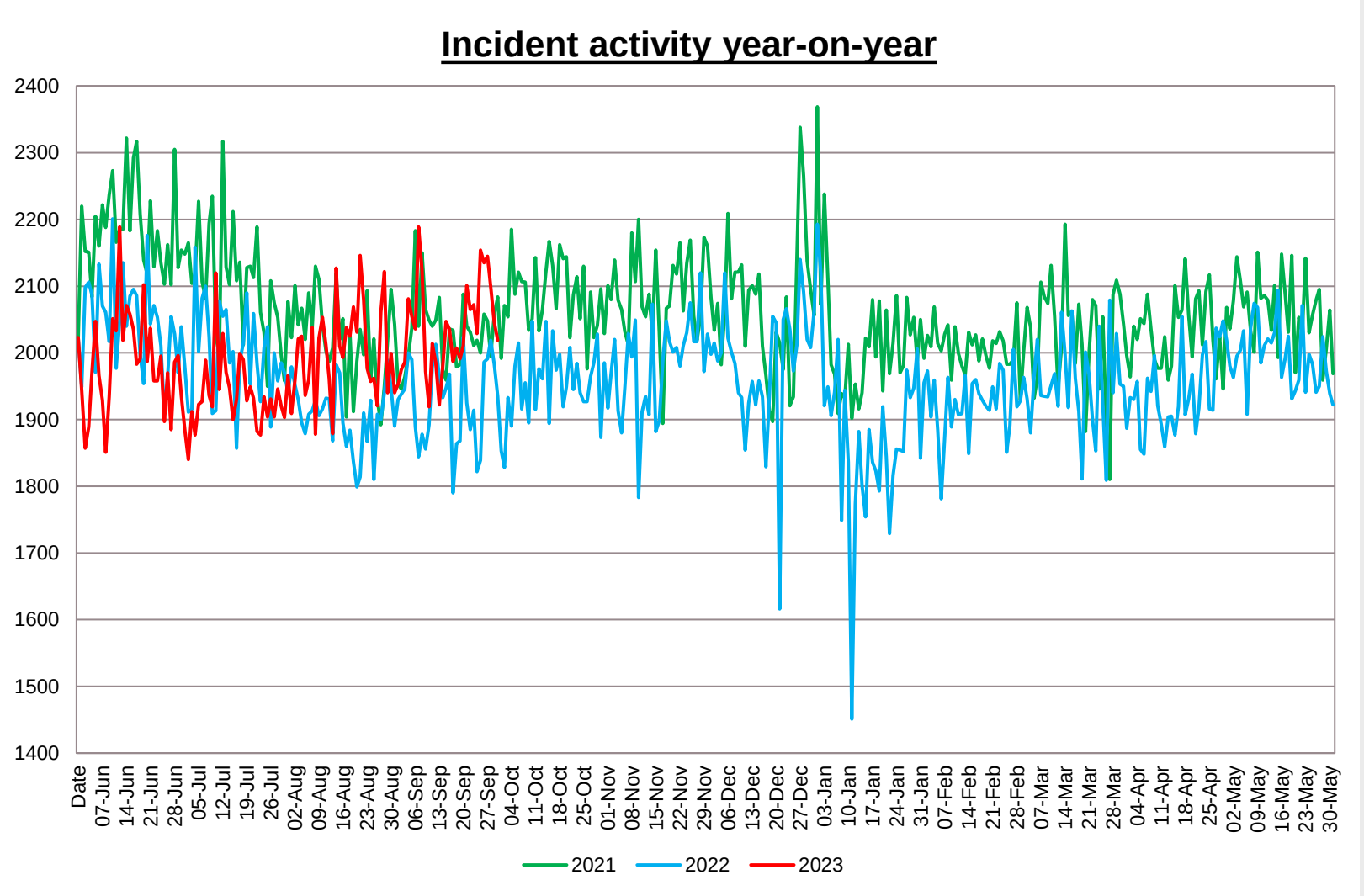
- The Trust is currently not meeting ARP performance standards for either the previous month or YTD. NHSE have stipulated that there are 2 priority metrics for 2023-24:
  1. Call answering mean – SECAmb is significantly off track for this metric. A full review and comprehensive suite of additional actions has been drawn up to improve this position in both the short and longer term.
  2. C2 mean – The requirement for this financial year is to achieve a mean of 30mins or less. As of 30/09/23, the Trust are delivering well against this target and in comparison, to the overall national position.
- Workforce challenges remain one of SECAmb's highest priorities – whilst significant focus and work has resulted in an improving sickness and overall abstraction rate, the sustainability of this position may become more difficult over winter.
- The balance of demand and resources results in extended periods of time at high levels of escalation.
- Ongoing high levels of system engagement focus on supporting use of care pathways in the community as an alternative to ED, plus building/maintaining strong local links to manage local surges affecting hospital handover.

2. Learnings from winter 2022-23

- Weekly system-wide (multi-ICB) escalation calls allowed shared situational awareness and pre-emptive actions to be planed.
- Early escalation to ICBs regarding acute hospital issues to support early resolution of ED issues.
- Access to the Trust business intelligence system allowed the ICBs to resolve some of their own issues and reduced the need for frequent reporting of key metrics.
- Separating out the industrial action (IA) from core business allowed the Trust to continue focusing on core business whilst mitigating the impact on preparation and delivery of actions relating to the periods of IA. Military assistance proved invaluable on these occasions.
- An Incident Coordination Centre which was set-up for the IA served a dual purpose on these days of overseeing the impact of IA and winter pressures on these specific dates.
- SBAR reporting was implemented at times of significant pressure, such as IA, BCIs etc. The utilisation of this method of sharing information reduced the need for additional system/regional calls.

3. Year on year activity

- The start of 2023 commenced in a way more akin to 2022, however over August & September activity increased to be more closely aligned to the 2021 year – a higher level of activity across the winter period.
- To note: the dates with significant lower activity in 2022 relate to days of ambulance service industrial action



4. Objectives

999 Objectives

- Call answering mean within 5 seconds.
- C2 mean at 30 mins max.
- Heat & Treat as per trajectory (>12% and improving).

111 Objectives

- Call answering improvements.
- Continued system support system via ED direct booking, and ambulance revalidation.

Staff Welfare Objectives

- Monitoring of meal break compliance.
- Continued improvements in late sign off.
- Christmas period additional welfare support.

5. Winter 2023-24 – Predicted Activity

Awaiting data for:

- 999 Calls
- 999 Incidents
- 111 calls

5. Winter 2023-24 – Predicted Resourcing

Awaiting data for:

- 999 EMA resourcing
- 999 DCA/Front-line resourcing
- 111 HA resourcing

Notes:

- Emergency Medical Advisor (EMA) recruitment and retention within the call handling function in the 999 Emergency Operations Centres remains a Trust key focus with performance seen through the summer andearly autumn significantly off plan.
- Field operations completed a full rota change implementation in early July which maps resource provision more closely to demand/need.

5. Winter 2023-24 – Predicted Performance

Awaiting data for:

- Call answering (plus trajectory)
- C2 mean (plus trajectory)
- Hear & Treat (plus trajectory)

5. Winter 2023-24 – Staff Welfare & Support

- Annual leave across the period will be granted in alignment with Trust policy – over the 2 weeks of Christmas (W/C 25/12/23 and 01/01/24) this is set at a lower level considering predicted significant additional pressures over this winter.
- Additional welfare support is planned for the Christmas period and should there be particularly inclement weather – this to include the provision of welfare vans and additional consumables at base stations.
- The Trust's welfare hub will continue to provide signposting and access to physical and mental services such as physiotherapy and counselling for staff who self-refer for support.

6. System Partnerships

A range of activities specific to winter continue with Trust engagement. These included but are not limited to:

- Continued participation in Local Health Resilience Partnerships (LHRPs), working with health provider partners across all counties to develop shared plans for the continuation of care delivery in all circumstances.
- Continued participation in county-based Local Resilience Forums (LRFs) winter preparedness programmes – each forum holds an annual summit delivering integrated planning across health and non-health organisations.
- Participation in local, regional and national exercises, e.g. Kent winter planning follow-up event 28/09/23.
- Continued engagement with commissioning partners through a schedule of functional governance and engagement meetings on a weekly/monthly basis.

7. Expected/predicted challenges

- Workforce challenges due to high levels of abstraction and staff turnover continue to bring significant challenge to the ability to deliver a consistently robust service. This is particularly relevant in the 999 EOCs where additional high priority actions are being undertaken particularly in relation to the EMA workforce.
- Long-term weather forecast predicting warmer weather however adverse weather potential continues – this will have an impact on demand on Trust resources, capability of staff to attend the workplace and mobile resources to attend patients as required.
- The annual letter from the NHS England Chief Medical Officer has yet to be published – this usually provides predictions relating to the impact & duration of the influenza/covid season.
- There is the significant potential for continuing industrial action by Junior Doctors and Consultants within acute and other Trusts.

8. SECAmb winter specific actions

- The Trust will run a winter table-top exercise in November to test both operational and support aspects of the winter plan.
- The MOU with St John Ambulance will imminently be signed which will support SJA volunteer crews working alongside SECAmb crews as part of the national programme of ambulance support.
- Additional 4x4 vehicles will be sourced as required according to weather requirements.
- A further learning from the days of IA was that there are non-operational staff who are prepared to undertake support roles at times of significant pressure. Engagement with all departments will be undertaken to identify these individuals and ensure they receive adequate training/preparation to assist as required over winter.

Appendices

Version control

Version No.	Comments
0.1	Initial draft by Dave Williams, Head of Resilience & Specialist Operations
0.2	Updates following presentation of initial plan at EMB on 27/09/23

Team/area specific content
under development

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	52-23

Name of meeting	Trust Board
Date	05 October 2023
Name of paper	999 Call Answering Overview
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Emma Williams, Executive Director of Operations John O'Sullivan, Associate Director for Integrated Care (999 & 111)
Update summary	• Call answering performance continues to be significantly challenged as a Trust which has a significant impact on both the patients/the public we serve and the Emergency Medical Advisors (EMAs) who answer the 999 calls received by the Trust. • This paper/these slides provide an overview of contributing factors including but not limited to recruitment & retention, culture & engagement, efficiencies, and other contextual factors. • It draws to a close with a list of actions that are live, under development and potential actions for consideration.
Recommendations, decisions, or actions sought	• Trust Board members to fully comprehend the underlying factors/issues that contribute to the 999 current call answering performance. • Agreement that the actions identified and proposed are appropriate and that there is a clear link to delivering associated benefits.

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

999 Call answering overview

September 2023

		Agenda No	
Name of meeting	Trust Board		
Date	05 October 2023		
Name of paper	999 Call Answering Overview		
Responsible Executive	Emma Williams, Executive Director of Operations		
Authors	Emma Williams, Executive Director of Operations John J O'Sullivan, Associate Director of Integrated Care (999 & 111)		
Update summary	• Call answering performance continues to be significantly challenged as a Trust which has a significant impact on both the patients/the public we serve and the Emergency Medical Advisors (EMAs) who answer the 999 calls received by the Trust. • This paper/these slides provide an overview of contributing factors including but not limited to recruitment & retention, culture & engagement, efficiencies, and other contextual factors. • It draws to a close with a list of actions that are live, under development and potential actions for consideration.		
Recommendations, decisions, or actions sought	• Trust Board members to fully comprehend the underlying factors/issues that contribute to the 999 current call answering performance. • Agreement that the actions identified and proposed are appropriate and that there is a clear link to delivering associated benefits.		

Contents

1. Hypothesis

The current challenges with the Trust's 999 call answering performance is because of insufficient EMA establishment.

The cause of this deficiency is a direct result of two main factors, recruitment and retention:

1. Inability to attract the right calibre staff, in the right numbers, to work at the right time
2. Inability to retain staff over the long term and achieve optimal productivity

Contributory factors are:

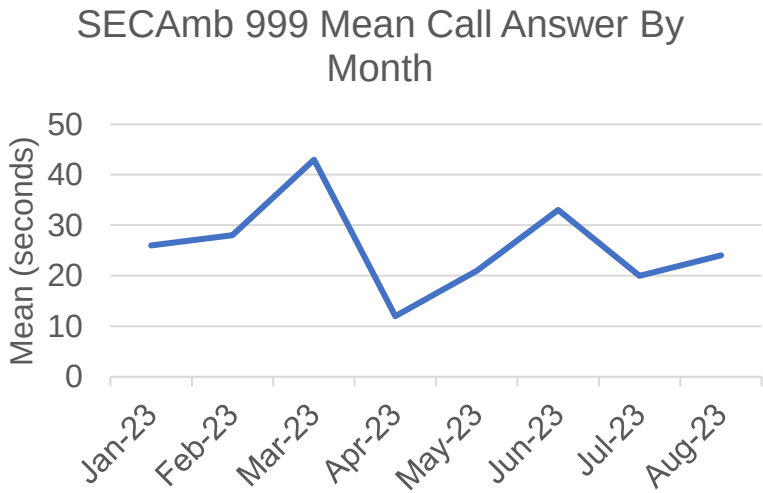
- High-pressured environment
- Relatively poorly paid job for what is required
- Location of Contact Centres
- Delay in moving to Medway and associated uncertainty
- Historically challenging culture with some poor embedded behaviours
- Outdated operating framework and ineffective EMA rotas

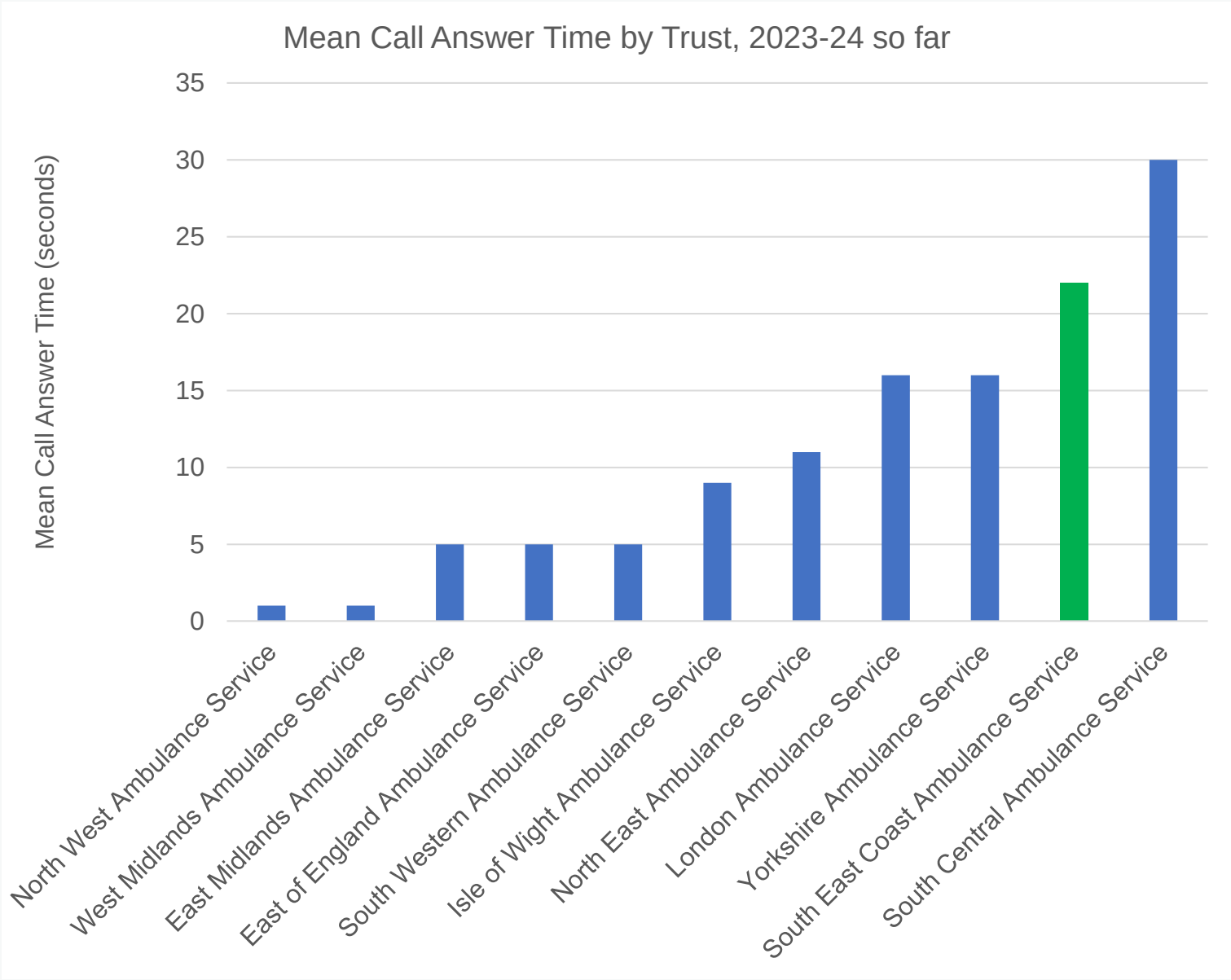
2. Current Performance

SECAmb 999 call answer performance has not reached the expected AQI standard of 5secs

Year To Date Mean call answer is 22secs vs. National average of 11secs

South East England (SCAS, LAS & SECAmb) average 999 Mean is 22secs vs. 6secs for the rest of England





3. Patient impact

Call handling may have an impact on patient safety & quality of care provided for individuals with serious and/or time critical presentations due to:

- A delay in completing an appropriate triage and/or following a triage,
- A delay in providing support/directions for action to care for the patient prior to the crew arrival, or
- Inadvertently driving an increase in duplicate calls that then increase pressure on capacity and mask those callers deteriorating whilst waiting for attention

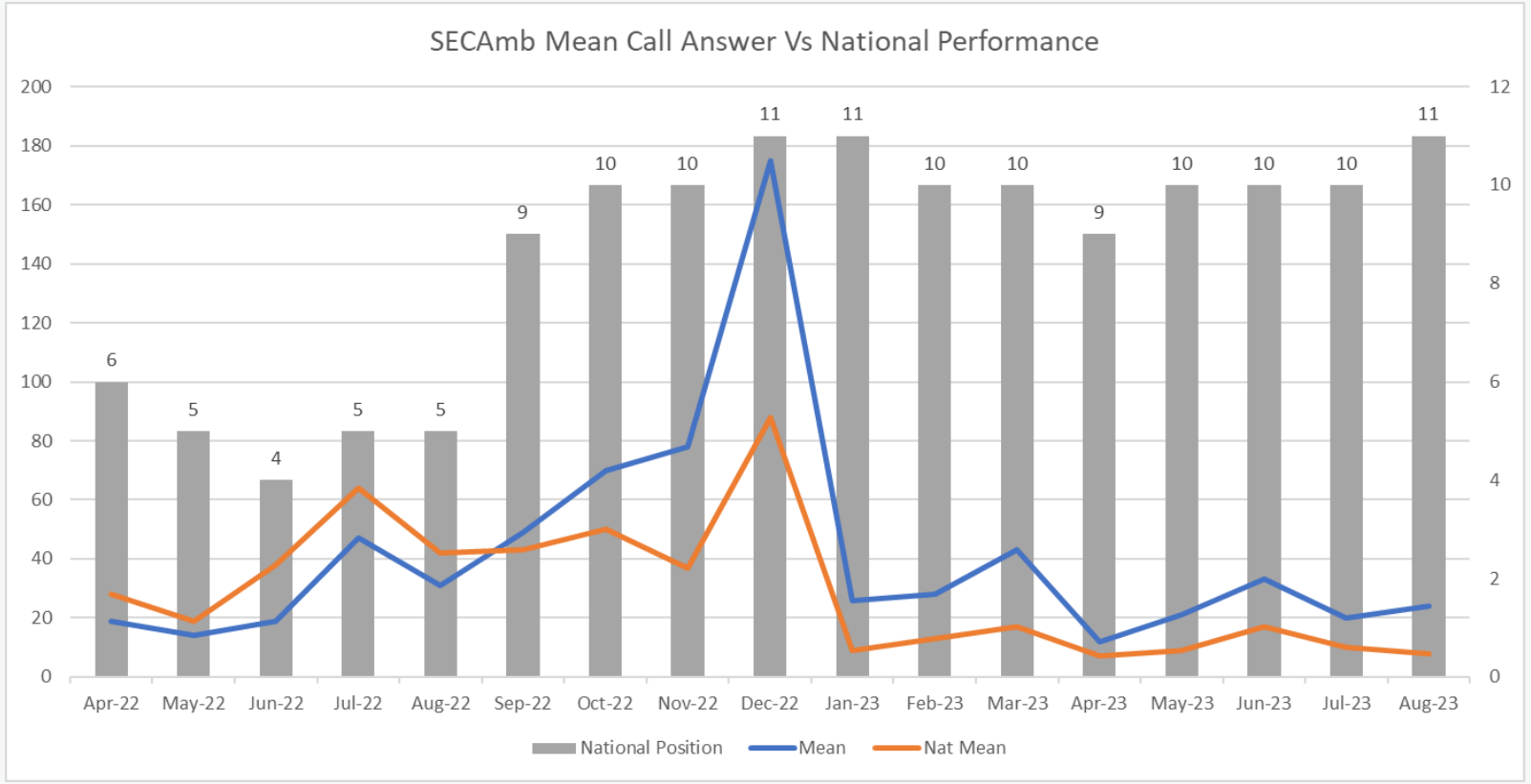
There are a range of activities that occur within the Trust governance mechanism that can include consideration of the implication of long call answering performance:

- Incident review & escalation to the Serious Incident Group
- Tall audits – the last one related to ‘back pain’ presentations, completed June 2023
- A thematic harm review undertaken by the SIG where groups of similar incidents are considered.
- A QI Programme focused on ‘Keeping Patients Safe in the Stack’ has been tasked to address the duplicate calls issue.

4. Contextual factors

A. Performance

- SECAmb performance deteriorated from August 22 due to a fall in Whole Time Equivalents (WTEs). Average monthly WTE fell from 251 Apr- Aug 22 to 210 Sept – Aug 23.
- Primary driver - poor recruitment numbers - 12.75 WTE p/month Aug-December 22 (planned 24 WTE p/month), with 4 courses having to be cancelled April – August 23.



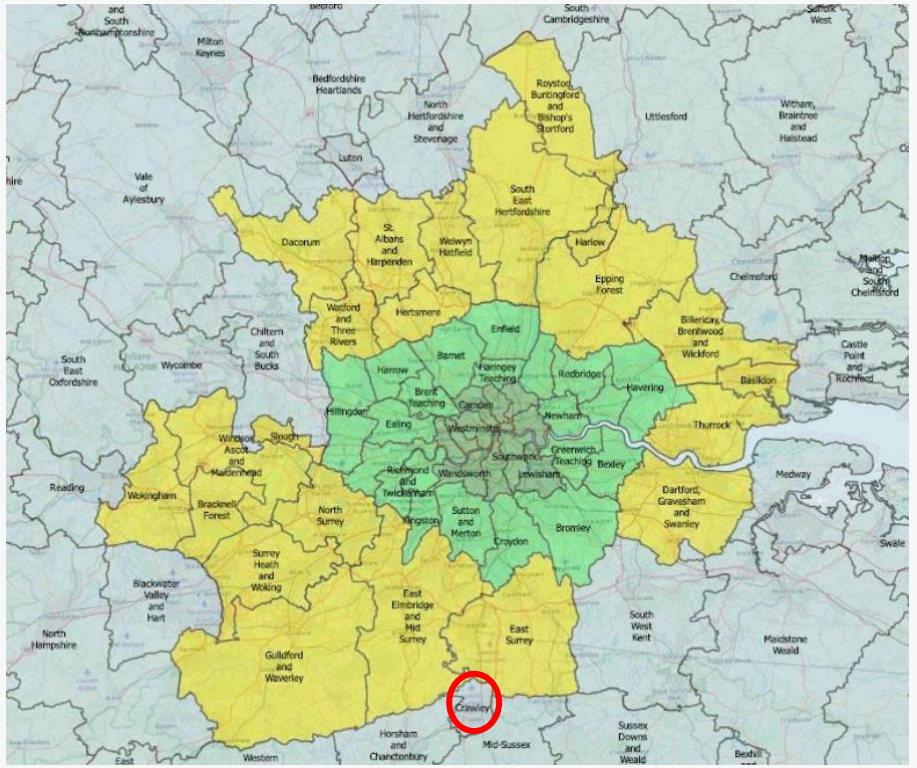
From Sept 22 to Aug 23:

- 432 training slots made available with 264 starting (61% fill) & 224 passing NHS P (85%)
- Forecast 288 WTE new EMAs with only 190 WTE passing NHS P training (66%)

4. Contextual factors

B. **External factors**

- **West EOC** is located in Crawley, a relatively affluent area just to the south of the "High Cost" Area Supplement Agenda for Change payment, and a competitive marketplace. Crawley Borough Council reported 1.46 jobs per working-aged resident in Dec 2018. (Crawley Borough Council - Local skills gaps and needs Crawley)



- **East EOC** has moved from Coxheath to Medway this month. Initial impressions are that this move will support recruitment in future, but the transition and the delays in this move resulted in redundancies (14 colleagues have been made redundant at the time of move; 19 will start a trial ending 10th Dec 2023) and recruitment challenges over the past 12-18 months, due to uncertainty about where people would be working.

- **The NHS** is facing national recruitment challenges, with poor pay and a media image of an organisation facing constant crisis and controversy within and outside of the care environment.

4. Contextual factors

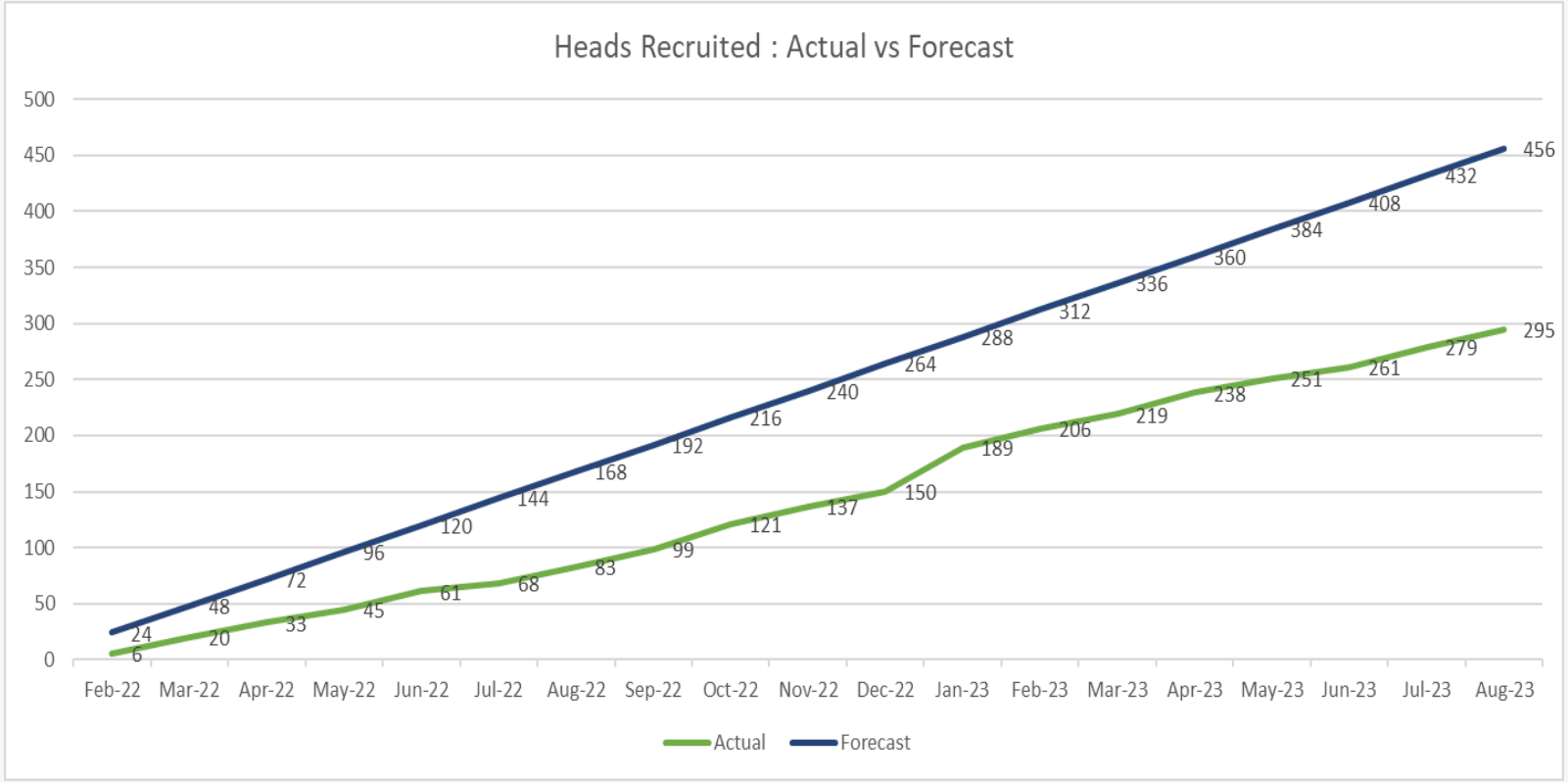
3. **Internal factors**

- Internal staff progression – large proportions of EMAs leave for roles within EOC and the Trust
- Poor rotas – legacy rotas from previous contact centres are still in place (6 years after moving)
- No restructure – Trust moratorium placed on organisational change in EOC and 111 until after the Medway move
- No fit for purpose workforce tool – unable to complete basic tasks such as dynamic heat maps to optimise staff deployment
- Staff tenure – EMA Average Handling Time improves proportional to duration of service
- Staff sickness – Highest category of absence in EOC and 111 is linked to stress and anxiety
- Onboarding is lengthy, complicated and uncertain – candidates for training must pass the NHS P course or their contract is terminated, thereby inflating attrition numbers
- Candidates are not always at the standard required to fulfil their role
- Advertising and attraction for the role has been limited and unclear

5. Recruitment challenges

Forecast assumptions:
57 courses - 3 training courses p/month planned
684 new trainees - 36 per month
570 Heads to pass (456 WTE) - 30 p/month (24 WTEs)

Actual recruitment:
55 courses planned
445 trainees planned
338 attended and passed NHS P training (295WTE)



Recruitment support from IUC Operations started Aug 22:

- Additional paid advertising
- Re-design of advert and use of external agencies
- Staff support given to HR Recruitment
- Redesigned interview templates to be more robust
- Started Psychometric Testing Procurement

Impact:
Feb 22 – Dec 22: 56% vs target
Jan 23 – Aug 23: 75% vs target

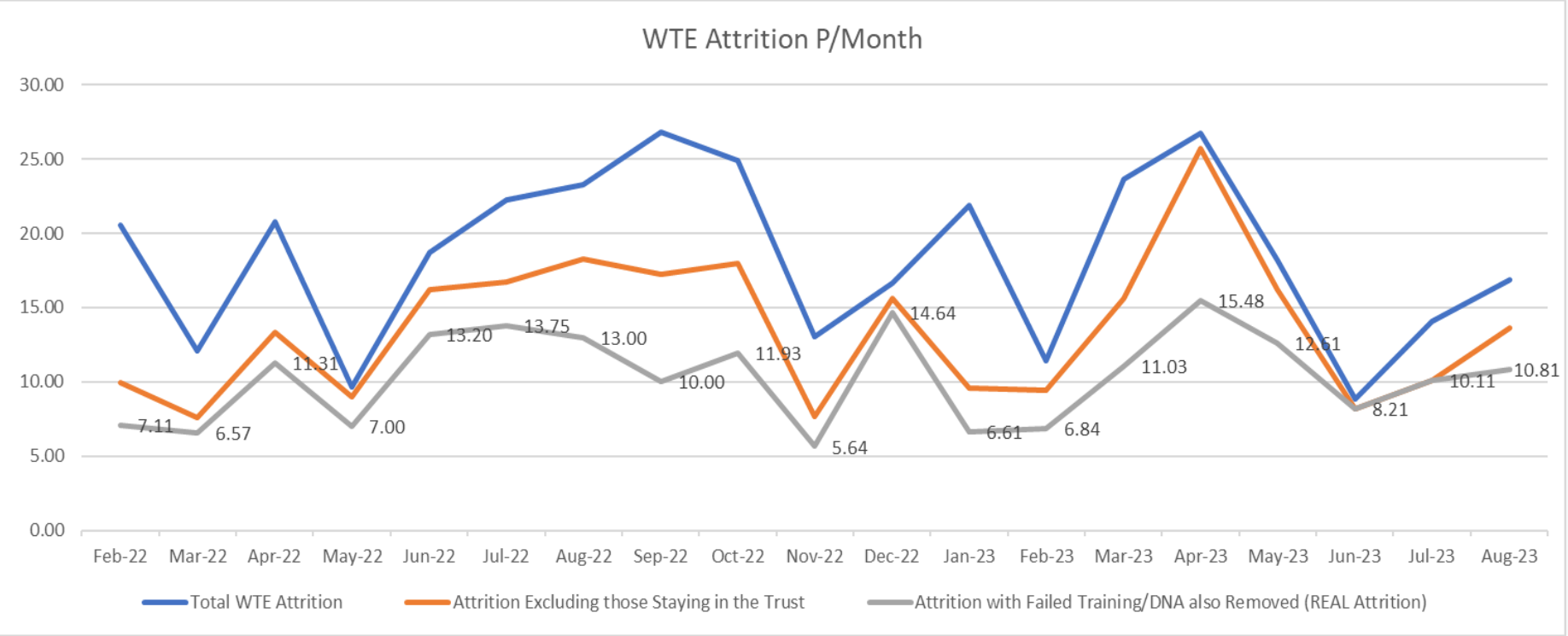
6. Retention issues

Retention of EMA colleagues remains a key focus

Attrition rates have been reported including those moving to other roles/secondments in the Trust as well as those who have not attended or failed NHS P training, a requirement for the EMA role.

Last 19 months:

- Total attrition 350 WTE
- Excluding those staying in the Trust 258 WTE
- Excluding those DNA/failed training 195 WTE



Steps to improve Retention:

- Mentoring & Diamond pod process reviewed
- Flexible rotas – 54% on part-time/non-core rotas

7. Culture & engagement

Staff Survey results in 2022 showed a challenging picture on engagement and morale for EOC, but the Pulse Survey for July 2023 shows an encouraging improvement, moving into 2nd and 4th place out of 17 OUs surveyed on percentage of colleagues feeling positive.

Staff Survey 2022

OU / Department	Staff engagement	Morale
CCP East	6.1	6.1
CCP West	5.9	5.9
111 Urgent Care	5.6	5.3
OU - Medway	5.6	5.2
OU - Thanet	5.4	5.2
OU - Dartford	5.6	5
OU - Chertsey	5.3	5
HART East	4.5	5.3
OU - Ashford	5.0	4.8
OU - Guildford	5.2	4.6
OU - Tangmere & Worthing	5.0	4.7
OU - Gatwick & Banstead	4.9	4.4
OU - Paddock Wood	4.9	4.4
EOC East	**4.7**	**4.3**
EOC West	**4.6**	**4.4**
HART West	4.5	4.4
OU - Brighton	4.4	4.1
OU - Polegate and Hastings	4.5	4

Pulse Survey July 23

Percentage of colleagues feeling positive

OU / Department	% Positive
Banstead	71.4%
EOC West	**68.2%**
111 Urgent Care	58.1%
EOC East	**50.0%**
HART	50.0%
Thanet	50.0%
Polegate	43.8%
Tangmere	42.9%
Brighton	42.4%
Medway	42.1%
Chertsey	40.0%
Paddock Wood	36.8%
Gatwick	35.7%
Guildford	31.8%
Ashford	30.0%
Worthing	26.3%
Hastings	25.0%

We know there is more to do to improve, and we know that challenges remain ahead to improve EOC culture and that there is no room for complacency, hence the clear focus and support of the EOC CCG.

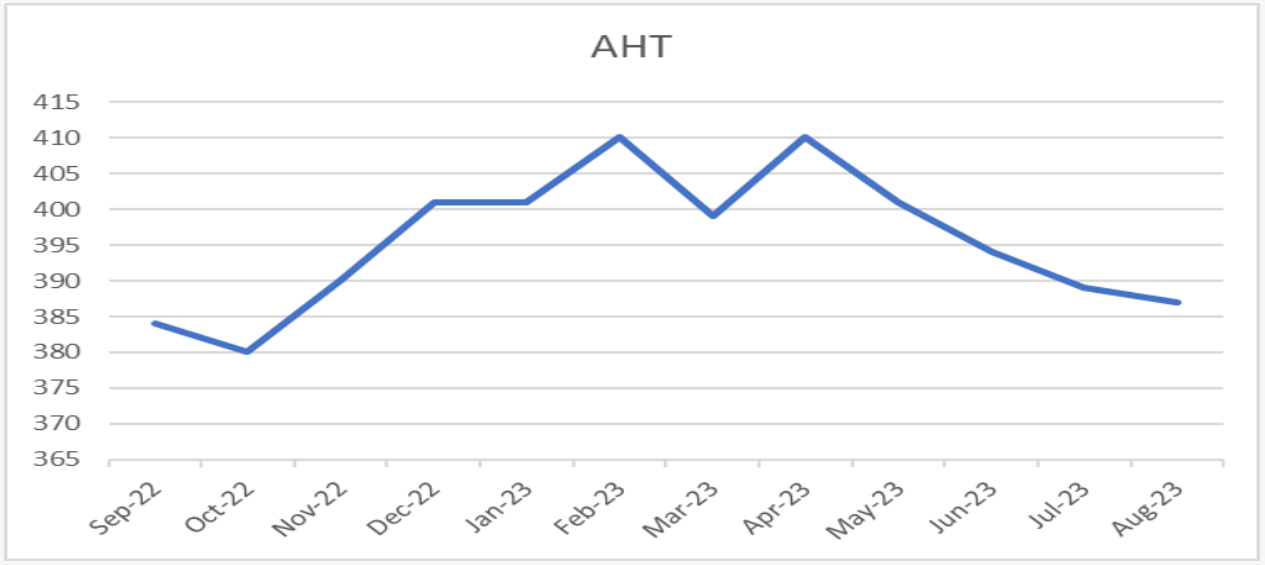
7. Culture & engagement

EOC Culture Actions

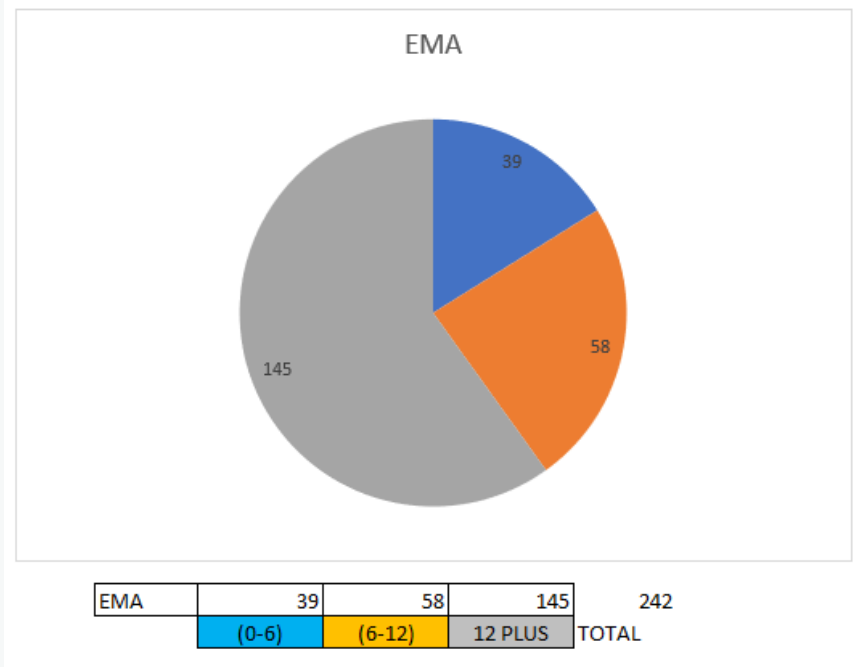
- EOC Comms Report and EOC Comms Leads
- EOC Culture Change Group (CCG) agree on priority issues:
  - Communications
  - Cross skilling, development and training
  - Mentoring
- Moorhouse action plan – Quick Wins
- Union engagement and collaboration embedded
- Leadership focus e.g., Project Delivery Managers, greater visibility of SLT, more senior visits i.e., NEDs, Execs, Commissioners etc.
- Commitment to implementing Schwartz Rounds

8. Efficiencies (1)

Mean AHT has increased from 378secs Sept 21 – Aug 22 to 390secs Sept 22 – Aug 23. This has added the requirement of an additional 7 call handling hours p/day. Higher AHT is driven by complexity of calls and short tenure of EMAs. AHT for EMAs in the business less than 6 months is 45secs longer than those over 6 months.
16% of workforce has less than 6 months tenure & 40% less than 12 months.



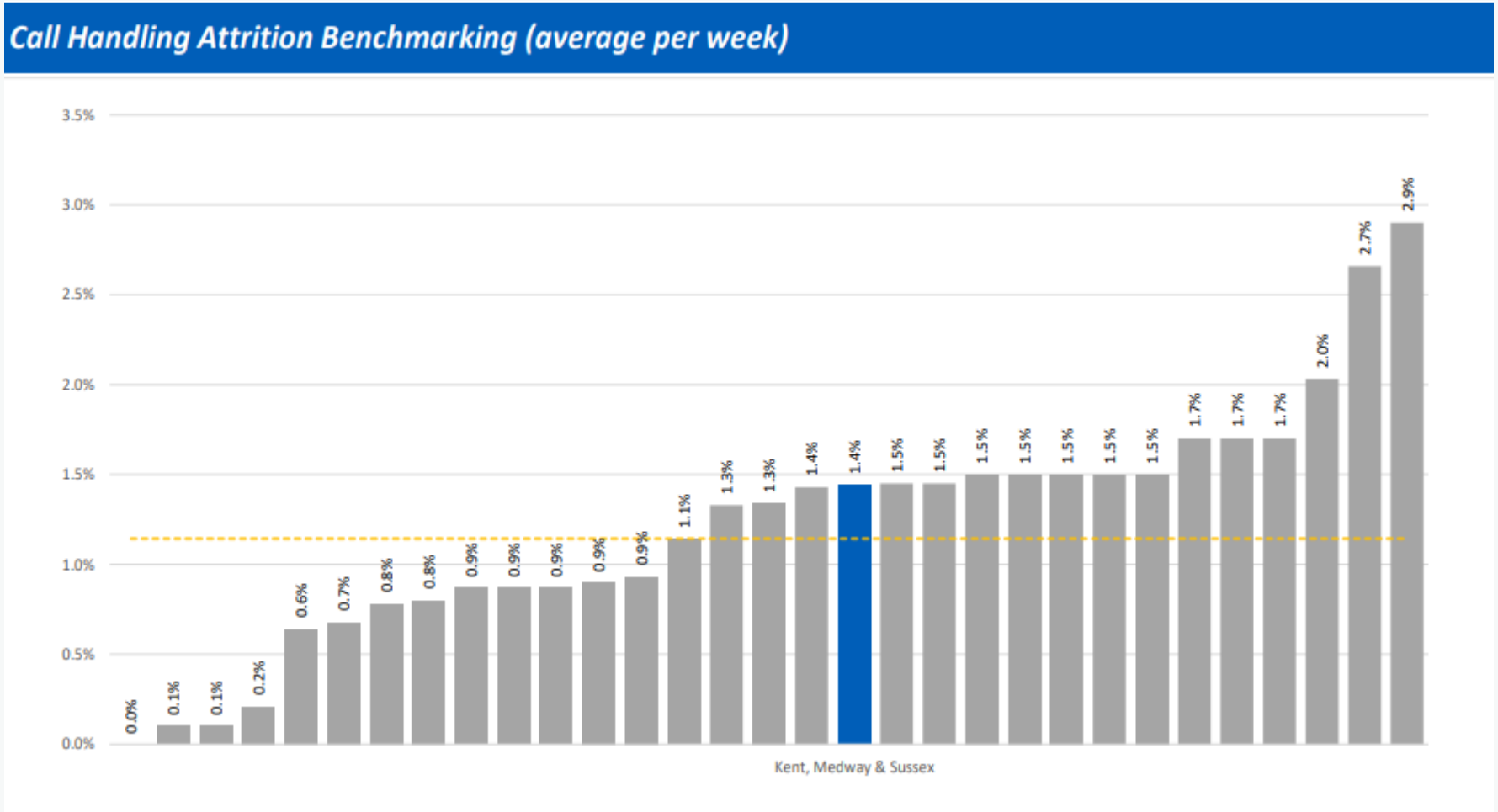
New EMAs require 3 weeks of 1-2-1 Mentoring. Mentors are experienced EMAs (Coaches/SEMAs) and Mentoring impacts their AHT and performance giving this vital training and feedback live on shift.



8. Efficiencies (2)

National attrition benchmarking is only available to 111 providers. This shows SECAmb only slightly above the national average (Q1 23-24).

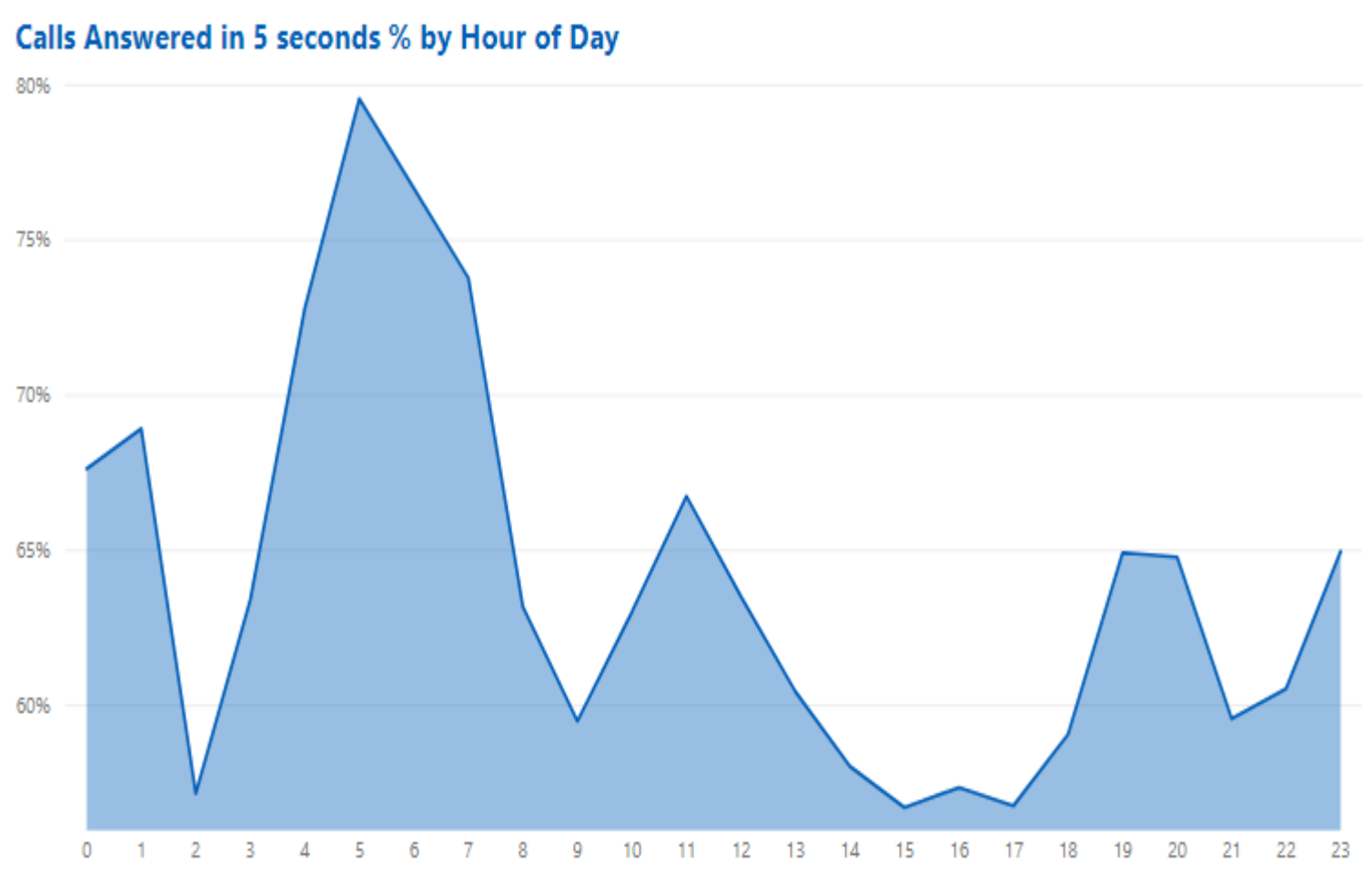
SECAmb asked the NHS E IUEC central team to replicate this form of data analysis for 999 services and share the results.



8. Efficiencies (3)

Inefficient Rotas mean there are times when we are overstaffed against required. The average calls answered in 5secs is 63% for Sept 22 – Aug 23 with a variance between 56% at 15:00 & 17:00hrs to 80% at 05:00.

A workforce tool and new EMA rota will improve overall rota fit, ensuring we have the right numbers of EMAs working when we need them to meet demand and achieve the 5secs Mean call answering target.



9. Efficiency Opportunities

1. Improving tenure is important – as demonstrated, length of service is linked to lower AHT and improved productivity
2. Reduce the impact of “new recruit conveyor belt” – mitigating the impact of providing mentoring, coaching, diamond pods, 1:1s etc.
3. Introduction of new EOC Call Handling procedure – improving call handling efficiency and reducing AHT
4. Recognition and reward – feedback in the EOC CCG and via 1-to-1s reinforces the importance of positive endorsement
5. Duplicate call management – review of processes to streamline data capture
6. Sharing best practice from 999 and 111 providers – e.g., SMS text care advice
7. Work with the Trust BI team to improve AHT and 999 call handling performance via the use of AI

10. Immediate Actions (1)

Action	Description	Timescale for implementation
Source additional CA capacity	Several other ambulance services are purchasing planned additional capacity off each other to support in the short/medium term. Negotiations are progressing well with support from NHSE.	October ‘23 to end FY
Incentivising of shifts	Incentivisation of a specific cadre of additional shifts – supported by the additional monies secured to end Oct. Potential to bid for additional non-recurrent monies over winter to continue this.	Live
‘Big event’ recruitment	Change of recruitment tactics to have larger, more publicised events – the initial event in Medway has resulted in higher levels of attendees and applicants than seen previously.	Live
Dual-skilling of 111 Health Advisors	111 health advisors dual-trained to undertake 999 calls – voluntary. Initially limited numbers, however since the move to Medway, significantly more interest from staff.	Live
Staff resilience	Psychometric testing commences in November to support ensuring staff with good personal resilience.	November ‘23

11. Other Actions (2)

Action	Description	Timescale for implementation
EMA to SEMA in 18months	Proposal to support pay progression via 12-month extra spine-point uplift plus automatic transition to SEMA at 18 months.	Development underway
EMA rota tool	Improved scheduling tool required to support better management of staff resources – akin to that within 111. A full rota review is required to improve overall alignment of resources to demand, to better support flexible working and to step away from 'Lewes', 'Banstead' etc rotas linked to previous locations/teams of EOCs.	TBC
Pay mechanisms	Learning from others – LAS have implemented a 'Work & Save' methodology which enables staff to get paid as and when it suits them and to a level that is required, e.g. weekly or to only partially draw down their wages each month but twice a year take a larger payment.	To be developed.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	53-23

Name of meeting	Board
Date	05.10.2023
Name of paper	Achieving Sustainability & Working with Partners
Strategic Theme	**Sustainability & Partnerships**
Author / Lead Director	Saba Sadiq, Chief Finance Officer David Ruiz-Celada, Executive Director for Strategic Planning and Transformation

Executive Summary

Strategy Development (Strategic Goal SP1)

We have started in August with the development of a clinical case for change, working with our patient data and engaging extensively with clinical and operational colleagues, as well as a Board Development session in September to refine this initial diagnostic piece of work. The paper enclosed in the Board contains a summary of the work done to date including the Clinical Case for Change.

The procurement for a partner to support us on the development of the strategy has now concluded and we are now focussed on the engagement, analysis, and delivery phase of the work.

Our ICB partners have been engaged through the Strategic Commissioning Board in 2 separate sessions, and we have planned 3 individual ICB workshops where we will be furthering the Clinical Case for Change in overlay with the individual needs of their local populations and their Joint Forward Plans.

Strategic Partnerships (Strategic Goal SP2)

We have gone live with the new governance model including establishing ICB-level teams, with a nominated lead executive for each system with quality leads, a partnership manager, and operational leads for each.

The paper included provides an update on the work we are doing within each ICB including UEC Recovery support to Tier 1 systems, our planned response to Right Care Right Person, as well as the progress made towards integration of data with system partners to have better visibility of Alternative Care Pathways as we go into the winter.

Financial Update (Strategic Goal SP3)

At M5 (August) year-to-date the Trust's financial performance is in line with its financial plan with a surplus of £0.3m. The efficiency programme has delivered £1.6m of efficiencies which is £0.6m behind plan. There is a continued focus on ensuring that the Trust delivers its efficiency programme with a workshop to be held in October 2023 to support this as well as weekly check and challenge sessions.

The Trust is forecasting delivery of its 2023/24 financial plan.

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

Agenda No	53-23

Name of meeting	Board
Date	5th October 2023
Name of paper	Strategy Development – Clinical Case for Change
Strategic Theme	**Sustainability & Partnerships**
Author / Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning and Transformation Rachel Oaten, Chief Medical Officer

Executive Summary

The Board approved the development of a new strategy as part of the objectives for 23/24 (Strategic Goal 1 under Sustainability and Partnerships). This is to ensure it can sustainably address our BAF Risks 14 (Operating Model), 255 (Workforce Plan) and 16 (Financial Sustainability). In addition, the development of a Strategy has been agreed with NHSE as a new Recovery Support Programme (RSP) Exit criteria by 31 March 2024.

The work has started in August with the development of a Clinical Case for Change. This has been done in conjunction with our clinical and operational managers and using a strong data-driven evidence base. With the on-boarding of a consultancy partner to give us additional capacity to do this work, we will start an extensive programme of engagement from October with our people, patients and partners.

We are aiming to have a complete strategy ready for publication in March 24, with the Board having clear sight of the direction of travel between December and January. By the end of this work, we will have a clear vision for the future with an associated clinical delivery model that meets the needs of our patients, with a supporting 5-year delivery plan and associated workforce and sustainability plans that will provide the Board with a roadmap to realise the new vision.

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

Strategy Development Update

Clinical Case for Change

1. Background and Programme Update

1.1. In 23/24 we are developing a new Clinically Led Trust Strategy that will support SECAmb's future direction of travel for the next 5 years.

1.2. The Board, working closely with the Councill of Governors, developed a clear set of expectations for how this strategy would be developed;

1.2.1. A clinically led strategy that is evidence based, helping us design our future models of care for our patients.
1.2.2. A focus on our people, ensuring we have a plan for our future workforce.
1.2.3. Inclusive engagement, ensuring all of our stakeholders have an opportunity to have their voice heard.
1.2.4. An ambition to be innovative in our approach to using technology to improve services and support the clinical delivery.
1.2.5. A plan that ensures long-term financial sustainability.
1.2.6. A collaborative approach with our ICB partners, ensuring there's a common shared vision for the role of the Ambulance Service within our systems.
1.2.7. A realistic delivery plan that allows the Board to have assurance that the transformation plan following from the strategy will be delivered.

1.3. The Board decided to seek external support to deliver this strategy, to ensure we had sufficient capacity to engage and bring in out of sector expertise. A competitive procurement process was started in July. Due to challenges to the process, the original start date of the 1st of August with a partner was delayed to the end of September.

1.4. We have now completed the procurement and a detailed programme is being put together, including stakeholder engagement plans and key milestones for Board approval.

1.5. At the time of writing (25/09) a detailed programme is being developed with our partners, and there is a risk that the original plan to have a draft strategy in time for December Board will not be achieved. We expect the work to be significantly progressed by February Board, alongside a progressed delivery plan. A full strategy for publication in March 2024 remains our target.

1.6. To mitigate the delays, the Trust has started it's clinically led diagnostics work. This has been done through 4 workshops including our clinical and operational managers, alongside our patient data analysis, to help us develop a starting point for our clinical case for change.

1.7. This work was reviewed by the Board in September, and presented to the public through our Annual Member's Meeting.

2. Clinical Case for Change

2.1. During the development of the clinical case for change, the Trust has explored 3 key questions; 1) Who are our patients? 2) Why do they call us? And 3) How do we respond today?

2.2. Through the data, we have established facts and figures that support the Draft Clinical Case for Change (Appendix 1)

2.3. As a summary:

2.3.1. Our patients are presenting with increasing complexity, and we have an aging demography that will exacerbate this problem in the coming 10 years.

2.3.2. Our operating model is not differentiated enough to ensure we are meeting patient's needs, from social and urgent care through to emergency and critical care.

2.3.3. We have an opportunity to improve our differentiation upstream through better integration, validation, and early clinical intervention, in particular working in collaboration with system partners, and playing a greater part in system design and prevention to improve population health.

2.3.4. This will require re-defining our approach to responding to patients, moving from a traditionally time-driven model to a patients-outcomes driven one.

2.4. Some of the facts and figures that have supported the development of the draft Clinical Case for Change can be found in Appendix 2.

3. Next Steps

3.1. We have now on-boarded a partner to help us deliver the Strategy, the programme team will kick-off the work on the 27th of September. This will include the development of a full engagement and week by week plan which will be overseen through a weekly programme meeting with executive oversight.

3.2. We expect to continue engagement with our people through the month of October, expanding on our Clinical Case for Change, and engaging with our ICB systems individually through three facilitated workshops.

3.3. A full stakeholder engagement plan is a priority for the programme team and our partners, and this will be available to share verbally with the board on the 5th of October, however is not ready at the time of writing (25/09)

Appendix 1 – Draft Clinical Case for Change

The problem

Our patients have diverse needs spanning the spectrum from social care to critical care. However, only a small proportion truly require emergency or critical care. Despite this changing variety and increasing complexity, we currently respond to all patients in an undifferentiated, time-driven way. This one-size-fits-all model does not meet all our patients' needs or support our workforce.

Our current model fails to match appropriate resources to patient needs. Higher clinical registrant grades respond to similar low acuity patients as our non-registrant grades. Our workforce feels pressured to justify decisions through rote tasks and documentation to avoid perceived risk. This creates an anxious, unsupported workforce culture. Our approach lacks nuance, fails to optimise our limited capacity in a way that truly meets patient needs, and sometimes fails our most critically unwell patients, causing patient harm and moral injury to our people.

The opportunity

There is an opportunity to differentiate and plan responses based on four layers of patient needs: social care, urgent care, emergency care, and critical care. Differentiating in this way and managing lower acuity calls differently may better serve emergency and critical patients. It would also allow better matching of our finite resources to patient needs, e.g., exploring different workforce models and skills for urgent/social versus emergency/critical calls. Technology and diverse clinical leadership could enable better operational and deployment decisions, whilst empowering our staff to embrace a pragmatic clinical decision model to ensure patients receive the most appropriate care.

Strategically, we must decide how far upstream to differentiate and respond based on patient needs and our capabilities. This could be central to our role in improving population health and managing demand at a system level. Our unique data and insights can help system partners close care gaps and work together with other providers to address health inequities. We could also embrace risk and complexity in lower acuity calls by adapting our response model or more proactively manage boundaries with other system providers to address social and urgent care needs.

Our partners want greater primary and community care integration, less default conveyance to ED, and a system-centric approach focused on population health. We must consider not just responding and transporting, but definitive care, outcomes, and rehabilitation following patient presentation to us, given the high repeat contact rate that we see. They expect greater clinical validation of all responses before dispatch, utilising our data for early intervention and intelligent system design, including better data integration.

The Case for Change

Our model does not match patient needs or support our workforce. Data shows patients require a more differentiated response with the right resource at the right time for successful outcomes and experience. This requires bold decisions on our target operating model and cultural shift around the role of the Ambulance Service.

Our strategy must meet these expectations, and we need to make decisions around how we might increase upstream differentiation and working with systems to develop response models that address the nuanced needs of 999/111 callers. We can achieve this through data-driven intelligence, a supported diverse workforce, and a culture focused on successful patient outcomes.

1. Through the

Appendix 2 – Supporting facts and figures

The Facts and Figures

Who are our patients?

- As an ambulance provider, our patients can be anybody who dials 999, however we see a prevalence in over 65s who make up 54% of our total demand, despite making up only 20% of our population. This is 2% higher than the national average.
- Within this cohort, we see a disproportionately higher number of female patients. We also have a high proportion of 50–60-year-olds who will enter the 65+ bracket in the next 5-10 years.
- Falls are the 5th most common reason we attend patients, and 1 of every 10 hours we spend with patients on scene is with a faller.
- Mental health is the 6th most common reason we attend patients, accounting for 7% of our activity. Note: there needs to be further analysis on the differentiation for Mental Health patients, as this is coded at a high level and there may be multiple drivers behind this, so this is broad term that required refining.
- Social problems account for nearly 4% of our attendances, and 86% of patients are left at home.
- Out of 719,000 incidents last year, we estimate 433,000 unique patients, indicating high repeat contacts.
- 80% of our patients have at least 1 comorbidity, with 50% having 4 or more.
- 50% of our patients take 5 or more medications.
- This increase in complexity drives an increase in the time our clinicians spend with patients, with 40yr olds driving an average cycle time of 85 minutes vs 80yr olds driving an average cycle time of >100 minutes.
- 72% of calls come from 999, 17.5% come from 111, and 5.5% from care-line providers.
- We serve a vast geography with areas of high deprivation and areas of affluence.
- We are also rurally disperse with no major cities, however we have a highly transient population due to our transport links.
- Overall we are seeing an increase in the complexity and variety of presentations from our patients, and this is largely driven by social and urgent care patients who are deciding to access services through 111 and 999.
- Patients who called 5 times or more accounted for only 3% of our patients but 17% of our activity

How do we respond today?

- There is very little variation in the conditions our crews attend, regardless of the grade of the crew on the DCA, based on highest NEWS score by attendance. This indicates that there is limited differentiation at the point of dispatch and validates the lived experience from our clinicians on the road and those operating in dispatch.
- However, there is a significant difference in the ability of a crew to determine the outcome for a patient, with increased clinical expertise driving higher levels of see and treat, as an example.
- This confirms the opportunity that we have at being more differentiated, targeted and nuanced in our approach to meet patient needs with the right type of care in every case.
- There are examples of how we do this today, in particular with Cat 3 / 4 validation, and Cat 2 Segmentation, so there is an opportunity to learn and expand on these as part of our review of the model.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	53-23

Name of meeting	Trust Board
Date	05.10.2023
Name of paper	Partnerships update
Strategic Theme	**Sustainability and Partnerships**
Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning & Transformation
Author(s)	Matt Webb, Associate Director of Strategy & Partnerships Ray Savage, Interim Head of Strategic Partnerships
Primary Board Papers	BAF – Sustainability and Partnerships Goal 2

This paper provides an overview of the Trust's key initiatives and strategic priorities with its partners. It covers the alignment of governance structures with the Trust's Integrated Care Systems (ICSs), updates on Integrated Care Systems, the regional mental health response, the Regional Ageing Well Programme, and the development of integrated data sharing and reporting. Each initiative is focused on improving healthcare service delivery, patient outcomes, and collaboration across the Trust's four ICSs.

Governance and Reporting Alignment with ICS

The Trust has made good progress in aligning its governance and reporting structures with the multiple ICSs. The first supra-ICS Strategic Commissioning Group was held on 11th August 2023.

This is to be followed by three (ICS) system-focused clinical quality meetings, starting in Q3 2023 for which dates have now been set. The Surrey and Frimley systems (ICS's) have been grouped together.

There is further work required to integrate the oversight model including 111/999 and embed the new ways of working, and it's expected this will take the remainder of the year at least while we improve.

UEC Recovery Plan Delivery and Improvement Support

NHS England's new UEC Recovery Plan delivery and improvement support aims to enhance patient care and improve response times, with the Trust coordinating tailored support across three system levels. This involves targeted initiatives, resources, and a 'Recovery Champions' programme running until March 2025. Each system was 'tiered' in July, with Kent and Medway in tier 1 and subsequently requiring additional intensive support from NHSE. Frimley are in the second tier with NHSE support on area deep dives. Surrey and Sussex sit in the third tier, with the focus being on sharing best practice.

Integrated Care System Updates

Following the finalisation of the Joint Forward Plans (JFP) each system has now established an ICS specific governance structure for the delivery of the JFP. Our governance includes an executive lead for each system who will provide SECAmb representation at the executive delivery Boards.

Regional Mental Health Response

The Trust is supporting a regional mental health response, including the development of the "Right Care Right Person" model and initiatives in line with the 2022 Mental Health Commissioning Guidance. Both Kent and Sussex Police have held system meetings to review intentions and timelines for implementation. The Surrey system response is being incorporated through a separate working group and alongside the review of the MH response model, has been agreed to report up into Surrey Mind and Body Collaborative, through which the Trust is now providing representation.

Regional Ageing Well Programme

The Trust's Regional Ageing Well Programme has recently taken stock of its aims that were set out last October (2022) and agreed to build on the key achievements to date to enhance care for lower acuity patients with strategies optimising patient flow and data capture.

Recommendations, decisions or actions sought	The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in October (2023).

1.1. Integrated Care System Updates

1.1.1. Each ICB has established its governance structures and work programmes to deliver the improvements set out in the JFPs and fulfil the delivery of its strategy.

1.1.2. The Trust is in the process, through a phased approach, of aligning its governance to that of the ICBs (section 2.1).

1.1.3. NHS Kent & Medway

1.1.3.1. West Kent started a four-week pilot of a care coordination hub which is nearing conclusion. Early indications are that it has provided a noticeable reduction in conveyance rates. The data will be fully evaluated upon completion and recommendations made on the evidence obtained.

1.1.3.2. The ICB has also started to explore the creation of an enhanced Single Point of Access (SPoA) in East Kent following on from the initial success that has been demonstrated by the care coordination hub. This approach would support SECAmb by re-directing low acuity calls rather than dispatching an ambulance and supporting ambulance crews to access ED alternatives.

1.1.4. NHS Sussex

1.1.4.1. Sussex community providers have led the way in supporting the daily touchpoint calls when they are given access to view the C3 and C4 incidents in the clinical stack to increase the opportunity for direct referral. As a result of their commitment to the daily touchpoint calls, they will be the first system to access the clinical stack via the forth coming online portal.

1.1.4.2. Data integration has also been agreed as a priority to enable successful evaluation of identified pathways. The Trust's BI lead is working with Integrated Care System opposites to explore data integration, monitoring and evaluation.

1.1.4.3. Sussex Police have now declared their timeline for the implementation of 'Right Care Right Person' (RCRP) and highlighted the ambition to bring forward from their original 18 months implementation to 10 months. They have established a 4-phase approach with the aim for completion of all phases by June 2024.

1.1.4.4. The continued development of the Sussex ICS 'shared care record' platform involves the Trust's critical systems team and strategic partnerships. While this is a priority action, progress is slow due competing Trust priorities e.g., the decant from Orbital House and Coxheath into the Medway MRC.

1.1.5. NHS Surrey Heartlands

1.1.5.1. The NHS Surrey Heartlands JFP, emphasising the ICS strategy and the NHS Long Term Plan, was submitted to NHSE on the 30th of June 2023. The plan advocates a multi-sector collaboration to refresh service delivery for the Surrey Heartlands community.

1.1.5.2. NHS Surrey Heartlands is also progressing its One System One Plan, incorporating the Fuller Stocktake, focusing on five key areas. These serve as groundwork for interventions aiming to fulfil the ICS's main objectives, especially improving UEC services and patient outcomes. As part of the Fuller Stocktake, the Neighbourhood approach is being developed at Place with ICS oversight. Through engagement in the key developing areas of East Surrey and Guildford and Waverley places, we will establish any potential role for 999 service development. This will be discussed as part of the Trust's Integrated Care Delivery Model strategy workstream with the inaugural meeting set for 3rd October.

1.1.5.3. The Surrey SPOA is under discussion for enhancement during Winter, with the NW Surrey leading the way on enabling access to the UCR, Frailty SDEC and Medical SDEC referrals via one access point. Other place developments will follow any improvement areas enabled. Relevant pathway gaps for the non-injurious Falls Level 1 pathway, and capacity and funding concerns with East Surrey UCR and SDEC provision have been escalated to relevant ICS and place UEC forums with actions and next steps identified during September. Once the Trust / ICS Governance structure is in place, the System Clinical Quality Governance Group may provide a more appropriate monthly forum for such escalation. The A-tED process will also provide a cross ICS comparator once rolled out from Kent to Surrey, Frimley and Sussex systems.

1.1.5.4. The Wellbeing Responder Pilot, resulting from the Trust working in partnership with Surrey County Council and Mole Valley, continues to demonstrate success with local authority employed responders being contacted by Tech Enabled Care providers (pendant activation contact centres) to respond to identified non-injurious/minor injury fallers. This is in place across 3 of the 4 paces currently, the remaining North West Surrey place is currently responding via the UCR team and this anomaly is being highlighted, however additional local authority funding to mobilise this pathway is proving challenging.

1.1.5.5. The newly established Delivery Oversight Group (DOG) is vital in ensuring effective JFP and strategy delivery governance. Its focus on workforce development and care coordination is anticipated to benefit the Trust by improving UEC services. The DOG, which remains separate to the UEC Committee, reports to the ICB and includes partner provider executives and place leaders. Executive representation is now in place for the monthly DOG and the bi-monthly ICS Board meetings part2. A Trust executive update is being provided for the ICS September Board on the 'Evolution and Direction of South East Coast Ambulance Service'. This is proposed to be replicated in Frimley during October.

1.1.6. NHS Frimley

1.1.6.1. NHS Frimley's JFP, in alignment with the ICS strategy, underscores its contributions towards shared ICS goals. It identifies three overarching objectives: enhancing local community health and well-being, delivering high-quality patient care, and ensuring service sustainability.

1.1.6.2. The strategic review of the minor injuries and minor illness provision within the ICS has been reworked based on Strategic Partnerships identification of a gap in the Frimley South provision. The final solution was signed off at the September UEC Delivery Board and included an enhanced solution for the whole system, including a key provision in Aldershot and Bracknell communities, so providing critical appropriate pathways that will enable 999 referrals daily and reduce dependency on emergency services. This is an excellent example of how effective strategic partnership engagement can influence change for our system populations.

1.2. Regional UEC Mental Health Response

1.2.1. The forthcoming implementation of the National Police Operating Model, Right Care Right Person, is causing concern amongst commissioners, mental health providers, local authorities, and the Trust.

1.2.2. We are developing a standard and structured approach to understanding how each police force is planning to implement RCRP, and have established a supra-ICB group to

oversee the impact to SECAmb and the rest of the healthcare and social care system once we understand the data behind the likely volumes of citizens that may be impacted by this change.

1.3. Regional Ageing Well (UCR) Programme

1.3.1. The Trust is also participating in ICB initiatives and pilots e.g., West Kent have piloted an enhanced clinical coordination hub. The Trust is providing a Paramedic Practitioner to work alongside hospital consultants and community clinicians in the hub to optimise community pathways and admission avoidance.

1.3.2. Recognising the need for accurate data capture, the Trust has established a BI dashboard, accessible by commissioners and community providers, indicating referrals accepted and referrals rejected, also rejection reasons for all incidents reviewed during the daily touch points.

1.3.3. Additionally, the Trust is taking steps internally to improve data quality, including enhancement of the electronic Patient Clinical Record (ePCR) system for more comprehensive information capture when a referral is made and development of a Power BI report capturing with changes made to the 'referred to' option for a non-conveyance (S&T). This enhancement uses the pathways listed in the forthcoming ambulance data set (ADS). The data captured through ePCR will give greater clarity of referrals made to UCR on the Trusts BI 'incident outcome' dashboard (S&T) and will support the development of the regional dashboard.

2.7. Data Sharing Initiatives

2.7.1.1. The Trust's BI lead is liaising with ICB BI leads to discuss ways of collaborating and corroborating on system data to support the development of strategies and initiatives for improving models of care and an integrated system response.

2.7.2. In addition, the Trust's BI team are also working with commissioners to develop a regional dashboard led by the NHS Surrey Heartlands Business Intelligence team. This tool will allow providers and commissioners to review regional appropriate primary care, secondary care, and community pathway activity, understand capacity, map care pathways, and ensure compliance with national standards.

Item No	53-23

Name of meeting	Trust Board
Date	5th October 2023
Name of paper	M05 (August 2023) Financial Performance
Executive sponsor	Saba Sadiq - Chief Finance Officer
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Kevin Steer (Head of Financial Accounting & Compliance), Rachel Murphy (Financial Manager - Projects, Business, and Investments)
Synopsis	This report provides an update on the Trust's Financial Position for month 5 year-to-date (YTD). In summary, the Trust is reporting the planned, £0.3m surplus for M5 YTD. Efficiencies of £1.6m were delivered compared to the plan of £2.2m. This is an adverse variance of £0.6m and represent an improvement of £0.3m from last month. There are emerging financial risks that may impact upon delivery of the financial plan. These financial risks are overspending in our Operations directorate (e.g., £1.1m YTD on 999 and 111 predominantly in pay) and under delivery of the efficiency programme. Mitigations are being developed to address these emerging financial risks. Consequently, the Trust is forecasting achieving financial breakeven at year-end. Our cash position of £41.2m was slightly better than plan by £0.2m and compared to last month by £0.5m. This is due to the timing of invoice payments to our key suppliers IC24 and Churchill. The Trust is forecasting a cash position of £47.5m at the end of March 2024, which is £2.9m below plan. The financial risks outlined above would result in an adverse impact on the cash position and under delivery against the target.
Recommendations, decisions, or actions sought	The Trust Board is asked to note the a) The M5 financial performance b) The challenges facing the Trust in delivering its efficiency programme; and c) Mitigations are in development to address overspends and under-delivery of the efficiency programme.

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	N/A

2023/24
Finance Report to the Board of Directors
5 Months to 31 August 2023

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Executive Summary

The Trust reported a £0.3m surplus at M5 year-to-date (YTD) that is in line with plan.

£000s	Year to August 2023				Forecast to March 2023			
	Plan	Actual	Variance		Plan	Actual	Variance	
Income	£132.8m	£133.8m	£1.0m	✓	£319.0m	£322.0m	£3.0m	✓
Operating Expenditure	(£133.5m)	(£136.5m)	(£3.0m)	✗	(£323.5m)	(£326.0m)	(£2.5m)	✗
Trust Suplus/(Deficit)	(£0.7m)	(£2.7m)	(£2.0m)	✗	(£4.5m)	(£4.0m)	£0.5m	✓
Non-Recurrent Adjustments^	£1.0m	£3.0m	£2.0m	✓	£4.5m	£4.0m	(£0.5m)	✗
Reported Suplus/(Deficit)	**£0.3m**	**£0.3m**	**£0.0m**	✓	**£0.0m**	**£0.0m**	**£0.0m**	✓
Cash	£41.0m	£41.2m	£0.2m	✓	£50.4m	£47.5m	(£2.9m)	✗
Capital Expenditure	£5.9m	£8.2m	(£2.3m)	✗	£25.9m	£26.8m	(£2.2m)	✗
Efficiency Target	£2.2m	£1.6m	(£0.6m)	✗	£9.0m	£9.0m	£0.0m	✓

^Planned non-recurrent adjustments are expected from provisions and property sales.

Year to Date (YTD)

- To deliver this financial performance there were upsides and downsides. Upsides included £1.8m of profit on sale of assets, £0.9m of interest received, £0.9m non frontline vacancies across the Trust and £0.8m underspends in vehicle running cost and training. Downsides included £1.1m overspend in the Operations directorate. These are outlined more in detail later in this report.

- Delivery of £1.6m efficiencies YTD is £0.6m below plan. This is however an improvement of £0.3m compared to last month due to overachievement in-month. We are making inroads although at a slower pace than expected. Five schemes progressed within the month to delivery phase at a value of £0.4m, which were largely non recurrent, notably income generation of £0.2m and budget underspends. This means the YTD recurrent schemes represent 77% of the savings and 23% on non-recurrent basis. In view of the in-month movement, £5.9m or 66.2% of schemes have been moved to the delivery phase against the target of £9.0m. However, the emerging risks impacting the delivery of three schemes including our largest scheme “Hear and Treat” means when this is the risk adjusted, the efficiency savings forecast reduces to £5.3m. Leading to a £3.7m gap compared to the £9.0m target. Overall, the Trust must deliver £7.4m savings in the next 7 months to deliver the £9.0m target. This will be challenging amidst winter and the anticipated operation pressures. Mitigations in place to bridge the shortfall, include greater drive to develop the existing identified validated and scoped schemes at a value of £2.0m on the pipeline tracker; recognition of non-recurrent underspends; review of new opportunities including the ideas identified from the communication and our people engagement.

- Forecast includes the additional £2.5m of income and costs associated with the successful bid for additional capacity as part of the £200m national pot.

- The cash position increased by £0.5m this month to £41.2m. The M5 cash balance is £0.2m above plan, mainly due to the timing of invoice payments to large suppliers IC24 and Churchill.

- Capital expenditure of £8.2m is £2.4m 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) for the year. The £0.9m adverse variance for the full year is off set by the net book value (NBV) of asset sales, mainly from the sale of Redhill.

Forecast Outturn

- The Trust is forecasting to achieve a breakeven at year-end. As required by NHS England and the host ICB, the Trust has reported an overall forecast breakeven as planned.

- Mitigations are in progress to support the downsides driven by the emerging risk by reducing overspends to bring them in line with budgets including a concerted focus on delivering the efficiency programme.

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

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

1. Income

	Year to August 2023				Forecast to March 2024			
	Plan	**Actual**	**Variance**		**Plan**	**Actual**	**Variance**	
999 Income	£119.0m	£119.6m	£0.6m	✓	£286.0m	£288.5m	£2.5m	✓
111 Income	£11.2m	£11.2m	£0.0m	✓	£26.9m	£26.9m	£0.0m	✓
HEE Income	£1.1m	£1.1m	£0.0m	✓	£2.4m	£2.6m	£0.1m	✓
Other Income	£1.5m	£1.9m	£0.4m	✓	£3.6m	£4.0m	£0.4m	✓
Total Income	**£132.8m**	**£133.8m**	**£1.0m**	✓	**£319.0m**	**£322.0m**	**£3.0m**	✓

- 999 income is £0.6m greater than planned, due to the additional capacity funding to offset costs. The plan is based on the latest financial envelope and includes the additional £8.9m from NHS England to support ambulance capacity to achieve the C2 mean of 30 minutes.
  - The additional £8.9m national funding has been allocated to the Surrey Heartlands ICB and a catchup payment has been made last month, in June 2023.
  - An additional £2.5m of support funding has been allocated to the Trust as part of a successful bid to increase call handling and frontline capacity over the next few months.

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

- HEE income is as planned. The Trust has now received the funding schedules for 2023/24. Please note that Health Education England has merged with NHS England.

- Other income is £0.4m above plan and is linked to additional costs associated with international paramedic recruitment under HR and recovery support funding as part of the improvement journey, £0.3m has been achieved through disposing obsolete equipment.

2. Expenditure

By Directorate	Year to August 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Chief Executive Office	(£1.9m)	(£1.8m)	£0.2m	✓	(£4.7m)	(£4.5m)	£0.1m	✓
Finance	(£9.5m)	(£9.8m)	(£0.2m)	✗	(£23.5m)	(£24.1m)	(£0.6m)	✗
Quality and Safety	(£1.5m)	(£1.4m)	£0.1m	✓	(£3.6m)	(£3.6m)	£0.1m	✓
Medical	(£7.8m)	(£6.9m)	£0.9m	✓	(£19.0m)	(£18.2m)	£0.8m	✓
Operations	(£74.6m)	(£75.4m)	(£0.9m)	✗	(£183.0m)	(£184.5m)	(£1.5m)	✗
Operations - 111	(£11.2m)	(£11.8m)	(£0.7m)	✗	(£26.8m)	(£27.1m)	(£0.3m)	✗
Strategic Planning & Transformation	(£11.7m)	(£11.3m)	£0.4m	✓	(£28.2m)	(£28.3m)	(£0.2m)	✗
Human Resources	(£2.1m)	(£2.7m)	(£0.6m)	✗	(£5.1m)	(£5.9m)	(£0.8m)	✗
Total Directorate Expenditure	**(£120.3m)**	**(£121.1m)**	**(£0.8m)**	✗	**(£293.9m)**	**(£296.1m)**	**(£2.3m)**	✗
Depreciation^	(£7.1m)	(£7.0m)	£0.2m	✓	(£19.1m)	(£19.0m)	£0.1m	✓
Financing Costs	(£1.0m)	£1.7m	£2.7m	✓	(£2.3m)	£1.4m	£3.7m	✓
Corporate Expenditure	(£5.1m)	(£10.1m)	(£5.0m)	✗	(£8.2m)	(£12.3m)	(£4.1m)	✗
Total Underlying Expenditure	**(£133.5m)**	**(£136.5m)**	**(£3.0m)**	✗	**(£323.5m)**	**(£326.0m)**	**(£2.5m)**	✗
Non-Recurrent Adjustments	£1.0m	£3.0m	£2.0m	✗	£4.5m	£4.0m	(£0.5m)	✓
Total Expenditure	**(£132.5m)**	**(£133.5m)**	**(£1.0m)**	✗	**(£319.0m)**	**(£322.0m)**	**(£3.0m)**	✗

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

YTD performance against plan

- Total expenditure at M5 YTD was £133.5m, which is £1.0m higher than plan.

- The net adverse variance is largely due to increased spend in Operations service area of £0.9m, including £0.6m for costs associated with the additional capacity funding; £0.7m in NHS 111 whilst the higher costs in HR of £0.6m relating to the International Paramedic Recruitment drive is matched by income. These are offset by non-recurrent benefits in financing costs of £2.7m explained below.

- We saw an underspend of £0.4m in the month within Operations, leading to a further reduction in the net YTD overspend to £0.3m higher than plan, excluding the £0.6m additional capacity spend matched by income. The main driver remains the higher than planned productive hourly rate (based on hours 'on the road') of £39.14, tracking 11.0% above plan of £35.25, although slightly improved compared to the 12.9% worse reported last month. The key factors remain the following:

    - The YTD provision of substantive staff hours continue to track below plan at 11.3%. The main driver is that almost a quarter of the current new recruits are undergoing their training and yet to become operational. The position is being supported by the positive YTD abstraction of 28.5 against the plan of 31.9 %, and attrition is tracking as expected.
    - The shortfall in substantive hours is partly mitigated by increased utilisation of overtime, including late sign off at 7.4% of the total hours compared to the planned hours of 4.6 %, at an additional cost of £0.2m. This results in an overall YTD under provision of hours of 7.8% below plan, a slight improvement compared to the 8.2% lower than plan last month.
    - The bank holiday in August increased the overall YTD bank holidays days to six. Therefore, with over 60% of our staff currently on the Section 2 enhanced Unsocial Hours rate, the impact compared to the planned annual average Unsocial Hours rate

payments exceeded plan £0.3m. This is just timing and expected to be normalised by year end.
  - Recruitment is higher than plan, due to the expanded recruitment at the start of the financial year leading to circa 50 further new recruits at a value of £0.3m.
  - These are partly offset by underspends in other business areas, notably £0.4m EOC due to challenges in recruiting clinicians.

- The overspent in NHS 111 reduced to £0.7m higher than plan YTD, an improvement of £0.1m compared to last month as the reliance on agency clinicians steadily decreased in line with the controls in place. As a result of the higher sickness abstraction than planned, (11.4% against a target of 7%) and the challenging recruitment, the requirement to utilise increased GP services together with overtime and agency at higher premium rates have been vital to facilitate a safe service particularly during Q1. The move to Medway in June is expected to lead to steady stability while focused recruitment is underway to bridge the shortfall in establishment.

- Partly mitigating these, are favourable finance cost of £2.7m, notably £1.8m of profit on sale of assets, including the sale of Redhill Ambulance Station in July 2023 of £1.5m and £0.9m greater bank interest received reflecting the high interest rates. Further underspends are driven by vacancies in support and back-office functions of £0.9m relating to timing of restructures and 9.4% lower than planned fuel rate together with timing of training contributes £0.4m each.

- Depreciation and Rights of Use are slightly below plan by £0.2m due to timing. This is offsetting the higher inflationary driven utility costs in Estates.

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

NHSE Categories	Year to August 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Pay/Staff Costs	(£93.9m)	(£94.3m)	(£0.4m)	✗	(£227.8m)	(£233.5m)	(£5.7m)	✗
Depreciation (including Rights of Use Assets)	(£7.2m)	(£7.0m)	£0.2m	✓	(£19.1m)	(£19.0m)	£0.1m	✓
Premises Costs	(£0.5m)	(£0.8m)	(£0.3m)	✗	(£1.7m)	(£2.1m)	(£0.4m)	✗
Transport Costs	(£7.4m)	(£7.0m)	£0.4m	✓	(£17.8m)	(£17.7m)	£0.1m	✓
Purchase of Healthcare (PAPs;IC24;HEMS)	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Supplies and Services	(£3.8m)	(£3.8m)	£0.0m	✓	(£9.5m)	(£9.7m)	(£0.2m)	✗
Establishment	(£2.2m)	(£2.2m)	£0.0m	✓	(£5.2m)	(£5.4m)	(£0.2m)	✗
Education Costs	(£0.9m)	(£0.5m)	£0.4m	✓	(£2.3m)	(£2.0m)	£0.3m	✓
Operating Lease Expenditure	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Finance Costs	(£0.8m)	£0.1m	£0.9m	✓	(£2.0m)	(£0.1m)	£1.9m	✓
Clinical Negligence (CNST)	(£0.8m)	(£0.8m)	£0.0m	✓	(£1.9m)	(£1.9m)	£0.0m	✓
Gains / Losses on Asset Disposal	£0.0m	£1.8m	£1.8m	✓	£0.0m	£1.8m	£1.8m	✓
Other	(£16.0m)	(£22.0m)	(£6.0m)	✗	(£36.2m)	(£36.4m)	(£0.2m)	✗
Total Underlying Expenditure	**(£133.5m)**	**(£136.5m)**	**(£3.0m)**	✗	**(£323.5m)**	**(£326.0m)**	**(£2.5m)**	✗
Further Trust Savings Required	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Non-Recurrent Adjustments	£1.0m	£3.0m	£2.0m	✓	£4.5m	£4.0m	(£0.5m)	✗
Total Expenditure	**(£132.5m)**	**(£133.5m)**	**(£1.0m)**	✗	**(£319.0m)**	**(£322.0m)**	**(£3.0m)**	✗

Full year performance against plan

- Despite some overspends for the year, mainly in pay, which includes the additional £2.5m of costs matched by additional support income. The Trust is planning to achieve financial

breakeven, subject to mitigating actions put in place to reduce and eliminate risk associate with under delivery against efficiency programme and budgetary overspends.

3. System 'Control' Adjustments

- The table below shows the adjustments made to the Trust's financial performance to the reported system position.

- For the year-to-date and forecast there are no significant adjustments to reported position.

	Year to August 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Trust Surplus / (Deficit)	**£0.3m**	**£0.3m**	**£0.0m**	✓	**£0.0m**	**£0.0m**	**£0.0m**	✓
System 'Control' Adjustments:								
Remove Impact of Donated Assets	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Remove Impact of Impairments	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Reported Surplus / (Deficit)*	**£0.3m**	**£0.3m**	**£0.0m**	✓	**£0.0m**	**£0.0m**	**£0.0m**	✓

*Reported Surplus / (Deficit) represents the system (Control total) position.

4. Efficiency Programme

Proposed schemes

Scheme Category	Fully Validated	Validated	Scoped	Total Schemes	Proposed	Total
	£000	£000	£000	£000	£000	£000
Discretionary Non Pay	107	-	84	191	-	191
Efficiency target	-	-	-	-	421	421
Estates and Facilities optimalisation	323	-	-	323	-	323
External consultancy & contractors	12	17	-	29	-	29
Fleet - Fuel: Bunkered Fuel & Price Differential	439	-	-	439	-	439
Fleet -Other Efficiencies	129	-	-	129	40	169
Income generation	205	-	-	205	-	205
IT Productivity and Phones	-	-	237	237	-	237
Make Ready Process	-	-	250	250	-	250
Medicines Management - Consumables	50	100	-	150	-	150
Medicines Management - Equipment	18	-	-	18	-	18
Operations Efficiencies	2,459	7	843	3,308	-	3,308
Optimisation in establishment - non clinical	-	-	14	14	-	14
Optimisation in Training	97	-	-	97	-	97
Policy & service reviews	1,590		129	1,719	-	1,719
Procurement contracts review	380	-	34	414	-	414
Taxi & Other Vehicle Hire	-	9	-	9	-	9
Travel and subsistence	76	-	-	76	38	113
Unidentified	-	-	-	-	881	881
Grand Total	5,884	133	1,591	7,608	1,380	8,988

- The Trust's efficiency target for the financial year is £9.0m, which represents 3% of operating the expenditure. This must be delivered to achieve the financial breakeven.

- The table above shows the progress on developing the plans at YTD M05. The overall number of identified schemes increased by 3 non recurrent schemes in the month at a value of £0.2m. This means we currently have 43 schemes on the Pipeline Tracker at a value of £7.6m.

- Fully validated schemes increased by £0.4m as 5 schemes were transferred to the delivery phase at a value of £0.4m after QIA approval. This included 2 schemes progressed from "validated" phase together with the non-recurrent schemes mentioned above. We are currently reporting 30 schemes totalling £5.9m in delivery phase.

- £0.1m (4 schemes) are in “validated” phase, and 9 “scoped” schemes equalling £1.6m are pending CFO/ Director sign off or QIAs review before transfer to delivery phase.

- There is an urgency to identify and develop the remaining £1.4m proposed schemes on the Pipeline Tracker.

Efficiency Delivery YTD August and Forecast Outturn by Directorate

Directorate	2023/24 M05 YTD Plan £000	2023/24 M05 YTD Actual £000	2023/24 M05 YTD Variance £000		2023/24 Annual Plan £000	2023/24 Risk adjusted FOT £000	2023/24 Risk adjusted FOT vs. Plan Variance £000		2023/24 Fully Validated Schemes £000	2023/24 M05 Annual Plan vs. FVS Variance £000	
Chief Executive Office	15	0	(15)	✗	37	0	(37)	✗	0	(37)	✗
Finance & Corporate Services	254	116	(138)	✗	632	669	37	✓	827	195	✓
HR	64	0	(64)	✗	154	0	(154)	✗	0	(154)	✗
Medical	125	221	96	✓	499	221	(278)	✗	221	(278)	✗
Operations	929	281	(648)	✗	4,771	1,944	(2,827)	✗	2,376	(2,395)	✗
Quality & Nursing	0	0	0	N/A	0	0	0	N/A	0	0	N/A
Strategic Planning and Transformation	340	637	297	✓	1,084	1,070	(14)	✗	1,070	(14)	✗
Trust wide	423	330	(93)	✗	1,811	1,391	(420)	✗	1,391	(420)	✗
Total	**2,150**	**1,584**	**(566)**	✗	**8,988**	**5,294**	**(3,694)**	✗	**5,884**	**(3,103)**	✗

- The Trust delivered £1.0m savings in month, (August 2023) against a plan of £0.7m. This resulted in a YTD achievement of 1.6m, which is £0.6m behind plan, an improvement of £0.3m compared to last month. 77.0% of the YTD savings were recognised on a recurrent basis with 23.0% schemes non recurrently.

- We are forecasting a full year efficiency savings of £5.3m against the £5.9m fully validated schemes. The £0.6m reduction is due to the emerging risk associated with the delivery of 3 schemes, notably Hear and Treat (£0.4m), and £0.1m lower each, in the Estates optimisation and the Procurement contracts review. This leads to a shortfall of £3.7m compared to the £9.0m efficiency target for the year.

- Recurrent schemes currently represent 93.1% of the total risk adjusted schemes of £5.3m. This is likely to reduce if additional non recurrent underspends are relied on to mitigate the shortfall in the efficiency programme.

- The overall efficiency delivery risk remains red. The Trust is required to deliver £7.4m savings within the next seven months to deliver the £9.0m efficiency targets. This is expected to be challenging to achieve during the winter with the potential operational pressures.

- Greater collaborative working across the Trust is required to focus on developing proposed schemes and explore new opportunities including non-recurrent savings to facilitate the delivery of the £9.0m target in the financial year 2023/24 and to build a pipeline of sustainable schemes beyond.

- All Budget holders are required to make a concerted effort to work with their FBP to support delivery of their identified efficiencies, including our people's suggestions.

- Senior Management Group (SMG) members are expected to develop and quantify the plans to contribute to the further £2.5m efficiencies to ensure the delivery of the 2023/24 efficiency target.

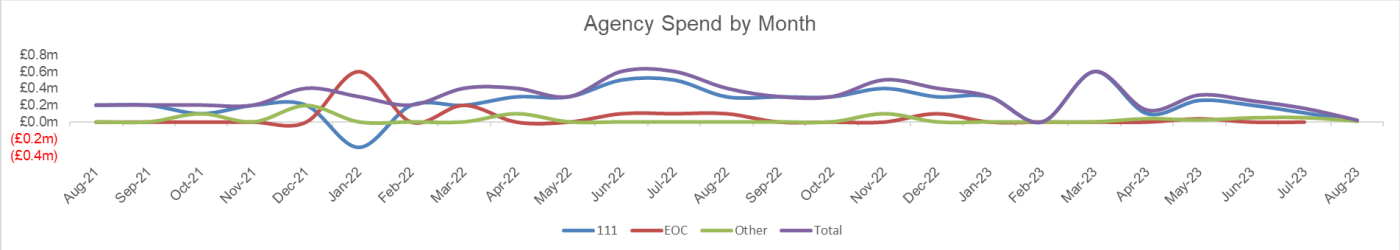
- A workshop is being scheduled in for EMB and SMG members to peer review efficiencies, align objectives and to agree next steps to close the gap.

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

5. Agency

	Year to August 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
Agency Expenditure	(£0.8m)	(£0.9m)	(£0.1m)	⊗	(£1.8m)	(£2.0m)	(£0.2m)	⊗

- Overall spend with agencies over plan by £0.1m. August expenditure was less than £0.1m, the forecast includes expected additional agency spend to deliver the requirement of the additional capacity funding. Majority of the agency spend YTD was in NHS 111.



6. Statement of Financial Position and Cash

	£000 Previous Month	£000 Change	£000 Current Month	£000 31 March 2024
NON-CURRENT ASSETS				
Property, Plant and Equipment	116,977	(184)	116,793	123,160
Intangible Assets	1,999	(117)	1,882	2,143
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**118,976**	**(301)**	**118,675**	**125,303**
CURRENT ASSETS				
Inventories	2,477	(41)	2,436	2,486
Trade and Other Receivables	11,810	93	11,903	10,441
Asset Held for Sale	657	0	657	657
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	40,693	531	41,224	47,506
Total Current Assets	**55,637**	**583**	**56,220**	**61,090**
CURRENT LIABILITIES				
Trade and Other Payables	(46,100)	(889)	(46,989)	(53,711)
Provisions for Liabilities and Charges	(10,289)	0	(10,289)	(10,289)
Borrowings	(7,377)	1,133	(6,244)	(8,170)
Total Current Liabilities	**(63,766)**	**244**	**(63,522)**	**(72,170)**
Total Assets Less Current Liabilities	**110,847**	**526**	**111,373**	**114,223**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(9,528)	0	(9,528)	(9,528)
Borrowings	(22,562)	(425)	(22,987)	(26,184)
Total Non-Current Liabilities	**(32,090)**	**(425)**	**(32,515)**	**(35,712)**
TOTAL ASSETS EMPLOYED	**78,757**	**101**	**78,858**	**78,511**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,204	0	109,204	109,204
Revaluation reserve	6,871	0	6,871	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(37,562)	0	(37,562)	(37,562)
Income and expenditure reserve - current year	244	101	345	(2)
TOTAL TAX PAYERS' EQUITY	**78,757**	**101**	**78,858**	**78,511**

- Non-Current Assets are down by £0.3m in the month represented by new assets under construction of £1.0m, plus new Right of Use assets of £0.1m net of monthly depreciation of £1.4m.

- Trade and other receivables are up by £0.1m. The major movement is a £0.7m decrease in VAT receivable after the payment in month and the delay in processing IC24 invoices through the ledger. Partially offsetting this was an increase in accrued income by £0.6m.

- Cash was up £0.5m being the recovery of increased VAT on previous IC24 invoices paid which reduced trade and other receivables above.

- Trade and other creditors were up by £0.9m which was primarily an increase in trade payables of £0.9m where the most significant increase was IC24 invoices awaiting payment of £1.3m. The balance is made up of an increase in taxes payable of £0.2m and a decrease in accruals of £0.2m.

- The provision balances are unchanged from last month.

- Borrowings decreased by £0.7m after payments on property rent and DCA leases in the month.

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

7. Cash Flow Position

Cash Flow	Year to August 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance	
EBITDA	£8.4m	£5.6m	(£2.8m)	✗	£21.4m	£17.6m	(£3.8m)	✗
Working Capital / IFRS 16	£2.3m	£2.1m	(£0.2m)	✗	£13.8m	£10.7m	(£3.1m)	✗
Capital Payments	(£10.8m)	(£10.8m)	£0.0m	✓	(£18.4m)	(£19.0m)	(£0.6m)	✗
Proceeds from disposal of assets	£0.0m	£2.8m	£2.8m	✓	£0.0m	£2.8m	£2.8m	✓
IFRS 16 Lease Payments	(£3.0m)	(£3.3m)	(£0.4m)	✗	(£8.4m)	(£9.0m)	(£0.6m)	✗
Net PDC and interest	(£0.2m)	£0.6m	£0.8m	✓	(£2.2m)	£0.3m	£2.4m	✓
Cash Movement	(£3.2m)	(£2.9m)	£0.2m	✓	£6.3m	£3.4m	(£2.9m)	✗
Opening Cash Position	£44.1m	£44.1m			£44.1m	£44.1m		
Closing Cash Position	£41.0m	£41.2m	£0.2m	✓	£50.4m	£47.5m	(£2.9m)	✗

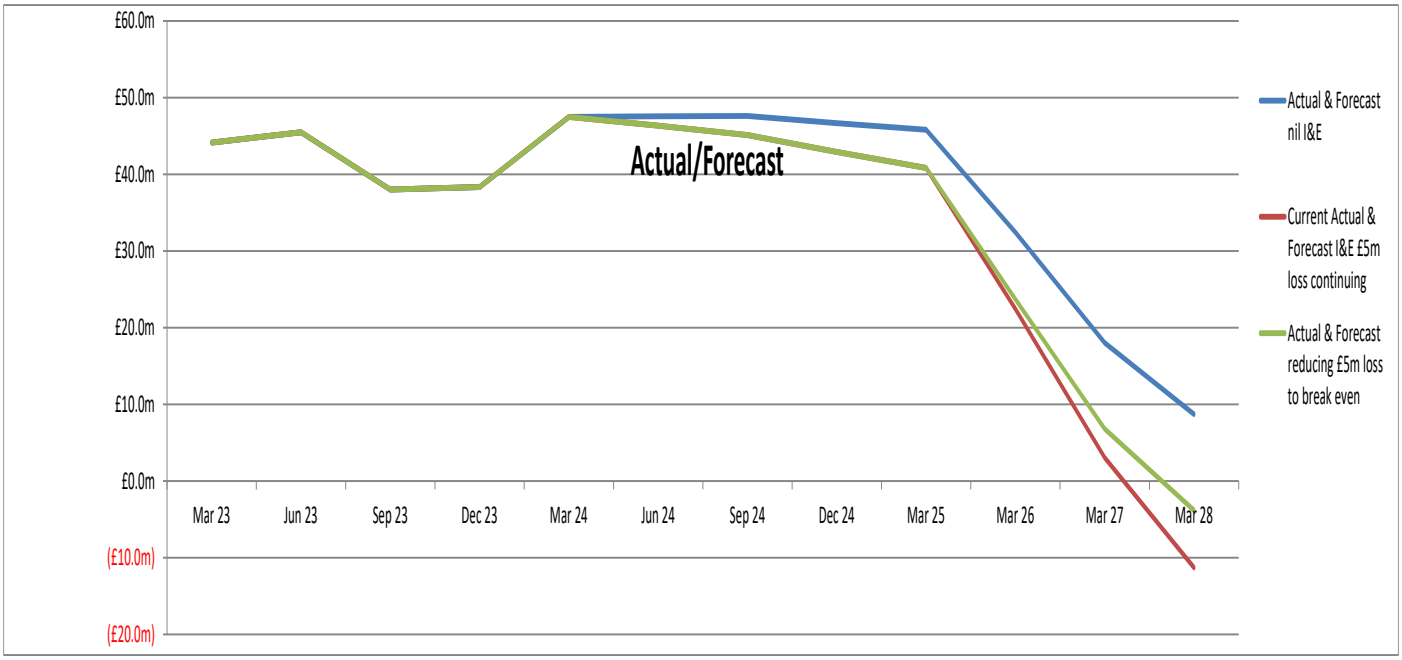
- The Trust's cash balance as at M5 2023/24 was £41.2m. The receipts for the year-to-date were £149.4m including proceeds from sale of Trust assets of £2.8m.

- Capital cash payments were £10.8m for the year to date along with other expenditure of £141.5m meaning the net decrease of £2.9m for the year in the table above.

- The actual cash balance was £0.2m higher than plan primarily due to the timing of VAT recoveries in the month.

- This decrease in the surplus on the I&E position of £2.8m is being covered by the disposal proceeds from asset sales of £2.8m and higher interest receivable of £0.8m.

8. Cash Forecast



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

- The upside case is indicated by the top blue line above, where a break-even I&E position has been assumed for all future years. This means our cash position will be around £8.7m by 2026/27 due to significant planned capital investment.

- The middle green line predicts the eroding cash position if the Trust reports a £5.0m deficit in 2023/24 and then report break-even for future years. The red line shows the impact of what happens should the trend of deficits continue.

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

9. Working Capital Ratios

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	14	
Debtors % > 90 Days	5.0%	44.8%	
Trade Creditor Days	30	43	
BPPC - Value of inv's pd within target (ytd)	95.0%	80.1%	
Cash (£m)	41.0	41.2	

- Receivable days at month end are 16 days ahead of marginally down from last month. Settlement of NHSE. Kent & Medway ICB invoices has been offset by new invoices to KSSAAT.

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

- Payables days are off target by 13 days for the month. The level of payables has increased in the month after increases in IC24 and to Omnicell invoices of £1.3m and £0.5m respectively in the month. Excluding accruals, the measure would be on target at 30 days.

- The BPPC for value of invoices paid has declined in the month to reduce the YTD 80.1% short of the target of 95%. The shortfall in the month was the catch-up payments to IC24 and Churchill mentioned above. There were 9 IC24 invoices valued at £2.7m and 4 Churchill invoices for £1.7m where delays in processing the invoices against the purchase orders led to failing terms. Without these invoices the BPPC would have been 89.3%.

- Cash is above plan at month end after the level of pay and non-pay expenditure reduced month on month outweighing the reduction in receipts after last month's sale of Redhill ambulance station. There is some timing whereby the increase mentioned above in payables will reduce cash in September. In addition, the Trust has benefited from the higher interest rates with unplanned interest income of £0.9m year to date.

10. Capital

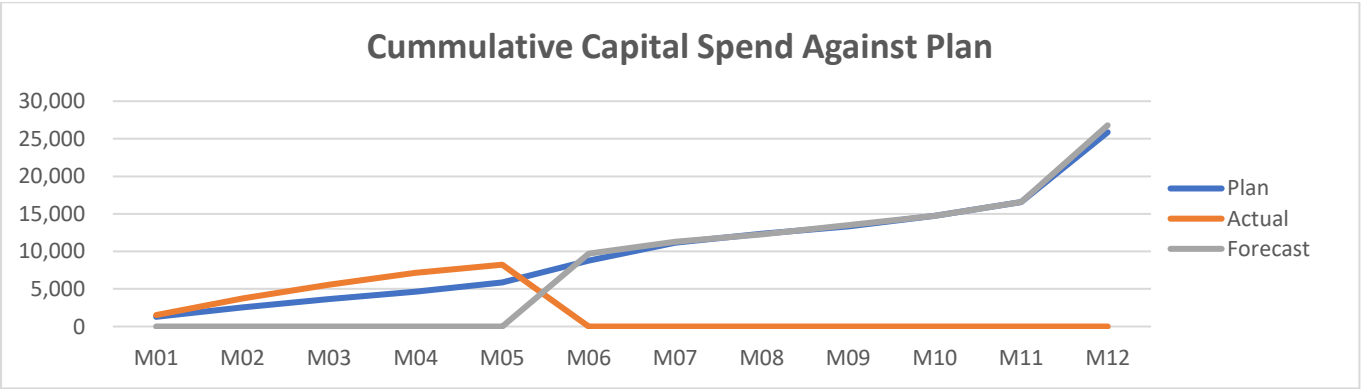
	August 2023				Year to August 2023				Forecast to March 2024			
	Plan	Actual	Variance		Plan	Actual	Variance		Plan	Actual	Variance	
Estates	£0.1m	£0.0m	£0.1m	✓	£0.2m	£0.2m	£0.0m	✓	£0.6m	£0.6m	£0.0m	✓
Strategic Estates	£0.0m	£0.0m	£0.0m	✓	£1.5m	£1.2m	£0.3m	✓	£2.4m	£2.1m	£0.3m	✓
IT	£0.2m	£0.1m	£0.1m	✓	£1.2m	£2.5m	(£1.3m)	✗	£4.7m	£5.1m	(£0.4m)	✗
Fleet	£0.6m	£0.4m	£0.2m	✓	£1.3m	£1.1m	£0.2m	✓	£4.2m	£5.0m	(£0.8m)	✗
Clinical Operations	£0.0m	£0.4m	(£0.4m)	✗	£0.0m	£0.5m	(£0.5m)	✗	£0.4m	£0.5m	£0.0m	✓
Total 'System' ICB Capital	**£1.0m**	**£1.0m**	**£0.0m**	✓	**£4.3m**	**£5.4m**	**(£1.1m)**	✗	**£12.3m**	**£13.3m**	**(£0.9m)**	✗
PDC Funded	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓	£0.0m	£0.0m	£0.0m	✓
Right of Use Assets (Leases)	£0.2m	£0.1m	£0.2m	✓	£1.6m	£2.8m	(£1.2m)	✗	£13.5m	£13.5m	£0.0m	✓
Total Capital	**£1.2m**	**£1.1m**	**£0.1m**	✓	**£5.9m**	**£8.2m**	**(£2.4m)**	✗	**£25.9m**	**£26.8m**	**(£0.9m)**	✗

The in-month capital spend is £1.1m which is £0.1m higher compared to the plan of £1.2m. This is due to timing on the remaining Medway spend and will even out by the end of the year.

The year-to-date capital spend is £8.2m which is £2.4m higher compared to the planed £5.8m. This overspend is due to timing differences relating to spend associated with 2022/23 and the lease for the 34 SRVs that has gone live earlier than planned.

Capital Delegated Expenditure Limit (CDEL)				
	£k			£k
			Funded by:	
Plan CDEL			Depreciation	10,158
Purchased	12,327		Cash Reserves	2,169
Leased	13,540		Lease Liability	13,540
	25,867		NBV from sales	925
Adjustment - Redhill Sale	916		**Expected CDEL**	**26,792**
Adjustment - Vehicle Sales	9			
Expected CDEL				
Purchased	13,252			
Leased	13,540			
	26,792			

The Trust anticipates meeting its CDEL by year end. There are a couple of possible variations to the forecast plan that have not yet been incorporated. The Trust will receive a CDEL increase for the net book value of any sales made in the year, this could be up to £3.4m, as per the above table the Redhill NBV has already been incorporated. There is expected to be an overspend against the plan for the MDC refit of circa £0.5m and potential spend on Crawley HQ of circa £1.2m. These projects are still in the early stages of progress and costs and timings are not yet known.



11. Risks and Opportunities

Risk	Impact	Likelihood	Score
The Trust's future capital expenditure plans could be constrained by capital limits (CDEL) imposed on our host ICB.	>£2.0m	Likely >50%<=80%	20
While the Trust currently has adequate liquid resources to meet its short-term plans, there is a need to generate cash surpluses to ensure sufficient funds for future investment to sustain and improve our services.	>£1.0m <=£1.5m	Likely >50%<=80%	12
The Trust has a challenging cash releasing efficiency target. Slippage in achieving this target could have an impact on the Trusts ability to meet its I&E target	>£1.5m <=£2.0m	Unlikely >20% <=50%	8
Forecast reflects the expected costs; This risk reflects any further deterioration to the forecast for any unforeseen and unexpected costs.	>£0.5m <=£1.0m	Possible 50/50	6

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

Opportunities	Impact	Likelihood
Additional sales of Trusts unused properties would improve the I&E position and increase the capital expenditure (CDEL) limit, which would allow the Trust to invest further than planned	>£2.0m	Possible 50/50
Impact of inflation, including the potential reduction in run rate due to reduced inflation especially with regards to fuel and energy costs.	>£0.0m <=£0.5m	Unlikely >20% <=50%

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

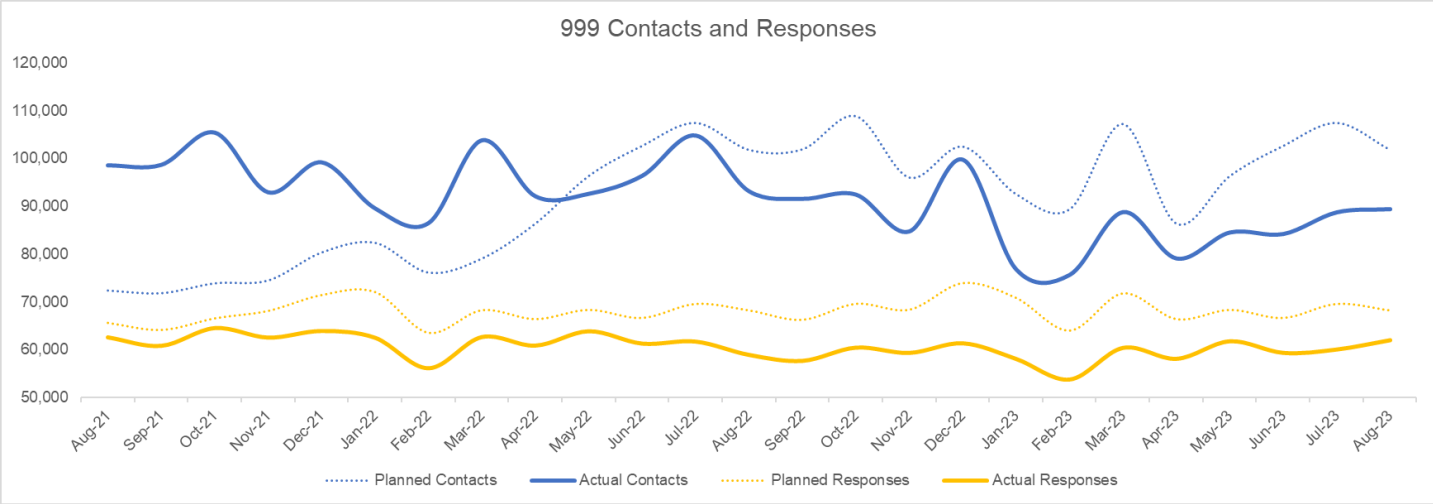
Appendices

A. Finance Pack

SECAmb_Finance_Pack_M05.pdf

B. Activity

999 Activity:



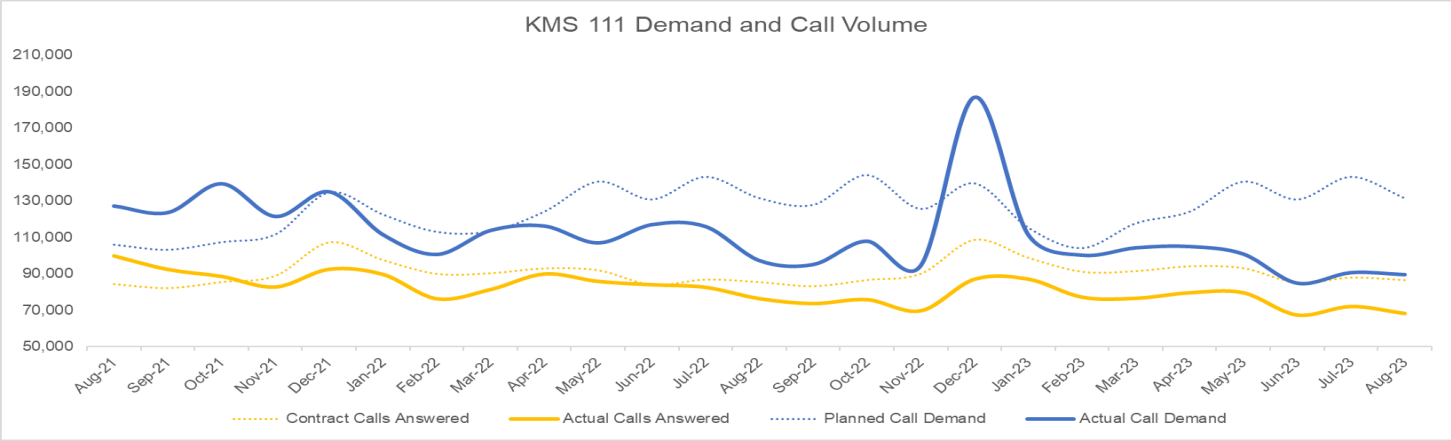
999 contacts (demand) 14.1% down against last year, with response activity being 3.5% lower.

This reduction in demand and activity has contributed to an improvement in Category 2 mean response times versus last year, with the C2 mean improving to 27.5 minutes year to date compared to 35.1 minutes last year as at M5 (August), mainly because of the demand being lower and improved handover delays.

Handover delays have an impact on the availability of crews to reach patients in time, 12,230 hours less were lost in the year to August 2023 compared to last year, this would be the equivalent of 7 extra ambulance shifts per day, helping to improve performance times.

C2 Mean currently stands at 27.5 minutes year to date against a plan of 30.6 minutes.

111 Activity:



August 2023 saw demand (calls offered) fall slightly by 1.2% than July 2023.

Both demand and activity are down versus the same period last year with demand 14.9% lower and activity 12.4% percent down. This trend would indicate the Trust requires less staff to meet future demand.

Calls answered in 60 seconds performance dipped to 40.2% for July against 46.1% in July 2023. National KPIs have changed for the 111 service, with proportion of calls abandoned and average speed to answer being the main KPIs being monitored going forward. SECAmb currently sits at 14.3% (10.0%) and 284 (183) seconds for these metrics (national) for the year to date. Standard target is 3.0% and 20 seconds.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	54-23

Name of meeting	Trust Board
Date	5 October 2023
Name of paper	People and Culture - Executive Summary to the Board
Strategic Goal	Focus on People and Culture
Lead Director	Ali Mohammed, Executive Director of HR and OD
Primary Board Papers	BAF Risks i. Workforce Plan (255) ii. Retention (13) iii. Culture and Leadership (348) Integrated Quality Report
Executive Summary	**Risk Overview** The previous combined risk of retention, culture and leadership has been split into two risks with one now specifically focusing on retention and the other now confirmed as Culture and Leadership (risk 348). The Recruitment risk has now been relabelled as Workforce Plan. The IQR is reflective of the current risks (except for industrial action) through the key metrics set out in the Overview. **Industrial action** has been paused by most unions now. No further action is currently anticipated by unions recognised within SECAmb. Action by the BMA, primarily in hospital partners, continues with combined senior and junior medical staff taking place within our geography in week commencing 18 September 2023. As previously reported, the **national pay** arrangement for Agenda for Change staff was implemented successfully in June 2023. Details are still awaited at the time of writing in respect of VSM pay (affecting executive roles) and medical pay. **Workforce Plan** The SPC charts within the IQR now show both 'volume' or cohort and 'ad hoc' recruitment. The former are to fill spaces on both contact centre and field operations planned courses, whilst the latter are to fill vacancies in other positions that arise throughout the year. 371 WTE staff are planned to be recruited by end of 23/24 with the following breakdown. • 139 NQPs • 87 International Paramedics • 110 ECSWs • 35 AAPs

	The IQR sets out progress with the recruitment plan and notes areas of some under and overachievement against plan. A Quality Improvement project to improve Time to Hire (TTH) and onboarding has now commenced fully and an update is provided in the IQR on the current status of the work. **Retention** Staff **retention** remains a high concern. The Board will receive a separate presentation on our developing plan to address the retention challenge in the context of the new NHSE Long-Term Workforce Plan. Sickness absence has continued the downward trend to 6.8% due to the continuing focus on its management. We are **not an outlier** compared to other ambulance Trusts. Monthly scrutiny of action plans at Operations Senior Leadership meetings continue with support from HR Advisors. **Culture and Leadership** The Trust Board agreed a new **People and Culture Strategy** at its April 2023 meeting. The executive team has worked together to identify Year 1 priorities, actions and KPIs. It will be critical to ensure that the implementation of the strategy is communicated to, seen and felt by all our people particularly as this strategy also now effectively forms our response to the Staff Survey by focusing on actions which our people have asked us to consider in the survey. An **executive team development programme** is being developed under the leadership of the CEO and Trust Improvement Director. A development partner has also been appointed and the first development session with the partner took place on 29 September 2023. The number of **suspension cases continues to decrease** showing progress both in process terms but also in terms of considering alternatives to suspensions and removing suspensions as soon as practically possible. As a result, we have moved from **c.20** suspensions at the beginning of 2022 to **five** open cases with an average length of suspension also decreasing substantially to an average of 72 days, well below the previous average of over 100 days in 2022. Importantly, the continuation of the focus on sexual misconduct means that we currently **do not have any** sexual harassment cases within the five suspensions. The People and Culture Webinar on 9 October will focus on the next phase of our Until It Stops campaign – our focus on improving sexual safety at work – in addition to our regular update on P&C delivery plan actions. Further to the Improvement Case being fully approved to increase employee relations capacity by creating a specialist ER team separate to the HR Business Partner team, the **new Head of ER** will start with the Trust in October 2023.Two specialist ER managers are now being recruited to complete the senior tier within the new team – one has now been appointed.

	As updated at the last Board, the next steps on the work with ACAS **mediation** to improve working relationships with Trade Unions proceeds. A proposal from ACAS was received and agreed to by the Trust and its five recognised unions. The proposal involves two days of the executive team meeting with the GMB and then two days with all five unions. The days with the GMB were completed in July and the wider dates with all unions are now confirmed for 20 and 31 October. A separate mediation meeting will take place with UNITE on 9 October. To supplement this work, the CEO is meeting each full-time officer individually to establish positive working relationships. The Director of HR and OD now meets each Branch Secretary on a monthly basis and weekly briefings continue with all unions by the executive team. The latest **National Quarterly Pulse Survey** closed on 31 July 2023. The number of responses was the highest ever at over 900 responses. Previously our highest response was 812 in April 2023. The latest **annual NHS staff survey** commenced on 18 September 2023. The work to continue accessibility to previous staff surveys continues and the 'Getting It Right for Our People' page on The Zone together with six-weekly People and Culture Strategy updates at Trust-wide webinars are key measures to increase visibility and engagement. Concerns raised through the FTSU team remain high with continuing concerns about detriment. The themes appear to be similar to previous months including **bullying and harassment, inappropriate behaviours and safety/wellbeing**. Focus on **detriment** is now an area of action for the FTSU team.
Recommendations, decisions or actions sought	We continue to face a number of operational and workforce challenges. These are reflected with the BAF and Trust Risk Register and by the scale of the work set out in the strategic objectives and associated delivery plans. The development and approval of a new People and Culture Strategy is an important and critical step forward in our aspiration to create a better place of work for our people. Our work on staff retention and recognition The **delivery plan** is a key step forward and the visibility given to that delivery plan on an **open space within the Staff Zone** is a major step forward in terms of transparency. It is recommended that the Board **discuss** and **endorse** the actions taken to date and **individually and collectively own and support** the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	54-23

Name of meeting	Trust Board
Date	5 October 2023
Name of paper	**Retention** - Executive Summary to the Board
Strategic Goal	Focus on People and Culture
Lead Director	Ali Mohammed, Executive Director of HR and OD
Primary Board Papers	BAF Risks i. Workforce Plan (255) ii. Retention (13) iii. Culture and Leadership (348)
Executive Summary	**Risk Overview** Staff **retention** remains a high concern. This Board will receive a presentation on our developing plan to address the retention challenge in the context of the new NHSE Long-Term Workforce Plan. This presentation sets out **draft principles** for the plan and a set of **draft pledges** which we propose to make to our people. **Staff engagement** is a critical part of developing our approach to retention and the presentation sets out the engagement journey so far and that necessary to ensure that there are as many voices as possible reflected in the plan. The development and approval of a new approach to retention as part of our **People and Culture Strategy** is an important and critical step forward in our aspiration to create a better place of work for our people. Our work on staff **retention, reward and recognition is being developed simultaneously** and will need to be meaningful to our people. A **delivery plan** is also being developed in accordance with the timetable set out in the presentation.
Recommendations, decisions or actions sought	The Board is asked to **note** and **endorse** the actions taken to date. The Board is asked to **agree** to receive the final plan in its December 2023 meeting. The Board is asked to **discuss** the draft principles and pledges within the draft plan.

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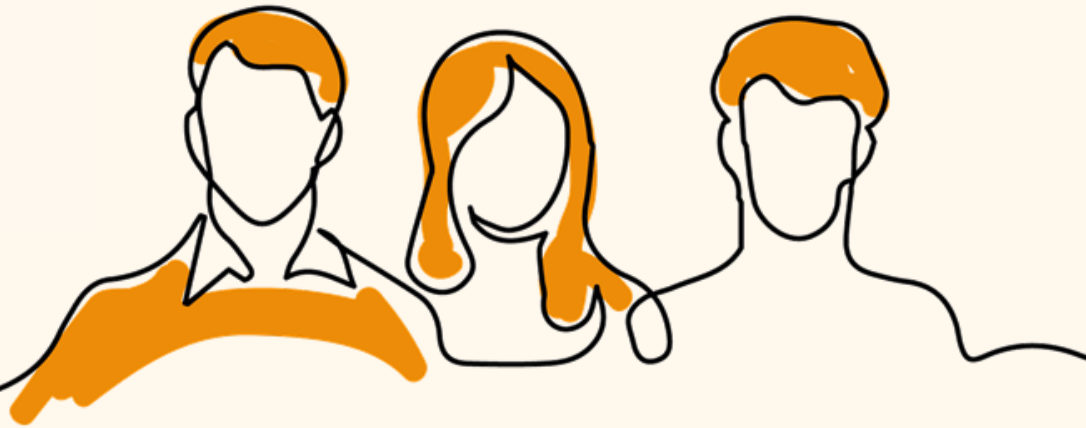
Retention Plan 2023 (DRAFT)

GETTING THINGS RIGHT
FOR OUR PEOPLE



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South East Coast Ambulance Service
NHS Foundation Trust

Introduction

The rationale for our new retention plan

- Our turnover continues to be a risk for the Trust, and despite the introduction, and delivery, of a Trust retention plan in 2022, turnover continues to increase. Currently 18.94% (August 23).
- Since the development of the initial retention plan, NHS England has launched its Long-Term Plan, and the Trust has launched its People and Culture Delivery Plan. The later aimed at addressing the comments/concerns identified in the 2023 Staff Survey and previous surveys.
- A timely review of Trust strategies and plans against the NHS long-term plan, with a focus on workforce, has identified opportunities where we can focus further on retention, taking ambitious and innovative approaches that will really make an impact.

The National Retention Programme

NHS
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NHS Foundation Trust

Delivering the People Promise

'Our focus is on evidence-based interventions that have the greatest impact for our NHS people. Based on the evidence we have, there are two important principles which will support retention ….'

Targeted interventions for different career stages: early career, experience at work and later career. There are different risk points related to job satisfaction and retention at these stages, and our response and support needs to be tailored accordingly.

Bundles of high-impact actions are more effective than single actions. A bundle approach is needed to deliver sustained gains, applied to the different career stages and informed by evidence of what drives job satisfaction, experience and therefore retention.

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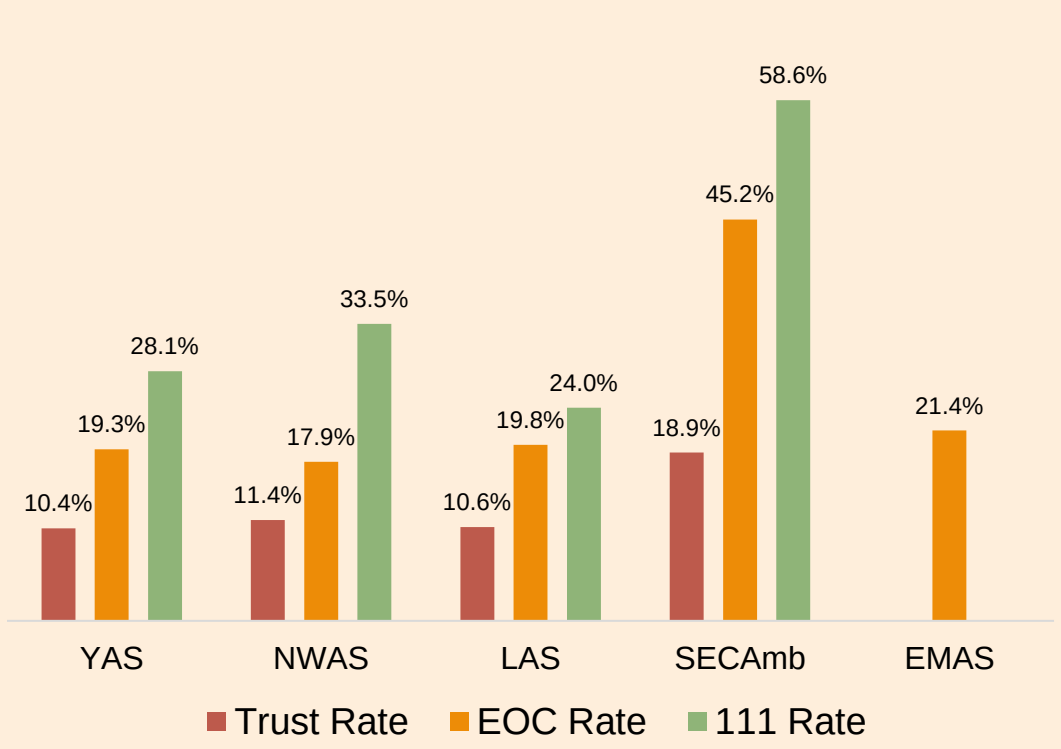
Life at SECAmb Now

Trust Retention Data

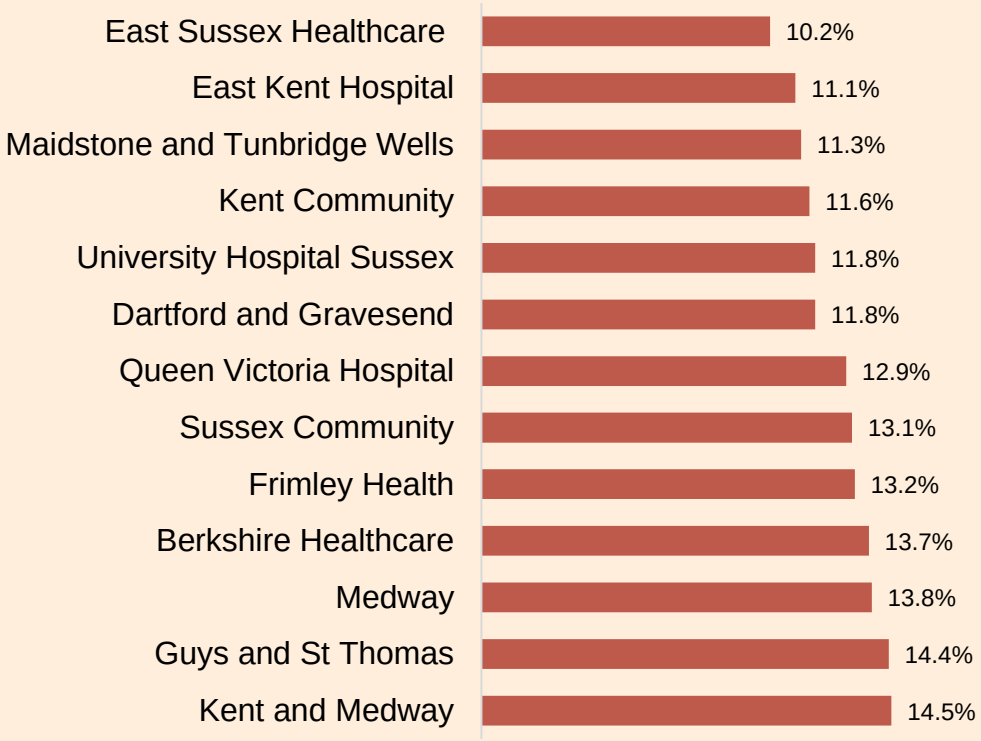
Understanding the wider context

South East Coast Ambulance Service NHS Foundation Trust

Ambulance Trust Comparison



South East Comparison



Best Practice

Initiatives across the NHS

NHS
South East Coast Ambulance Service
NHS Foundation Trust

South Central Ambulance Service

- Developing a new call center in Milton Keynes ¼ Piloting home working for health advisors
- Developing career progression pathway for health advisors
- Leadership and management training for team leaders and clinical shift managers

London Ambulance Service

- Improving staff wellness
- Extended periods of leave
- Travel loans

NHS Retention Community of Practice

- Just & learning culture (Mersey care)
- Addressing staff engagement and cultural awareness (NE London)
- 90 improvement initiatives (Bristol & NW Somerset)
- Real-time feedback mechanisms (Northumbria)
- Itchy feet conversations (Bristol)

Best Practice

National Retention Programme Case Studies

South East Coast Ambulance Service NHS Foundation Trust

West Midlands Ambulance Service

- **Using the NHS Health and Wellbeing framework diagnostic tool**
- Revised health & wellbeing strategy, employed psychotherapists to support staff, purchased health check equipment for use with staff, invested in management development

The Royal Free London

- **Improving joy at work – electronic self-rostering**
- Self-rostering was key to offering staff shift flexibility and choice. This was piloted in the ICU in Jan 2018 and then implemented across 32 areas from Sept. 2018 to May 2019.

Milton Keynes University Hospital

- **The Milton Keynes Way**
- Milton Keynes University Hospital (MKUH) has developed a unique staff benefits programme for its 4,500-strong workforce, incl. flex working, enhanced special leave, and much more.

https://www.england.nhs.uk/looking-after-our-people/looking-after-our-people-case-studies/

Our Principles

Our plan has drawn on the expertise and creativity of all involved to develop into something that is owned by our people and will make a real difference in their eyes.

The plan is based on the following principles:

1. Address the principal reasons for leaving
2. ‘Do no harm’
3. Promote inclusion and diversity
4. Creative and brave ideas
5. The impact must be measurable

Our Pledges

NHS
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1. Provide you with more control over your working time
2. Become a more flexible employer
3. Take a proactive approach to career development
4. Promote health, happiness, and joy at work
5. Take a total reward approach to pay, terms & conditions
6. We will not miss opportunities to make improvements

Our Engagement Journey

South East Coast Ambulance Service NHS Foundation Trust

- Trust Board, including the Operational Management Team
- Senior Management Group
- Trade Union Partners
- HR & OD Directorate
- EOC Culture Change Group
- Staff Networks

In addition to the data and staff feedback already available to us, we have engaged a number of groups to gather suggestions and further feedback.

We will continue to engage colleagues across the Trust throughout the development and implementation of our plan.

Engagement - Hours & Patterns of Work

Becoming a more flexible employer & providing individuals with more control over their time at work

NHS South East Coast Ambulance Service NHS Foundation Trust

- Flexible working for all
- Stop having meetings that could easily be emails
- Better planning to reduce the stress of last-minute requests
- Ensure that band 7 vacancies in ops are offered as part-time to support work/life balance
- Ensure there are 10 minutes between meeting times (start at 5 past, end at 5 to)
- Reduce the number of meetings and introduce no-meeting days
- Self-Rostering
- Allow staff control over their own breaks and allow more breaks
- Shadowing in other roles in varied departments
- 4-day week/less hours same money
- Shorten meetings
- Colleagues able to flex/be agile with own working hours
- 1 or 2 days off a year for (verified) volunteering roles
- Normalise dropping out of meetings if attendance not essential (no value added)
- Efficiency not presentism
- Reasonable expectations around what can be achieved with time and resources available
- Introduce 1 hour lunches without impacting pay
- Allow paid TOIL for those who have to work extra hours to finish tasks
- Only work the hours paid, with permission to stop when 37.5 complete.
- Be able to work from abroad
- Recognise that AFC does not fit all roles, especially corporate
- Improve rotas in 111 and EOC
- Flexibility for annual leave and bank holidays – self-management of when to take
- Replace GRS with a more advanced system to make rota and shift planning easier
- Reduce or completely remove relief from rotas
- Allow condensed hours for those who want to work that way
- Ensure policies work for both Ops and corporate staff
- Ensure training and induction is flexible, not full time for part time staff

We each have **a voice that counts**

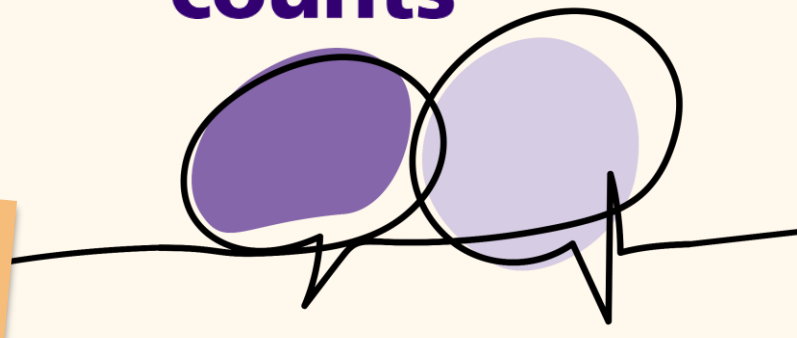
Engagement - Career Development

A proactive approach to managing your career at SECAmb

South East Coast Ambulance Service NHS Foundation Trust

- Development opportunities with systems, national, and partner organisations
- Better internal progression routes
- Formal training packages, CIPD funding, apprenticeship levy
- Reduce time it takes to recruit replacements, the authorisation process should be simpler
- Add links to the actual job advert in vacancy emails and make it clear if internal applicants only
- Protected time within working hours for training and development for everyone
- Better training when starting new roles to better support staff and make them want to be here
- Be aware that some staff don't want to progress, so support and appreciate the work they do
- Involve all key stakeholders when considering service transformation or restructuring
- Introduce key skills type days for all staff, similar to Ops but on varied topics such as management basics
- Create framework to allow managers direct ability to allocate study, CPD time etc. to team members to support meaningful appraisals
- More shadowing of individuals, teams and departments within work hours
- Mentoring, interview skills, application writing for internal candidates
- Improve recruitment process into permanent roles for those on secondment and performing well
- 'Day in the life' synopsis of each role on The Zone
- Formalise hybrid roles between ops and corp teams – run programme similar to graduate scheme
- Redesign SECAmb careers website to showcase development pathways
- Improve access to management training and development
- Introduce formal succession planning and talent management
- Show career pathways for niche job roles
- More observing shifts in different areas
- Training roles with HR & OD - ESR in house trainer/expert
- Overhaul appraisal system so it feeds into training needs analysis
- A focus on developing in role, rather than just on progression
- Internal secondment policy
- Internal promotion policy

We each have **a voice that counts**



Engagement - Health & Wellbeing

Promoting health, happiness, and joy at work

South East Coast Ambulance Service NHS Foundation Trust

- Work buddy – someone to talk to other than friends or manager
- Personalised mental health support for different groups
- Measure the benefit of current wellbeing provisions
- Wellbeing days at each OU with local volunteers leading the day with Wellbeing Hub support
- Subsidised packages for discounts at the gym, like Gym Pass
- Review sickness stages (and whole policy) to make more supportive
- Efficient OH team
- Wellbeing options for each dept. to make it easier to signpost your team
- Training for all staff on menopause
- Timely and supportive return to work meetings
- ER processes to be timely and sufficiently triaged prior to an individual entering the process
- Identify the poor contributors to poor wellbeing
- Review the process and support for meaningful wellbeing conversations that are woven through all aspects of work life
- Access to EAP that doesn't restrict support available
- More vegan options in vending machines
- Reasonable adjustments pathways to be standardised
- Mental health days that are not included in sickness
- Bank of sick days for colleagues with disabilities/ review provisions for disability leave
- OH advice to be more specific when being used for sickness records
- Better food provisions on site
- Period days/menopause days/special leave days for different requirements
- Allow staff to work from home more often if they feel they work better in their own environment
- More mental health support for corporate staff
- Promote / subsidise activities that have a positive impact on health
- A focus on financial wellbeing
- Annual wellbeing day to spend as you wish
- 'School dinners' - one funded hot meal, such as lunch, each day at the larger sites. Or breakfast option on all sites each day
- Support staff and their family members to access MH support

We each have **a voice that counts**

Engagement - Pay, Terms & Conditions

Taking a total reward approach

South East Coast Ambulance Service NHS Foundation Trust

- Gaps between AFC pay-step points are too long – can we introduce local pay-steps?
- EOC break times should not include toilet breaks. Increase current 75 mins as this is not long enough during a 12-hour shift
- OT paid weekly instead of monthly to support staff
- More options for paid OT to reduce normal working hours and pressures across the week
- OT opportunities in corporate directorates
- HCA per base location
- Use bank workers and part-time EMA's etc to cover relief schedule
- Increase pay directly for hard to recruit/retain roles e.g. EMA's, VMT's
- Introduce enhanced provisions for family leave, such as carers, bereavement, neonatal loss, fertility treatment etc.
- 111 break allowances to match 999
- Shorter shift times
- Paid lunch breaks
- Incentivise team-based performance with reward and recognition that is meaningful
- Introduce a retention bonus or RRP – or refer a friend scheme
- Ensure fair pay and consistency across the Trust
- Purchase food for all staff when Board and other large meetings take place at different sites
- Additional day of leave for birthday
- Purchase Blue Light Card for all staff

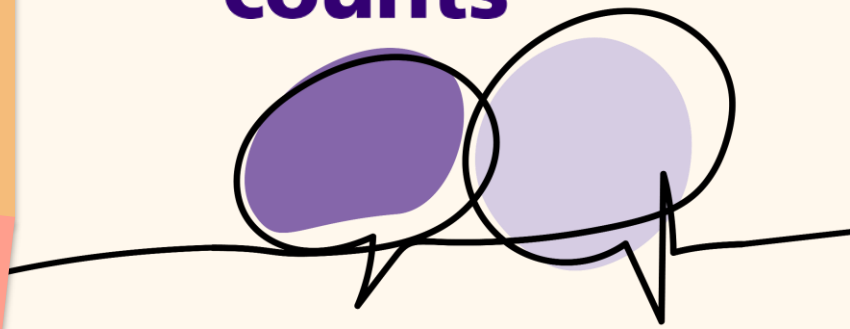
Engagement - Other Opportunities

Ensuring we don't miss other opportunities to make improvements

South East Coast Ambulance Service NHS Foundation Trust

- Better induction for those working from home
- Clear expectations of role from the outset, specifically around case load and pressures
- Education for managers around retention – applying flexible working, wellbeing conversations etc.
- Review and improve the DBS process
- Improve systems so they can 'talk to' each other
- When employee not able to be in pension scheme, Trust could use the money it would have contributed for something else
- EMA's – Can the training be done in the evenings while individuals are still in their current jobs so that they know whether or not the job is for them before leaving their current role
- Improve recognition for all colleagues
- Review and improve onboarding process
- Improve end of shift arrangements – giving colleagues a choice of whether they are tasked with a job in the last minutes of their shift for example
- RVs purchased by the Trust that staff can rent for holidays etc at cost plus a bit. Fleet could easily manage these through a central location such as Banstead
- Less reliance on external consultants – promote and use internal expertise
- Reward no sick days during a year
- Networking days for agile working colleagues
- Increase the number of staff in corporate teams
- Develop clear individual performance reporting that incentivises and is fun, so that people can see how they are doing regardless of role
- Overhaul the interview process
- Charity Days
- Explore further non-pay benefits

We each have **a voice that counts**



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Life at SECAmb Now

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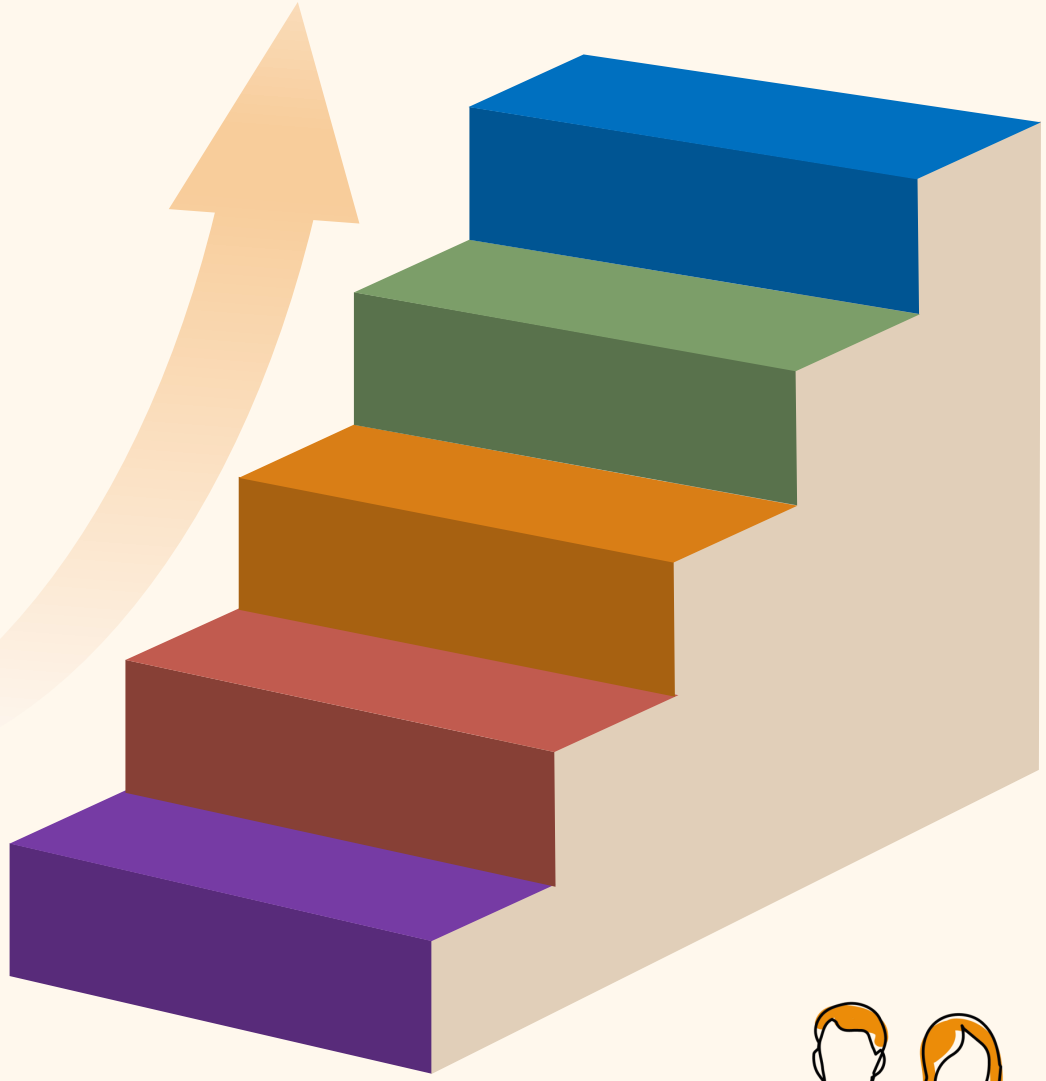
A Brighter Future Ahead

Next Steps

1. Complete engagement in October with Staff Networks and wider staff
2. Bring back to EMB fortnightly for updates
3. Update at People Committee (9th November)
4. Final Version to come back to EMB for sign-off with action plan on 22nd November
5. Final version to Board on 7th December



South East Coast Ambulance Service NHS Foundation Trust

Agenda No	54-23

Name of meeting	Trust Board
Date	05.10.2023
Name of paper	Culture Transformation Program - Update to the Board
Strategic Goal	Focus on People
Lead Director	Ali Mohammed, Executive Director of HR and OD
Author	Dr Tina Ivanov, Programme Director - Culture Transformation
Executive Summary	The purpose of this paper is to provide assurance against the People and Culture Delivery Plan, which includes the 'housekeeping' actions. The author is assured the project remains on track for full delivery. 31/08/2023: Of the 111 actions, 36 are complete and none are overdue-at risk. 10 actions were closed in this reporting period. 9 actions have not been completed in Q1/2 as planned, and this is in-part, related to the recruitment of staff. The Programme Director has met with the action owners to confirm how these actions will be achieved in Q3. The Operational Unit Managers (OUM+) group development program is underway, with attendance at 2 board Development sessions, to increase connectivity between Board and management. The National Quarterly Pulse Survey (July 2023) had the highest number of respondents (902) to quarterly survey to date. The results showed that the engagement score has improved (4.3 to 5.3 July 2022 – July 2023), and it is the first time that number of respondents feeling positive outweighs number of respondents feeling negative (51.7% to 48.3%).
Recommendations, decisions or actions sought	The Board is asked to **discuss** the progress and the plans for Q3, as part of the overall approach to culture transformation. It is recommended that the Board continue to endorse the actions taken to date and individually and collectively own and support the programmes aimed at improving organisational culture, leadership practice and staff experience.

1. Introduction

1.1 'Getting things right for our people' is one of our three strategic priorities for 2023/24 and will be achieved through the delivery of the Culture Programme and the People & Culture Strategy. In Year 1, our focus is listening to our people, acting on their feedback, and continuously enhancing their work experience. To ensure we have strong foundation for leading change across our geographically disperse organisation, we have increased our internal communication and invested in leadership development for our executives and managers.

People and Culture Strategy and Delivery Plan, including 'Housekeeping'	Culture Communications Plan	Executive and Manager Development
• We are directly addressing the issues raised by colleagues, including choosing a new and more accessible ambulance for the future, revising key policies like Annual Leave and Unsocial Hours to offer better work-life balance, and reducing shift overruns • We are taking action, responding to our people, and building trust	• We have enhanced communication across the Trust, and created new spaces for dialogue between our people and our managers, and our leaders and our Board. • We are informing our people, sharing our future, connecting with our people and creating safe spaces to talk	• We are investing in leadership and management development and key skills training more than ever before. Our executive development program is under development, our manager fundamentals program continues, our middle managers program is under development and our targeted program to support the OUM+ group has commenced. • We are building capacity, confirming autonomy and responsibility, and resetting roles.

2. Progress

2.1 **People and Culture Strategy:**

2.1.1 Progress against the People and Culture Strategy (including the housekeeping) continues, noting that several of the actions are sub-actions to larger pieces of work which will be complete in Q4. Therefore the impact of those major changes will not be obvious till Q1/2 2024. 36 (32%) items are closed, and 44 (40%) are in progress. 9 tasks are overdue and are discussed in the table below.

2.1.2 A positive impact has been seen through an improvement process in uniforms. There had been a significant delay in providing new starters with uniforms and with filling internal orders. Some people had waited up to a year, many were waiting more than 6 months. The logistics team have applied QI to their workflow, and significantly shortened time to deliver. The backlog is now clear (except for hard to supply items), and new orders are being turned around within a week. Note we have removed manager approval from the process, which was a main cause for delays. We have also removed embroidered names from shirts, as we trial the NHS 'Hello My Name Is.. ' badges across the Trust, again saving time to deliver and also reducing costs.

2.1.3 In addition, the uniform policy has been reviewed, and a round table held to challenge historical inclusions. Feedback on this approach was positive, and further changes made to be a more inclusive policy. A survey has opened to all staff to explore what our future 'uniform' could be from a point of view of style, quality, comfort, safety, identity, and being inclusive.

2.2 **Communications:**

2.2.1 Internal communication has increased across the Trust, inline with the agreed Culture Communications Plan. Since last report, 2 People and Culture Webinars have occurred, and further planned at 6-weekly intervals (next webinar 09/10/2023). Other webinar forums include 'The Big Conversation' hosted by the CEO, and 'Town Hall' hosted by the Operations Senior Managers.

2.2.2 Leadership visits are now confirmed till end of year and include both corporate and operational teams.

2.2.3 The Culture Awareness Workshop ('Building a Kinder SECAmb') content now confirmed, internal facilitators trained to support the external provider, and workshops will commence October.

2.3 **Executive and Management Development:**

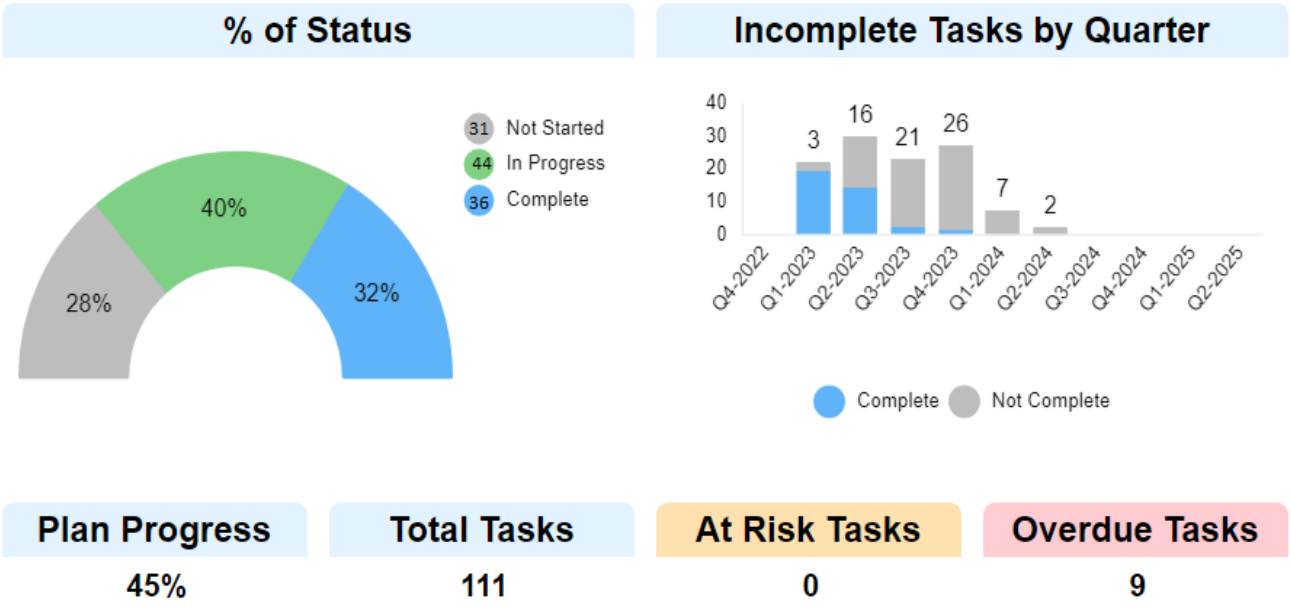
2.3.1 The Executive development program has been confirmed, and due to commence. This program will inform the key messages and approach for the senior managers development programs.

2.3.2 The communication is supported by direct investment in the leadership of the Trust, with the Operational Unit Managers (OUM+) group attending the Board development days. This has increased

connectivity between board and Senior Managers, and forms part of the development program for OUM+, with the formal program due to commence October.

2.4 We recognise that while addressing all the housekeeping items is critical to rebuilding trust within our organisation and improving our people's experience, we also understand that some of the items have far greater reach and impact than others. Members of the executive team are using more recent intelligence, such as from the quarterly pulse survey, leadership visits and staff forums, to confirm the higher priority items. This will result in intensive and targeted support to resolve them at pace, with ongoing monitoring at EMB.

2.5 People and Culture Delivery Plan Progress Dashboard (as at 31/08/2023):
(Full delivery plan is available on the Staff Zone)



2.5.1 The following table outlines the overdue tasks and actions to address progress. The delays in these actions do not place delivery of the plan at risk. The Programme Director is assured these will be completed.

	Action	Progress
1	All our corporate teams have scheduled time for every team member to participate in appraisal (2 hours per person)	Discussed at People Committee and a report to be presented at next committee.
2	Re-confirm through communication to our people, our commitment to training being held, list the programs that will be ring-fenced, and ensure REAP and other policies reflect this	This action has been delayed in finding a relevant comms to place the message within. There have been reminders in senior meetings across the Trust, but not as a whole Trust comms. This will be added to the next REAP status update.
3	In reference to the Senior Leadership visits, a communication package to be developed and published	The package is developed and was due to be published. However, delays in updates to the Staff Zone page has required a refresh of the posters. This action expected to be completed by early October.
4	In relation to manager essentials modules: Identify subjects matter experts	In progress, completion date to be confirmed.

5	"Conduct a deep dive into the policy and process for managing absence and attendance, and provide an updated education module, including: -Managing Health & Attendance -Managing Stress and Enhancing Wellbeing -Alternative Duties"	Paper has been prepared for the Efficiencies Group (EG) and SMG. Timing for presentation has impacted closure of this action. Initial meeting held to discuss developing training modules as part of Manager Fundamentals. A working group will now be established to take this forward. The education modules will be developed as part of the managers development work, so this action can be closed once paper is presented to EG / SMG. The module development will be tracked through the manager action.
6	"Establish a working group to create a cohesive and supportive approach to family-friendly working, consolidating the following policies: -Maternity Leave -Paternity Leave -Adoption Leave -Shared Parental Leave -Special Leave"	Initial meetings have been held, and update underway. The Programme Director is establishing a representative group to provide direct input to the updated approach. The action was due for completion in June, however ensuring we hear the voice of our people in this area is critical, so new completion date to be confirmed.
7	Review access and allocation of overtime and other scheduling decisions, including splitting crews, to evaluate fairness of process	Review underway
8	We will communicate the current Datix position to our people, showing the action plan for addressing and learning from the current open incidents	Current Datix position is reported and action plans available. With the introduction of Datix Cloud, further work is underway to improve communications and find alternative ways to share learning. Programme Director working with action lead to close.
9	We will review all cases in the previous 12 months that specifically identify concerns about clinical care, and deceased patients, to confirm an investigation / actions have been taken.	Initial review suggested this has been completed, however team are now applying further 'curiosity' to be assured and consider how to communicate the actions. Programme Director working with action lead to close.

2.5.2 Work Accomplished (since last report):

TASK NO.	DESCRIPTION
GFRC01.4	The process for completing and recording the appraisal will be reviewed in order to reduce the number of steps and time taken to record appraisal completion
GFRC03.1	In relation to overruns: Establish project governance, group, lead, sponsor and scope
MIPE02.3	Create sustainable process for removing and archiving superseded policies
MIPE05.01	In relation to manager essentials modules: Identify subjects/topic to include
IEOP01.1	OH referrals and Welfare calls for people on sick leave
IEOP01.1.2	An OH process review to evaluate the effectiveness
IEOP01.2.1	Audit to confirm all TRIM cases have been acknowledged and are being managed

IEOP01.2.2	A TRIM process review to evaluate the effectiveness
IEOP01.23	Complete spot audits of operational stations / ACRPs to review suitability of break out spaces and meal areas, including access to hot meals
IEOP04.5	Schedule of Awareness day workshop published notifying course location and learner spaces

2.6 EOC:

2.6.1 Intensive support from the Programme Director is underway, and the EOC Culture Change Group has been meeting fortnightly.

2.6.2 Attendance has been consistent, with approximately 10-15 attendees per meeting from a range of roles in EOC.

2.6.3 EOC has appointed a Communications lead, initially only at the West until the Medway move was completed. An East representative will commence soon. A survey was completed with staff for ideas to improve the sharing of information, with over 200 responses. Actions are now underway as a result.

2.6.4 The group has confirmed the other 2 key items to improve culture: Cross skilling, development and training; and Mentoring. The next meeting will focus on the mentoring, where the group will confirm approaches to quickly addressing these elements.

2.6.5 The latest quarterly pulse survey has seen EOC move to a much more positive position overall. This is only a snapshot in time, and the overall numbers of respondents are small, but it is a step in the right direction.

3. Measures

3.1 A Dashboard working group has been established to consider which metrics should be included, and the first draft of the dashboard is complete. This will be presented to People Committee in October.

3.2 ‘Sentiment’ measures are now live and were used in the Quarterly Pulse analysis.

3.3 The National Quarterly Pulse Survey (NQPS) July 2023 shows an improving position. The Trust had the highest number of respondents to quarterly survey (902), engagement score and employee engagement sub-themes have improved, the first time that the number of respondents feeling positive outweighs number of respondents feeling negative (51.7% to 48.3%). The majority of comments are consistent with previous surveys, citing a lack of communication and concerns about the understanding and capability of senior management. This confirms, despite some green shoots, more work is required.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	54-23

Name of meeting	Trust Board
Date	5 October 2023
Name of paper	People Committee Escalation Report – September 2023
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 18.09.2023 and confirms whether any matters require specific intervention by the Trust Board.

Item	Purpose	Link to BAF
An action from the last meeting was to receive the draft Violence Reduction Strategy. Some feedback was provided including to ensure wider consultation, particularly with any victims, in development of the strategy. Also, to clarify how we will know this has an impact in ensuring a safer environment for our people. The strategy will be reviewed again in November and will then come to the Board in December for approval.		
Process of Training Evaluation	To set out how the executive is ensuring evaluation of training.	P&C Objective 4- 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
This was a gap in assurance identified by the Board earlier in the year. The committee was asked to seek assurance that we have a consistent process in place that ensures we evaluate the impact of training (using appropriate metrics) to test that it delivers what is expected, to include specifically Fundamentals and Sexual Safety. There are examples of where there is good analysis. For example, the paper received included a good evaluation of the Fundamentals training completed to-date. The feedback from cohorts is being used to continually improve this training. This is positive. However, there is still work to do to confirm and embed a consistent approach to the evaluation of all training. In the paper was reference to the well-established Kirkpatrick model of evaluation. The committee suggested we adopt this. It will ask for further assurance on progress later in the year.		

With regards the evaluation of the sexual safety training, the executive felt it is too early to robustly assess the impact, but there are positive indicators, such as more people talking about this important issue. There is assurance with the delivery of the training. The committee cautiously noted the green shoots, for example there has been a 50% reduction in reported sexual safety incidents and the most recent Pulse Survey showed improvement in the questions related to support from managers.		
Professional Standards	To seek assurance that the professional standards function is adequately supporting appropriate professional standards.	
The executive is in the process of undertaking a review of the professional standards function, acknowledging a new approach is needed, learning from others. The aim is to have this in place by the end of the year and is linked to the development of an organisational learning framework as part of PSIRF. At present the function is too broad in scope and therefore somewhat undefined. This is leading to a lack of clarify of the role of the team. The committee has asked for an assurance paper to come back once the review has concluded.		
NHS Long Term Workforce Plan – Our Response	Following the Board in August, this is to receive details of how the executive is intending to respond to the Plan, in particular in relation to retention. And to seek assurance the process and timetable is both robust and ambitious.	P&C Goal 3 – Improving the Experience of our People.
Following the Board Development session in September, the committee reinforced the will of the Board to ensure we develop a retention plan that is brave and ambitious. It explored the importance of flexible working given the consistent feedback from staff about this. Of note there were differing views about the extent to which the Trust already offers flexible working and so the committee asked the executive to bring back to the next meeting the data that confirms the actual position. In the meantime, the development of the plan was supported and this is scheduled for the Board in October.		
Pulse Survey	To receive the results of the latest Quarterly Pulse Survey	
As mentioned earlier, while it is important not to overstate these results, the latest Pulse Survey is encouraging. It received the largest response for a Pulse Survey, itself a positive sign of engagement, and there is some optimism coming through supported by an improved 'mood' score. The committee encouraged the executive to ensure it maintains the things that are deemed to be making a positive		

difference, for example in relation to feeling informed about important changes – an improvement in year from 19% to 34%.

For the next meeting the committee has asked for a management response on how it is ensuring targeted support to the areas that consistently have poor scores and how this is being triangulated with other data.

People & Culture Objective 1 - Respond to issues raised in Staff survey and recent reviews (housekeeping)	To seek assurance that there is sufficient focus on these actions and that they are being implemented in a timely way.	PC Objective 1

The Big Conversations, OUM development, and the engagement in the development of the new Trust strategy are all positive steps towards making SECAmb a better place to work.

The focus on these 'housekeeping' actions is critical to building trust with our people. The committee reinforced therefore the need to deliver against our commitments. It explored specific areas, such as appraisals and an issue identified for support services to capture the schedule / bookings of appraisals. The committee has asked for further assurance that at the very least people have 1:1s / Appraisal meetings scheduled. At the next meeting the executive has been asked to provide data on this for all teams (support and operational), and assurance that our people have meaningful objectives.

People & Culture – Objective 7: Project to analyse and make changes to improve compliance against overruns**.**	To seek assurance on the approach and design of this project and how intends to reduce shift overruns.	PC Objective 7

The committee noted there has been some improvement, which the executive assess as relating at least in part to the new rotas. There was a deep discussion about this longstanding issue and the complexity with the way crews are allocated towards the end of their shifts. Some radical approaches were explored, and the committee drew the very clear link between this as staff welfare and retention.

The committee is assured that there is a good understanding of the issues driving shift overruns. There are not easy solutions but the executive is focussed on the right areas to ensure incremental improvement. Later in the year the committee will review the cost of overruns, such a toil and overtime to help inform perhaps more radical solutions.

Lastly, in relation to the new rotas, the committee has asked the Quality & Patient Safety Committee to review the impact of this on patient safety.

Specific Escalation(s) for Board Action	There are no specific escalations for the Board's intervention. However, in addition to the summary above, the Board is asked to note that the committee under AOB received a verbal update on the position with International Recruitment and will receive a paper in November setting out the learning review being undertaken.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	55-23

Name of meeting	Board
Date	05 October 2023
Name of paper	Keeping Patients Safe Executive Summary
Strategic Theme	**Quality Improvement**
Author / Lead Director	Margaret Dalziel, Executive Director of Quality & Nursing (interim) Rachel Oaten, Chief Medical Officer

Executive Summary

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

The BAF report reflects the expected progress made across all three Goals. All goals are green as all actions are on track for completion at the current time.

The IQR reflects the continuous improvement across all the patient safety areas.

Additional activity not captured in these papers are

- Acknowledging September as Patient Safety Month, and the launch of the National Patients Safety Strategy, the CEO led a trust-wide Big Conversation,raising the profile of Patient Safety and PSIRF across the Trust. Further engagement is planned and was demonstrated with the celebration of World Patient Safety Day, the week commencing 17 September 2023.
- Five successful Quality Assurance Visits (QAV) have now taken place in line with QI 8 and have received positive evaluations from staff and those undertaking the visits. Thematic Analysis has been undertaken on the first four visits to identify common themes, trends, and challenges at a systemic level and recommendations from this have been shared at Joint Leadership Forum. Work is now underway in collaboration with the People and Culture team to ensure that this process works effectively alongside the leadership visits, avoiding duplication and sharing learning.
- A patient focus group was held on 13 July 2023 and reported in the last paper for the Board. Since then, work has continued to deliver on our Patient Engagement strategy. This has been evidenced in the delivery of our inaugural Community Forum in September and engagement with patient and public stakeholders at our Annual Member's Meeting. The go live of our 999 Patient Experience Questionnaire is planned for the end of September 2023.
- A steering group has been set up to progress the Medicines Distribution Centre scheme in order to address the riaks associated with the current situation.

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

	Executive.

Quality Priorities

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

The Quality Improvement team is now embedded within the Trust. The first of three planned 30-minute virtual sessions to introduce the QI strategy has been held and the team continue to spend time every week with operational colleagues in the EOC or rotating around OUs engaging staff closest to the problem in QI. The team have trained 147 colleagues across the Trust in Introduction to QI and have seen the positive outcome of this realised with several teams requesting support with QI projects. One example has been the Fleet and Logistics team who attended QI training and then went on to deliver a highly successful QI project to improve the uniform ordering process for staff. Work to design a new front-end ordering process has been completed and feedback received from staff is positive. The team are now working to an agreed Service Level Agreement of 95% of uniform orders being completed within two weeks, making a real difference for our people.

The Keeping Patients Safe in the Stack QI project continues to progress. Three key improvements have been identified:

- Automating the closure of duplicate calls.
- Cessation of welfare calling within its current capacity and replace with an automated SMS process.
- Amendment to call handling instructions which involves development and implementation of a standard process of advising of Estimated Time of Arrival (ETA) for C2, C3 and C4 calls to effectively manage patient expectation, empower patient decision making and reduce the number of duplicate calls into the service.

There have been delays to scoping the above improvements due to a lack of capacity within the critical systems team who have had to focus all efforts on the Medway move and the implementation of C2 segmentation. However, the team are working collaboratively with Critical Systems and Operational teams and a revised time frame for implementation has been agreed.

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

<u>Incident Management Process</u>

The (IQR) indicates that the progress made in the past year has been consistently sustained. Currently, there are only three instances of breached Serious Incident (SI) reports, 2 breached reports occurring in July and September 2023. There are 14 active cases under investigation (including three breached reports), 11 of which are on track for completion within the specified deadlines. This positive trend is also observed in SI-related actions.

The number of Datix incidents exceeding the 45-day cycle has decreased significantly, falling to 7.22% thus consistently remaining below the target of 10%.

<u>Patient Safety Incident Response Framework (PSIRF)</u>

The PSIRF program is adhering to the established milestones outlined in the program plan. The PSIR Plan will be distributed to members today, aligning with national expectations and preceding the confirmation of ICS sign-off. The PSIRF launch is scheduled for November 2023, a timeline determined by concurrent changes required in the design and full implementation of the incident module on Datix Cloud.

Training for a core team to meet the minimum national standards has been devised and the

improvement case has gained approval with the support of EDTG. While funding has been sanctioned, there is a delay in the delivery of training due to the limited number of NHSE approved suppliers.

Patient Engagement
The Patient Experience and Engagement delivery plan is being implemented successfully. On the 27 September 2023, our inaugural Community Forum will be taking place, followed by monthly events. We want to give the public a greater voice in shaping our ambulance trust's future and so are calling on members of the public to help us achieve our aim by joining our Community Forum.

We are also on plan to launch our 999 Patient Experience Questionnaire by the end of September 2023. This will be advertised via our website, social media and through use of a QR code in the back of ambulances. We hope to achieve an average of 100 Patient Experience Questionnaires returned online each month. We are working in collaboration with our BI team to help us to report on this information and translate the data into information for improvement.

Learning Framework
As an organisation, we have undertaken a period of improvement across quality, clinical governance, and incident management process, establishing processes to ensure sustainability of these changes. The next step for enabling organisation change from incident and wider sources, and evidencing this is setting out a learning framework, enabling us to become a learning organisation which is a fundamental aspect of operational improvement. Work is continuing to complete a review of conceptual frameworks and will be presented at the next QPSC in October. The Quality and Nursing team will then begin a co-design exercise across all directorate to ensure a 'best fit' conceptual framework and to agree how this can be applied in practice.

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

Risk management Update
As per paper presented to Audit committee on 21 September 2023, all but one of the actions following the internal audit by RSM in May 2023 have now been closed. The due date for the remaining action is 31 December 2023. The Trust has made significant progress in three key areas as reported to RSM. On 31 August 2023:

- 97% of Trust risks had been reviewed within their due date;
- 97% of risks had controls; and
- 94% of risks had assurances.

These figures were at 60% compliance at the time of RSM's audit in May; which represents a huge amount of work from Risk Owners and Risk Leads across the Trust.

The Audit and Risk Committee was updated on priorities for quarter 3, which include the development of a Risk Management Strategy for the Trust. The strategy will pull together existing workstreams of which the Board will be aware (e.g. risk appetite) but will also review current risk management arrangements, and awareness with a view to maturing the approach to risk across SECAmb.

Improvement Journey

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

The Freedom to Speak Up (speak up) policy was approved by SMG on 19 September 2023 and will now be published and disseminated across the organisation.

A paper was presented to the Audit Committee on 21 September relating to detriment from FTSU cases. Detriment is recorded in our data, when a member of staff who has raised concerns through any route in the past, perceives that they have experienced this. A workshop was held on 11th August 2023 to develop SECAmb's approach to effectively manage this. Three key areas were identified:
•Proactive response
•Reactive response
•Learning from detriment

The opportunity for SECAmb to ensure appropriate processes are in place to mitigate the risks of detriment, requires additional exploration. Further discussions are planned to develop on these initial ideas.

FTSU month is taking place in October 2023 and the team have planned a significant number of engagement activities to raise the profile of FTSU across the Trust. The team commenced this process at the Annual Member's Meeting and are asking staff to make a pledge in respect of how they will support a positive culture of speaking up and supporting and listening with intent those who do. This is particularly pertinent considering the national focus on the importance of listening to staff concerns in the context of the verdict following the Lucy Letby case.

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

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

- **Dashboard.** Now live and undergoing further testing to ensure accuracy and information governance compliance.
- **e-PCR & coding development**. Review of Ambulance Data Set (ADS) and SNoMed coding to support greater granularity of crew coding in ePCR to better inform the dashboard data. Developments within cleric e-PCR to ensure accurate coding are now on pause, given the re-procurement of the product. We are now not likely to see accurate coding for some months, until the new e-PCR is well established in practice.
- **Sustainable collaboration and discussion.** Network engagement and collaboration ongoing. There are plans to host a 'launch' meeting to showcase the data dashboard with key stakeholders. However, it was felt this would be best done after the data has been studied by the data scientist team. They currently don't have capacity to assist.

Future work planned:

- 111 & 999 data accuracy
- Verification of death broken down by place of care
- Inequalities data
- Skill mix / resource utilisation/ number of resources on scene
- Metrics and targets will be developed through the PaEOLC Model of Care work under the Integrated Care Delivery Model.

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

- A PGD compliance report is now up and running and reported in the IQR. Data has been cleansed in the last couple months and will continue to be until we are more assured of the data. The data is pulled across manually from ESR which is a significant time burden.

Work is progressing with adding locations to all staff on JRCALC, this will make it easier for reporting as the data can then be manipulated. There has been a decrease in compliance seen for this IQR but that is due to a Diazepam solution PGD release and staff needing to sign up to it (this will be closely monitored in next data pull)

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

Paddock Wood Medicines Distribution Centre Update (BAF Risk 27, 136)

The EMB on 09 August 2023 agreed to progress an interim option (phase 1) for Paddock Wood MDC that would mitigate the health & safety risks and potentially mitigate some of the clinical risk.

The immediate ask is for the following:

- a suitable lift to be installed through the mezzanine floor – there is concern that the expected installation is May 2024, a Task & Finish group has been established to progress this work
- Increase the footprint of the MDC to include the majority of the mezzanine floor. This would allow for the separation of the packed and returned medicines pouches (reduce the clinical risk)
- Increase the working area for the MDC team (new staff are being onboarded that have nowhere to work) that are having to work scattered through three different locations at this time. This does not allow for adequate supervision.

A Consultation paper has been developed but is delayed due to not having sufficient space in the MDC to onboard new staff, this consultation will look to reduce the operating hours of the MDC, this will allow supervision by registered Pharmacy professionals.

The long-term plan for Paddock Wood MDC including Operations is being explored as phase 2, this is running concurrently to phase 1 and will be dependent on a suitable site that can accommodate both business areas, if a suitable site is not available then the Operations and Medicines aspects will be separated.

At the time of writing (25/09/2023) the lift at Paddock Wood has broken again, this is resulting in both the Medicines and Logistics teams having to manually move crates of medicines pouches up and down stairs.

Operation Carp (BAF Risk 188)

Of the seven recommendations in the report, all are progressing with reports being presented to QPSC.

Below is a short update on the progress:

Access to CAD System:

- A working group continues looking at role-based access to systems
- A new Confidentiality Code of Conduct Policy has been approved and published.
- The audit of trust systems has not progressed as expected, this is partly due to both the resourcing required and where the responsibility sits.

Medication Management:

- Training for Operational Team Leaders is being delivered as part of Teams C meetings (43 out of 194 trained so far)
- The DOOP (CD Destruction) trial was completed, and the review has approved a trust wide rollout, an improvement brief is being developed to progress this.
- A case study on Controlled Drugs diversion is included in this year's Key Skills

Acting in Concert:

- A policy on relationships at work was developed, however was rejected to progress by SMG as it was felt that this would be difficult to oversee and could impact a colleagues Human Rights of monitoring what people do at work.
- This action will no longer be progressed.

Raising concerns:

- People & Culture, and FTSU work is progressing as part of their own action plan

Trauma Informed practice:

- The Clinical Supervision trial in the Guildford OU is progressing well with the teams now looking at how the Trust can roll this out across all OUs.

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Patient Safety Incident Response Plan 2023/24

South East Coast Ambulance Service NHS Foundation Trust

Contents

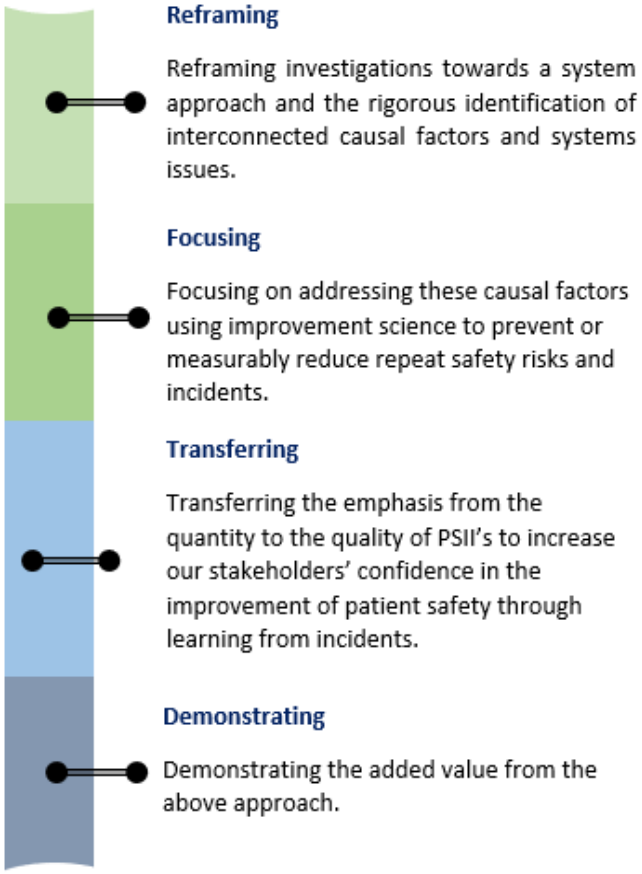
Foreword

Part One

Introduction

This patient safety incident response plan sets out how South East Coast Ambulance Service NHS Foundation Trust (We) intends to respond to patient safety incidents over these next 12 to 18 months. The plan is live and may be subject to change. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This plan will help us measurably improve the efficacy of both local and cross-system patient safety incident investigations (PSII's) by:



About us

Our call centre staff are trained to assess patients over the phone and respond with the most appropriate response to meet the needs of patients. This could be:

- An emergency ambulance response for life-threatening situations
- A Critical Care Paramedic who can provide treatment on scene for the critically injured.
- A Paramedic Practitioner who can provide specialist treatment in person or by phone
- Clinical advice provided over the phone by a GP, Nurse, or Paramedic when appropriate.
- We also work with our partners to provide referrals to a GP, Nurse, Mental Health or Maternity team.

We have **110 sites** across the 3,600 miles of Kent and Medway, Surrey, Sussex and North East Hampshire

We have over **5,000** employees at SECAmb from 49 nations

We have **two** Emergency Operational Call Centres that include 999 and 111 services

We receive over 2.1 million calls per year, responding to over 700,000 incidents

Our Stakeholders

We aim to be a trusted partner in our region, and we continue to embrace this philosophy whilst developing our Patient Safety Incident Response Plan.

We recognise we have several key external partners and prioritise engagement with those directly linked to our 999 and 111 services such as:

- MEDDocc
- HERE Brighton
- ABC Healthcare Ltd
- Practice Plus Surrey
- IC24
- Kent, Surrey, Sussex Air Ambulance
- Private Ambulance Providers

We are committed to identifying and supporting multi-organisation, or cross-system patient safety incidents to make healthcare safer for everyone.

We have also developed a 'PSIRF Ambulance Network' with each Ambulance Service in England and aim to continue to facilitate the sharing of learning across this network.

We developed and utilised this stakeholder engagement map when defining our safety profile and improvement plans, which include our Patient Experience Group.

Our Stakeholder Map

High power, high influence	High influence, high power
Senior Management Group	Consultant Paramedics
Serious Incident Group	Operating Unit(s)
Quality Governance Group	Patient Experience Group
Trust Board	Ambulance PSIRF Network
Integrated Care Board	Staff Networks
Learning from Death Group (LfD)	Emergency Operations Centre / 111 Teams
Quality, Patient Safety Committee	Subject matter experts i.e., safeguarding / IPC etc
Freedom to Speak Up Guardians (F2SU)	Health Watch
High power, low influence	**Low influence, low power**
Coroner	System providers
CQC	SECAmb Legal Team
Trust Governors	Local Authority

Part Two

Defining our patient safety incident profile

We have profiled patient safety incident risks using organisational data from patient safety incident reports (DATIX), complaints, freedom to speak up reports, mortality reviews, regulation 28 reports, clinical audit, staff survey results, claims and risk assessments.

The Trusts Incident Management and Response Steering Group engaged with Staff Network chairs, Subject Matter Experts, representatives from the Patient Experience Group, Clinical and Operational teams to identify these priorities.

Our co-designed plan was consulted internally via the Leadership team meetings at each Operating Unit, the Trust's Patient Safety Oversight Group, the Quality Governance Group, the Quality and Patient Safety Committee, the Trust Board and externally with Surrey Heartlands Integrated Care Board (ICB), as our lead commissioner.

We have identified themes where the systemic causes are believed to be well understood. Through this elimination process, these five priorities remain due to the risk they continue to pose. It is believed further learning can be extracted using the Systems Engineering Initiative for Patient Safety (SEIPS) framework. Our plan enables equal focus on low harm or near miss incidents as it does severe harm.

Priorities identified
ST Segment Elevation Myocardial Infarction
Harm Identified Following Discharge on Scene
Inter-Facility Transfer (IFT)
Incorrect administration of 1:1000 adrenaline
Delays to 'hands on chest'

We acknowledge the value in recognising emerging themes and remaining flexible with our priorities. Our policy reflects how our Incident Review Groups will do this at system-level.

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Improving our patient safety culture

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

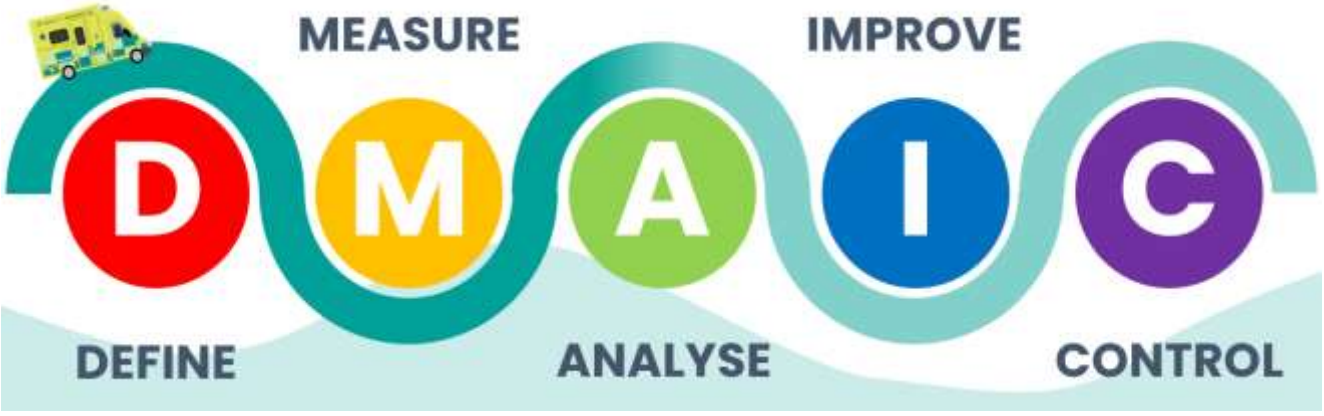
We encourage and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). The Trust promotes a 'just culture' approach to any work planned or underway to improve patient safety.

Defining our patient safety improvement profile

We recognise that the findings from learning response methods including Patient Safety Incident Investigations (PSIIs), or other related activities must be translated into effective and sustainable action that reduces risk to patients.

To achieve this, we will apply knowledge of the science of patient safety and improvement to develop a robust patient safety improvement plan.

We have begun rolling out our Quality Improvement training using the 'Define, Measure, Analyse, Improve and Control (DMAIC) methodology to provide staff with the skills to initiate sustainable improvement at every level of the organisation in line with our Quality Improvement strategic aim.



Several strategic programmes and projects as well as locally designed patient safety improvement plans are underway across the Trust.

These relate to full plans, rather than individual actions, designed and prescribed to address known issues with all of them incorporating previous PSIs, review, audit, or risk assessment.

Our Patient Safety incident profile identified harm related to delays in call-answering, ambulance attendance and issues with triage, as an area of concern. In line with the Patient Safety Incident Response Framework, our focus will be on sustainable, meaningful quality improvement in this area, and this has begun.

We are developing a learning framework to complement our co-designed patient safety incident response plan. We aim to identify 'best practice' and 'outstanding care' through our learning responses and not solely following patient safety incidents.

The Improvement Journey for our current priorities will be monitored by the groups below, reporting to the Quality and Clinical Governance Group (Q&CGG).

The Q&CGG will also be responsible for testing the effectiveness of improvement workstreams derived from new learning.

No.	Incident Type – PSIRF priorities	Monitoring Group
1	ST Segment Elevation Myocardial Infarction (STEMI)	TBC
2	Harm Identified Following Discharge on Scene	Post-discharge review project
3	Inter-Facility Transfer (IFT)	TBC
4	Incorrect administration of 1:1000 adrenaline	TBC
5	Delays to 'hands on chest'	Cardiac arrest improvement plan

Part Three

Our patient safety incident response plan: national requirements

Nationally defined incidents requiring local PSII

Patient safety incident type	Required response	Anticipated improvement route
Incidents that meet the criteria set in the Never Events list 2021	PSII	Create local organisational actions and feed these into the quality improvement strategy
*Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care	PSII unless death is clinically assessed as more likely than not due to delayed 999 calls answering, incorrect triage, and delayed ambulance response	Create local organisational actions and feed these into the quality improvement strategy

*The Trust will continue to provide case reviews to a small, randomised cohort of patients known to have died whilst in our care, after handover, or within 24-hours of contact with our services. Structured Judgement Review (SJR's) are also completed where concerns are raised by staff, families and/or external partners.

Nationally defined priorities for referral to other bodies or teams for review and/ or PSII

Patient safety incident type	Requirement
Maternity and neonatal incidents: 'Each Baby Counts', Maternal Deaths	Healthcare Safety Investigation Branch (HSIB)
Maternity and neonatal incidents: all cases of severe brain injury	NHS Resolution's Early Notification Scheme
Maternity and neonatal incidents: all cases of severe brain injury all perinatal and maternal deaths	Mothers and Babies: Reducing Risk through Audits and

Patient safety incident type	Requirement
	Confidential Enquiries across the UK (MBRRACE)
Mental health related homicides by persons in receipt of mental health services or within 6 months of their discharge	NHSE Regional independent investigation team (RIIT)
Child deaths	Child Death Overview Panel (CDOP)
Deaths of persons with learning disabilities	Learning from lives and deaths – people with learning disabilities and autistic people (LeDeR)
Safeguarding incidents	Local authority
Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract	Prison and Probation Ombudsman and Care Quality Commission (CQC)

Our patient safety incident response plan: local focus

Locally defined incidents requiring local PSII

Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been agreed by the Trust for the next 12 to 18 months. These local priorities will be reviewed on an ongoing basis via the Patient Safety Oversight Group with a formal review of the PSIRP no later than 18 months from the date of issue.

We will complete at least **one PSII** for each of our 5 priorities. Additional PSII's where learning may be extracted will be considered by our Incident Review Group(s) and prescribed by our Patient Safety Oversight Group. This group is also responsible for PSII closure at per our policy.

Patient safety incident type	Planned response	Anticipated improvement route
Incorrect administration of 1:1000 adrenaline	PSII where incorrect use and/or dose of 1:1000 adrenaline is administered	Feed into Trust wide improvement plan utilising QI methodology
ST Segment elevation myocardial infarction (STEMI)	PSII where STEMI is not recognised, managed appropriately and/or conveyed to the most appropriate receiving centre	Feed into clinical pathways improvement work
Harm following discharge on scene	PSII where concerns are raised following discharge on scene	Feed into Trust wide improvement plan utilising QI methodology
Delays to 'hands on chest'	PSII where a patient safety incident occurs where there is a delay initiating CPR once a cardiac arrest is identified	Feed into Trust wide improvement plan utilising QI methodology
Inter facility transfer (IFT)	PSII where a patient safety incident occurs when the service is unable to complete an IFT in a timely manner	Feed into Trust wide improvement plan utilising QI methodology

Locally defined incidents requiring alternative response

We recognise that both local Safeguarding and Infection Prevention and Control incidents should be responded to in line with their respective policies.

Patient safety incident type	Planned response	Anticipated closure route
Safeguarding incident	Safeguarding investigation	Local Authority
Control Incident	Support partners with investigations	Commissioning IPC Panel

Locally defined emergent patient safety incidents requiring PSII.

An unexpected patient safety incident that represents an extreme level of risk for patients, families and carers, staff, or organisations, and where the potential for new learning and improvement is so great that it warrants the use of extra resources to mount a comprehensive PSII response. The Patient Safety Incident Review Group have a responsibility to monitor and respond to emerging themes.

Locally predefined patient safety incidents requiring investigation.

Key patient safety incidents for PSII have been identified through analysis of local data and intelligence from the past three years and agreed as a local priority. It is important to note that incidents not identified as priorities within this PSIRP will be investigated using appropriate and proportionate techniques.

The investigation methods for this category of investigation will be agreed by the Patient Safety Incident Response Group (IRG) using the following planned responses (appendix A).

- Patient safety incident investigations
- After Action Review
- Multi-Disciplinary Team review

This plan provides a detailed explanation of the various learning methods available to us in appendix B. The IRG will ratify where our leaders proactively implement immediate safety actions and/or learning responses following a PSI.

Some additional proportionate responses not noted in the PSIRF may also benefit those effected by patient safety incidents and support the Trust to identify new learning. These can be found at appendix C.

Where a LfD review does not indicate a PSII should be completed, the Trust will prepare a factual report upon request from the Coroner. The report should focus on the chronology, analysis, and link to our Trust Wide Improvement Plan. Learning should be identified using the proportionate response prescribed by the IRG.

Part Three

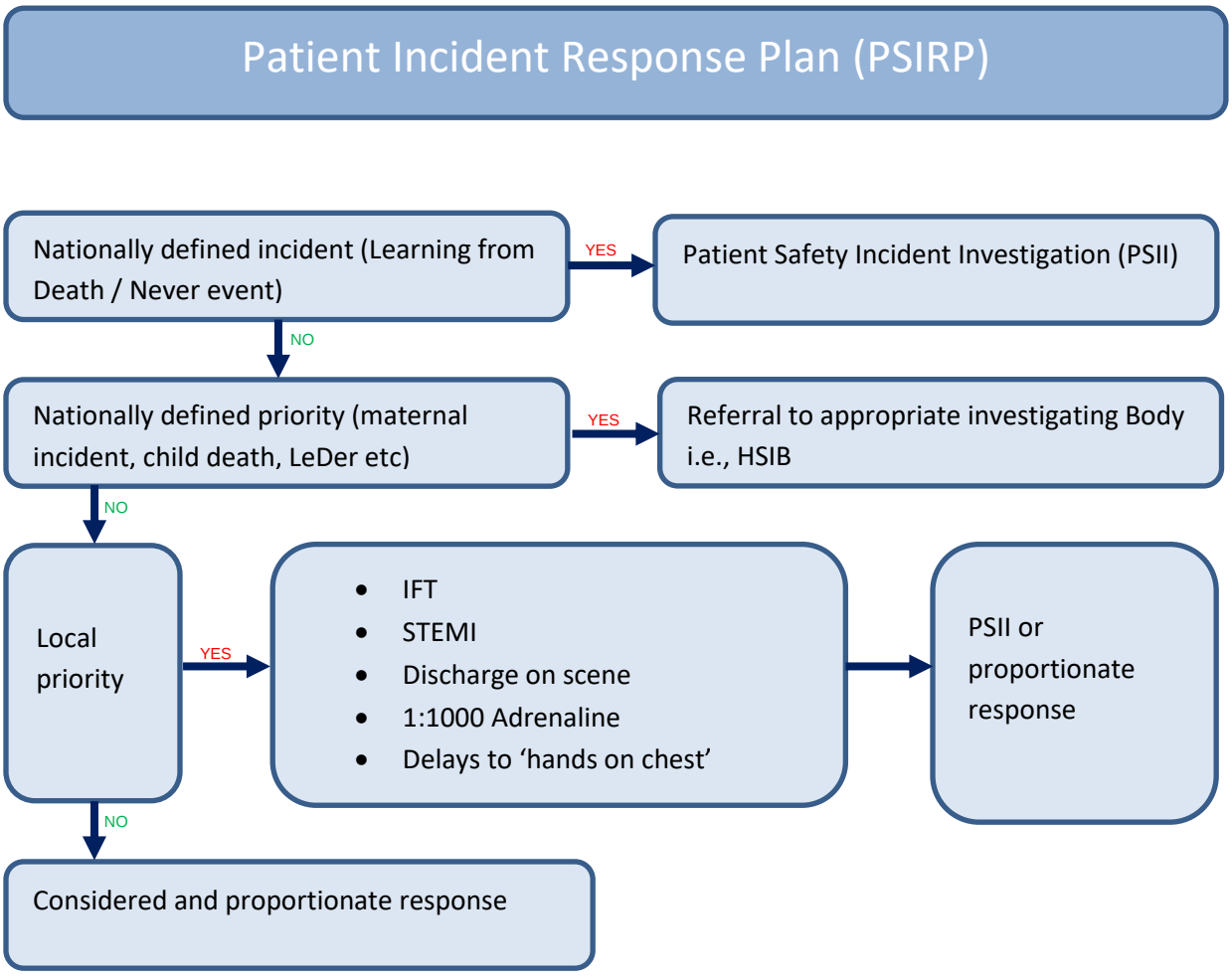
Glossary of Terms

Term/Acronym	Definition
AAR	After Action Review is a method of evaluation that is used when the outcomes of an activity or event have been particularly successful or unsuccessful.
Arbitrary or Subjective	Chosen randomly or influenced by/based on personal beliefs or feelings, rather than on facts
Being open	Being open and transparent with patients and families when treatment or care goes wrong.
Care Group	A grouping of multi-disciplinary staff working together to provide care within a certain area.
CQC	Care Quality Commission - independent regulator of health and social care in England
Definitions of Harm	Unanticipated, unforeseen accidents (e.g., patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease
Duty of Candour	Statutory duty of candour legislation requiring the Trust to be open and honest when moderate or greater harm occurs.
Governance Structures	System that provides a framework for managing organisations
HSE	Health and Safety Executive, an independent regulator for workplace health and safety.
HSSIB	Health Service Safety Investigation Body (formally HSIB)
Human Error	A human error is an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome
Inequalities data	Facts and statistics collected relating to health inequalities which are unfair and avoidable differences in health across the population, and between different groups within society.
Integrated Care Board (ICB)	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.

Term/Acronym	Definition
Just Culture Approach	The treating of staff involved in a patient safety incident in a consistent, constructive, and fair way.
MDT	Multi-Disciplinary team
Neonatal Death	A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born
Never Events	Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
NHSE	National Health Service England
Principles of Proportionality	The least intrusive response appropriate to the risk presented
PSI	Patient Safety Incident (unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare)
PSII	Patient Safety Incident Investigation (PSII) is a formal investigation tool which aims to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
SEIPS	System Engineering Initiative for Patient Safety - a framework for understanding outcomes within complex socio-technical systems.
SOP	Standard Operating Procedures
Stakeholder	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

Appendix A

The planned flow of patient safety incidents through the Trust when triaged at the Incident Review Groups (IRG). It's important to note that whilst PSII's are recommended for our local priorities, not all incidents will be included, and the focus will remain on compassionate engagement with staff, patients, and families.



Appendix B

Patient Safety Incident Investigation (PSII)					
What is it?	**When would you use this tool?**	**Time required to complete?**	**Who leads it?**	**Research and evidence to confirm its efficacy?**	**Who is involved?**
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how	When there has been serious harm to a patient or patients outside of the PSIRF priorities	20 to 80 hours, over several weeks	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis, and writes the recommendations report	Extensive research has been undertaken into the structures processes and outcomes of PSII across the world	People directly involved in the incident and senior clinicians
Strengths			**Weaknesses**		
• It is a well-established approach which is widely recognised and valued by patients and their families. • PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified. • Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements in each provider.			• Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed. • Outcomes are less system focused than other tools. • Staff are only involved when they are interviewed, and this can feel very stressful.		

After Action Review (AAR)					
What is it?	**When would you use this tool?**	**Time required to complete?**	**Who leads it?**	**Research and evidence to confirm its efficacy?**	**Who is involved?**
A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT	After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected	Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating	Led by a trained AAR Conductor - this could be anyone from within the MDT, local or remote to the participants	Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety	Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included
Strengths			**Weaknesses**		
• The individuals learn for themselves what was happening and identify similarities and differences between themselves and others. • Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement. • It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety. • It is highly adaptable, suitable for a wide range of events. • Psychological safety is actively created and maintained throughout. • Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.			• Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority. • There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR. • Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.		

MDT Review					
What is it?	**When would you use this tool?**	**Time required to complete?**	**Who leads it?**	**Research and evidence to confirm its efficacy?**	**Who is involved?**
An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e., work as done	After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability	No defined time allocated. Likely to include a workshop lasting 2 to 3 hours	Normally chaired by a senior lead who generates a report	No specific research on the structures, processes and outcome of MDT reviews has been carried out	Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians
Strengths			**Weaknesses**		
• The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered. • Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.			• Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence. • Whilst participants will contribute and learn, it is not the specific purpose of the activity. • It is a planned event, and it may take many weeks to set up and ensure full MDT representation is available. • Resource intensive to undertake.		

SWARM Huddle					
What is it?	**When would you use this tool?**	**Time required to complete?**	**Who leads it?**	**Research and evidence to confirm its efficacy?**	**Who is involved?**
"A novel rapid approach to RCAs to establish a consistent approach to investigate adverse or other undesirable event"	After any event where patient safety was at risk	No more than 30 minutes	Normally chaired by a senior lead who generates a report	There is some research literature on its use in healthcare	Those directly involved in these events.
Strengths			**Weaknesses**		
• Immediate learning occurs with early actions identified. • Connecting immediately after event may reduce social isolation/ ruminating/stress for staff. • Evidence shows it can increase the reporting of incidents. • Quick and responsive. • Prompt and easy to undertake so increases likelihood of being done. • Reduces key information being lost by its immediacy.			• Scope of learning narrowed by limits on who is participating. • Learning is focused on a single event rather than the interactions in the system that come with wider participation. • Psychological safety is assumed to be present so full participation may not be achieved. • It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses. • Weak governance arrangements for tracking actions and collating learning through many SWARM Huddles.		

Appendix C

Technique	Method	Objective
"Being open" conversations	Open discussion	To provide the opportunity for a verbal discussion with the affected patient, family, or carer about the incident (what happened) and to respond to any concerns.
Debrief	Debrief	To conduct a post-incident review as a team by discussing and answering a series of questions.
Electronic Patient Care Record (EpCR) review	Clinical document review	To determine whether there were any problems with the care provided to a patient by a particular service. To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent discomfort, injury, or threat to life damage to equipment or the environment.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
Structured judgement review (SJR)	Clinical document review	Used to assess delays in both thematic reviews and individual cases. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

Contact us

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Patient Experience Team

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South East Coast Ambulance Service NHS Foundation Trust

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South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	55-23

Name of meeting	Trust Board
Date	05.10.2023
Name of paper	Quality & Patient Safety Committee Escalation Report – August 2023
Author	Tom Quinn, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 24.08.2023 and confirms whether any matters require specific intervention by the Trust Board.

There were two scheduled items that were deferred: Private Ambulance Provider Quality Governance & Safety; and the Controlled Drugs Accountable Officer Annual Report. Both will be received at the meeting in October.

Executive Escalation:
Under actions arising the committee received a verbal update on plan for the Medicines Distribution Centre at Paddock Wood, related to the risks there that the Board is aware of.

The committee then received some information from the Director of Quality and Nursing on the immediate steps being taken following the letter to all providers from NHS England, related to issues arising from Lucy Letby. This relates to ensuring there is board assurance on FTSU and the mechanisms to support staff harder to reach. A FTSU gap analysis has been undertaken in addition to the review of that was received by the Audit & Risk Committee (see separate report). Proactively, the executive is undertaking a stock take on all the areas of assurance related to clinical safety. This will be reviewed at the meeting in October before coming to the next Board meeting in December.

Item	Purpose	Link to BAF
NHS Pathways Audits	To assess the drivers for the special cause variation (IQR), to ensure clarity of the corrective action needed	n/a

At the April Trust Board meeting the special cause variation in the IQR was noted relating to NHS Pathways audits. The committee was asked to explore in the context of the NHS Pathways Audit requirements, the extent to which we are compliant with our license and in relation to staff welfare, the support mechanisms in place to support staff who fail audits.

Firstly, this issue relates to EMA audit where the target is 100%; it does not affect the license and there is recognition that human factors will impact the ability to get to 100%. However, compliance has been improving since April.

Some concern was expressed about the impact of delay in feeding back following audits, due to leave etc. There is a move to ensuring more live audits that will help resolve this.

The committee has asked for more thematic analysis from the audits and an update will be received later in the year on themes and how we are supporting our people to improve. The committee was pleased to hear that the relationship between the audit team and 111 EOC is more positive than it has previously been.

PSIRF	To provide an update on the plan for introducing PSIRF, to include an outline of any risks and mitigations on full implementation and set out the proposal for the PSIRF Plan to be presented to Trust Board in Q3	QI Objective 4 - Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF.

The committee was assured by the progress being made with the development of the PSIRF Plan. The Board has since had time at its development session on this and the final plan is on the Board agenda. We are therefore on track with the national timetable. The related policy is due to follow later in the year once there is a better understanding of what will be required.

The committee focussed much of its time on the learning framework and the steps being taken to establish this. The quality assurance visits are helping to identify the local learning that is happening and the aim is that this new learning framework will help coordinate this and ensure a systemic approach to learning from different areas across the trust. However, there is a longer lead in time for the development of this framework and the committee will stay close to this as it develops.

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

The committee receives this report on a quarterly basis and the assurance sought is that management is using information effectively to improve patient safety. The key points from QI include:

- 75% of reported incidents relate to patient safety, which is positive.
- SIs – reduction due to the approach with incidents related demand and capacity, which are reviewed as a cluster to aggregate the learning.
- Now only 11 active SIs and the backlog in closing actions much reduced with better controls.
- PALS contacts increased with more timely resolution – themes relate to delays and staff attitude. Noting we receive fine times more compliments than complaints.
- 35-day target for complaints response is at 96%.
- Key themes from inquests include delays. System wide solutions are needed and we are explaining to Coroners the work we are doing.
- There is a review underway of the learning from deaths policy in the context of PSIRF. The committee will get an update on this at the next meeting.

The committee also received information about two multi-disciplinary challenge learning forums that have been held, exploring patients' deterioration in the stack and those with a delayed response. This is a positive approach to seeking assurance and the executive expressed confidence in the former (linked to the related QI project) and will be continuing these sessions to ensure we are continuing to take all reasonable steps to ensure patient safety.

The committee then heard from the Head of Legal Services, who provided some initial reflections from the recently published NEAS report, relating to concerns about the quality and transparency of information being provided to Coroners. There was good assurance provided on the system of communication and provision of information between SECAmb and Coroners, managed by the legal team. All documents requested are provided without amendment or interference. The committee is also assured with the process of SI investigations which are provided to Coroners, although to be absolutely sure that when amendments to draft SI reports are made, as part of the quality assurance process, the executive is reviewing the process so there can be no doubt that these are made only with the intention of enhancing the learning.

Quality Improvement - Objective 1: ***Quality Improvements on how we keep patients safe in the EOC stack during periods of escalation and at points of discharge?***	To ensure adequate progress and assurance that we are doing all we can to ensure safety of people waiting in the stack while this QI project concludes.	QI Objective 1

The committee is assured with the progress being made with this QI project. It is on track as per the agreed timeframe. There is learning identified through this project related to automation e.g. use of texts. While management is working with Cleric on the necessary updates, the committee challenged the executive to push harder given the lead in time there sometimes is for updates to be made.

While the committee is assured with progress it accepts that not all the actions being taken will have the impact expected but is confident that there will be a reduction in the level of harm experienced by our patients.

Quality Improvement - Objective 3: Training and engagement in QI for our people	To assess progress with achievement of this objective and how embedded QI is becoming.	QI – Objective 3

A helpful paper was received giving assurance that there is focus not just on training but the actual QI projects that are coming out of this, demonstrated in part by the number of people now asking the QI team for support with local projects. There are now ten separate QI projects being supported, each with the aim of improve patient safety and/or staff welfare and experience.

Responsive Care – Objective 2: *Call Answer Mean time of 10 seconds.*	Acknowledging the poor call answer performance in the last year, to seek assurance that there is clarity on the different actions needed to ensure improvement.	QI – Objective 2

We have not achieved this objective in the timeframe originally set by the executive. The principal issue is the failure to recruit the number of call handlers, and there is an improvement plan in place, which includes dual skilling with 111. The committee explored the correlation between delays in call answer and harm, acknowledging that despite positive C2 performance, delays in call answer mostly impact those requiring a C1 response. See the escalation section below.

Annual Reports		

As part of its annual cycle, the committee considered at this meeting three annual reports, the links of which are included for the Board's information:

1. Complaints (Patient Experience) PALs Annual Report 2022-2023

As the Board is aware from the reports it has seen in the reporting period, there has been good improvement in the timeliness of complaints responses. 4% of all complaints were re-opened (indicating a dissatisfaction with the original response) and this is one of the areas of focus this year.

The committee explored the 60% upheld or partially upheld complaints and the related themes / hotspots. Also, how we use reflective practice in response to complaints. More work is needed on the latter including how we support staff subject of a complaint.

2. Infection Prevention & Control IPC Annual Report 2022-2023

This report provided good assurance on the governance and control for ensuring a positive IPC culture. There is generally good returns and feedback from the audits, and the IPC quality assurance visits conducted in year (9 of 10 dispatch areas) demonstrated good engagement.

The executive did set out concern about fluctuating compliance linked to culture, and so a key priority is to really build on the IPC awareness.

The committee noted the feedback from some of the NED members who have picked up from leadership visits an indication that some areas are more lenient than others, for example with wrist watches / bare below the elbow. The executive confirmed that the IPC improvement plan this year aims to pick this up via the IPC champions.

In terms of winter preparedness, the committee sought assurance that there are no concerns with stock, such as PPE.

Overall, there is good compliance with requirements The Health and Social Care Act 2008: Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance.

Safeguarding Safeguarding Annual Report 2022-2023
During 2022/2023 there was increasing demand on the safeguarding function across the Trust. The past year has demonstrated new and innovative practices that embedded safeguarding approaches within other vital functions of the Trust.

Learning from incidents, complaints and safeguarding reviews have allowed the team to contribute to organisational learning and the priorities for 2022/2023 will ensure that, despite the continued rise in the overall safeguarding activity, protection and learning will be central to the safeguarding function.

Almost 90% of Safeguarding training was completed, which the committee felt was a good achievement.

Overall the report sets out a positive picture highlighting both the achievements and the challenges, which include management of mental capacity. This is being picked up with support of our Head of Legal Services, to support our people in this area to ensure we identify where gaps in capacity might exist. There is more work to do on this issue.

Specific Escalation(s) for Board Action	Call answer performance remains a concern. The aim at the start of the year was to achieve a mean of 10 seconds and as per the IQR we are significantly adrift of this, and one of the worst across the ambulance trusts in England. The Board is asked to pay particular attention to this at the next Board meeting to seek assurance the executive is clear on the corrective action needed and that there is a robust plan in place to make sufficient improvement in the coming weeks.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	

Name of meeting	Trust Board
Date	5th October 2023
Name of paper	Reinforced Autoclaved Aerated Concrete (RAAC): Review of SECAmb's Estates Portfolio
Responsible Executive	Saba Sadiq – Chief Finance Officer
Authors	Paul Ranson – Head of Strategic Estates & Facilities Saba Sadiq – Chief Finance Officer
Synopsis	This paper provides an update to the Trust Board in relation to a review performed on whether the Trust has RAAC buildings in its estates properties. A review was performed, by the Trust's agent, Chawton Hill Associates, when the RAAC issue was first highlighted in the NHS in 2019. This review confirmed that the Trust does not have RAAC used in its estates properties.
Recommendations, decisions, or actions sought	For information.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	N/A

1. Introduction

Reinforced Autoclaved Aerated Concrete (RAAC) planks used to build prefabricated schools, hospitals and other buildings between 1960 and 1984 have been known about for many years in the NHS.

The Institution of Structural Engineers (ISE) in connection with the Institute of Civil Engineers (ICE) and the Health and Safety Executive (HSE) released a Standing Committee on Structural Safety (SCOSS) Alert regarding the use of RAAC Planks in May 2019.

The SCOSS Alert recommended owners of commercial buildings dating from 1960 to 1980s with flat roofs to inspect for RAAC planks and to monitor and manage any potential risks from failure due to the material now being beyond its expected service life.

2. Review of SECAmb Estate Portfolio

In November 2019 NHS England wrote to all NHS organisations asking for a data collection on the issue of RAAC.

To enable the Trust to respond to NHSE, SECAmb commissioned an independent structural survey, performed by Chawton Hill Associates (Chartered Surveyors - the work was performed by a structural engineer and a quantity surveyor) across its estate portfolio.

Chawton Hill Associates Ltd were provided with a list of 27 sites that had been identified as sites that may contain RAAC panels due to the age and form of construction.

The ‘1996 BRE Information Paper IP 10/96 – Reinforced Autoclaved Aerated Concrete planks designed before 1980’ outlines a preliminary inspection procedure that SECAmb, via its agent, Chawton Hill Associates, followed to inspect the various sites.

A total of 27 properties were identified as potential for the use of RAAC, based on date of build and construction type. The Trust’s other properties were not either within the build period or construction type.

The completed site surveys included the internal and external areas of the buildings across the SECAmb geography. The scope of the surveys was to attend the various sites and identify any visible RAAC panels or sites where further intrusive investigations may be required.

3. Conclusion

The survey (Appendix A) found no evidence of RAAC in SECAmb's estate properties. Consequently, the Trust submitted a nil return to NHSE in 2019 and this was reported to the Trust Board at that time.

This paper has been brought to the Board following a further letter from NHSE asking Boards to be sighted on the RAAC issue and the Trust's response to it (Appendix B).

4. Recommendation

The Trust Board are asked to note the contents of this paper.

CHAWTON HILL
CHARTERED SURVEYORS

3258.20 - SECAmb AMBULANCE STATION SURVEYS

REINFORCED AUTOCLAVED AERATED CONCRETE (RAAC) PANELS INVESTIGATIONS

South East Coast Ambulance Service NHS
NHS Foundation Trust

No	Location	Postcode	Survey Date	Area Inspected	RAAC Found	Further Action	Notes.
1	Banstead Regional Office	SM7 2AS	10/03/2020	Office Block: ground, 1st & 2nd floors	No		Plastered, painted or suspended ceilings.
				Vehicle bay	No		Stramit decking with North light windows.
				Control Room & Canteen area ground floor	No		Plastered, painted or suspended ceilings.
2	Battle ACRP	TN33 0EE	18/03/2020	Garage	No		Shallow pitched metal standing seam roof over steel frame.
				2 Storey Admin	No		Pitched, timber, cut roof over main building
3	Bexhill ACRP	TN39 3LG	18/03/2020	Garage	No		Shallow pitched metal standing seam roof over steel frame.
				2 Storey Admin	No		Plaster boarded ceilings,
4	Brighton Ambulance Station	BN2 3EU	11/03/2020	Service Area left hand end	No		Metal sheets on steel beams.
				5 vehicle bays	No		Metal sheeting supported by steel trusses
				Admin areas	No		Combination of boarded, plastered and suspended ceilings.
5	Burgess Hill Ambulance Station	RH15 9BT	11/03/2020	Garage	No		Shallow pitched metal standing seam roof over steel frame.
				Admin	No		Plaster boarded ceilings.
6	Chertsey MRC	KT16 0PJ	06/03/2020	Vehicle bay	No		Metal sheeting supported by steel trusses.
				Wash bay	No		Metal sheeting supported by steel beams.
				2 storey training area ground floor	No		Suspended ceiling tiles at 1st floor.
				2 storey training area 1st floor	No		Plastered and painted at ground floor.
				General stores areas right hand side	No		Boarded and painted.
7	Coxheath EOC & Regional Office	ME17 4BG	19/03/2020	3 storey EOC and Admin	No		Timber cut pitched main roof with pitched metal clad standing seam roof above extension wings.
8	Dorking Ambulance Station	RH5 4EG	25/03/2020	Single storey Admin	No		Woodwool slab panels.
				Garage	No		Woodwool slab panels.
9	Dover South ACRP	CT17 9TT	19/03/2020	2 Storey Admin	No		Suspended and plaster board ceilings with deck.
				Garage	No		Pitched metal standing seam with steel supporting frame.
10	East Grinstead Vehicle Training Centre	RH19 1HA	11/03/2020	Training bay	No		Painted plaster board ceiling.
				Vehicle bay	No		Painted plasterboard ceiling.
				2 storey Admin block	No		Pitched roof with plastered ceilings.
11	Eastbourne (East) ACRP	BN22 8DL	18/03/2020	2 storey Admin	No		Suspended and plaster boarded ceilings with deck above.
				Single storey Admin	No		Suspended and plaster boarded ceilings with deck above.
				Garage	No		Steel and timber framed roof over garage.
12	Farnborough Ambulance Station	GU14 8JL	06/03/2020	Vehicle bay	No		Sloping Stramit decking supported by steel trusses.
			10/03/2020	Admin areas	No		Plastered, painted or suspended ceilings.
13	Hailsham ACRP	BN27 1TU	18/03/2020	Garage	No		Steel and timber frame with slate roof covering.
				Single storey admin	No		Suspended and plasterboard ceiling with deck above
14	Hastings Make Ready Centre	TN34 1ET	18/03/2020	Single storey admin	no		Plaster boarded ceilings throughout.
				Garage	No		Metal farmed, sloping decking, corrugated panelling.
15	Haywards Heath Ambulance Station	RH16 1TX	18/03/2020	Admin areas	No		Timber framed roof and deck with felt above.
				Garage	No		Metal clad standing seam on steel supports over the garage.
16	Heathfield ACRP	TN21 8RA	18/03/2020	2 storey admin	No		Timber to main roof with first floor deck
				Garage	No		Metal corrugated roof.
17	Leatherhead Ambulance Station	KT22 7BW	06/03/2020	Vehicle bay	No		Sloping Stramit decking supported by steel frames.
			10/03/2020	Admin areas	No		Plastered, painted and suspended ceilings.
18	Lewes Ambulance Station	BN7 2PX	11/03/2020	Stores	No		Metal deck.
				Vehicle bay	No		Suspended ceilings
				Vehicle bay adjacent to admin area	No		Suspended ceilings
				Admin areas (2 storey)	No		Suspended ceilings.
19	Littlehampton Ambulance Station	BN17 6AP	11/03/2020	Vehicle bay	No		Metal deck.
				Admin areas	No		Suspended ceilings under a metal deck.
20	Medway Ambulance Station	ME5 7HE	25/03/2020	2 storey admin	No		Sloping Stramic decking supported steel trusses
				Single storey admin	No		Plaster boarded and suspended ceilings roof deck above.
				Main garage	No		Steel frame with wood wool slab panels and bituminous felt above.

				Fleet garage	No	Steel frame with insulated panels and bituminous felt above.
21	Newhaven ACRP	BN9 0DP	18/03/2020	2 storey admin	No	Timber to main roof
				Garage	No	Metal corrugated roof.
22	Paddock Wood MRC	TN16 6BE	19/03/2020	2 storey admin	No	Sloping deck above second floor. Plasterboard ceilings.
				Garage	No	Metal standing seam.
23	Redhill Ambulance Station	RH1 6JU	10/03/2020	Vehicle bay	No	Plaster painted supported by steel trusses.
				Admin areas	No	Plastered, painted or suspended ceilings.
24	Shoreham Ambulance Station	BN43 6YD	11/03/2020	Admin areas	No	Suspended ceiling on metal grid.
				Vehicle bay	No	Metal deck.
25	Sittingbourne Ambulance Station	ME10 3HU	25/03/2020	Admin	No	Pitched corrugated metal clad roof.
				Garage	No	Pitched corrugated metal clad roof.
26	Thameside Ambulance Station	DA11 8NT	25/03/2020	Admin	No	Timber roof structure with bituminous covering.
				Garage	No	Metal clad underside, standing seam above.
27	Walton On Thames Ambulance Station	KT12 1RZ	06/03/2020	Vehicle bay	No	Sloping Stramit decking supported by steel beams, steel sheets to the open rear bays.
				Admin areas	No	Plastered, painted or suspended ceilings.

To:
- All NHS trusts:
  - chairs
  - chief executive officers
  - estates leads

cc.
- Integrated care boards:
  - chairs
  - chief executive officers
  - estates leads
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

5 September 2023

Dear Colleagues,

Reinforced aerated autoclaved concrete (RAAC)

Last week new guidance was published by the Department for Education regarding the approach to the presence of RAAC in the school estate. This has generated heightened public interest in the presence of RAAC in the NHS estate, and a number of questions from colleagues.

You are all aware of the risks associated with RAAC as part of the extensive programme of work undertaken over recent years. We are writing to reiterate the position in the NHS estate, and to outline actions you should be taking to assure yourselves as far as possible that RAAC is identified and appropriately mitigated, to keep patients, staff and visitors safe.

To provide co-ordination to these actions, we will be communicating via regional operations centres. **Please therefore ensure that appropriate arrangements are made within your organisation to be able to respond to communication from your regional operations centre (ROC) on this subject.**

Guidance on RAAC identification, monitoring and remediation

All guidelines on RAAC are based and driven by expert advice from the Institute for Structural Engineers (IStructE). There has been no change in IStructE guidance, which government has confirmed continues to be the basis of action to manage the situation in the NHS and wider public sector. We continue to work closely with government departments and technical advisory groups and have asked to be made aware of any changes to the guidance so that we can share these with you immediately.

Following an alert issued by The Standing Committee on Structural Safety (SCOSS) in 2019, the NHS in England put in place a now well-established programme to identify RAAC, support providers to put appropriate mitigations in place, and plan for eradication. We have worked closely with the trusts managing the 27 previously identified sites, including securing funding for investigative, safety/remedial and replacement work, with three of those sites now having eradicated RAAC.

As part of this ongoing work, in May 2023 NHS England sent out additional guidance to organisations including all provider trusts (including mental health, community and ambulance) following updated national guidance from IStructE on RAAC identification, management and remediation and Further Guidance on Investigation and Assessment (April 2023).

Identification of RAAC

We asked trusts to assess their estate again based on this updated guidance. Initial assessments of additional sites identified through this process are already being undertaken and are expected to be completed by the end of this week. The national RAAC programme team are collating information from these assessments, including where appropriate mitigation plans and the steps necessary to remove this material from use.

Given the importance of this work, we ask that – in any instances where this has not already been the case – boards ensure they support their estates teams and review the returns they provided to assure themselves that the assessments made were sufficiently thorough and covered all buildings and areas on your estate (including plant/works, education and other non-clinical areas/buildings).

ICBs will want assurance about the primary care estate and should work with their local primary practices and PCNs to ensure you have confirmation that no RAAC has been identified or, where it has, on the identification and management of RAAC. Guidance for the primary care estate was circulated in January of this year, which ROCs can reshare.

Management of identified RAAC

Trusts which have previously identified RAAC will have put in place management plans in line with the IStructE guidance.

In light of the need to maintain both the safety and confidence of staff, patients and visitors, **we recommend that in those organisations where the presence of RAAC has been confirmed and is being managed, boards take steps now to assure themselves that the management plans in place for each incidence – and particularly where panels are currently subject to monitoring only – are sufficiently robust and being implemented.**

Where you think you require assistance in completing this work, please contact: england.estatesandfacilities@nhs.net.

Planning for RAAC incidents

Effective management of RAAC significantly reduces associated risks; but does not completely eliminate them. Planning for RAAC failure, including the decant of patients and services where RAAC panels are present in clinical areas, is therefore part of business continuity planning for trusts where RAAC is known to be present, or is potentially present.

A regional evacuation plan was created and tested in the East of England. Learnings from this exercise have been cascaded to the other regions.

We would recommend that all boards ensure that they are familiar with the learning from this exercise and that they are being incorporated into standard business continuity planning as a matter of good practice.

This exercise is, however, essential for those organisations with known RAAC, and should be done as a matter of priority if it has not already been completed.

Thank you to you and your teams for the work on this to date, particularly in those organisations where RAAC has been found and management/remediation plans have been enacted. As mentioned above we will communicate further information through ROCs.

Yours sincerely,

Jacqui Rock
Chief Commercial Officer

Dr Mike Prentice
National Director for Emergency Planning and Incident Response