South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors
Meeting to be held in public.

28 November 2023
Crawley HQ, McIndoe Rooms 1 & 2
1000-1230

Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
045/23	10:00	Chair's Introduction	-	-	Chair
046/23	10:01	Apologies for Absence Ann Osler Simon Dobinson	-	-	Chair
047/23	10:01	Declarations of Interest	-	-	Chair
048/23	10:02	Minutes from the previous meeting, Action Log and Matters Arising	Y	-	Chair
Statutory duties: performance and holding to account					
049/23	10:05	Strategy Update	-	Discussion	David-Ruiz Celeda
050/23	10:35	Chief Executive's Report	Y	To receive an update from the CEO	Simon Weldon
In order to drive the discussions above, included are the Board Committee Escalation Reports, the Integrated Quality Report and the Board Assurance Framework Report.					
-		**Area of assurance**	-	Holding to account, assurance and discussion	All Non-Executive Directors present
051/23	10:45	Quality and Patient Safety	Y		
052/23		People	Y		
053/23		Finance	Y		
054/23		Audit and Risk	Y		
11:45 - COMFORT BREAK					
Statutory duties: Member and public engagement					
055/23	11:55	Membership Development Committee Report MDC ToR for CoG Approval.	-	-	-
Committees and reports					

056/23	12:00	Nomination Committee Report	**Y**	Information	MW
057/23	12:10	Governor Development Committee Report	**Y**	Information	Leigh Westwood
058/23	12:15	Governor Activities and Queries Report	**Y**	Information	Leigh Westwood
059/23	12:20	Annual Members Meeting Minutes	**Y**	Approval	Chair
General					
062/23	12:20	Any Other Business (AOB)	**-**	-	Chair
063/23	12:22	Questions from the public	**-**	Accountability	Chair
064/23	12:23	Areas to highlight to Non-Executive Directors	-	Assurance	Chair
065/23	12:24	Review of meeting effectiveness	**-**	-	Chair
Date of Next Meeting: **14 March 2024, Banstead**					Chair

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

PLEASE NOTE: This meeting of the Council is being held in person at **Crawley HQ Centre,** in addition to using Microsoft Teams. The meeting will be video-recorded and made available for public viewing following the meeting. Anyone who asks a question gives consent to being recorded and the publication of their participation in the meeting.

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

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 14 September 2023

Present:

David Astley	(DA)	Chair
Simon Weldon	(SW)	Chief Executive
Michael Whitehouse	(MW)	NED and Chair of Audit Committee and Senior Independent Director
Brian Chester	(BC)	Public Governor, Upper West
Leigh Westwood	(LW)	Public Governor, Lower East
Martin Brand	(MB)	Public Governor, Upper West
Linda Caine	(LC)	Public Governor, Upper East
Kirsty Booth	(KB)	Staff Governor (non-operational)
Harvey Nash	(HN)	Public Governor, Lower West
Peter Shore	(PS)	Public Governor, Upper West
Andrew Latham	(AL)	Public Governor, Lower West
Nicholas Harrison	(NH)	Staff Governor (operational)
Chris Gonde	(CG)	NED
Barbara Wallis	(BW)	Public Governor, Upper East
Colin Hall	(CH)	Public Governor, Upper East
Mark Rist	(MR)	Appointed Governor – Fire Service
Liz Sharp	(LS)	NED
Subo Shanmuganathan	(SS)	NED and Chair of People Committee

In attendance:

Peter Lee	(PL)	Company Secretary
Matt Webb	(MW)	Associate Director Strategic Partnerships/System Engagement

Apologies:

David Ruiz-Celada	(DRC)	Executive Director of Strategic Planning and Transformation
David Romaine	(DR)	Public Governor, Lower East
Vanessa Wood	(VW)	Appointed Governor -Chief Exec of Age UK - Thanet
Max Puller	(MP)	NED
Paul Brocklehurst	(PB)	NED
Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee, Chair of Operational Performance Committee
Ann Osler	(AO)	Public Governor – Upper West
Angela Glynn	(AG)	Appointed Governor – University of Brighton
Tom Quinn	(TQ)	NED

Minute takers:

Richard Banks	(RB) Assistant Company Secretary
Karen Rubins-Lawrie	Corporate Governance Administrator (by recording)

Item No.	Introduction and matters arising
031/23	**Introduction** DA welcomed all to the meeting.
032/23	**Apologies for Absence** As referenced above.
033/23	**Declarations of Interest** None.
034/23	**Minutes from the previous meeting, action log, and matters arising.** The minutes of the previous COG held 22 June 2023 were recorded as a true and accurate record, with no amendments.
	Statutory duties: performance and holding to account
035/23	**Chief Executive's report** SW welcomed and thanked everyone for coming. SW commented that Medway EOC had gone live this morning and wanted to acknowledge everyone who had been involved in delivering the facility. SW said it is truly class leading that all should be immensely proud of, noting it has already attracted a lot of interest. It has truly been a team effort to have this completed and asked for colleagues to thank all staff who supported this. We should be hugely proud of this. SW drew out some elements from his report. SW reflected that he attended a national UEC stocktake hosted by the Prime Minister yesterday (13 September 2023). This was to look at winter preparedness and how the NHS is going to be meeting the challenge to maintain a safe emergency service, continuing to make inroads into the waiting lists across NHS. SW commented that the meeting was positive, focussed and helpful and further reflected that the politicians were keen to hear from us and our ideas about how we could do more and go further. SW added in our issues from the ambulance service into those discussions. SW advised that at the Board meeting next month, you will hear more on our winter plans and where we are in respect of that. In the Board meeting last month SW presented his priorities and sought, and received, endorsement. SW's priorities are his work and actions over the next

	two to three years from a personal level. SW felt it was important that the Board heard what SW had seen and heard and saw in his first 100 days in post. As a Council of Governors you will be supporting the strategy for the future. Our commissioners have been engaged early and significantly. There is a debate if all the work we commenced during Covid if it will continue or not? The strategy will be ongoing and CoG colleagues will be involved throughout the process and will be informing the process. SW confirmed this will be a dominant thread of conversation over the next six months. SW confirmed his aim by the start of next year is to come back with the new strategy and about how our ambulance service is funded. The expectation is on us to deliver and it is up to us to set the leadership tone in that debate. SW asked for all the tricky questions to be put out into the open. DA invited any clarity questions and confirmed his NED colleagues can deal with all matter of assurances. KB thanked SW for the Medway move and commented it was brilliant to see and staff were happy with the move, and it was the start of a new journey. SW thanked KB for the comments and reaffirmed that part of attracting and retaining colleagues is feeling good about the building in which you work in. DA reaffirmed, from a non-executive perspective, he was pleased with the leadership change from Ashford and Coxheath as the environments were not the best, and he was happy to see staff were happy, noting some staff have left the organisation because of this. MW thanked SW for his assurance the strategy would not be put on them and would be able to co-created. MB sought assurance and asked: 1. Can you expand on what you mean by empowering senior leadership and development? MB commented the ambulance service is not good at delegation and empowering downwards. 2. There are obstacles to on Boarding Paramedics and an issue relating to C1 licences and for those of modest means. 3. MB outlined one example where a fully qualified paramedic failed the grip test by 0.1% and then needed to re-take. These are a lot of small but important obstacles for on Boarding quickly. DA asked for SW and SS to respond. SW responded:

	1. We recently held a workshop for the opportunity for colleagues to feel involved and shape the strategy in the outset. As we go forward this will be a topic that CoG will have an opportunity to input to on a number of occasions. SW was proud this will be a clinically led process co led by Dr Rachel Oaten and commented we will be reaching out to communities in which we live to hear those voices. SW commented it was key we include our commissioning partners, right across the region, for the right answer who are delighted to be part of this with us. 2. We held a Board development day, which was a second in the series and SW hoped the OUM's feel they have meaningful autonomy where they have more control and more say. The process started in July and the Board gave each OUM £3,000 to spend on what they wanted to in relation to looking after their staff. Part of the Board development was "what have you done with it?" SW noted the NHS Bureaucracy and agreed we need to improve processes to reduce. SW noted that some of the OUMs have already started to make changes, e.g., changing a vacancy from a paramedic to a scheduler role which SW hoped empowered front-line leaders to make the right decisions locally. SW noted the next Board development session in November would take the conversation further. 3. **Action** SW confirmed that this issue will be looked into and fed back." *There are obstacles to on Boarding Paramedics relating to C1 licences and for those of modest means*". SS, chair of people committee, confirmed that formal training is being pursued and that does include people management training at all levels. This does include corporate teams. SS confirmed that at the next people committee an evaluation of training will be presented to oversee its effectiveness. KB noted that in SW report it mentions extra funding for extra clinical staff, and we need to make sure they are safe. KB asked for assurance that the back-office function, i.e., audit, anything else to bring these extra staff on, we need to make sure that they are safe and want assurance we are including the audit aspect of that as currently we are not including the bank office function. SW confirmed that part of the work being undertaken is looking at all structures which is starting at the end of September with the executive team. It is very important that patients receive great service, that we invest and consider what we need to invest in to support structures when we go into a structure review. This will be discussed in the months ahead. As an example, SW confirmed he has held a conversation with SS to strengthen finance and procurement function. Other areas would be medicines and work. We need to have appropriate safe medicines and several other areas which are a focus and will be part of the work with the executive team end of September. MW commented that within the Audit committee they are assured through indicators that it is an efficient and effective level of investment for corporate colleagues, appropriate for the delivery model and commented that MW supports the direction SW is taking.

	MB asked: • Medical Distribution Centre and EPPR being reviewed – the question is how assured we are firstly in terms of medicine management can we keep the show on the road and; • Are we were prepared for a major event? • How do we ensure privacy for patients with body worn cameras? SW responded. An external review has been commissioned of major incident capability and capacity to response and shall be reported through the October Board and be public in November. In terms of a medical distribution centre, we are currently in a building not fit for purpose and we need to take immediate action to add in a lift to support medicines being moved safely within the building. Facility is currently sub optimal for staff. Broadly we are to continue to look at Paddock Wood as a facility. There are lot of issues with layout and do we need think about a separate facility. If we go for a separate one, how do we future proof it, do we look for a combined version? The estates team are currently reviewing this. His does not mean we will not work on Paddock Wood currently and stabilise the issues around it, the first of which being the lift. DA confirmed that NEDs are assured this is being given management attention. Comments were made from NH regarding Paddock Wood noting it has had issues from the start noting it has outgrown it's purpose. A new lift is only one part however this is not solving the issue. In March a BCI was declared because there weren't enough medicine as the building is not fit for purpose. There is currently a vermin infestation being investigated. NH wanted assurance this is a top priority. SW confirmed it was one of his three key operational priorities to resolve and are looking at options, including to ensure future proofing. SW confirmed this will involve considerable money so no decisions will be rushed. SW confirmed that the Board and council will be kept up to date. It was reflected to SW that the release of autonomy to OUMs is a brilliant idea. OUMs should have that ability to tailor service within guidelines and should feel better relations with localised autonomy. SW responded and thanked colleagues for the feedback and appreciated it. OUMs have been delegated autonomy however they have been asked to consider what this looks like with accountability. The next part of the conversation is to consider local autonomy regarding staffing structures to fit local sites. It was noted that regarding culture, which is being pursued by the People Committee and Board, there is work to do and is being closely monitored. HN queried:

	• Statutory and Mandatory training as currently reported 10% below target (target 85%). Appraisals at 58% (Target 85%). The target has not been reached. • Is this a cultural issue where statutory and mandatory training is targeted, but what about the other development and training that we do need which is not targeted. Should this happen? Is there time for this to happen and is it happening? It is great to hear OUM are on Board however there is a layer below them before the people on ambulances. How do we get to them? SW confirmed that this is why the relationship and work happening now with the OUMs is very important. OUMs believe it is important to ensure all of these people are having these conversations so they can come to me and advise "This is what I want you to know". It was noted we need to do more and do better for staff personal development. We are encouraging the relationship with the OUMs. The date that we see only tell us that they have had appraisals, not the quality of the conversations. The quality of these conversations needs to be focussed on. SS commented from People Committee perspective that we are on a journey to ensure we are having the conversations for career development. A key element to underpin is to build upon 121 conversations and coaching / mentoring / training those people. We need to review the granular details and then need to review impact. MW gave additional assurance that it is about getting the basics right for our staff noting SW needs time to get it right as it can't be achieved right away. HN noted it involves changing the mindset of a huge number of people.It is right this is raised. We have a history of dealing with symptoms and not the cause. And this is why we support SW to ensure we get the basics right. SW agreed was noted that this issue will take time to resolve over a 2-3 year period and with the sustained effort and commitment from himself this will be achieved. DA commented the Board is aligned on this approach.
036/23	**Development of the new trust strategy – Clinical Case for Change** Matt Webb, Associate Director Strategic Partnerships/System Engagement, introduced himself and offered apologies of David Ruiz-Celeda, Executive Director of Strategic Planning and Transformation. MW went through the slides and confirmed that the aim was to create an ambitious and innovative long-term strategy that champions sustainable high-quality, equitable care for our patients, enhances the experience of our people, supports our partners, and protects our environment. The approach is centred around patients, internally driven and is clinically lead. The gaps currently in the organisation are around change management to make the strategy achievable and sustainable going forward to improve the organisation. Programme stages are based around a recommendation from NHS England:

- Weeks 1 – 5: Framing the strategy, forecasting and diagnosing,
- Weeks 9 – 17: Generating five strategic options with an associated operating model. This will be working with colleagues across the organisation, the Board and the Council of Governors.
- Weeks 18 – 25: Implementing transformation. How do we ensure the organisation is set up to design and implement the strategy in a succinct and effective manner?

MW framed the 'Wicked' Questions which were raised in workshops around the organisation:

- What is our vision, purpose and role in the broader health system?
- What does our service model need to look like to fulfil our purpose?
- How do we engage, retain, and develop our workforce to deliver the strategy?
- How do we harness technology, data, and innovation to transform our services?
- What partnerships, financial resources and political alignment do we need to successfully execute our strategy?
- How do we reduce health inequalities, and enhance environmental sustainability?

A key strength we have is that SECAmb is a data rich organisation, and we can support systems with access to that data to support understanding of complex health conditions.

MW stated that we have now moved into the diagnosis stage, understanding and recognised the lived experience of our people. This is centred around data and evidence understanding the needs of patients, partners and how we prioritise those.

We aim to understand the impact on the UEC sector, the external influences and what they key drivers of change are. We need to understand our population health needs, complete SWOT and PESTLE analyses to understand external and internal influences then using the data to ensure support functions are set up around those.

We have used a series of workshops with our partners, people and patients. These have been centred around three key questions:

- Do we have an understanding of who our patients are?
- Do we have a true understanding of the reasons they are calling us?
- How are we responding?

MW noted this is about having a good understanding other root cause as opposed to responding and reacting to the symptoms.

	The workshops brought together operational leaders, operational service delivery and clinical leaders which raised constructive and challenging points. We are now moving into a four-week diagnostic phase looking at insights from staff, financial performance and local providers and their strategies. MW shared a slide detailing the top 15 patient conditions. MW advised our strength at SECAmb is that we are a data rich organisation with an understanding of complex health conditions. Our weaknesses include the fact that we have a significant transient population which makes the job challenging. We need to prioritise the data to use it effectively and understand the service gaps. Opportunities include looking at how we tailor our services to the demographics of our patients, using clinical coding to guide interventions. We currently have a model focussed around transportation and injury but the upper most four conditions are complex medical and health conditions. The data indicators may not be set up in the right way to serve the evolving needs of our patients. MW shared figures on the types of call received noting that 3% of our patient demographic generate 20% of demand. Last year we responded to 719,000 incidents with 433,000 unique patients meaning a number of patients generating repeated calls. Our strengths are that we are seen as a well-regarded, reliable organisation which is easily accessible with a prompt response from our highly skilled workforce. Weaknesses include the fact we do not self declare our capacity. We are solution orientated but we need to understand what the needs of our patients are and not have a one size all fits approach. We recognise the need to support the public health agenda embracing technology and innovations as well as integrating with our partners. MW shared a graph detailing Hear & Treat, See & Treat and See & Convey, inviting the room to visit the Strategy Stand during the AMM in the afternoon to look at it more closely. Points to note include the fact the we see a large number of patients that we do not offer further interventions. We need to see where we can redirect these patients to support them with their care. We need to understand much earlier in the call to appropriately redirect patients. There are a number of emergency category calls that result in Hear & Treat and See & Treat, we need to understand why these calls are happening to understand how we move forward. Our patient needs are more diverse than ever with a growing complexity. Our one size fits all time reactive model is not working and increasing stress on the workforce and increasing patient risk. We need to look at how we can best optimise clinical expertise and new technology to support changes moving

	forward so we can meet patient needs and partner expectations. We need to ensure we send the right resource for the patients within the appropriate time frame. Immediate next steps include our strategic partner joining us in mid-September, we are finalising the next steps with them. The three key priorities with the strategic partner will include: • Integrated care delivery model • Data analytics • Meaningful engagements. MW commented that the Council of Governors are invited in early October within ICS workshops. The Council of Governors will also hear more about the strategy in November. On the 26th October their will be a Board Strategy Workshop at which point we will be on the forecasting stage. DA commented that hearing from governors is important as it is the people we represent. PS noted that projects like this tend to grow bigger than initially expected and asked how you assure yourselves that this project is not going to grow and go over budget, and also the amount of time staff dedicate to this. What are the processes to manage this? MW responded advising we will be watching and shall be ensuring that there are clear milestones and timescales. The strategy will need resource and investment. It was noted that we will need to ensure the strategy needs to be aligned with the NHS Business Cycle. MW commented that if the strategy cannot be delivered within 6 months then we have failed. LS commented that want to be assured that we are making a difference to patients and staff and that this will be measured through the quality committee. SS mentioned that within the People Committee, the workforce plan is being reviewed to ensure skill mix is influenced. CG commented that he wanted to ensure that we support staff to be a part of the strategy ensuring that this is clinically led. MB commented that he and David Romaine (DR) were invited to be involved in the selection process for the trust and was assured it was a robust process. The concern is the tension between realism and implementation of the plan ensuring it ties in with planning rounds. MB commented he is concerned that the focus is mainly on the strategy, not the implementation and asked for rigorous assurance. SW commented that we have already been given some of the planning assumptions for next year. These are out in draft and will guide and shape the

	strategy. The key to what we can afford will be what the NHS financial settlement is. Our commissioners are committed and aligned to this work and will support us to achieve our goals with it working over a multi year basis. SW noted the core product is the workforce that supports it. SW used an example of the large number of Specialist Paramedics in the trust and questioned if this is something we will need to support the model going forward. Our commissioners recognise the challenge and want to work with us to help us create the right product and making sure we deliver them correctly. SW stated that NHS planning timescales are always to a certain degree floating but advised we are all pointed in the right direction to ensure we have a really great workforce plan. BC raised concerns about front line staff that are sent into emergencies who make important decisions, deliver patients to hospital and then do not find out outcomes. SW responded advising that 20% of what we do is social, mental health or within the frailty space. We need to ask ourselves who is going to do what, such as primary and social care. Will it stay the same as it is? If it stays the same the ambulance service will likely need to continue to grow. Feedback will be key to the strategy, and it gives people answers. It would also support clinicians to learn (and SECAmb becoming a brilliant learning organisation) and possibly increase confidence to try something different. SW noted that technology is improving in order to be able to feedback to operational staff and he feels it needs to be a key part of our strategy. This will demonstrate that we are a learning organisation. SW stated that governors scrutinise SECAmb's work and they should also be scrutinising our partner's work. SW noted that 3% of our patients account for large proportions of our demand. If we improved on wrap around services, imagine how many hours back into the system we would get. DA noted we need to work closely with our blue light colleagues to gather their input and ensure we are all consistent in what we do. MR agreed. NH commented that Mental Health and End of Life care are complex and difficult jobs and with thorough feedback confidence would increase supporting better decisions. NH noted we have a fairly young and inexperienced workforce and giving them the feedback could bring about massive change. A two-tiered approach about where patients go and who provides that service is needed. We cannot afford to provide the care at the rate we are going forward which is at the detriment to the patient. NH noted that frequent callers have found ways around the system to get repeated ambulances out, querying how we can manage that. We need to be radical moving forward. SW commented that we can do better integrating our data. All of us hold parts of different patient's story. We are moving into an era where patients expect us to share their information to help provide a better service. We have to be bold enough to say we can't be all things to all people, but we can provide certain services.

	HN commented that feedback to services and a job well done to our people needs to be quick and timely otherwise it loses impact. HN questioned whether other ambulance services are undergoing similar strategy processes, and if so at what point do they share it. SW commented that the key challenge is that we are spending public money. The National Association of Ambulance Services is starting to refresh it's approach and there is a workshop planned next week. NHS England are looking at its own strategy around urgent care and the ten high impact changes have been provided by them. SW noted we should be working in collaboration with other ambulance services and he will look at that as we start to develop our strategy. To get the best out of our public money we need to look at what we can do together. DA noted that we want the organisation to speak and have a voice. Our workforce needs to be in a better place than they are currently, and we need to build on the feedback they are given. This can help us influence the national debate.
037/23	**Areas of assurance:** • People and Culture Strategy - delivery • IT resilience • Impact of additional funding on operational performance In order to drive the discussions above, included are the Board Committee Escalation Reports, the Integrated Quality Report and the Board Assurance Framework Report. PS asked if we have any benchmarking data and are we using it? SS confirmed we do have and do use benchmarking data against other trusts. SS is concerned that it is potentially stifling ambition and potentially leads to complacency. Benchmarking data is important but we need to be ambitious about what we want achieve. SW confirmed that he supports the ability to be ambitious and at Board in October we will present the first draft of the retention plan following the launch of the NHS Long Term Workforce Plan. SW asked all to look at the retention plan in October and ask is this the best we can do? SW confirmed we have worked with union colleagues to look at improving working conditions and to improve retention. This is not just for CoG /Executives/Unions and SW looks forward to everyone having the conversation together at October Board. PS noted that benchmarking data also helps awareness of what we are doing well.

	DA noted that we need to be more enquiring when looking at the data. It can help us ensure we are spending public money well and spending every direct pound on patient care. NH commented on the retention strategy asking how do we find out why people do not want to work here, are we collecting data through properly executed exit interviews? We cannot make assumptions as to why people leave. SS replied and confirmed that we have delved into that data recently as to the main reason why staff leave and it has not changed over the years. The questions now are how have we changed and adapted to respond to them? How have we responded to that? One of things we need to do to ensure we improve is flexible working. Do we really support our staff to work as flexibly as we can? We are having open discussions about why our retention strategy is not reaching the 10% and it is still at 18%. The next People Committee will be deep diving into this. DA provided assurance that we need to ensure we triangulate feedback and ensuring we are speaking to staff to get behind the data. Staff have now got more confidence to approach NEDs and speak up. DA noted we need to improve staff relationships with their line managers to improve retention overall. We need to ensure responsible and open communication within SECAmb and work hard on the feedback. DA confirmed he is assured that SW and the team responding to this appropriately. MR queried staff wellbeing and the reported high volume of RIDDOR injuries. SS confirmed that she could not agree more. SS recently observed a Polegate night shift where she was given a pack to carry and she nearly fell over as could not manage to lift it. This made her realise how physically strong in addition to other skills our staff need to be. There has been a change in the timeframe of when these injuries are reported so they are reported within the appropriate time frame. SS confirmed that she does have assurance regarding the RIDDOR reports and that the Health and Safety wraparound care is good. We are also focussing on support around Mental Health care, and SS feels we are getting the balance right. DA noted we need to do appropriate physical assessments to ensure we can embrace all people who want to work in the ambulance service. LC queried the QIPC report looking for assurance around the safety of the electronic prescribing system. LS replied that we have upgrades to the system and it is safer now for medical and non-medical prescribers. LS advised that Rachel Oaten has been overseeing this. We are limited in our number of non-medical prescribers and recruitment is ongoing. We have not yet got to the point where we train our Specialist Practitioners to do non-medical prescribing however this is work in progress. LS stated that we get frequent callers into the 111 service trying to

	access medication. The committee has asked for full assurance following the changes to the system and RO's review as Clinical Safety Officer. MB stated that we have 900 public access defibrillators installed by British Heart Foundation and that there is a risk that these are not owned by anyone, we do not know where they are and their expiry date. There is a big patient safety risk if a member of the public tries to use one when someone is in cardiac arrest. Are we assured that people won't die as a consequence of not getting hold of one in a timely manner. A lot of people associate defibs with the ambulance service so is there assurance this will not affect our reputation, and will this take place within a timely manner. LS commented that not all defibrillators were put in by BHF however BHF runs the network of current compliant defibs available to us and the general public. They recently asked everyone to register a current AED that had been serviced and capable of working in an emergency. There was a lack of response for hundreds of defibrillators, so we are not assured that these are compliant, serviced or even having their general checks. Emma Williams is looking at it and the current available network is available to our teams and Community First Responders. There is a cost element to consider if we adopted all defibrillators as it would take a team of people to resolve. There is a risk with this, and we are looking at it now. It is a risk we can accept partially. MB queried Category 3 and 4 validation programme to use CFRs for falls patients. Given statistics around falls and the fact we are trying to develop CFRs, are we assured this problem is being resolved? LS responded that C2 and C3 and C4 validation discussions have taken place. When we looked at the data falls perspective only 5 were referred to CFRs which was worrying given the time invested in this project. A lot of work is required to meet the government target of 30 minute response time. The longer C3 and C4 patients are kept waiting the sicker they become. Rachel Oaten, Chief Medical Officer (member of public audience) Rachel commented that three quarters are sitting in C3. Through feedback and Datix we are exploring this. We need to ensure that patients are getting a timely response from local community resources. We aren't yet fully assured and there is still work to be done. Evidence shows we have not got it right and we are looking at data (Datix and feedback) to triangulate. The quality committee are aware of this and are pursuing this. DA noted that we want to make sure we are using the CFR resource to it's maximum benefit as it can have such a positive outcome. MB commented that it is reported that we are £4.8m off track. MB asked what the situation was now. MB also noted that there is an issue with recruitment to ensure vehicles are kept on the road. MW commented that Finance and Investment Committee will have this on the agenda for ten days time. We are under pressure and are alert to risks within

	the efficiency programme with balancing books. We are not in a different position to 12 months ago. We don't just look at finance but also from the view of quality and patient care, MW confirmed we are not cutting budget to patient care. Saba Saddiq (Chief Finance Officer) confirmed we have a £9m target and the plan is £2.2m for end of August. We have successfully created savings of £1.6m which is slightly behind plan however retrievable. DA noted that we are keen to pursue recurring efficiencies as opposed to non-recurring and that SECAmb have a history of handling finances well. SW commented that DA and SW attended a national leader's event last week and that money is a topic to be discussed going forward. Amanda Pritchard, NHS England Chief Executive, confirmed that we are not there to balance books, we are here to manage risks/money/delivery and patient safety. Quality and delivery risks always need to be at the back of our minds. We are having those discussions at Board to ensure we are delivering on efficiencies in the correct manner. DA advised the Board have been very driven in pursuing a balance driven solution and not a solution at the detriment of any areas such as staff welfare or patient delivery. NH commented that some directorates are making efficiencies. Some are not and are either not capable or not bothering? Is there assurance that colleagues are being held to account for not achieving these goals? Are we setting unachievable targets? DA stated that both he and the finance committee are keen to ensure everyone plays their part with no exception. The efficiencies need to be recurring with a focus on improving the business. We want to see a consistent approach to trust values and this is being pursued with vigour. MW replied that he does not think this is an issue of people not pulling their weight however it is a timing issue. We cannot get it exactly right. MW noted his observation on SECAmb is that we cannot keep finding efficiencies within the operating model. An overarching review of the costing model is needed to ensure everything is costed correctly so we can balance patient care and have meaningful outcomes for the future.
Statutory duties: member and public engagement	
038/23	**Nomination Committee Report** The report was taken as read.

	MW noted that DA's term of office comes to an end in just over a year and advised that the process to find a successor has begun. Three potential head-hunters were interviewed by the nomination committee and Gaten By Sanderson have been appointed. This will be a major exercise of consultation with a range of stakeholders. The timetable is noted in the report. DA advised it was nine months until the end of his term of office.
Committees and reports	
039/23	**Governor Development Committee Report** The report was taken as read. KB wanted encourage fellow governors to attend and drive the agenda for future Council of Governor meetings.
040/23	**Governor Activities and Queries Report** The report was taken as read. LW advised it was good to see that the list of activities extends with each report that comes out. LW thanked his colleagues on the council for getting out and about and being active in their role. One amendment as Kirsty Booth was present for recent nomination committee on 22nd August.
General	
041/23	**Any other business** None
042/23	**Questions from the public** CFR – Crowborough: The audience member and CFR gave up C3 calls many years ago because he couldn't stand the wait for crew. There was a three to four hour wait which was unsustainable and took up his personal time. If the response to C3s was sped up there may be more CFR response to them. DA advised this was part of the ongoing work to ensure an appropriate and timely response is actioned. Executive colleagues are encouraged to speak with CFRs to ensure they are part of the solution. DA stated we have been listening to the CFR communities over the past few years including a number of meetings recently with MW. CFR input is valued and we are grateful for the feedback.
043/23	**Areas to highlight to Non-Executive Directors**

	DA acknowledged staff engagement and stated that we are keen to pursue two-way communication. This is the theme around reorganising leadership arrangements around the trust by SW, to ensure we have a more inclusive workforce. DA also stated there has been an enthusiasm for the work on the strategy and there is still a lot more work to do with engagement. He feels there have been some positive signs that people are beginning to feel more engaged with the process. We now need to ensure that their input contributes to the output. This includes both the governors and wider membership. When writing our strategy we need to ensure we consult with our wider membership, including our staff who make up a large number of the membership, along with our partners and the public we serve. We need to ensure that their input influences discussions going forward. DA noted that there was still a lot of work to do especially with regards to the current challenges faced by the NHS and other parts of the public sector.
044/23	**Review of meeting effectiveness** DA noted the strategy discussion was particularly helpful. DA stated papers were produced 9 days prior to meeting noting a timing issue with the pre-meet with Governors. DA reminded everyone that the papers were the same as what the Board see and are publicly available by the website. Papers are available electronically if required. Any further comments about the meeting can be directed to the Company Secretary.
	Date of next Formal Council of Governors Meeting: 28 November 2023 – Banstead. The Board will next meet in public on 5th October.

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	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 FINAL.docx

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_Version-0.10 FINAL.docx

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.

3. Safeguarding Safeguarding Annual Report 2022-2023.docx

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 Foundation Trust

Agenda No	52-23

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	53-23
Name of meeting	Trust Board	
Date	05 October 2023	
Name of paper	Finance and Investment Committee Escalation Report – 28 September 2023	
Author	Howard Goodbourn, Independent Non-Executive Director – Committee Chair	

This report provides an overview of issues covered at the meetings on 28 September 2023

Item	Purpose	Link to BAF
YTD Financial Performance including Capital Delivery	To provide information on the Trust's financial performance, including issues and risks to delivery and to seek assurance that there is robust budget management to ensure we meet our financial plan.	SP Objective 6 – Meeting our financial BAF Risk 16 – Financial Sustainability

At Month 5 the Trust is on plan, with a £346k surplus delivered against a plan of £330k and the forecast is still for a break even position. More focus is required around the efficiency programme noting the target was £2.2m this month but only £1.6m was delivered.

The Committee was informed that whilst the financial plan is deliverable, it will need reserves to 'cross the line' due to the efficiency programme, and looked forward to receiving an update at the next FIC in November.

Capital is on track, however right of use assets will be an area for concern if vehicle purchases are not made in a timely way due to supply chain issues, and lead times will be critical in achieving this. The Committee welcomed the news that money from Estate disposals will be re-invested, and noted that Thanet in particular was part of a rolling programme to benefit from this investment.

The Cash forecast dip in March 2025 was highlighted, noting that this relates to the withdrawal of COVID funding, and a paper will be presented at the next meeting which will give more of a deep dive around the next five years cash forecast versus capital spend, and how this will be appropriately stress tested.

An update was received around the potential reduction of 111 funding, subject to formal confirmation, which could be in the region of £6m.

Overall the Committee is partially assured in terms of delivery of the over arching plan to break even on 31 March 2024, due to the risks around the efficiency programme.

Efficiency Programme	To set out the efficiency schemes and seek assurance that they are robust and being tracked to ensure effective delivery.	SP Objective 7 – Cost efficiency improvements to ensure resources are focussed on delivering patient care. Risk 16 – Financial Sustainability

An update was received on the progress of the proposed £9.0m efficiency programme for 2023/24.

Currently the Trust is estimating delivery of £5.3m but this figure remains unstable. The committee received updates on the plans to achieve this which include:

- Check and challenge meetings with Teams
- Executive Workshops with Deputy Managers
- Looking at pay (historically only non pay has been considered)
- Addressing policies which impact on efficiencies

The Committee challenged the Executive to drill down on some of the bigger ticket items, particularly in Operations, for example there was £3.6m in Operating Units identified, but there was little detail around these schemes. It also suggested that efficiencies need to be planned much sooner in the year, as presently it is not until April until schemes are identified and these should be done before the end of the previous financial year. It was felt that each year there appears to be a problem with efficiencies, and processes need to be reviewed to establish why these are consistently failing to be achieved, this also links to governance, accountability and transformational change. More effort will be needed across the Trust to turn this around next year.

The Committee is not assured that the current efficiency programme for 2023/24 will be delivered.

Benchmarking	To provide an update on benchmarking SECAmb against the NHS England Model Ambulance Portal	

An informative paper was received detailing how SECAmb presently benchmarks against other Ambulance Trusts. Essentially this exercise identifies opportunities where the Trust can feed into its efficiencies programme for next year.

The paper highlighted areas such as payslip costs, legal costs, stock management and logistic efficiencies, essentially each Directorate would identify a management response to take each item forward within their respective portfolio.

The Committee looked forward to receiving an update at the next meeting which would also incorporate a more detailed account of the PLICS submission. A Board Development session early next year would also be welcome in order that all of these improvement areas could be collated and aligned with patient harm and quality.

Update on External Review of I.T	To update the Committee on key findings prior to the receipt and issuance of the report	

An informative paper was received, outlining some of the findings expected in the imminent report conducted by Barry Thurston, the external Consultant commissioned to review I.T. It is expected that the report will highlight issues related to leadership, collaboration, project planning, and resilience.

The Committee agreed that there needed to be a balance around how this is taken forward. Clear milestones will need to be set, with a clear measured improvement plan, but also the plan must recognise some of the good work that has been achieved by the I.T Dept, such as the delivery of Medway MRC. Greater assurance is still needed in relation to I.T, and some key lessons learnt, particularly around gaps in Leadership, which on reflection should have been addressed earlier. The Committee sought assurance that the Improvement Plan will address digital resilience, particularly as Winter approaches so there is no adverse impact on patient care.

Medway Benefits Realisation	To provide a full overview that the objectives identified in the original Business Case in the build of the New Medway MRC/EOC/111 have been achieved	

This paper illustrated the process that will be followed to enable the formal tracking and realisation of benefits of the £26million investment. The Committee were particularly impressed with the framework used to capture the benefits, referred to as the 'Six P's' it encompassed Patients, People, Pounds, Performance, Planet and Partnerships. Members agreed this methodology should be adopted on all future projects across the Trust.

Members noted some of the benefits had iterated, in that more had been identified, and some were not now seen as benefits. However, whilst it was clear that some Estates costs had reduced, i.e. the sale of Coxheath and Medway, it was apparent the reduction in Estates running costs were not as clear, and as such the financial benefits remained thin. The Executive were asked to provide more detail around the benefits linked to maintenance costs and running costs. It also considered that substantial Redundancy costs had been identified, which were not captured in the initial business case, and these must be included to give an accurate and transparent financial picture.

Estates Maintenance Update including Disposals	To seek assurance on the governance and oversight related to how property is valued, and marketed and is aligned to the Estates Strategy.	

The committee received a paper detailing a progress update on statutory compliance and general planned and reactive repairs, and were assured that the Trust were meeting these requirements, and there were no identified backlogs. However, the paper lacked forward planning, and in the absence of any specific KPI's or other metrics, it was difficult to ascertain how well the Estates Team are delivering on their SLA's, and the Committee looked forward to seeing a more detailed set of metrics in the next update which will provide reassurance in some of the other areas of Estates.

Members also discussed the current facilities management contract, and a separate piece of work is underway to align value for money against maintenance costs, including a deeper dive into the Procurement elements around this contract.

Due to its sensitivities, a more detailed update will be provided at the November meeting around the relationship with Westridge, and next steps following the recent announcement that they had gone into administration.

Operational Performance	To seek assurance that SECAmb is reaching the targets agreed, and mitigations are in place to address any gaps.	

The committee welcomed a new style report on Operational Performance, which they felt aligned the data effectively and gave a more complete analysis.

The Committee noted call answering remains in a difficult position with no improvements in August – significant factors causing this are staff recruitment, retention and erratic call profiles.

C2 mean remains strong, with August's performance at 26mns 43sec against the 30-minute C2 mean target, whilst recognising that the other ARP metrics are significantly off target and SECAmb performs poorly in comparison to other ambulance Trusts.

Hear and Treat finished the month with a 12.1% average, resulting in a top third position nationally. C2 segmentation commenced in early September with positive initial outcomes, recognising that it has been initially implemented on a limited scale.

The change in budget for 2023-24 in 111 requires the delivery model to be changed with commissioners expecting more clinical work to be provided by down-stream providers.

Specific Escalation(s) for Board Action	There are no escalations requiring specific Board intervention, however for awareness the Board is asked to note the risk to the delivery of the efficiency programme. The committee will continue to seek assurance and will escalate to the Board as required.

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 FOUNDATION TRUST

Membership Development Committee (MDC)

Terms of Reference

1. Constitution

1.1. The Council of Governors hereby resolves to establish a Committee of the Council to be known as the Membership Development Committee (MDC), referred to in this document as 'the Committee'.

2. Purpose

2.1. The purpose of the Committee is to make recommendations and report to the Council about membership recruitment, communications, involvement, and representation. The Committee is not responsible for the delivery of all decisions but will work with the Council to facilitate its delivery.

3. Membership

3.1. The Committee shall not have less than five members. One of the members will be appointed Chair of the Committee and one Deputy Chair by the members of the Committee.

3.2. Membership of the Committee is open to all Governors. Governors are encouraged to join a meeting to establish whether they wish to become members.

Membership is also extended to include representation from key staff leads who are involved in staff engagement, inclusion and equality and diversity work.

3.3. The minimum membership comprises:

- Elected governor (Chair)
- Governors x 4
- Equality, Diversity and Inclusion Lead x 1
- OD Representative

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be four members and shall include two public governors.

5. Attendance

5.1. The Assistant Company Secretary and/or Corporate Governance & Membership Manager shall attend meetings.

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

5.3. The Corporate Governance Team will provide secretarial duties to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

5.4. Members and officers unable to attend a meeting are asked to send their apologies to the Corporate Governance Team as far in advance as practicable.

5.5. The Chair of the Committee will follow up any issues related to prolonged non-attendance with the member concerned.

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

6. Frequency

6.1. Meetings of the Committee will be held at least three times each year. Meeting dates will be diarised on a yearly basis and Extraordinary meetings may be called between regular meetings to discuss and resolve any critical issues arising. The venue for the meetings will rotate around the region or be central to the Committee Members.

7. Authority

7.1. The Committee has no powers other than those specified in these Terms of Reference.

8. Duties

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

8.1.1. Advise on and develop strategies for recruiting and retaining members to ensure Trust membership is made up of a good cross-section of the population

8.1.2. Plan and deliver the Council's Annual Members Meeting

8.1.3. Advise on and develop strategies for effective membership involvement and communications

9. Reporting

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

10. Support

10.1. The Committee shall be supported by the Corporate Governance Office and duties shall include:

10.1.1. Agreement of the meeting agendas with the Chair of the Committee.

10.1.2. Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings.

10.1.3. Enforcing a disciplined timeframe for agenda items and papers, as below:

i. At least ten working days prior to each meeting, agenda items will be due from Committee members;

ii. At least seven working days before each meeting, printed and emailed papers will be due from Committee members;

iii. At least five working days prior to each meeting, papers (printed and emailed) will be issued to all Committee members and any invited governors, Directors and officers.

10.1.4. Recording formal minutes of meetings and keeping a record of matters arising and issues to be carried forward, circulating draft minutes to the Chair for approval within a reasonable time frame.

10.1.5. Advising the Chair and the Committee about fulfilment of the Committee's Terms of Reference and related governance matters.

11. Review

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

11.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Council for approval.

11.3. These Terms of Reference shall be approved by the Council and formally reviewed at intervals not exceeding two years.

Review Date: ***September 2025***

South East Coast Ambulance Service NHS Foundation Trust

Membership Development Committee Report

1. Introduction

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

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

2. Membership update

2.1. The total staff membership including bank members as of October 2023 was just over 4,950.

2.2. Current public membership by constituency (as of 9th November 2023) is 9241. Break down data provided as follows.

Constituency	Members	% of Membership	Base	% of Area	Index
Total Membership	**9241**	**100.00**	**14133282**	**100.00**	
Lower East SECAmb	1815	19.64	857528	6.07	324
Lower West SECAmb	1426	15.43	879351	6.22	248
Upper East SECAmb	3290	35.60	6333281	44.81	79
Upper West SECAmb	2192	23.72	6063122	42.90	55
Out of Trust Area	518	5.61	0	0.00	0

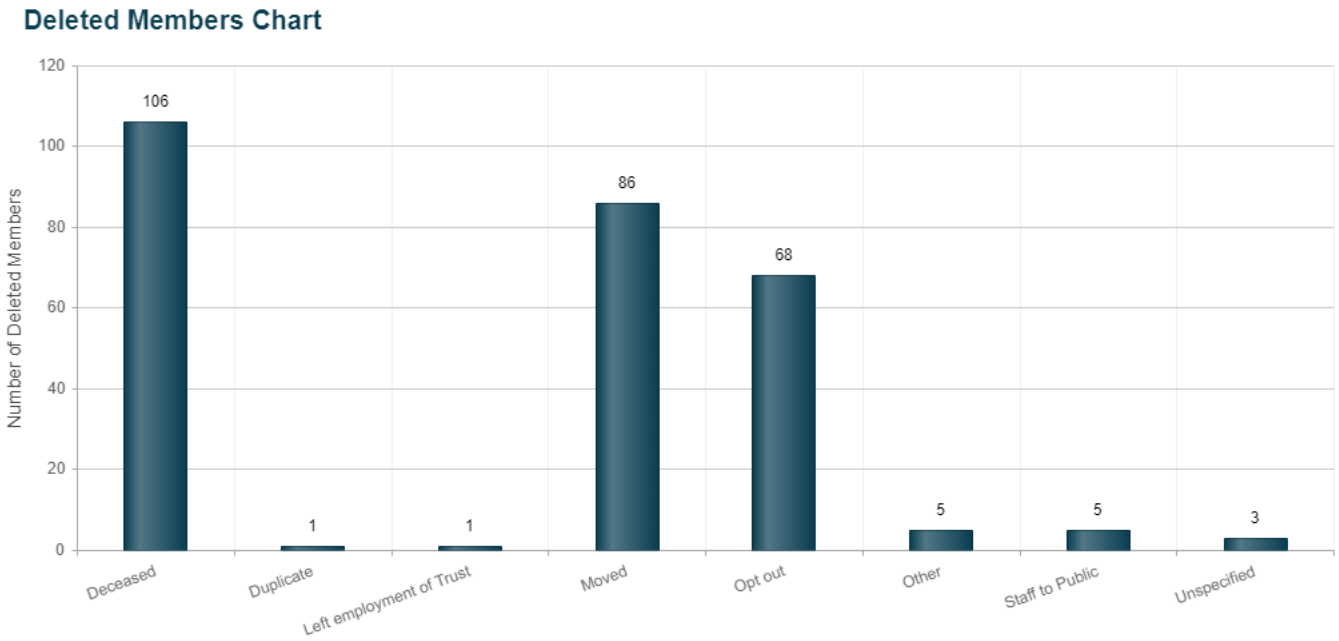
Key: % of membership = Percentage of members within the constituency. Base = Population of people within each constituency. % of Area = Total percentage of members within the constituency which have not joined. Index = A figure indicating how represented the membership by using the percentage of membership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

3. Membership history report

The table below shows the number of memberships that have been deleted since 9th November 2022 to 9th November 2023.

Total Membership	**546**
Public Constituencies	**275**
Out of Trust Area	4
Lower East SECAmb	61
Lower West SECAmb	34
Upper East SECAmb	100
Upper West SECAmb	76

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



4. Membership recruitment update

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

- To attend local events that the governors have researched at the beginning of 2023, this is to include a large footfall event such as Brooklands and the South of England Show. We attended the Edenbridge & Oxted show, English Festival, Godalming Show, Spring Live and the South of England Show. We had other events planned but due to the lack of support from Governors and operational staff we were unable to attend.
- Attend as many events as possible with Blue Light vehicles, to help interaction with the public. Opened invites to CFR's, paramedics, EOC and recruitment. Each of the events we attended had a blue light vehicle with a green operational member of staff. A couple of events a interactive resus doll was taken, this proved a great help with engagement.
- Continued presence on social media, adding a sharable post to LinkedIn, Twitter, and Facebook.
- Look at possibly attending winter events, this was put on hold due to the Winter clash but with the new Strategy planning there are talks of holding mini events in town centres, supermarkets.

5. Membership Engagement Update

- The Summer members newsletter was sent out by post and by internet at the end of August to our public members. A post was added to Viva, staff portal, for staff to click onto a link which would take them to the newsletter.
- This winters members newsletter will be due out middle of December, we are working closely with Comms and NHS Creative to make a more appealing newsletter.
- We have moved back to in person formal Council meetings which are held majority in Nexus House. The public, members and staff are welcome to join and observe these meetings with time for questions at the end.

- A continued presence is on our social media platforms sharing our meeting dates, we have also emailed our members with details of our meeting dates and how they are able to join us, either in person or online.
- Thanks to those Governors who observed the recent Board meetings. The feedback has been extremely vaulable
- We will continue to advertise these meetings to members. Recordings of the meetings are availiable on our website.
- We have moved the GDC and MDC to in person and on the same day to encourage more attendance.

6. Membership Strategy

- The membership Strategy is a working document to aid membership recruitment and engagement.
- As the Trust wide is writing a new strategy the council of governors would like to link in with this therefore Trust wide communications needs to be increased as well as the support.
- It was agreed that the Governors would attend three to four events in a year and have the support of operations to make it a bigger and better appearance at the events. This should be written and agreed with the Trust within the membership strategy.
- A proposed membership leaflet was presented to the governors, and it was agreed to go ahead with the leaflet title being 'Being a Trust Member'. There was a need for a slight adjustment once this has been done the leaflet will be put forward for approval via email rather than waiting for the next meeting, which is February 2024.

7. Being a Kinder SECAmb

Yvette Bryan gave an overview of this workstream, the work will be ongoing for 18 months and will be starting 19th October 2023. The aim is to ensure culture / values / behaviours are worked on following feedback from the staff survey which has told us SECAmb does not always feel like the best place to work. This will support culture change. The group shall be a mix of workforce from across the organisation which will ensure we have meaningful conversations in one room. The workshops are being designed to be conversational sessions and not teaching sessions. They have been co designed by colleagues to be discussive and focused on resolving issues and how we work together to create the 'Kinder Culture'. It was confirmed that we are working with an external company, "A kind life" whose motto is "Spreading kindness throughout healthcare". The governors have been invited to attend the workshops, as have the Executives and Non-Executives.

8. Patient Engagement

Victoria Baldock gave an overview on the projects that are currently running, the work on the Patient Safety Action plan is working well. The launch of the Community Forum and supporting QI for keeping patients safe in the stack is going well with improvements being made.

On 13th July 2023 a focus group was held with 7 members attending, this number was a good figure and due to the AMM had increased from just 2 members. The feedback gained from this meeting was feedback to the QI group. The summary of the feedback was:

- Patients need more information regarding patient demand.
- Information on what type of ambulance is being organised.
- What is the difference between category 1 and category 3.

- What happens when you call 999 documents. It was noted a lot of trusts have this currently.
- What advice is being given to patients?
- ETA updates should be provided on the ambulance.

Victoria Baldock is keen to encourage more input from the public.

The first Community Forum was held on the evening of 27th September 2023, going forward they will be bi-monthly on MS Teams initially to hear firsthand on the important work that is being done on the Trust strategy. It was mentioned about the importance of keeping it about the patient voice and that going forward there will be SECAmb guest speakers who will have a short 10 minute slot to update on their project work. The discussions were meaningful and feedback with 999 / 111 colleagues.

9. Recommendations:

9.1. The Council is asked to:
  9.1.1. Note this report.

9.2. All governors are invited to join the next meeting of the GDC on 23 February 2024 at Nexus House, Crawley.

SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST

Council of Governors

Nominations Committee Report

28 November 2023

1. Introduction

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

1.2. This report provides an overview of the most recent chairperson recruitment activity.

2. Chair recruitment

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

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

2.3. The committee has appointed Gatenbysanderson.

2.4. Longlisting has been completed and we have 5 candidates who will be taken through preliminary interviews ahead of shortlisting which is due 21 November 2023.

3. Next Steps

3.1. Interviews are scheduled to take place in Nexus House on 13 December 2023.

3.2. Three Governors from the Nominations Committee form part of the interview panel. Angela Glynn, Nick Harrison and Andrew Latham.

3.3. COG are invited to be part of a stakeholder group.

3.4. An extraordinary COG is being held 20 December 2023 to receive the recommendation from the panel (virtually at 10am)

4. Recommendation

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

Michael Whitehouse

Chair (on behalf of the Nominations Committee)

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor Development Committee

28 November 2023

1. Introduction

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

1.2. The duties of the GDC are to:

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

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

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

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

1.6. The minutes are attached as an appendix of the both GDCs held 28 September 2023 and 16 November 2023.

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

2. Items of note

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

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

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

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

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

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

2.7. Governors are reminded to complete the Governor Activity Form when any activity has been carried out to ensure a record has been made.

2.8. Governors were provided with the forward planner for 2024/25 and advised that invites for meetings have been emailed out. The only date to be confirmed is AMM as this may need to change depending on venue availability.

2.9. Governors were provided with the Governor Training plan for 2024/2025 highlighting the importance of attending the NHS providers sessions.

3. Recommendations:

3.1. The Council is asked to:

3.1.1. Note this report.

3.2. All governors are invited to join the next meeting of the GDC on 23 February 2024 at Nexus House, Crawley.

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

Training and development opportunity	Notes
Induction Day for new Governors - 02 February 2024	This invite is open to all Governors, new and currently standing.
Opportunities to observe NED committees	Once dates have been confirmed we will take a poll on dates governors can attend.
NHS Providers – Member and Public engagement Governwell: Core Skills Governwell: Accountability & holding to account. Governwell: Effective questioning & challenge Governwell: Member and public engagement Governwell: NHS finance and business skills Governwell: Recruitment – The governor role in non-executive appointments. (NomCom)	Confirmed 4 days of the year. Tuesday 9th April 2024 Monday 8th July 2024 Tuesday 1st October 2024 Tuesday 4th February 2025 These training sessions will help with the role of Governor. We are planning on having two courses running on one day with a lunch included. The schedule of the courses will be out as soon as they have been confirmed. SECAmb are paying for these training dates therefore please do let us know asap if you are unable to attend a date.
Core Skills: This course provides a comprehensive overview of the structure of the NHS; the statutory role and responsibilities of governors; an overview of NHS finance; the importance of quality in healthcare and key skills to hold the board to account effectively. Governors will gain: • An overview of the structure of the NHS and the governor's role within this context • An increased knowledge of their statutory role and associated duties • An understanding of the meaning of public accountability • An overview of NHS finance and quality focusing on key topics affecting the governor role	**Effective questioning & Challenge:** This course will help governors work confidently and effectively with their directors in posing effective questions to hold the board to account. Listening skills and questioning styles are explored along with how to frame effective questions and challenge within the context of the governor role. Governors will gain: • An overview of the governance of foundation trusts and the statutory duties of governors • An understanding of the importance of questioning, listening, and challenging as a governor • An opportunity to self-reflect on their own experience and style of listening and questioning along with considering potential changes in their approach • Confidence in their role to ensure they are holding to account effectively

• The key skills required to hold the board to account effectively • The opportunity to meet and network with governors from other • foundation trusts.	
Effective questioning and challenge: This course will help governors work confidently and effectively with their directors in posing effective questions to hold the board to account. Listening skills and questioning styles are explored along with how to frame effective questions and challenge within the context of the governor role. Governors will gain: • An overview of the governance of foundation trusts and the statutory duties of governors • An understanding of the importance of questioning, listening, and challenging as a governor • An opportunity to self-reflect on their own experience and style of listening and questioning along with considering potential changes in their approach. • Confidence in their role to ensure they are holding to account effectively.	**Member and Public engagement:** This course explores what it means to represent the interests of members and the public. This includes how governors can support engagement activities within their trust and effectively build relationships in order to present the views of members and the public to the board. Governors will gain: • Clarity on the governor and board duties in relation to this area • An understanding of the reasons behind why trusts have members and need to engage. • The opportunity to explore the challenges to member/patient engagement. • Knowledge on the importance of good relationships in fostering effective engagement. • A chance to explore examples of good practice and reflect on how governors can support engagement activities within the trust. • The opportunity to meet and network with governors from other foundation trusts.
NHS Finance and business skills: This course provides governors with an overview of a provider's finances and their business operations within the context of the governor role. This includes an overview of the national context; NHS funding flows; analysing financial information; asking questions of the financial reports. Governors will gain: • An understanding of the financial and operational context in which NHS providers are operating. • An understanding of financial flows in the NHS and the differences between the types of financial statements	**Recruitment – The Governor role in non-executive appointments:** This course enables governors to understand the process and procedures for the appointment of non-executive directors and the chair. It also provides an opportunity to practice formulating interview questions and to participate in a mock interview. Governors will gain: An understanding of the key principles of recruitment to public appointments • An awareness of current legislation affecting recruitment to non-executive positions • An opportunity to participate in interactive exercises to develop an understanding of the recruitment process including: o planning the recruitment campaign

• An improved appreciation of income and expenditure, cost improvement plans, and possible strategies to support organisation health. • The opportunity to discuss the governor role in major transactions and financial assurance to better understand the type of issues and questions governors should be asking. • The opportunity to meet and network with governors from other foundation trusts.	○ using the role description and person specification ○ carrying out a shortlisting exercise ○ preparing interview questions ○ participating in a panel interview exercise ○ making assessments of candidates ○ completing the recruitment process. • The opportunity to meet and network with governors from other foundation trusts.
NHS Governwell: Governor Conference 2024	We will advise the governors of the 2024 date as soon as this has been released.
Opportunities to shadow 999's & 111's	This is open to all governors, if you have a date you would like to shadow please get in touch by corpgovmeetings@secamb.nhs.uk and we will arrange with the relevant department.
Opportunities to attend the Quality Assurance and Engagement Visits	Open to all Governors, only one Governor per visit but you can attend more than one date. Dates currently available (correct at the time of putting papers together – dates are on a first come first serve basis) are: Polegate: 22nd November 23 – 0600 – 1600 Brighton: 20th March 24 – 0600 – 1600 Tangmere: 17th April 24 – 0600 – 1600 Medway: 22nd May 24 – 0600 – 1600 Dartford: 19th June 24 – 0600 – 1600 Hastings: 20th Aug 24 – 1200 – 1900 Hastings: 21st Aug 24 – 0600 - 1900

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Governor Activities and Queries

November 2023

1. Governor activities

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

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

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

1.4 Governors are asked to maximise attendance at both GDC/MDC and COG and where possible are reminded of the value add in attending board.

Date	Activity	Governor
17/09/2023	Attended Emergency Services Day at Brooklands to recruit new Trust members.	Martin Brand
21/09/2023	Observed Audit Committee	Harvey Nash
28/09/2023	GDC (including CPR training)	Leigh Westwood Brian Chester Ann Osler Kirsty Booth Angela Glynn Martin Brand Linda Caine David Romaine
28/09/2023	MDC	David Romaine Leigh Westwood Brian Chester Martin Brand Ann Osler Kirsty Booth
05/10/2023	Observed Board Meeting at Nexus House, Crawley	Harvey Nash
09/10/2023	ICB Workshop at Banstead	Martin Brand
09/10/2023	Attended Strategy Development for Surrey and Frimley ICBs at Banstead	Martin Brand

10/10/2023	Attended an observation shift at Gatwick MRC	Harvey Nash
10/10/2023	NHS Providers – Accountability and holding to account Training	Kirsty Booth Nicholas Harrison
17/10/2023	Quality Assurance and Engagement visit at Guildford	Harvey Nash
19/10/2023	Observed QPS Committee at Nexus House	Harvey Nash
November 2023	Awards Ceremony	Nick Harrison Martin Brand David Romaine

2. Governor Enquiries and Information Requests

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

Date	Query	Response
25 September 2023	Query from Linda Caine. The Transmission and Secure Storage of Confidential Information (Safe Haven) Policy still refers to fax machines" and this has not been used within the NHS since 2020 and has asked that this is reviewed and updated to remove reference to fax machines.	Response: As part of my review of 111 I did ask whether a fax machine was in use, it was confirmed that this is no longer the case. Therefore, the above policy will require further update which I will need to pick up on my return from annual leave.

28 September 2023	MB queried if the trust did not adhere to statutory responsibilities as the accounts were not laid before COG prior to the AMM. It was noted that they did not feel they had the ability to review or comment on the accounts.	PL Responded. The process as required by the Act is to 'present' the annual report and accounts - to both the COG and to members. It provides for this to happen in a joint AGM/AMM. In recent years we have combined the two in this way. While we did adhere to the statutory responsibilities, I accept the point made and so from next year let's use the June meeting (in private as we can't publish the report and accounts until they are laid before parliament) and invite KPMG to this to also present in a more formal way their report.

Recommendations

2.2. The Council is asked to note this report.

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

Governor Attendance April 2023 - March 2024

	CoG		Board		Joint Board/CoG	GDC				MDC		Events								Understanding SECAmb	
	22nd June 2023	14th September 2023	03/08/2023	05th October 2023	16th October 2023	18th May 2023	17th August 2023	28th September 2023	16th November 2023	18th May 2023	28th Sept 2023	Spring Live! 22nd April	Godalming 1st April	Brighton Marathon 2nd April	English Festival 15th April	South of England Show 9-11 June 2023	Edenbridge & Oxted Show 28th August	Brighton Speed Trials 3rd September 2023	Brooklands Museum 17th September	111 / 999 Shadowing	Observing Shift
Amanda Cool						✓				✓							✓				
Andrew Latham	✓	✓	✓		✓	✓	✓			✓											
Angela Glynn	✓					-		✓								✓					
Ann Osler	✓		✓			✓		✓	✓	✓	✓		✓						✓		
Barbara Wallis		✓																			
Brian Chester	✓	✓			Apologies	✓	✓	✓		✓	✓					✓			✓		
Colin Hall		✓				-									✓						
David Romaine	✓		✓		Apologies	✓		✓	✓	✓	✓	✓		✓		✓		✓			
Harvey Nash	✓	✓		✓	✓	✓	✓		✓	✓		✓				✓					**10th Sept 23**
Kirsty Booth	✓	✓			✓	-	✓	✓			✓										
Leigh Westwood	✓	✓	✓		✓	✓		✓	✓	✓	✓										
Linda Caine	✓	✓	✓			✓	✓	✓							✓						
Mark Rist		✓				-	✓														
Martin Brand	✓	✓			Apologies	✓		✓	✓	✓	✓		✓				✓		✓		
Nicholas Harrison	✓	✓			✓	✓				✓											
Peter Shore	✓	✓				✓	✓			✓											
Sam Bowden		✓				✓				✓		✓	✓						✓		
Vanessa Wood		✓				-															
Simon Dobinson									✓												

Jodie Simper
Corporate Governance Manager

Richard Banks
Assistant Company

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Audit Committee

The aim of the observation is for Governors to see and understand the assurance NEDs seek in action. The Trust is keen for NEDs to undertake their business as they would if Governors were or were not at the meeting.

Part A should be used for general observations about the functioning of the Committee. Please keep your observations brief and do not detail any confidential information leading to redaction.

If Governors have any individual concerns on NEDs performance or style, they can speak to the Chair directly (David Astley) or the Senior Independent Advisor and Deputy Chair (Michael Whitehouse).

Date of meeting: 21/9/23

Governors present: Harvey Nash

The following report is from the Governor, noting their observations.

1. Prior to the meeting:
Harvey received papers in advance. There was no pre-meeting with the Chair. Harvey attended on-line as did several speakers.

2. Introductions:
Harvey was introduced as an observer and welcomed to the meeting. The Chair (Michael Whitehouse) asked attendees to introduce themselves and also asked that NEDs and I remained at the conclusion for a short debrief.

3. Attendance:
The meeting was well attended with both in person and on-line attendees. NEDs attending were Michael Whitehouse, Subo Shanmuganathan and Howard Goodbourn (Tom Quinn sent apologies). Officials included Saba Sadiq, David Ruis-Celeda and Peter Lee, plus a representative for Margaret Dalziel. Representatives of KPMG were present for all but the last (Internal Audit) item.

4. Agenda:
There was a very full agenda covering issues from Contracts, Procurement, Risk and Incident management, IT risk, FTSU, Information governance and Internal Audit.

5. Discussion during meeting:
The committee worked very well with equal amounts of appropriate challenge, discussion and positive support from NEDs towards presenting members throughout the meeting. All three NEDs were fully engaged and made numerous good inputs, checking facts, aims, timescales and report-back arrangements. They were

consistently constructive yet firm and worked well as a team in seeking clarity and reassurance on all issues. They questioned beyond the basics to check on practicalities, support availability, training needed, competence and similar to ensure a full picture.

6. Chair:
Michael Whitehouse chaired the meeting very well, ensuring opportunity for all to engage with discussions while affording a high quality of input from meeting attendees. He ensured that even on topics of real concern the focus was on improvement, getting things right and clear ways for these. He made all present feel engaged and valued, which added to the quality of exchanges. He managed the agenda very well, providing useful summaries of concerns and actions throughout.

7. De-brief:
Michael, Subo, Howard and Harvey spoke for 10-15 minutes after the meeting with Michael very much seeking Harvey's views on the meeting and any 'Governor' inputs. Harvey shared their concern on issues around Contracts and Procurement and IT risks and was pleased at the robustness of debate and challenge in the meeting. There was discussion about the importance of language setting the right tenor (e.g. should we refer to 'war' on detriment, risk 'appetite' etc).

8. Conclusion:
This was one of the most effective board committee meetings that I have observed. While there are clearly some significant issues being tackled, I am wholly reassured that the NEDs involved are holding the Executive Board to account and doing so in a way that is firm and challenging, while constructive and practical.

Harvey Nash

South East Coast Ambulance Service NHS
NHS Foundation Trust

Annual Members Meeting
14th September 2023

The Orchards, New Road, East Malling, Kent, ME19 6BJ

Present:

- David Astley (DA) Chair
- Simon Weldon (SW) Chief Executive
- Michael Whitehouse (MW) NED and Chair of Audit Committee and Senior Independent Director
- Brian Chester (BC) Public Governor, Upper West
- Leigh Westwood (LW) Public Governor, Lower East
- Martin Brand (MB) Public Governor, Upper West
- Linda Caine (LC) Public Governor, Upper East
- Kirsty Booth (KB) Staff Governor (non-operational)
- Harvey Nash (HN) Public Governor, Lower West
- Peter Shore (PS) Public Governor, Upper West
- Andrew Latham (AL) Public Governor, Lower West
- Nicholas Harrison (NH) Staff Governor (operational)
- Chris Gonde (CG) NED
- Barbara Wallis (BW) Public Governor, Upper East
- Colin Hall (CH) Public Governor, Upper East
- Mark Rist (MR) Appointed Governor – Fire Service
- Liz Sharp (LS) NED
- Subo Shanmuganathan (SS) NED and Chair of People Committee

Formal Annual Members' Meeting

DA welcomed attendees and gave an introduction to the meeting. DA explained that they will be looking back over the past year and reflect on issues over the past year and to look towards the future of SECamb. DA gave thanks to Siobhan Melia, Interim Chief Executive, for the hard work put in over a very difficult few years with covid, the after effects of that and the CQC report. DA stated that over the past year they've been working hard to lay strong foundations for the future. They have been listening carefully to what members of the trust have said, as well as staff. They are now being led by Simon Weldon, Chief Executive. DA went on to explain that SECamb are looking towards the future with optimism. DA stressed that they want to foster a culture where everyone feels like they are able to speak up. Everyone's who works at for the organisation is important, their voice is important, regardless of rank or position. This is the tone that the board is seeking to set, under the leadership of the Chief Executive. People feel they're able to speak up without fear, is proud of the service they provide, but also able to reflect when things don't go as well as expected, learn lessons and move forward. DA explained some of the presentations that will be shown throughout the day. DA advised there were improvements in estates, such as the 999 move from Coxheath to Medway.

A short video was shown highlighting the improvements that have been made over the past 12 months.

Presentation of Annual Report & Accounts
Saba Sadiq, Chief Finance Officer

SS spoke about SECAmb financial performance in 2022 - 2023 and into 2023 - 2024.
SS highlighted that at the start of 22/23, SECAmb started to come out of the two most challenging years ever in NHS history.
As Covid 19 continued, its prevalence presented operational challenges across the NHS.

During 22/23, following the pandemic, the focus turned to restoring services back to pre-pandemic priorities and financial arrangements.

SS explained the process of the financial framework going back to normal post pandemic.

SECAmb submitted a break-even financial plan in 22/23 to surrey heartlands. SS explained the income and expenditure associated with the plan. At the end of 22/23 there was a small surplus of £46,000. There were efficiencies within the plan, delivering £5.4 million of savings in 22/23. There were also capital investments made. Spending £32.3 million supporting frontline workers, investing in infrastructure, digital capabilities, medical equipment, ambulances, and leased assets to support the delivery of high quality, safe patient care.

SS explained that there are two annual audits on SECAmbs accounts. One is for the financial statements. The external auditors used are KPMG. They give their opinion on our financial statements. They advised that SECAmbs accounts were true and fair,

They represented the correct financial performance for the organization, SECAmb applied all the regulations and accounting standards to the accounts.
On securing economy, efficiency, and effectiveness in the use of our resources, the auditor identified the main weakness arising from the CQC Well Led inspection.

SS advised that the internal audits are led by RSM. They were able to provide partial assurance that there is a sound system of internal control, designed to meet the trusts objectives and that controls are applied consistently.
More work has been performed on embedding risk processes across SECAmb since 22/23.

SS spoke briefly on capital. During 22/23 work was being done building Medway Make Ready Centre. £12.9 million was spent on the new make ready centre, the digital infrastructure was improved by buying new IT equipment, new ambulances were bought and kitted out with various medical equipment, single response cars were purchased for specialist response paramedics, some ambulances are leased.
SS stated that the £32.3 million spent during 22/23 was ensuring SECAmb was able to provide high quality, safe patient care.

SS went on to speak about the financial plan for 23/24.

Planning has returned to normal, there has been lots of work with NHS England and with the integrated care system to help achieve a break-even plan, submitted to NHS England.

Within this plan there is a £9 million efficiency target. Frontline staff have generated 177 ideas to help achieve this target. All those ideas are now in delivery mode. SS thanked staff for taking the time to submit these ideas.

The capital plan is £25.9 million to support infrastructure and the care delivered to our patients.

SS explained the many challenges faced delivering the 23/24 plan. Such as, workforce constraints, pressures on the service, inflationary pressures, and the efficiencies target of £9 million. However, we are on track to deliver our 23/24 financial performance.

Council of Governors Report: Leigh Westwood, Lead Governor

Our Governors represent you – our members. Hear what they have been up to on your behalf this year, plus – info on standing for election as a SECAmb Governor in 2024.

LW gave a presentation on the Lead Governors Report.
LW explained that there is a council of governors, made up of 18 volunteers, including members of the public, staff members and people from key partner organisations. Governors have two duties;

- To represent the interests of our foundation trust members and the wider public.
- To hold the Non-Executive Directors (NEDs) to account for the performance of the Board.

LW spoke about the many challenges faced throughout 2022/2023. He explained that throughput the year, the council has focused on ensuring the trust was doing its best to support staff and volunteers whilst also recognising that the demand on the service, at times, was very high.

Recruitment and retention remain challenging. But the council thanks all staff for their dedication and volunteers for their continued support within the trust. LW stated that as a community first responder for the trust, he sees first-hand the kindness, compassion and effective care given to our patients. Regardless of the challenges being faced in the background.

- LW advised that throughout the year, governors have continued to observe board meetings and committees, this has provided the council assurance that board scrutiny and oversight have continued.

- Foundation memberships engagement and recruitment as well as external events have now resumed after they had to be stopped for a few years.

- Membership numbers remain strong. However, we are always looking at ways to increase our membership and communication through our membership newsletter, Membership Matters, continues.

- By doing so, we ensure we are listening to what the people are saying and can continue to shape the trust into a service with vision, direction and a known strategy. Not just for staff but the public too.

LW went on to explain that the focus for not only the board and council but for the wider trust, the focus has been on responding to changes from the CQC rating, following the planned and unplanned inspections.
However, the council have continued to seek improvements in other areas of the trust also. This is done by submitting questions between formal meetings. As well as holding NEDs to account at the council meetings.

LW outlined areas of focus for the council. Such as;

- Operational performance in 999 and 111 – how well we serve our patients.

- Assurance around items highlighted in NED committee reports.

- The work of the councils committee.

- Plans for the trusts improvement journey.

- The launch of the volunteer emergency responder initiative.

- IT resilience.

- Reviewing the annual audit report via presentation from KPMG.

LW gave examples of governor questions put to the NEDs, such as;

- Safety of colleagues on the frontline.

- Seeking assurance on the provision of wellbeing and mental health support.

- Progress made regarding public access defibrillator locations and maintenance.

- Appropriate public communication on the pressure the service is facing.

- Supporting the effective use of our community responders, emergency responders and community falls teams to respond to calls.

- Recruitment and retention.

- Pulse and staff survey outcomes will be acted upon.

- Safety provisions for staff in relation to the estates programme and vehicles.

- The trusts work with partner agencies to ensure alignment and understanding of the wider demands across the area the trust serves.

LW advised on the newly appointed NED, Max Puller and the re appointed governors Howard Goodburn and Professor Tom Quinn.

The council elections were held this year with a good turn out in nominations and votes.

LW thanked the member for taking part and thanked the governors who were re-elected or newly appointed.

LW advised more could be found on the public, staff and appointed governors in the Membership Matters newsletter and encouraged people to stand as a governor. LW stated that as members of the trust they are able to stand for election or have a governor represent them.

Lastly, LW, on behalf of the council of governors, gave thanks and admiration to everyone working in the trust as well as the wider healthcare system throughout the year.
Governors must hold the NEDs to account for the performance of the board. LW thanked them for their open working relationship the governors continue to experience.
As a council, they will continue to ensure that they discharge their duties to the best of their abilities; to continue serving those they represent.

Review of the year: CEO Report
What our future looks like, CEO – Simon Weldon

SW firstly thanked the staff for their hard work that was put in to the AMM.

SW requested to spend a moment reflecting on the wider NHS.

He requested everyone's support in the speak up pledge. We all need to create the type of SECAmb that everyone wants to see and be a part of. The biggest thing that has come out of all of the news stories is that we all have a responsibility to speak up.

This is at the heart of what makes an organisation great, safe, what makes people feel like they belong. People have idea of what freedom to speak up is about, the message he wanted to convey was, it is whatever you want it to be. Any concern. Only when we have a culture that you feel safe to speak up about it, will we know that we have that kind of culture where we want to work at.

SW followed with his presentation, a year of continuing challenge.
SW started with speaking about the staff who have been with the service for many years and was impressed by the commitment and dedication shown by these individuals.

SW spoke briefly on 999 and 111 performance. He explained that call volume continues to rise compared to previous years and also the acuity in the patients contacting us.
Coupled with challenges in ensuring that we had sufficient staff available to meet demand, this meant that, at times, some patients waited longer for assistance.
Although we performed well compared to our ambulance colleagues nationally, we consistently were unable to meet national targets within 999 and 111.
We recognised that whilst trying to deliver performance improvements, we also needed to focus on keeping our patients safe.

SW shared some statistics on performance;

- 266 patients survived after suffering a cardiac arrest.
- Over 2.2 million calls were taken between 999 and 111.
- 229,000 patients were treated at home without requiring transport to hospital.
- 700,000 patients referred to other services, keeping ambulances for those who need them the most.

SW stressed that as an ambulance trust, we are not able to meet national standards. This is a continuing challenge for us and is constantly under public and political scrutiny.

SW went on to address the CQC inspection in August 2022. They reviewed the full range of our urgent and emergency care services, including resilience and specialist operations functions.

When the findings were published in October 2022, the trusts overall rating was changed to “Requires Improvement” – the individual rating for “Caring” remained rated as “Good”.

SW stressed that we are committed to continuing to make improvements we know we need to make.

SW spoke about the priorities for the year ahead. We stated that thew priority that he spends a lot of time thinking about is “how do we make SECAmb great? How do we make it a place where people want to come and work?”
SW advised that he was aware of the issues with last year’s staff survey. He spent his first few months in posts meeting and listening to what staff had to say about the challenges that they wanted addressing.
One of the core issues was to allow each OUM to manage themselves with as much autonomy as possible. Each OUM had their own way of doing things. We have started to invite OUMs into board development meetings. So they hopefully feel that they are part of the answer and able to create a solution.

SW felt very strongly that any issues within any part of the NHS could be solved with engagement and support to frontline staff. Union colleagues are also included. They have given SW valuable insight into the things that needed to be attended to. But knows that there is much more that needs to be done, together.

SW shared his seven priorities after now completing 100 days within the trust.
They have been developed from what he has heard from the trusts people and partners. They will take time to deliver, probably over several years.
Whilst it’s important to be ambitious in aspirations, we need to be realistic about delivering progress that is sustainable.

The seven priorities are as follows;

- Creating our future strategy.
- Changing the culture.
- Developing our leaders.
- Improve how we communicate and engage.
- Simplify how we do business.
- Set up to deliver.
- Getting the HR basics right.

SW summarised by saying that's 2023/24 is an important year for SECAmb.
We need to ensure we are fully focused on our priorities, which will mean we are able to properly deliver our evolving strategy.
Its vital that we build confidence in our colleagues that things in SECAmb are different and will continue to improve.

SW urged everyone to speak up in the strategy process and say what they want. We may not be able to do all of it, but he promises to be clear on the choices that he makes and the things that he cannot do.

Shaping our future together

David Ruiz Celada, Director of Strategic Planning and Transformation
Dr Rachel Oaten, Chief Medical Officer

RO spoke about the vision of the strategy and explain in more depth of what it meant.
"To create an ambitious, innovative, long term strategy that champions sustainable, high quality, equitable care for our patients, enhances the experience of our people, supports our partners and protects our environment."

RO echoed some of SW's comments and stated their approach needs to be bold and radical. We want all of our partners to be involved with this. we cannot do this on our own if we want a sustainable strategy. Its being clinically led. Its key for our clinical voice resonates through this and what we are doing is focusing on patient outcome and the people who are able to deliver those patient outcomes.

RO went on to explain the reasons for a new strategy;

- Diverse patient needs – our patients range from social to critical care requirements.
- Inadequacies of current model – the current one size fits all, time driven approach is not effective.
- Tailored response – patients require a differentiated approach – the right source, at the right time.
- Strengthening integration – imperative for closer working with primary and community care.

- Empowered decision making – leveraging data driven intelligence, technological advancements and diverse clinical insight.

MW, standing in for David Ruiz Celada, spoke on the “Wicked questions”.

1. What is our vision, purpose and role in the broader health system?
2. What does our service model need to look like to fulfil our purpose?
3. How do we engage, retain and develop our workforce to deliver the strategy?
4. How do we harness technology, data and innovation to transform our services?
5. What partnership, financial resources and political alignment do we need to successfully execute our strategy?
6. How do we reduce health inequalities and enhance environmental sustainability?

MW spoke on the 3 stages of the strategy;

- Stage 1-
  Frame, Diagnose, Forecast.

- Stage 2 -
  Generate strategy options, Evaluate.

- Stage 3 –
  Implement, Transform.

RO elaborated on the 3 stages and spoke about where we are currently in regard to the stages. RO spoke more in depth about the data analysis that has been used throughout the 3 stages.
MW showed some statistics gathered from the data;

- 54% of our demand is over 65’s (20% of the population).

- 20%of out incidents are cardiac issues (the most common call).

- Social problems, frailty and mental health make up 20% of our demand.

- 1 in 10 hours on scene are falls responses. (5th most frequent call).

- Last year we responded to 719,000 incidents from 433,000 unique patients.

- 3% of patients make up 20% of our demand.

MW went on to explain the strategy programme pillars and associated topics.
MW invited people over after the presentation to have further talks on the strategy and answer any questions they might have.

Question & Answer session with the Board

A Q&A was held with DA and SW with questions submitted by the members of public.

Q) For the new CEO and Medical Director, what is the biggest threat to SECAmb in the next 12 months and what will SECAmb look like in 5 years' time?

A) SW advised that the biggest threat would be to not cast a strategy. In his experience, organisations who don't do that eventually end up getting told what to do. Generally, when you get told what to do, it's usually not your preference.
We have a chance and we've created an opportunity to do that. Lets not mess it up. Lets engage with it. Because if we don't, eventually, others will move into the space of telling us what they want us to do. That happens all of the time in the NHS.
What does SECAmb look like in 5 years' time? SW spoke about his first observer shift with a PP ad stated they spent their first hour of the visit trying to work out who knew about the patient and what treatment they were receiving. The patient was at the point where she was threatening to burn her flat down and subsequently burn herself to death. It was important to find out if this was normal behaviour for her or did she require a more escalated response? Eventually, we found that it was normal and she was well known to mental health services. But we initially didn't know that.
Imagine a world where records are truly integrated. As soon as a call came into our stack, we were able to access that patients records and find out if it was right that we attended. We found out that 2 hours before we attended the patient, her mental health worker had attended her. Was it a good use of resources? But imagine if that data was integrated. Where we could see all of the health care interactions were. Imagine if, instead of just responding to that call, we're proactively navigating them to the right response. Imagine then, that when we do dispatch, almost 100% of the time we are taking someone to hospital. Everything else has been signposted to more appropriate care services.

RO went on to speak about what she sees as a threat over the next year.
One is undifferentiated patients in our community. We know a lot of patients wait for ambulances, and by the nature of waiting they end up deteriorating to the point whereby they get to a critical care point. When it initially was a simple falls call. Over the next year the strategy will help and support that. There is still work to be done to make this better.
We are quite privileged in the south east as a hospital handover delay, we are pretty good. Although sometimes it is difficult as a colleague outside of an emergency department. In the south west, some of our colleagues may wait 24 hours outside of A&E.
The other emerging threat is the "Right care, Right place" which is where our police forces have advised they will no longer attend mental health calls as they are deemed not a police matter. Ot is a healthcare matter. There's going to be a significant tidal wave coming our way and we need to be prepared in terms of what our role is, what we're going to offer. Colleagues from our joint response unit are already reporting quite a bit in Kent. Our geographical area is so big, this will be problematic for us and we need to engage with system partners now and local police forces to come up with solutions. London have plans in place and we need to move into that headspace quite quickly.
In 3 – 5 years I hope SECAmb will look very differently from how we respond to our patients and we will see an improvement in our patient outcome. I like to think we are part of a mature integrated care network. We have access to pathways for our patients and staff to use, that staff are getting the development time they need. We are still in the headspace where our staff need to take time off to pursue development. Id like to think we will have ever increasing opportunities for our staff, such as flexible working, career development in leadership or clinical.

Q) The interface between emergency ambulances arriving with patients at an A&E Department is vital. For some years, hospitals have not had the investment they need to modernise this important interface. What is todays best thinking in designing and managing a hopefully seamless and delay-less emergency arrivals in Kent, Surrey and Sussex?

A) EW advised that we need to recognise our handover position currently. This has come from a lot of work from local teams have done with local hospitals. Even during the times when we saw handover delays go up. It was the work of those local teams building relationships with their local matrons and ED staff that has allowed patients to move through the system. Does the physicality of the hospital always help? No. we have hospitals that are challenged due to their structures. These hospitals were designed for the flow of patients from ambulances that were only a fraction of what we use today. At this point, we need to build on the relationships that we have. It's about continuing to nurture those relationships locally and strategically to understand how we can all work together, especially when we see surges in demand at a hospital, there can be a divert put in place to ease pressures.

Q) A question submitted by a Governor for the trust, Can you please tell us more about the Medway Make Ready Centre, when will it be open and when will we be able to look around it?

A) SW stated that Medway, the fully integrated centre opened today. But please give us time before requesting a visit. They will be in touch in regard to visit dates, we welcome people to have a look around. SW requested that Richard picked this up as an action to give governors a structured visit around Medway. We are attempting to get a VIP to visit for a formal opening. We will share those details in due course. Other ambulance trusts are envious that we have this facility.

DA went on to say that they had the privilege to show the health minister around the facility last week, one of their colleagues said that they tried really hard to find something wrong with the building and we can't! that was the best compliment that they could get.

Q) how truly flexible is SECAmb in allowing flexible working for operational staff? It may cause more working in scheduling to allow for flexible working. The benefits that come with it are staff morale, retention and survey results are infinite.

A) AM advised that in some parts of the organisation SECAmb is pretty flexible. But as an organisation we get a lot of feedback that we aren't. there is work to be done. We know why people want to join SECAmb and we know why they want to leave as well. The most common reasons for leaving are hours of working, working pattern, career development, for example. We started work on the NHS long new term work force plan. Our main focus is going to be on retention. We cant ignore what people are saying to us. Both that are working currently and those that have left the trust in the past few years. There is a common theme.

SS spoke in support of what AM touched on. We have sought assurance that the trust is trying to be as flexible an employer as possible. We ask whether we have the right policy in place, what are our staff telling us? In particular, we look sources of data. Why are people leaving the organisation? If they tell us we're not flexible as an employer, as other employers may be, we look to look into that. The Medway move is one example. We implement new policies there to attract new staff and to increase the diversity of our workforce.

Q) how will you ensure professional representation of paramedics and ambulance workers on your Board?
SS advised that he alluded to this in his presentation earlier. At this end of the month he will have a "Time Out" session with the executive team and they are going to be considering what is the structure we need to put in place to deliver the strategy.
One element of that structure will be the national challenge for us to respond to how paramedicine and HPs are represented on our board. We will look at what's going on up and down the country. We are one of two ambulances services that hasn't responded due to SW being new in role. There are a variety of models out there and a considered debate is needed about which one is best suited to us or do we need

to make our own. Hopefully, this will be done for the Board meeting in November. But I put this question to everyone, what do you all think? We need to put a structure in place that works for *us.* It has to work for the whole organisation.
SW stated he will get back to everyone with an answer in the near future.

Q) Can a registered nurse join SECAmb?

A) SW stated yes, they can.

DA stated that nurses are welcome to join SECAmb. We have a large nursing workforce within the organisation.

JT went on to speak briefly on this question. There are approximate 137 nurses employed throughout the trust. There are approximately 90 staff with “Nurse” within their title. Its important to think about the professional support we give to our nurses. We are working with 111 and 999 in the EOC, which is where most of our nurses work. We’re looking into bespoke key skills for nurses, we’re also planning a nurses conference this year. Two will be held, on in east and one in west. It’s a really exciting time to be a nurse in SECAmb and we welcome any applications.

SW spoke about there not being enough professions created for us to fill our vacancies. We need to adopt a more pluralistic approach to our workforce. We are privileged to have a fantastic community first responder group working in the organisation. The need for their services is going to grow too. Hopefully, we can expand their scope of practice throughout time. This is an example of a traditional workforce model that isn’t going to be the answer to where we need to be over the next few years. We need to embrace all of the clinical professions and look at what they can bring to the service offer that we have.

Q) Could you elaborate on what activities Governors undertake to meeting and liaise with local constituents. Particularly, Medway and Swale. How do Governors evidence that they have held the NEDs to account during the past year?

A) LW advised that there are a handful of Governors within that area. They recently attended meetings in the Medway Maritime hospital, they have contact with the public through the Medway Voluntary Association, and they are hoping to hold an open meeting at the new Medway Make Ready Centre.

MW stated that DA, as Chair, has agrees the objectives of all of the Non Executives. The governors play in important part, most of the NEDs chair an assurance committee and governors frequently attend these. Observing how we operate and giving us genuine feedback on whether we are asking the right questions and sufficiently challenging. MW stated SW had previously said we have to be a curious organisation because that drives innovation. As an organisation, we could be doing more. We will continue to improve. The governance in this trust works very well.

DA went on to stress that all Executive Management are held to account by someone.

Q) Update on IHAG, Please?
DA explained that IHAG is the inclusion advisory group which advises the organisation on whether we are truly presenting opportunities to our staff.

A) AM firstly commended the work undertaken setting up the IHAG by Angela Raynor who worked for the trust and Asmina, our inclusion Lead.
We have been working closely with the Quality and Nursing directorate to make sure we have something fit for purpose, going forward. We think it will be an integrated approach between two areas, the inclusion

area and quality and safety area. There is a new community forum, meeting for the first time on the 27th September. Its currently being promoted on the zone as well as other areas. Local health watch teams are also advertising the new forum. We feel this will be a better approach going forward because we give the two different areas focus within the organisation. JTs team is also involved with this.

LS advised that she supports the Enable Network. Each NED has been challenged to produce objectives for the networks that they support. Over the next 12 months they are refreshing the networks and working with the networks. Giving an appropriate level of support, along with working with AM and JT and Carolanne, who leads this on behalf of the HR team.

Q) Looking ahead to 2030, what are the key challenges and what are the changes anticipated? At what stage do you seek the involvement of your employees to support new initiatives?

A) SW stated that the reason for today is that we are seeking your input. The best strategy is the one we create in this room together. But also, with partners and commissioners.
We will be clear about what we are doing and why and what we are going to have to stop doing too.
In regard to the 2030 date, I would focus on how we leverage the power of data and technology to really change the way healthcare is delivered. The NHS teds to lag around 20 years behind. Where as the commercial world is far more advanced. Are we prepared to trade better services for increased access to our personal data?

DA stressed that we must work towards our trust values as we move towards 2030. If we are working in partnership with our staff and partners, We all have a chance to shape the future and seek every opportunity we can to lobby and influence the policy makers.

Q) It has over the years been widely reported the cost of agency workers. Which is sometimes the more flexible and easier option. However, being used daily costs a lot. In SECAmb, there are private providers being used daily. Somewhere around 20 crews of ambulances over the course of 24 hours. With a high volume of shifts to be instructed to be turned off by operational management, why are we then using the resource that costs more than those you're also paying to stay at home?

EM explained that there has been a piece of work done on realigning resources to our demand. There's been a comprehensive review of rotas that has meant resource patterns have changed which means we've needed more people in certain places and in certain areas, less.
We have always had a level of private ambulance provision to support us. During Covid, it was essential. We need to recognise the funding costs are different, they don't have the benefits of working for the NHS. Such as pensions and sick pay. We use these to maintain resilience and dynamic deployment. We use agency staff in the control rooms. Particularly, clinicians in 111 and 999. Nurses, paramedics, mental health practitioners, dental nurses… we need them in order to adapt to changing demands, such as during bank holidays, when it is known they are very busy periods for the organisation. In terms of cost, we are very tightly controlling where the spend is. We are monitoring compliance because these are contracts. We have scaled back our use of agency within 111 dramatically within the pat 3 – 6 months.

SabaS spoke about NHS England as a regulator across all of the NHS. They set targets for the wider NHS as well as SECAmb to reduce agency spend. Its part of the strategy and innovation. How do we use all of the things spoken about today to reduce our agency reliance? How flexible are we in terms of flexible working? How can we engage with them to help them find rotas, help them find work to fill the gaps which we currently have?

LS spoke on the care quality perspective, we have regular reports on our ambulance providers, we monitor our complaints and clinical incidents to see if we're getting more through that contracted arrangement, we keep a very close eye on it through RO and the medical directorate. DA advised that any questions not answered today, they will have an answer sent to them in writing in due course.
Evaluation, closing summary and thanks DA thanked everyone who helped organise the day. DA spoke about an emergency call received by a woman who had a serious bleed after giving birth. With the collaboration of all partners, the patient's life was saved with minutes to spare. This couldn't have been done without our staff and partners working as a team. The patient gave special thanks to the paramedics that attended her. DA spoke about the many challenges that the NHS has faced over the past few years and remarked that the response was always phenomenal. DA thanked the board for all their hard work and all staff within the trust.
Formal meeting closes

Appendix One

IQR October 2023

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	Responsive Care	People & Culture	Sustainability & Partnerships
We listen, we learn and improve	*Delivering moderns healthcare*	*Everyone is listened to, respected and well supported*	*Developing partnerships to collectively design and develop innovative and sustainable models of care*

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

Icon Descriptions

	P	?	F	
H	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.
L	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.
H	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.
L	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.

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

Annual Plan

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

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

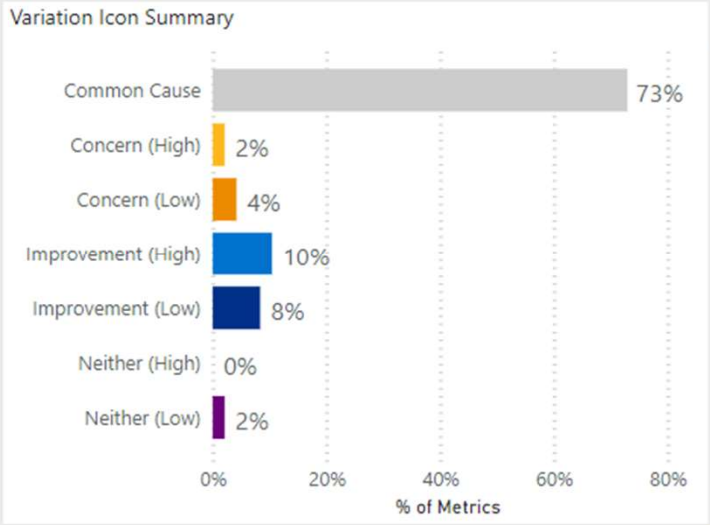
August 2023

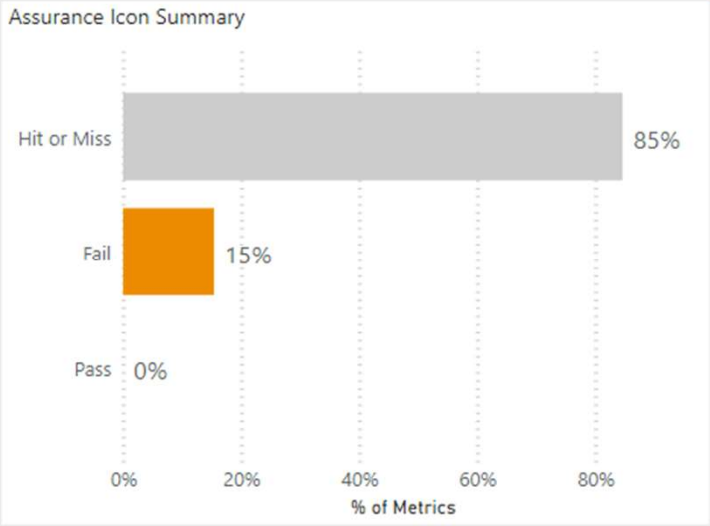
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Cardiac ROSC ALL % **Cardiac Survival ALL % Medicines Management % of Audits Completed Duty of Candour Compliance % Complaints Reporting Timeliness %	Single Witness Signature Use CDs Non-Omnicell	Complaints per 1000 999 Calls Answered Complaints 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)





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		

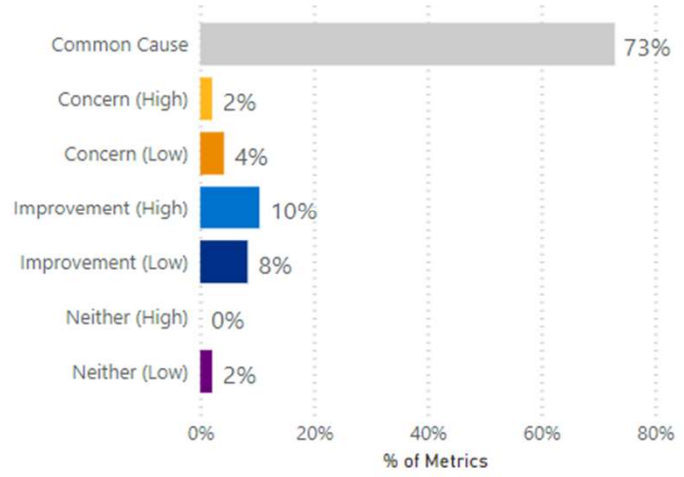
Patient Experience

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		

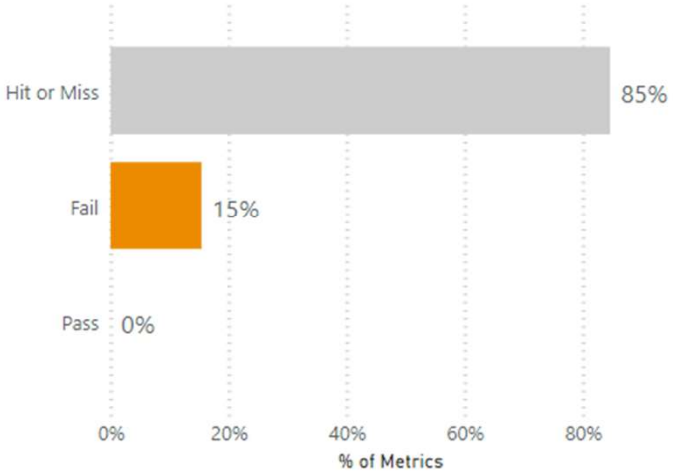
QUALITY IMPROVEMENT

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%		

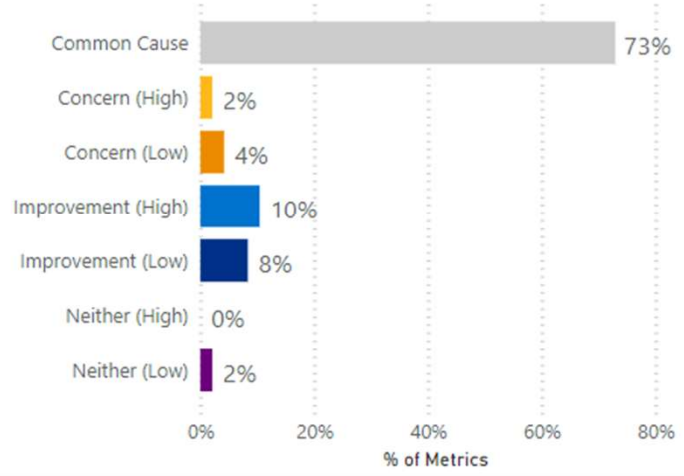
Infection Prevention Control

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%			

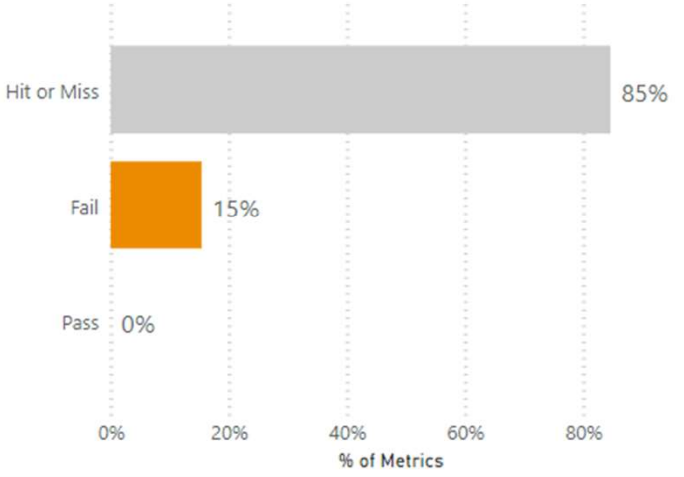
QUALITY IMPROVEMENT

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?

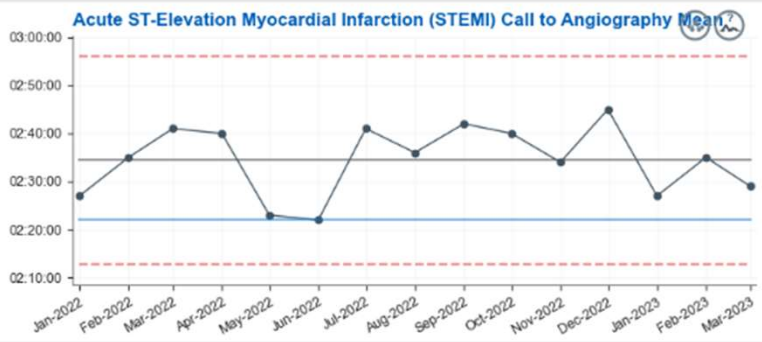
- Developing a robust mechanism of meaningful feedback to individuals / team and organisational wide learning.
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support continuous improvement.
- Continue to monitor 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

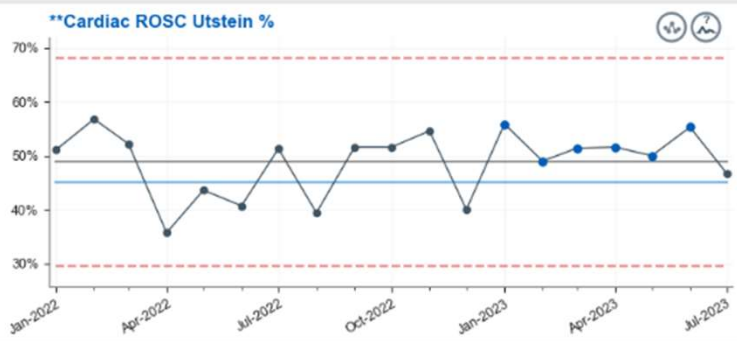
M-2

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

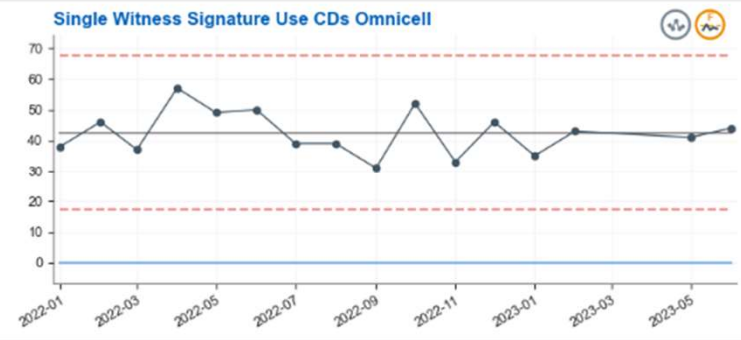
Special cause of a concerning nature where the measure is significantly HIGHER.

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

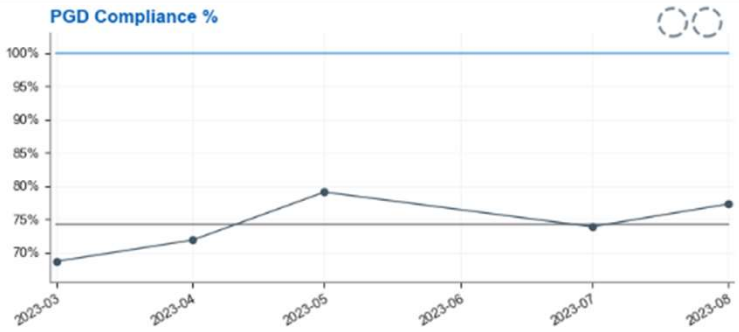
Note: Work is ongoing around reporting medicines incidents. Key skills 2023/24 has medicines in its lesson plan so this will be reported on going forward for assurance and oversight in the Trust.
Non compliance to medicines audits has improved over time. These audits are also discussed in medicines lead 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.

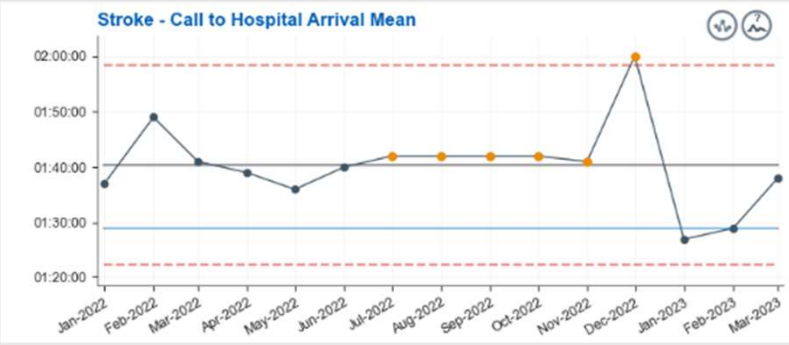
What actions are we taking?

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

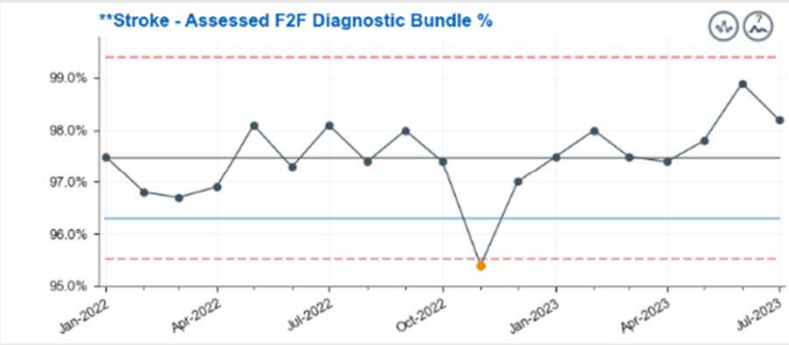


M-8

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.

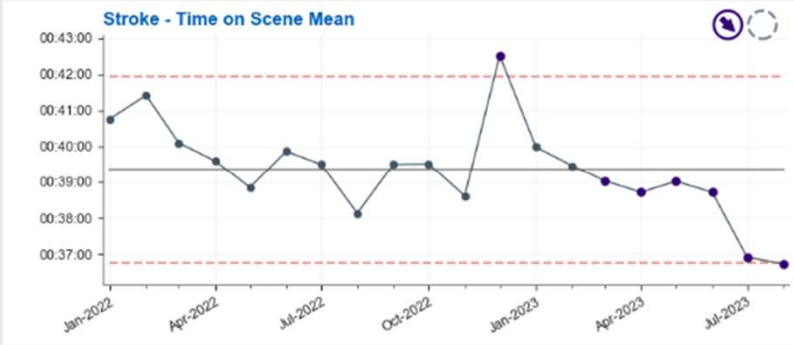
M-9

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

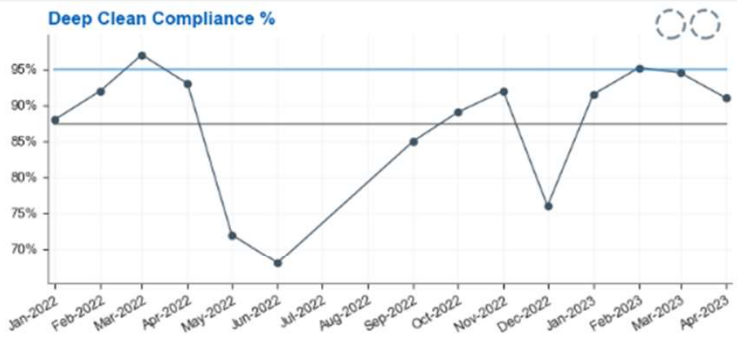
- Manual handling incidents reported in July 2023 were 16.
- Manual handling incidents reported in August 2023 were 26.

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

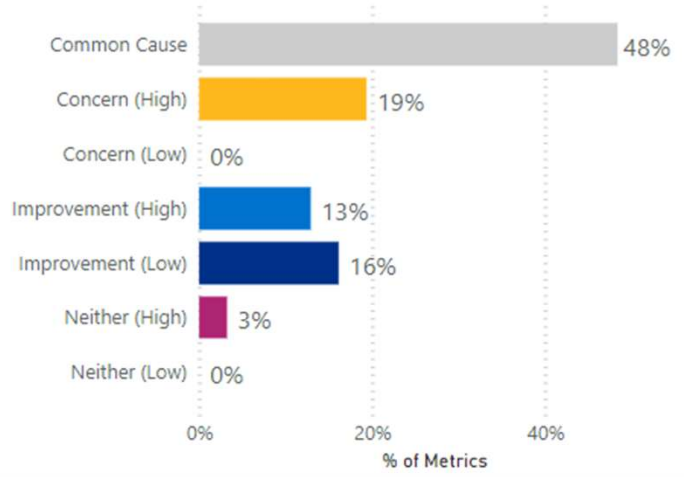
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		999 Frontline Late Finishes/Over-Runs % Current licence details held for Operational Staff % Freedom to Speak up: Cases Opened in Month Count of Until it Stops Cases	Number of Staff WTE (Excl bank and agency) Sickness Absence % Statutory & Mandatory 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.

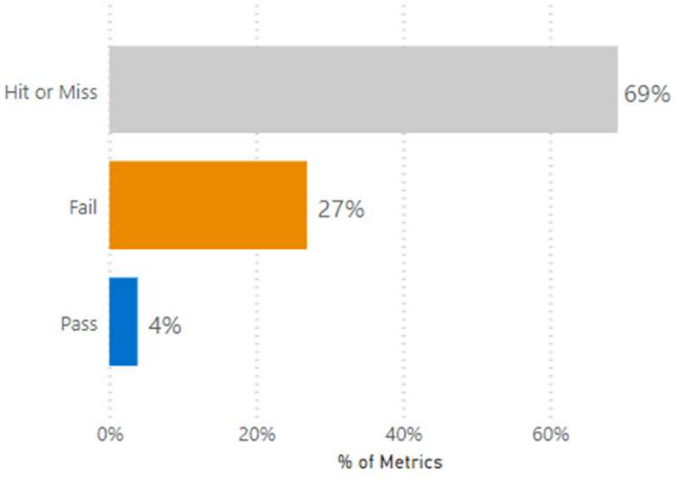
PEOPLE & CULTURE

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%		

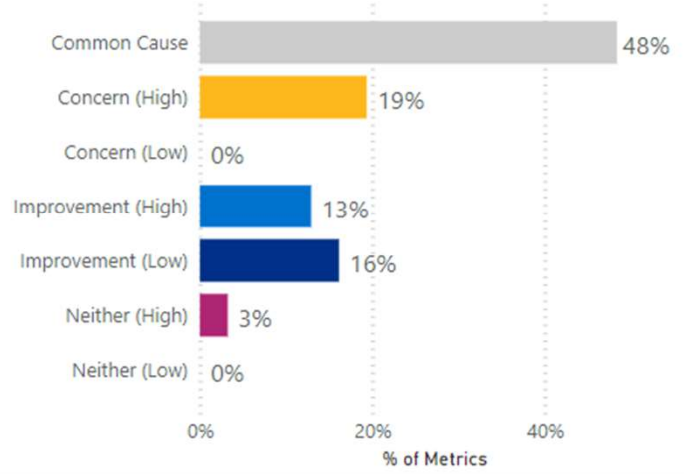
Employee Experience

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%		

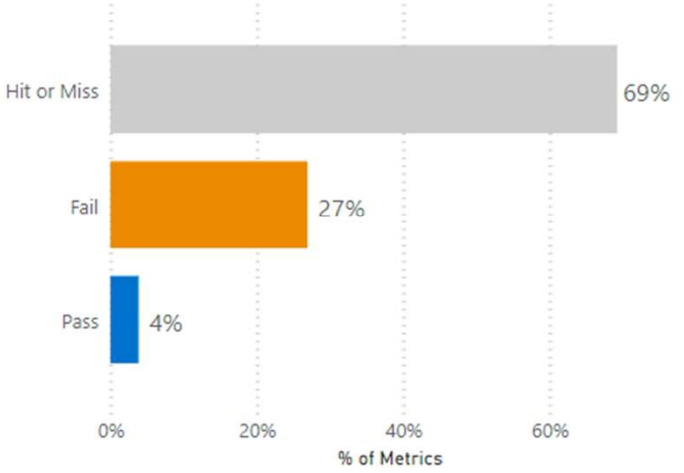
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

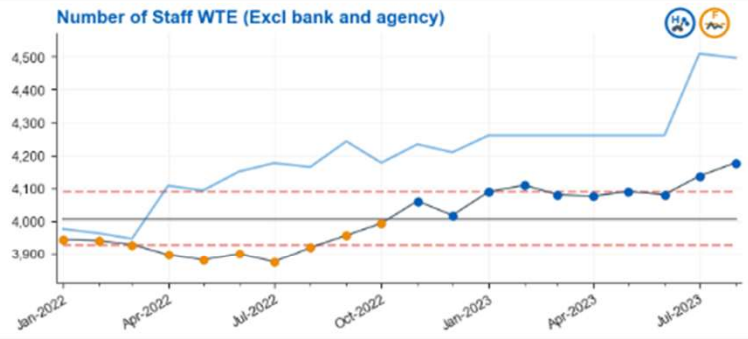
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Aug-2023	16	5	0.71	12.75	24.79		
Collective Grievances Open	People & Culture	Aug-2023	1	1	-1.62	1.6	4.82		
Count of Grievances Closed	People & Culture	Aug-2023	11	3	-1.38	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)

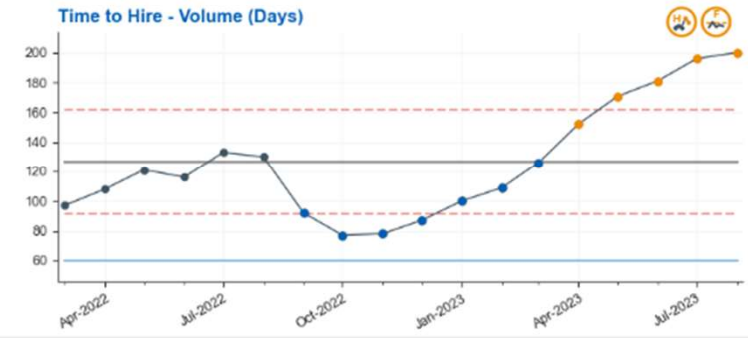


WF-1

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.

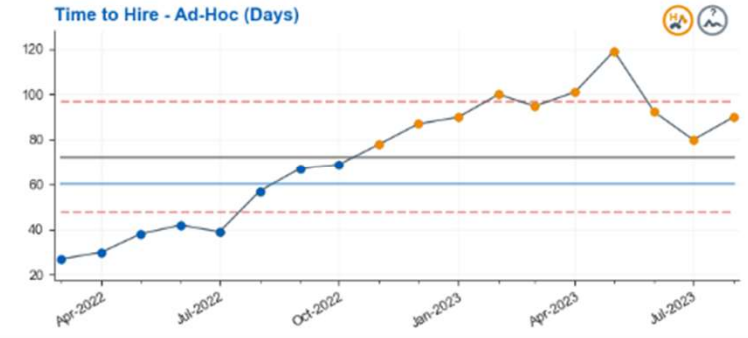
WF-4

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.

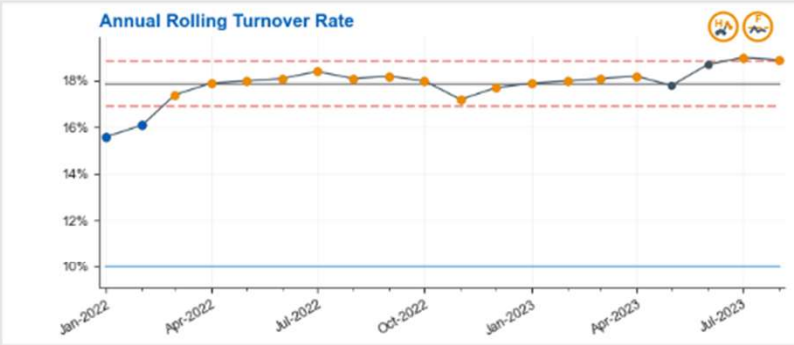
With an initial project focus on contact centre recruitment changes have started to help improve not only the candidate experience (streamlined application) but to also inform realistically of the roles that are being advertised (amendment to advert wording) This will continue through the process with 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

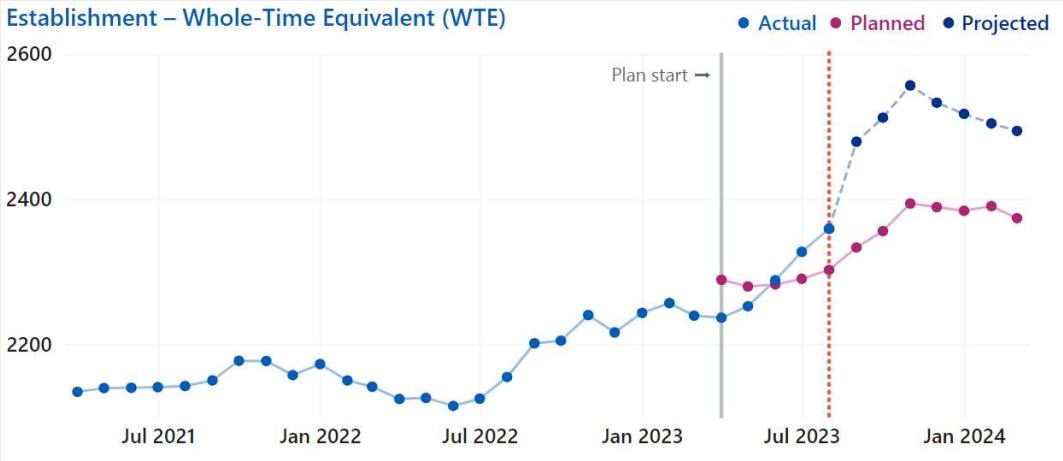
Tasked with being bold, creative, and ambitious, we have some good first ideas to evolve.
Engagement is key, and we have started with engaging the wider HR and OD teams, Unions, Networks, EOC/111, and New Starters.

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.

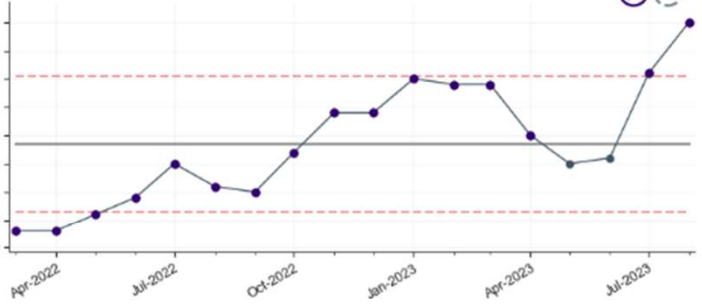
Mitigating actions – EOC EMA
EMA recruitment has been increased with focus on courses being filled to capacity. The compliance team resource has been increased to ensure that candidates are cleared in a timely manner and contact with them is consistent, to minimise dropouts. This is in place for both 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



QS-27
Dept: Quality & Safety
IP: People & Culture
Latest: 40

Special cause variation where UP is neither improvement or concern

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.

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.

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.

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.

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.

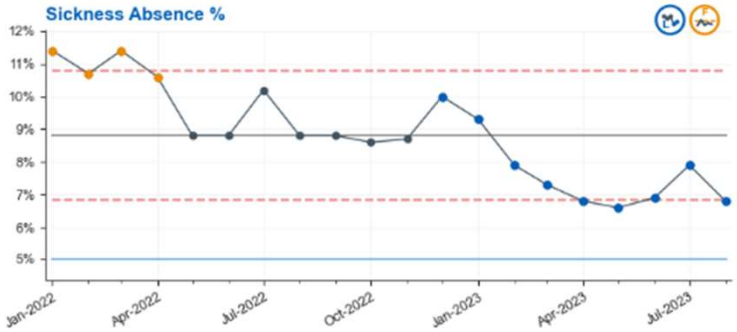
The People & Culture Strategy webinar on 9 October will focus on reflecting on the Until it Stops campaign so far and the next phase of the Campaign.

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.

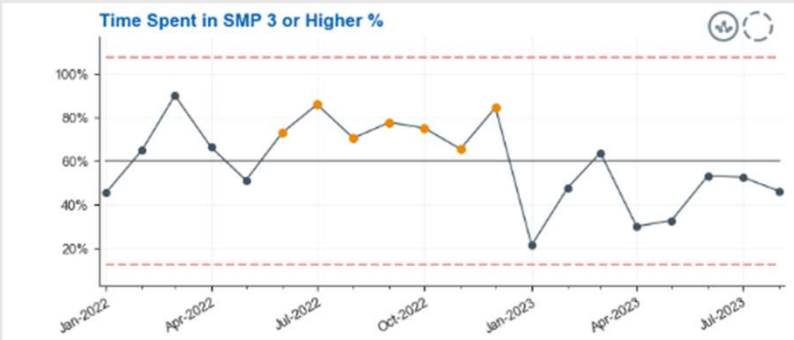
As well as the management focus on sickness absence, monthly scrutiny of action plans at Operations Senior Leadership meetings continue, with support from HR Advisors.

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:

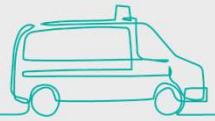
- A MS Word version of the appraisal form
- Improved Trust communications to promote the Appraisal Hub and eLearning
- Introduction of proxy access to allow delegation of administrative tasks

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

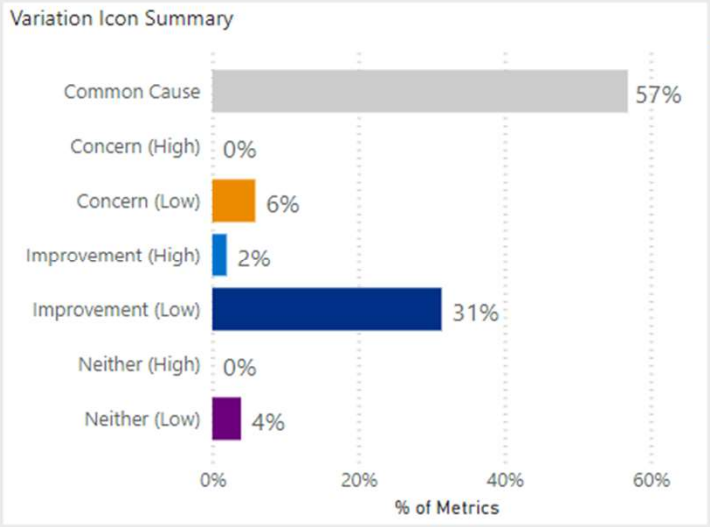
August 2023

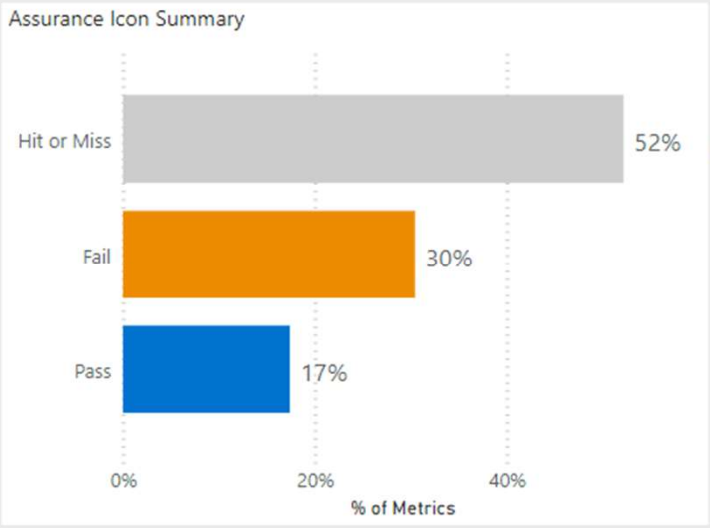
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %	111 Calls Abandoned - (Offered) % Cat 2 Mean Cat 2 90th Centile Cat 3 90th Centile	Hear & Treat %	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as 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)





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		

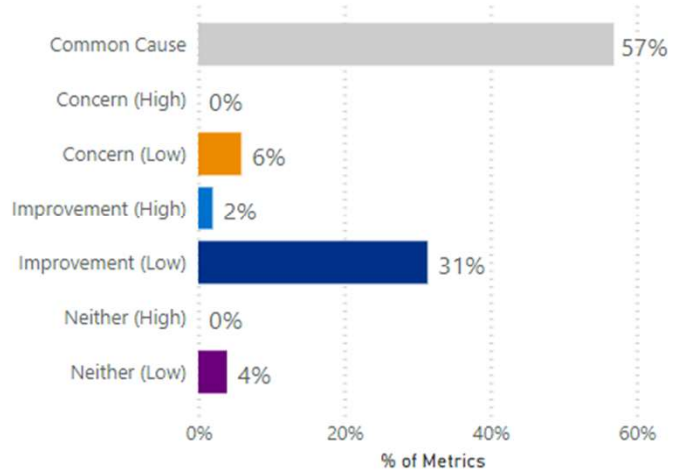
Emergency Operations Centres (EOC)

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		

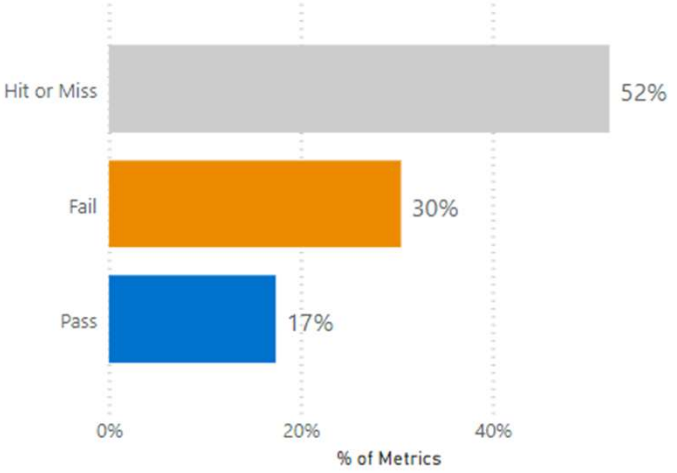
RESPONSIVE CARE

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		

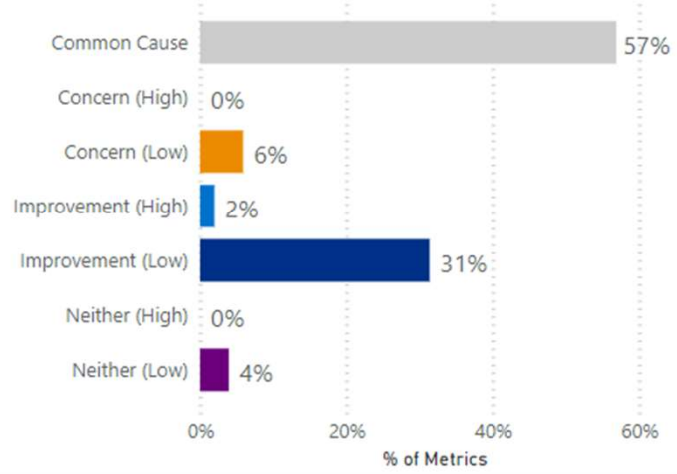
111

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		

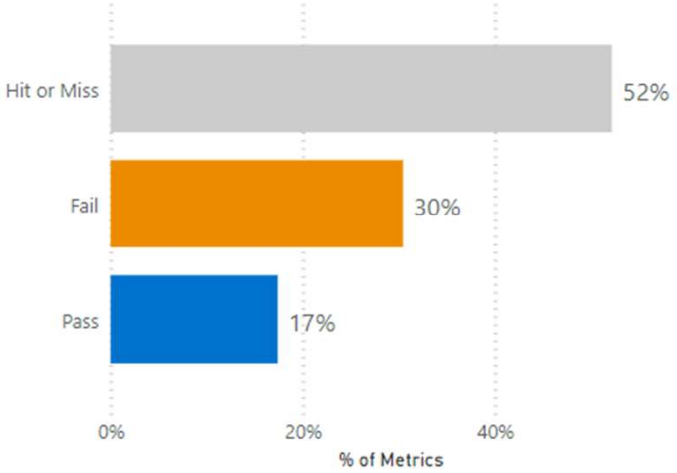
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

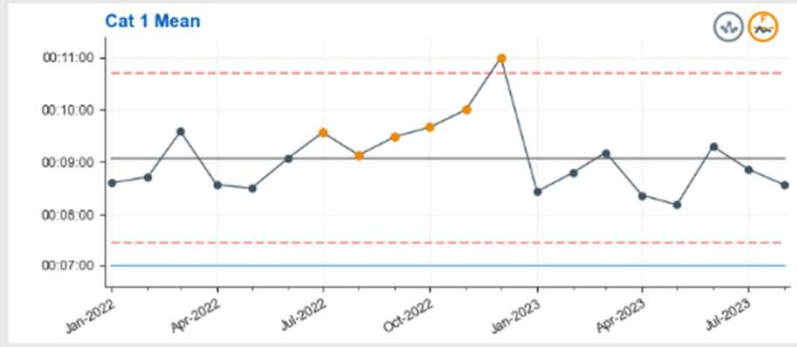
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Aug-2023	01:15:17		01:16:01	01:17:45	01:19:29		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Aug-2023	01:50:14		01:50:30	01:54:56	01:59:21		
Responses 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%		

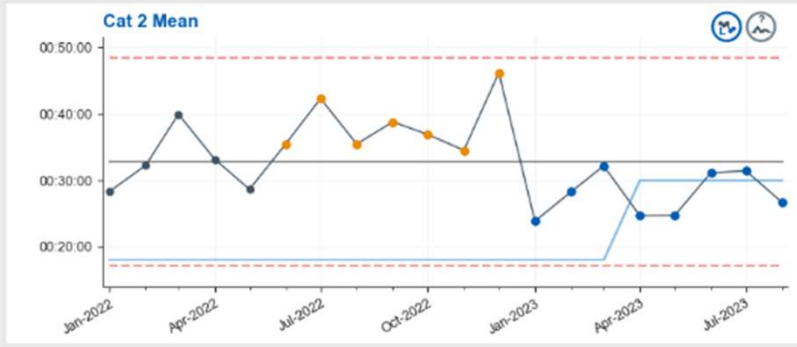
RESPONSIVE CARE

Response Times



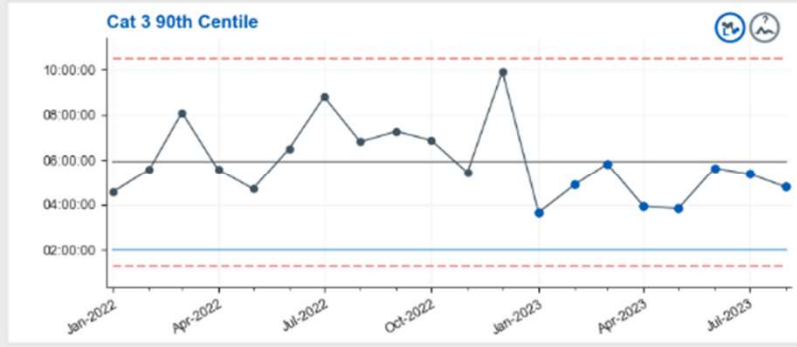
999-2

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.



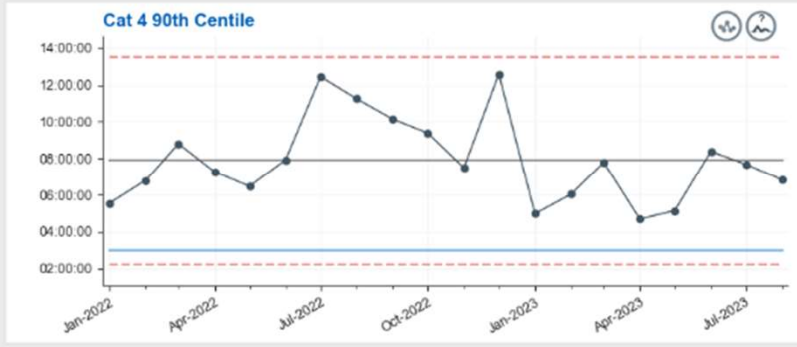
999-4

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.

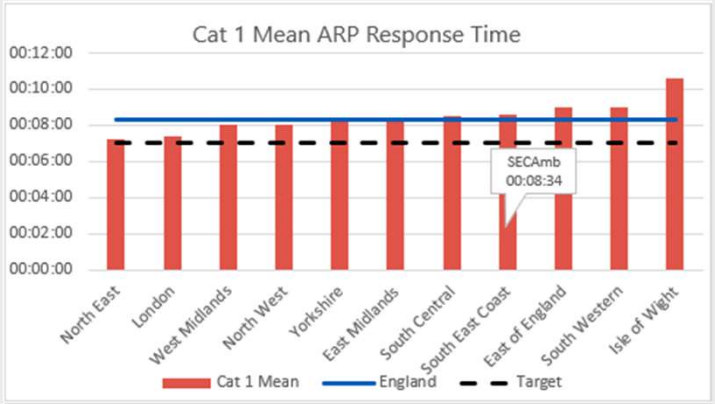
Summary

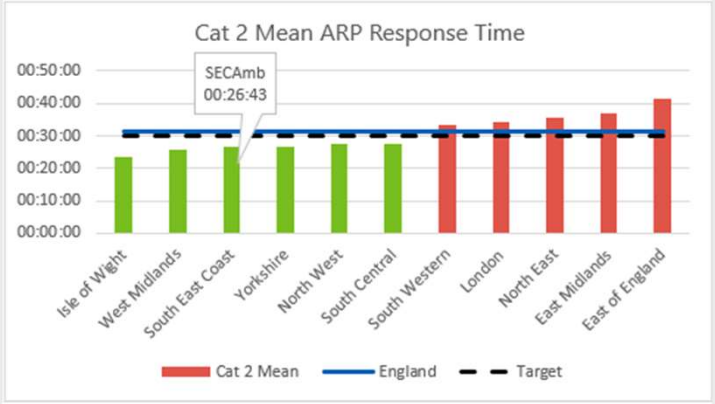
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against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

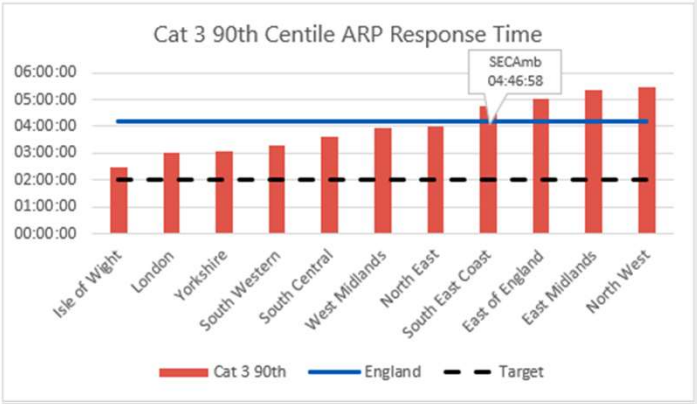
What actions are we taking?

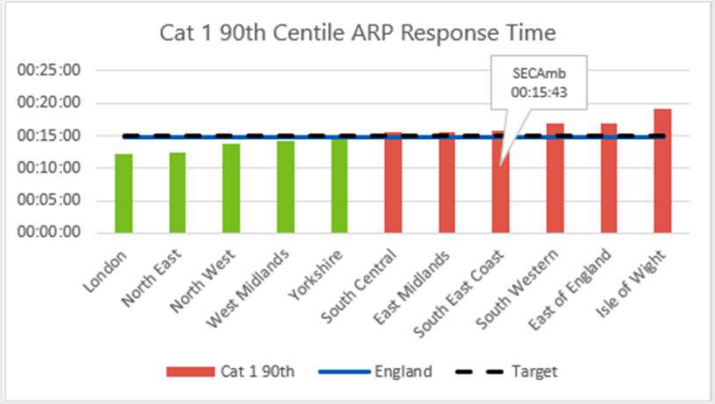
- Continuation of C3 & C4 validation, with a high proportion being validated in either the Trust's 111 (KMS 111) or 999 services. The aim remains to clinically assess every C3 or C4 call prior to ambulance dispatch.
- Continued focus on clinical staffing in EOC to maintain patient safety and support 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.

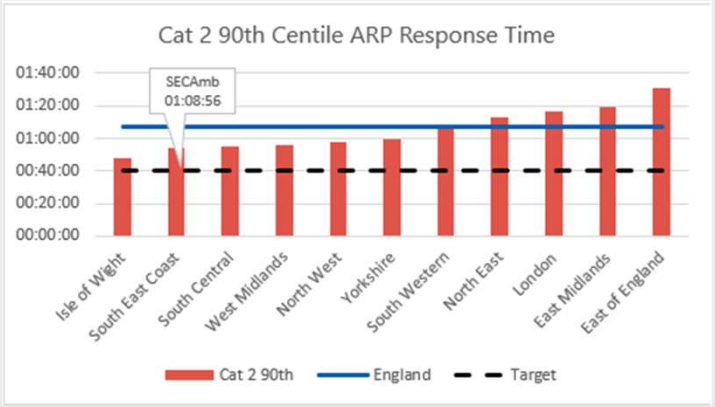
ARP Response Time Benchmarking (August 2023)

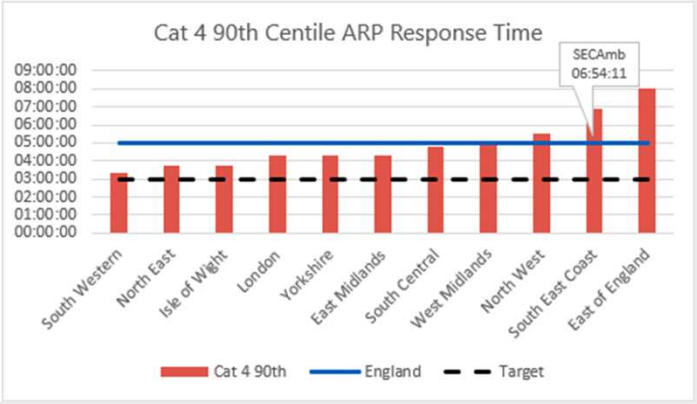












Summary

- 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.

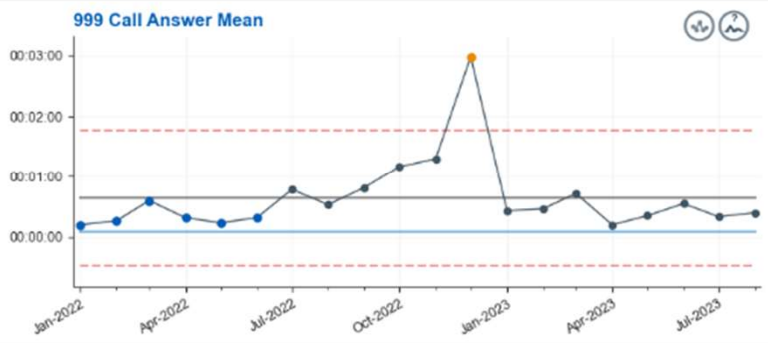
999-33

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

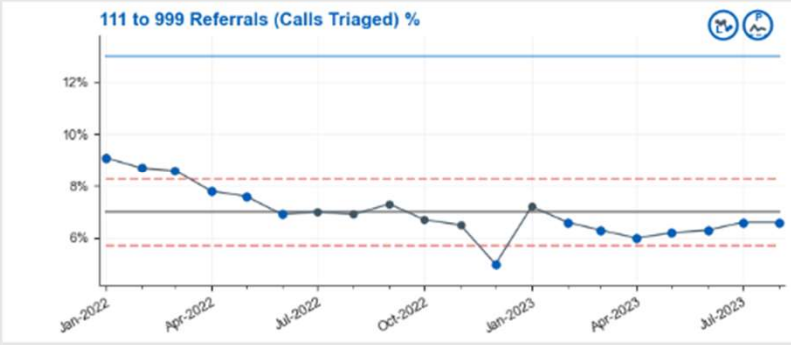
999-10
Dept: Operations 999
IP: Responsive Care
Latest: 61863

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

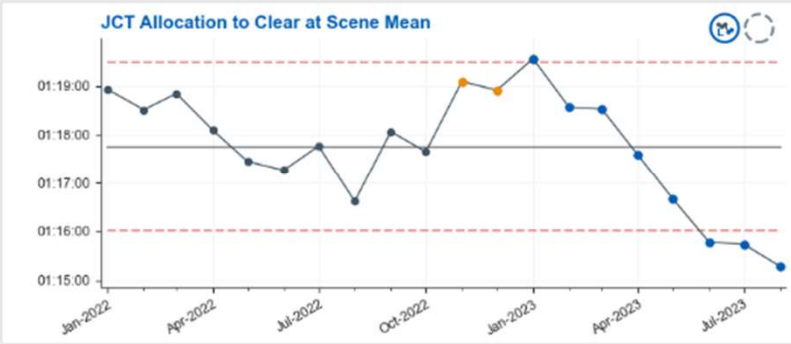
999-17

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

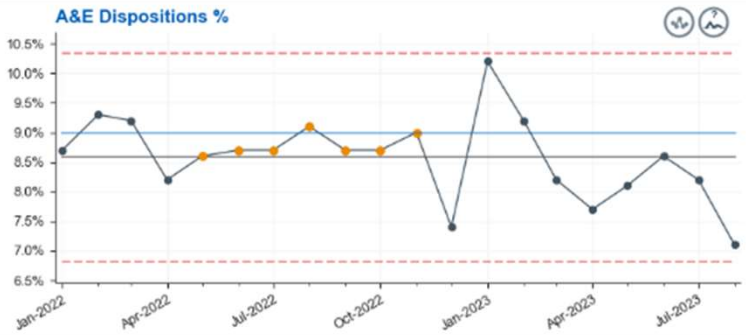
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with a deterioration in April however, August experienced a significant 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.

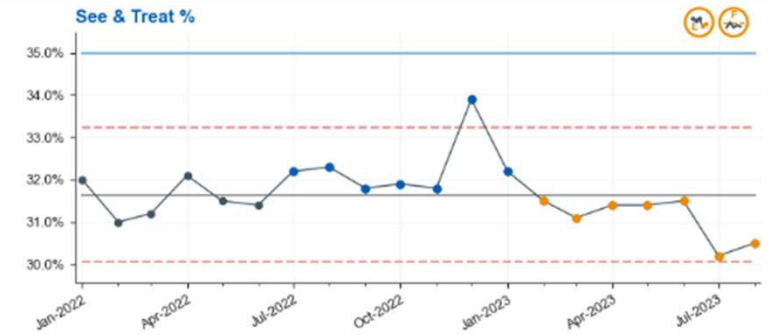
RESPONSIVE CARE

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.



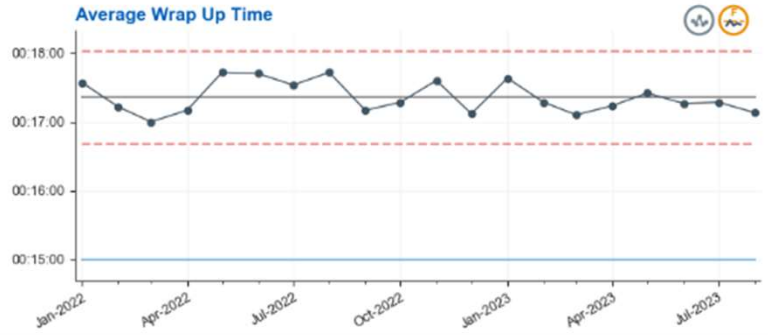
999-9

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

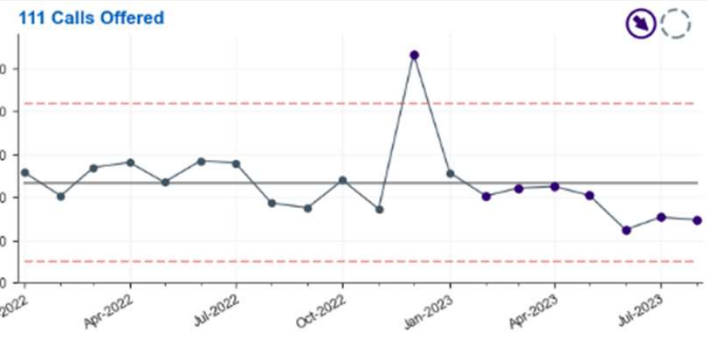
- The ***111 to ED disposition rate*** has been maintained at a very low level since the introduction of "111 First", Direct Access Booking (DAB) and ED validation. The Trust's 111 service has excelled at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111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

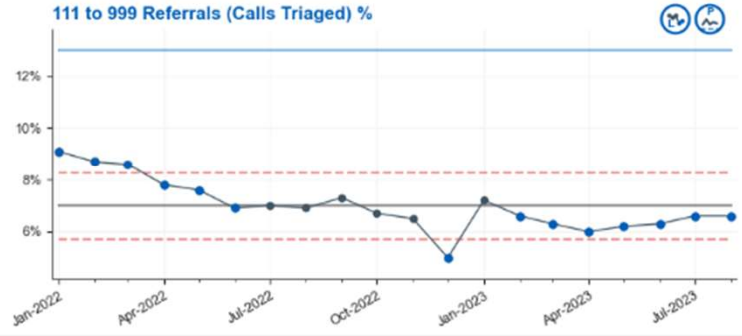
Special cause variation where DOWN is neither improvement or concern

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.

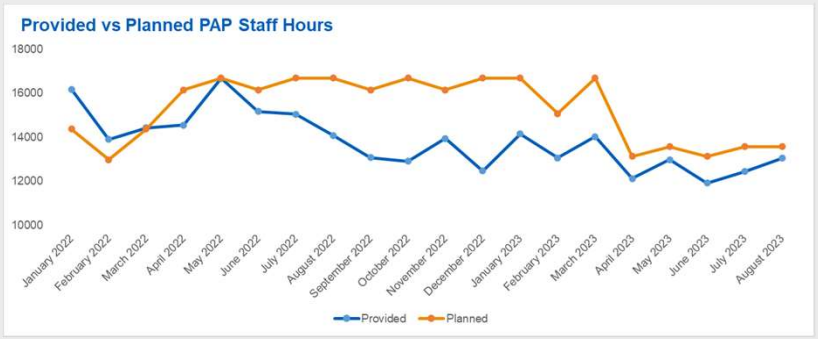
RESPONSIVE CARE

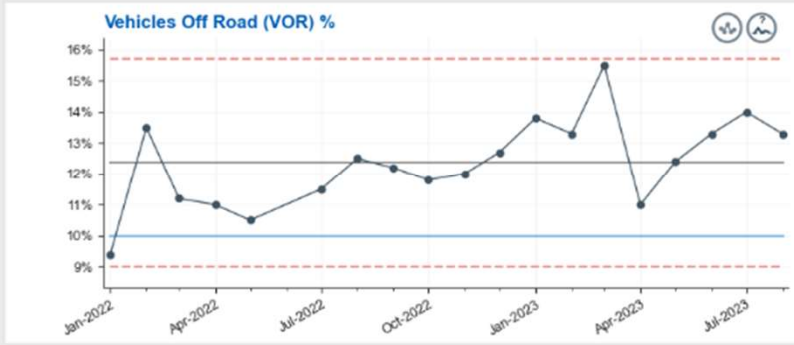
Support Services
Fleet and Private Ambulance Providers

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
South East Coast Ambulance Service
NHS Foundation Trust

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	✓

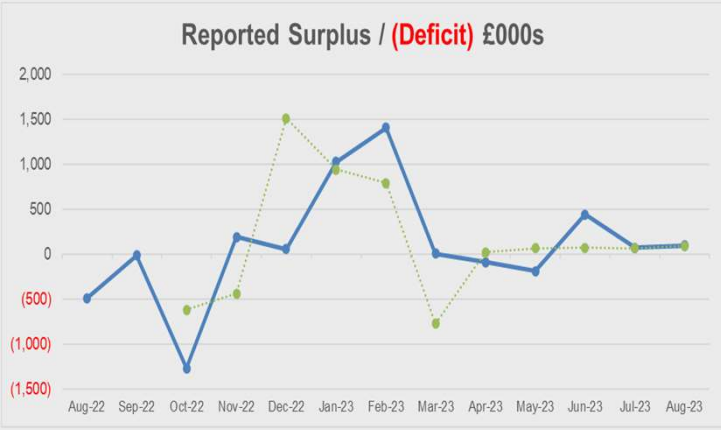
Summary

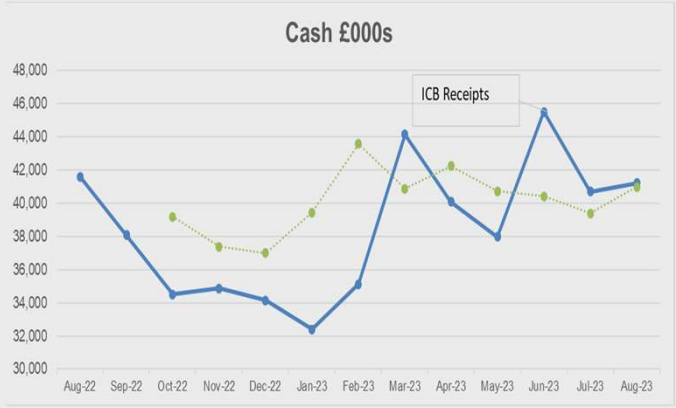
1. The Trust's financial performance is in line with plan with a surplus of £0.3m being reported YTD M5 (August). Financial pressures of £1.0m in operations were partly mitigated by vacancies across the Trust, profit on vehicle disposal and higher than planned interests received on cash in bank.
2. The 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.

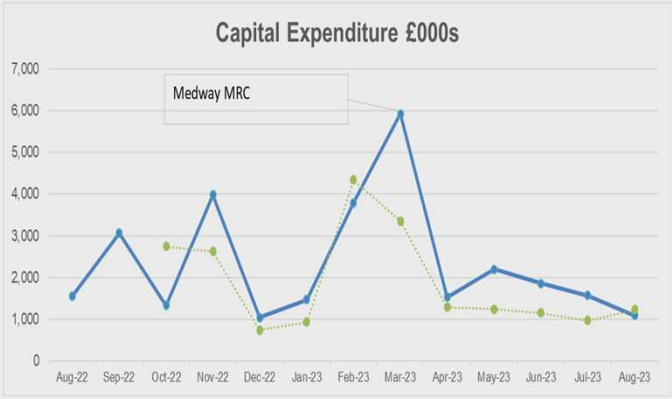
What actions are we taking?

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.

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.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

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

Appendix Two

Board Assurance Framework

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
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.

In Year Risks to achieving the objectives

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.

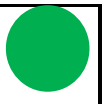
The programme has initially been revised at the advice of the core team and stakeholders involved, whilst we will still aim for draft options in December, the Board is likely to receive a developed option with high level delivery roadmap in February, with a full strategy ready for publication by the 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)	Integrated Quality Reports Metrics for Assurance	Variation	Assurance
▪ For 22/23, the Trust delivered a break-even result following remedial action plans with each directorate to deliver recurrent savings. ▪ A break-even plan has been signed off by the Board for 23/24. ▪ In order to continue the focus on financial delivery the Monthly review meetings for each directorate are continuing ensuring each area delivers on plan and its efficiencies.	**WF-1** "Number of Staff WTE"		
	F-9 "Income (£000s) YTD"	NA	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